Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1		15211111107111011152111	A. BUILDING: _	A. BUILDING:		
		HAL023045	B. WING		C 11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI SHELBY, N				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ΓE
D 000	000 Initial Comments		D 000			
		sure Section conducted an on on November 21, 2019 to				
D 270	10A NCAC 13F .0901 Supervision	(b) Personal Care and	D 270			
		e supervision of residents in resident's assessed needs,				
	This Rule is not met TYPE A1 VIOLATION					
	interviews, the facility	ns, record reviews, and failed to provide supervision sidents (Resident #1, #2, #3, falls.				
	The findings are:					
	to the facility to determine to the facility to determine the contribute to possible a staff was to complete the contribute of the facility of	e screened upon admission mine factors that may				

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

(X6) DATE TITLE

Division of Health Service Regulation

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					С	
		HAL023045	B. WING		11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	•	
NAME OF T	NOVIDEN ON OUT LIEN		DIN DRIVE	11 E, 211 GODE		
CLEVELA	ND HOUSE		, NC 28150			
			, NC 20150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 270	D 270 Continued From page 1		D 270			
	the fall.	to v/A dusinistrato v v v				
	-The Executive Direct					
	required to review all	•				
	contents, accuracy, a	tor/Administrator and Care				
	Manager was to dete					
	interventions required					
	circumstances of the					
		ave an assessment of				
	possible risks and co	ntributing factors to a fall				
	within 72 hours of a fa					
	-Contributing factors	and risks of a fall consisted				
	of lighting of location	of the fall, clutter or trip				
		nways, height of toilet seat,				
	resident wearing show					
		ges prior to fall, and proper				
	use of assistive device					
	-Residents with two o					
		e to have a physician's order				
	for a physical therapy	ve formal training on fall				
		s at a minimum of one				
	annually by a qualifie					
		minded of fall prevention				
	techniques during sta	•				
		e a 72 hour follow up on				
	residents falls to inve					
	circumstances contrib	outing to the fall and				
	document observation	ns for the period of 72 hours				
	after the fall.					
	_	ent team was to review				
	incident reports on a					
		ent team consisted of the				
		dministrator, Care Manager,				
		medication aide/Floor staff				
		ne as determined by the				
	teamThe Falls Managemeresident falls from the	ne as determined by the ent team will review all e past month for trends. le: falls occurring on the				

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STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL023045	B. WING		C 11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE		DIN DRIVE			
	OLINANA DV. OT		NC 28150	DDOWNEDIO DI ANI OF GODDECTIO	.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPL	ETE.
D 270	270 Continued From page 2		D 270			
	preventable falls due	s by the same resident, to the environment or completeness of 72-hour as needed and				
	07/08/19 revealed dia middle cerebral artery artery), coronary arter	t #1's current FL2 dated agnoses included acute v stroke (the largest cerebral ry disease, gastrointestinal aditioning and anxiety.				
		1's Resident Register was admitted to the facility				
	Review of Resident #1 incompetent.	1's Guardianship document was adjudicated				
	screening upon admis	1's record revealed no initial ssion to the facility to t may contribute to possible				
	revealed: -Resident #1 used a v -Resident #1 required	1's care plan dated 10/02/19 walker for ambulation. I supervision with toileting, notion, dressing, grooming				
	10/31/19 at 8:31am re-Resident #1 was fou her back, after an unv-Resident #1 had no i-Resident #1 was ale complaint of pain.	nd in her room, laying on				

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Division of Health Service Regulation

	or periornore		(VO) MUUTIDUE	CONCEDUCTION	(VO) DATE OUR VEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		OOMII EETED
					С
		HAL023045	B. WING		11/25/2019
			1		1112012010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARI	DIN DRIVE		
CLEVELA	IND HOUSE	SHELBY,	NC 28150		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 270	Continued From page	3	D 270		
52.0	Continued From page		52.0		
		nined and blood pressure			
	was 112/89, and puls	e 72.			
	-It was documented to	he Guardian and the			
	physician were notifie	ed.			
	-The Fall Prevention I	Program directive			
	instructions were initia	ated with the following			
		tal signs for three days every			
		ours for bruising, change in			
		lition, pain, and other injuries			
	related to the fall.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	-The Fall Prevention I	Program directive			
	instructions included				
	document any "chang	•			
	,	d not contain a post fall			
	assessment.	a not contain a poot fair			
		on indicated Resident #1's			
	care plan did not requ				
	care plan did not requ	ane updating.			
	Paview of Pasident #	1's progress notes revealed:			
		am, a resident notified staff			
		on the floor, Resident #1			
	reported no injuries, E				
	-There were no additi				
		onitoring that was required			
	according to the facili	ty's Faii Prevention			
	Program.	tation of increased			
	-There was no docum				
	supervision or monito	oring.			
	Dovious of Decident #	dia November 2010			
	Review of Resident #				
		Administration Record			
	(eMAR) revealed:	all with the fam of and a figure 100.			
		ck vitals for 3 out of 9 shifts			
	per their policy.				
	-The staff did not doc	•			
	changes for 3 out of 9	9 shifts per their policy.			
		ounding book at the nurses			
	station on 11/22/19 at				
	-The book was used t	to document hourly/30			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
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		HAL023045	B. WING		11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD	IN DRIVE		
CLEVELA	ND HOUSE	SHELBY,	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 4	D 270		
	minute checks on res	idents. nentation for hourly or 30 nented as performed on			
	10/31/19 at 9:15am (s -Resident #1 was fou her back, after an unv -Resident #1 had no i -Resident #1 was ale complaint of pain. -Resident #1 stated s -Vital signs were obta was 112/89, and puls -Resident #1 was tran room. -It was documented the physician were notified -The Fall Prevention I instructions were initial instructions: check vital	nd in her room, laying on witnessed fall. njuries requiring first aid. rt and verbal and had no he stood up and fell. ined and blood pressure e 72. hsported to the emergency he Guardian and the ed. Program directive ated with the following ral signs for three days every ours for bruising, change in			
	related to the fallThe Fall Prevention I instructions included a document any "change-The notes section did assessmentThe evaluation section care plan did not requestion to the floor by another section to the floor by another section to the floor by another section in the floor b	special instructions to ges or no changes". d not contain a post fall on indicated Resident #1's uire updating. 1's progress notes revealed: 7am Resident #1 was found or resident, stated she had felt dizzy and slid off the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	SURVEY	
						С
		HAL023045	B. WING		11/	25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
A. =. /=	ND 1101105	950 HAR	DIN DRIVE			
CLEVELA	ND HOUSE	SHELBY	, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	: 5	D 270			
	document 72-hour mo according to the facili Program. -There was no docum supervision or monito	nentation of increased				
	revealed: -The staff did not cher per their policyThe staff did not doc	1's November 2019 eMAR ck vitals for 3 out of 9 shifts ument changes or no 9 shifts per their policy.				
	station on 11/22/19 at -The book was used t minute checks on res -There was no docum	o document hourly/30 idents. nentation for hourly or 30 nented as performed on				
	11/02/19 at 12:16pm -Resident #1 was four her back, after an unvalue -Resident #1 had no i -Resident #1 was aler complaint of painResident #1 stated, "-Vital signs were obtat was 133/79, and puls -It was documented the physician were notified -The Fall Prevention I instructions were initial instructions: check vit shift, monitor for 72 here	nd in her room, laying on vitnessed fall. njuries requiring first aid. rt and verbal and had no she slid off her bed". ined and blood pressure e 88. ne Guardian and the d.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 12744	or contraction	IBENTII IOMITON NOMBEN.	A. BUILDING: _	A. BUILDING:		
		HAL023045	B. WING		C 11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARD				
		SHELBY,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 6	D 270			
	-The Fall Prevention I instructions included a document any "change-The notes section did assessment.	Program directive special instructions to ges or no changes". d not contain a post fall on indicated Resident #1's				
	-On 11/02/19 at 1:27p go to the hospital afte -There were no additi	onal notes added to onitoring that was required ty's Fall Prevention nentation of increased				
	revealed: -The staff did not cher per their policyThe staff did not doc	1's November 2019 eMAR ck vitals for 2 out of 9 shifts ument changes or no 9 shifts per their policy.				
	station on 11/22/19 at -The book was used t minute checks on res -There was no docum	to document hourly/30 idents. nentation for hourly or 30 is performed on Resident #1				
	11/06/19 at 9:45pm re -Resident #1 was fou her bottom, after an u -Resident #1 had no i	nd in her room, sitting on				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					c	
		HAL023045	B. WING			5/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
01 51/51 4	ND HOUSE	950 HAR	DIN DRIVE			
CLEVELA	ND HOUSE	SHELBY	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 270	D 270 Continued From page 7		D 270			
	-Resident #1 stated, ' -Vital signs were obta was 145/88, and puls -It was documented ti physician were notifie -The Fall Prevention I instructions were initia instructions: check vit shift, monitor for 72 h mental status or cond related to the fallThe Fall Prevention I instructions included a document any "chang -The notes section did assessment.	I'she was dizzy and fell". Inned and blood pressure e 72. The Guardian and the ed. Program directive ated with the following al signs for three days every ours for bruising, change in lition, pain, and other injuries Program directive special instructions to ges or no changes". d not contain a post fall on indicated Resident #1's				
	-There was not a prog the 11/06/19 fall at 8:3 -There were no additi document 72-hour mo according to the facili Program. -There was no docum supervision or monito Review of Resident # revealed;	onal notes added to onitoring that was required ty's Fall Prevention nentation of increased				
	per their policyThe staff did not doc changes for 4 out of 9 Review of Resident # physical dated 11/09/ -Resident #1 had falle	ument changes or no 3 shifts per their policy. 1's hospital history and 19 revealed:				

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AND PLAN OF CORRECTION IDEN				(X3) DATE SURVEY COMPLETED	
ı	TIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
HA	AL023045	B. WING		C 11/25/2019	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELAND HOUSE	950 HARDI	N DRIVE			
CLLVLLAND HOUSE	SHELBY, N	IC 28150			
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270 Continued From page 8 black stools all week. -Resident #1 was admitted on syncope, upper gastrointestina fracture of the right distal radiu forearm bones located on the fracture of the right ulnar styloi projection located on one of the bones located on the pinky fing. -Resident #1's principle dischaincluded fracture of the right diulnar styloid. -Resident #1's discharge order services. Review of Resident #1's progron 11/13/19 Resident #1 would the hospital and would upgrad facility. Review of the white rounding the station on 11/22/19 at 4:45pm. -The book was used to docum minute checks on residents. -There was no documentation minute checks documented as Resident #1 for 72 hours after 11/06/19. Telephone interview with Home 11/21/19 at 9:50am revealed: -Resident #1 was being seen to Nursing for nursing services. -Her last visit was on 10/17/19. -She provided services once a included for neurological check prevention and lab draws, if or she opened Resident #1 to Helphysical therapy evaluation on last fall on 11/06/19, and after Guardian for Resident #1.	al (GI) bleed, a us (one of two thumb side) and a id (a bone ue two forearm ger side). arge diagnosis istal radius and r included skilled ress notes revealed d not return from ue to a skilled book at the nurses revealed: uent hourly/30 for hourly or 30 s performed on her falls on e Health Nurse on by Home Health a week and services ks, safety, and fall rdered lome Health 11/08/19 after her	D 270			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:	
		HAL023045	B. WING		C 11/25/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	AND HOUSE		DIN DRIVE NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 270	-She educated the mithe personal care aid checking on Resident removed from his root clear, and assistive direach. Telephone interview of care provider (PCP) of revealed: -He was not notified of 10/31/19 and 11/02/11 -He was received a famobile x-ray because complaining of right of and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 directly and unable to move if the fall on 11/06/19 d	edication aides (MAs) and es (PCAs) weekly, on the #1, ensuring clutter was on, pathways remained evices remained within with Resident #1's primary on 11/21/19 at 1:52pm of Resident #1's falls on 9 and 11/06/19. ax on 11/07/19 requesting a resident #1 was exist pain, swelling, bruising that the gave a verbal order for an expected for the mobile on 11/08/19, Resident #1 vision (every hour), and ties of daily living to help give as needed Tylenol for the request for the mobile on 11/21/19 at 2:34pm were performed on the the urs unless there was a falls as instructed by the inator (RCC). oral issues or falls then the original market in the community of the community of the parameter of the mobile.	D 270		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		HAL023045	B. WING		11/25/2019	
		IIAL020040			1 11/25/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
01 = 1 = 1	ND HOUSE	950 HAR	DIN DRIVE			
CLEVELA	ND HOUSE	SHELBY	, NC 28150			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(* /	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
				DEFICIENCY)		
D 270	Continued From page	e 10	D 270			
		ok at the nurses station had				
		ne top but she was instructed				
	•	out the "one hour" and write				
	"30 minutes".					
		ks included observing the				
	normal behaviors or i	ther than" the resident's				
		ssues. am, Resident #1 was found				
		er resident who informed				
	her. Resident #1 did					
		am, Resident #1 was found				
		er resident who informed				
		iplained of a little pain.				
	-She was informed of	•				
		9 by another MA and shift				
	change.	9 by another MA and Shift				
	_	d Resident #1's vital signs				
		hour checks except once on				
	, ,	:00pm to 11:00pm shift. She				
		me during the shift she				
	checked Resident #1	•				
		ented vitals and any changes				
	to Resident #1 on 10	, ,				
		1/08/19 on 11/08/19 on the				
	•	hift. She could not recall the				
	' '	she checked Resident #1's				
	vitals.					
		n Resident #1 every 2 hours,				
		ed by the RCC, because that				
		s could handle because of				
	the amount of care re					
	residents.	•				
	 	44/00/40 4 6 55				
		on 11/22/19 at 3:39pm				
	revealed:	andina also also a				
	-The RCC told her ro					
		2 hours were she was to				
	_	ent and assist with anything				
	the resident needed a	al mal time.	1		1	

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-She knew Resident #1 had a fall on 10/31/19

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HARDIN DRIVE SHELBY, NC 28150 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)			HAL023045	B. WING		11	
CLEVELAND HOUSE 950 HARDIN DRIVE SHELBY, NC 28150 (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL			•				1/20/2010
CLEVELAND HOUSE SHELBY, NC 28150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)	NAME OF F	PROVIDER OR SUPPLIER			, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPILED.)	CLEVELA	AND HOUSE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE OF THE APPROPRIATE OF THE AP		1	SHELBY	7, NC 28150			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270 Continued From page 11 because that was her first day of work. -When Resident #1 took a bath, she helped her get dressed. -She did not check on Resident #1 every two hours because she only went into the room if the resident needed something or a specific task (time for meal, shower time,). -She was trained to check every 30 minute checks after falls, just to make sure the floor was not cluttered in the resident's room. -She checked one time during the shift and the floor was clear so she did not check every 30 minutes. Telephone interview with a second MA on 11/23/19 at 12:00pm revealed: -She was made aware Resident #1 had falls on 10/31/19, 11/02/19 and 11/06/19 during shift report. -She was trained by the Resident Care Director (RCD) and RCC there were orders put in the computer to "alert" them to do the every shift documentation on "changes or no changes" and vitals every shift post fall for 72 hours. -She was alerted when logging into Resident #1's eMAR to document lais every shift for 22 hours after her falls on 10/31/19. -She checked Resident #1's vital signs during the 72-hour checks and documented "no change" for 4 out of the 6 shifts she worked. -The 2 shifts she worked. -The the same above reason. -She was too busy with the residents during her shift (medications, falls, vitals, meals and showers). -She did not check on Resident #1 every two hours for the same above reason. -She was told by another MA and by the RCC Resident #1 was on every 30 minute checks on 11/03/19.	D 270	because that was he -When Resident #1 to get dressedShe did not check of hours because she of resident needed some (time for meal, showed) -She was trained to of checks after falls, just not cluttered in the redictions was clear so she minutes. Telephone interview to 11/23/19 at 12:00pm -She was made award 10/31/19, 11/02/19 are portShe was trained by (RCD) and RCC ther computer to "alert" the documentation on "co vitals every shift post -She was alerted whe eMAR to document was after her falls on 10/3 -She checked Reside 72-hour checks and of 4 out of the 6 shifts s -The 2 shifts she did she was too busy wit shift (medications, fa showers)She did not check of hours for the same a -She was told by and Resident #1 was on of	r first day of work. ook a bath, she helped her n Resident #1 every two only went into the room if the mething or a specific task er time,). Check every 30 minute that to make sure the floor was esident's room. The during the shift and the mething of a specific task er time,). The check every 30 minute that to make sure the floor was esident's room. The during the shift and the mething the shift and the mething the shift and falls on mod 11/06/19 during shift The Resident Care Director mething were orders put in the mething to the every shift mething or no changes" and mething the shift for 72 hours mething the shift and the	D 270	DEFICIENC	ΣY)	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.2 . 2.1.	5. 66.11.26.116.11	.52	A. BUILDING: _		00 22.25
			R WING		С
		HAL023045	B. WING		11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
	ND HOUSE	950 HARDI	N DRIVE		
CLEVELA	ND HOUSE	SHELBY, N	IC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 12	D 270		
	nurses station what the issues. The book had -She did not do the exdocumented Resident	ocument in the book at the ne resident was doing or any not been used in awhile. Very 30 minute checks just t #1 was "still on 30 minute was too busy with the			
	at 4:00pm revealed: -On 11/06/19 at 9:45p on the bedroom floor -She was informed ab and a fall on 11/02/19 -She performed vital s on 11/03/19, 11/04/19 -She did not documer during the 72-hour ch during the month of N -She did the 30-minut 11/02/19 and docume nurse's station.	oout the falls on 10/31/19 during shift report. sign checks on Resident #1 and on 11/06/19 after falls. ht any "changes or not" ecks for Resident #1 at all lovember. he checks on Resident #1 on ented them in the book at the			
	prevention program a -She was told to repo changed for Resident -She did not know she resident had no chang hours after a fallWhen the Fall Preventhere was an alert on to document every sh were changes or no coShe knew the Fall Prinitiated on Resident a the eMAR alertWhen she was hired routine checks were e	rt and document if anything #1. e had to document if the ges every shift during the 72 Intion Program was initiated the eMAR that required you ift vital signs and if there changes for 72 hours. The evention Program was not #1 because she never saw the RCC told her the every 2 hours and changed minutes for 72 hours and			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		HAL023045	B. WING		11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARD				
		SHELBY, N	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 13	D 270			
D 270	-She did not check or hours or every 30 mir hours after each fallShe was always "bus residents and other ta-She documented Re checks on 11/02/19 a from a 1:27pm entry twas still on 30 minute monitor, because she medications for reside shift. She "forgot" to consider the street of the street o	in Resident #2 every two nutes after falls during the 72 sy" with her medication for asks for her shift. Sident #1 was on 30 minute to 11:46pm as a "late entry" to document Resident #1 echecks and continue to ewas "busy" with ents and other tasks for her document the entry. With Resident #1's Guardian in revealed: We Resident #1 was on the was called about and hitting her head. aff to do every 30-minute dent #1 hit her head and her head. to go to the hospital and the ervices refused to transport spital for evaluation despite a incompetent. Ecility to do every 30-minute include checking on the her safety, ask Resident ents, administer any as and to call her and the sues or complaints. Story of falls but she was injuries. about the fall that occurred	D 270			
	Coordinator on 11/22					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. Boilesine.		С	
		HAL023045	B. WING		11/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI SHELBY, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 14	D 270			
	on 11/22/19 at 12:00p	om.				
	Refer to interview with 11/22/19 at 1:30pm.	n the Administrator on				
	12/31/18 revealed: -Diagnoses included of seizure disorder, ostedeficiency, vitamin B1 hip fracture.	2 deficiency, and history of oriented intermittently. evel of care was the				
	screening upon admis	2's record revealed no initial ssion to the facility to t may contribute to possible				
	revealed: -Resident #2 was forgremindersResident #2 used a v-Resident #2 was indeambulation, dressing, -Resident #2 required	2's care plan dated 11/28/18 getful and needed walker for ambulation. ependent in eating, toileting, grooming, and transfers. I supervision with bathing. tes to the original care plan				
	11/13/19 at 5:30pm re- Resident #2 was four room after an unwitne -Resident #2 had no i -Resident #2 was aler complaint of pain.	nd sitting on the floor of his				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVE COMPLETED	(X3) DATE SURVEY COMPLETED	
			7. Bolesino.		С		
		HAL023045	B. WING		11/25/20	19	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE			
CI EVELA	ND HOUSE	950 HAR	DIN DRIVE				
		SHELBY,	NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	(X5) DMPLETE DATE	
D 270	Continued From page	e 15	D 270				
	was 154/82, and pulsative family and the parties and the parties and the parties are related to the fall. The Fall Prevention instructions: check vit shift, monitor for 72 hamental status or concrelated to the fall. The Fall Prevention instructions included document any "changate" of the company of the	hysician were notified. Program directive ated with the following tal signs for three days every ours for bruising, change in dition, pain, and other injuries Program directive special instructions to ges or no changes". d not contain a post fall on indicated Resident #2's					
	-The evaluation section indicated Resident #2's care plan did not require updating. Review of Resident #2's progress notes revealed: -On 11/13/19 at 6:28pm, Resident #2's roommate notified staff of resident being on the floor, resident report he just fell, a plastic bag was beside resident's foot and no complaints of painOn 11/13/19 at 11:17pm, Resident #2's temperature 98.6, pulse 67, respirations 18, and blood pressure was 155/90There were no additional notes added to document 72-hour monitoring that was required according to the facility's Fall Prevention ProgramThere was no documentation of increased supervision. b. Review of Resident #2's incident report dated 11/17/19 at 11:00am revealed: -Resident #2 was found in his room without injury after an unwitnessed fallResident #2 had no injuries requiring first aid.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL023045	B. WING		C 11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI	N DRIVE			
CLEVELA	ND HOUSE	SHELBY, N	C 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 16	D 270			
	and pulse 81. -The family and the p -The Fall Prevention I instructions were initial instructions: check vit shift, monitor for 72 h mental status or cond related to the fall. -The Fall Prevention I instructions included a document any "change -The notes section did assessment. -The evaluation section care plan did not requ Review of Resident # -An entry dated 11/17	ated with the following ral signs for three days every ours for bruising, change in lition, pain, and other injuries Program directive special instructions to ges or no changes". d not contain a post fall on indicated Resident #2's uire updating.				
	Resident #2 had a se -There was no docum supervision.					
	11/17/19 at 2:00pm re-Resident #2 was fou injury after an unwitne-Resident #2 was ser ambulanceResident #2 was ale complaint of painVital signs were obta 138/78, respirations 2	nd in his room with a head				
	-The Fall Prevention I instructions were initial instructions: check vit shift, monitor for 72 h	hysician were notified. Program directive ated with the following tal signs for three days every ours for bruising, change in lition, pain, and other injuries				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		` '	SURVEY PLETED	
			A. BUILDING:	A. BUILDING:		
		HAL023045	B. WING		44	C
		HAL023045			11	/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CLEVEL A	ND HOUSE	950 HAR	DIN DRIVE			
OLLVLLA	IND HOUGE	SHELBY	, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 17	D 270			
	related to the fall. -The Fall Prevention I instructions included a document any "change. -The notes section did assessment. -The evaluation section care plan did not requestive. Review of Resident # 11/19/19 revealed: -Resident #2 had faller laceration to left foreing hematoma. -Resident #2 was admobservation and ongoing assessment. -Resident #2's principal subarachnoid hemotomia.	Program directive special instructions to ges or no changes". In a directive special instructions to ges or no changes". In a direction indicated Resident #2's gire updating. 2's hospital discharge dated and sustained a great with a significant special with a significant special speci				
	Review of Resident # -On 11/19/19, Reside with discharge diagnot hemorrhage, "will followisit." -On 11/19/19 at 11:07 temperature 98.7, pul blood pressure was 1 -On 11/20/19 at 6:38a temperature 98.8, pul blood pressure was 1 -On 11/20/19 at 10:12 temperature 98.8, pul blood pressure was 1 -On 11/21/19 at 1:21p good today, no compl -There were no additi	2's progress notes revealed: nt #2 returned from hospital posis of subarachnoid ow up with physician on next 2'pm, Resident #2's se 78, respirations 18, and 28/78. am, Resident #2's se 71, respirations 18, and 51/75. apm, Resident #2's se 83, respirations 18, and 27/70. om "resident has done very aints on anything".				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
741012741	or dorace mon	ibertii io/tiiottitombetti	A. BUILDING:		
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLEVEL A	ND HOUSE	950 HARDI	N DRIVE		
OLL VLLA		SHELBY, N	IC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 18	D 270		
	according to the facili Program. -There was no docum supervision.	ty's Fall Prevention			
	(eMAR) revealed: -Resident #2's vital si four out of nine times	Administration Record gns were not documented during the 72-hour equired according to the on Program.			
	9:40am revealed: -Resident #2's bed withe roomThe pathway to his bivide enough for a warklong the pathway thon the floorResident #2's surfact approximately 40 incheron entrance to Resident #2's surfact approximately 40 incheron his bed swinging his bedResident #2 remainer	e of his bed was hes off the floor. esident #2's room he sat up his feet over the edge of the ed sitting on the edge of his gling approximately 8-10			
	Interview with Reside revealed: -He fell getting off his -He could not remember to fallWhen he got out of be	nt #2 on 11/21/19 at 9:40am			

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		1141 000045	B. WING		C	10040
		HAL023045			11/25	5/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HARI	OIN DRIVE			
CLEVELA	ND HOUSE	SHELBY.	NC 28150			
040.15	QUMMADV QT	<u> </u>		DBOWDED'S DI AN OE CORRECTIO	ON.	0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
D 270	Continued From page	e 19	D 270			
	-The next thing he rea	membered he was on the				
	floor and his head wa					
		of his bed with his socks on				
	, ,	ached for his walker, and sat				
	•	d of his bed to put on his				
	shoes.	of his bed to put on his				
		nia raam ta bring bim				
	-The staff came into h	-				
		him of a meal time, time of a				
	bath, or clean the bat					
		ne into his room to ask him if				
		or check on him after his				
	falls.					
	Latera de la constitue De edute					
	Interview with Reside					
	11/21/19 at 9:50am re					
		ed on her to pick up his				
	belongings off the floo					
		th making sure his walker				
	was always close by					
		ne into their room to check				
		frequently after the falls, or				
		and clearing the floor of				
	items.					
	1					
		onal care aide (PCA) on				
	11/21/19 at 1:45pm re					
		#2 after his second fall on				
	11/17/19.					
		esident #2 had a fall earlier in				
	the day on 11/17/19.					
		g room cleaning up the				
		meal when Resident #2 fell				
	on 11/17/19.					
		dents when they called for				
	her assistance.					
	-Resident #2 asked h					
		his shoes on at times.				
		esident #2 with his bath, she				
	helped him dress and	I put his shoes on.				

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-Resident #2 would forget to put his shoes on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		· ,	(X3) DATE SURVEY COMPLETED	
		HAL023045	B. WING	·	11	C / 25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE	·	
CLEVEL A	ND HOUSE	950 HARI	DIN DRIVE			
CLEVELA	IND HOUSE	SHELBY,	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	20	D 270			
	the slippery floorShe was never told t every two hours.	ed and get up in his socks on o check on Resident #2 check on Resident #2 more lls.				
	11/21/19 at 10:30am -She was made awar 11/13/19 and 11/17/1 -She was alerted whe eMAR to document v after his fallShe had checked Re to the end of her shift -She did not know wh vitals and any change 11/19/19 to 11/21/19She must have forgo because she was too -She did not check or hours.	e Resident #2 had falls on 9 during shift report. en logging into Resident #2's itals every shift for 72 hours esident #2's vital signs close during the 72-hour checks. ey she had not documented es to Resident #2 on etten to document his vitals busy. en Resident #2 every two				
	(MA) on 11/21/19 at 2 -She knew Resident 7 two weeksResident #2 was pla prevention program a -During the 72 hours were checked every 9 -She was told to repo changed for Resident -She did not know sh resident had no chan-	the past three falls in the past ced on the 72 hours fall fter his last fall on 11/17/19. Resident #2's vital signs shift and documented. rt and document if anything the past of the pa				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					C
		HAL023045	B. WING		11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD	IN DRIVE		
CLLVLLA	ND 11003L	SHELBY, I	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 270	-She helped Resident bell requesting assista	#2 when he used his call	D 270		
	-She had to remind hi bell because he was f	m all the time to use his call			
	frequently after his fall	ls. vith Home Health Nurse on			
	11/25/19 at 2:01pm re				
	Nursing, Physical The TherapyShe opened Residen	erapy, and Occupational			
	services after he fell of	on 11/13/19.			
	-	ident #2 twice a week for afety, and fall prevention.			
	-She educated the MA	As and PCAs on checking			
		ing clutter was removed ays remained clear, and			
		ained within reach each			
	time she visited the re	esident.			
	Interview Resident #2 (PCP) on 11/25/19 at	's primary care provider 1:00pm revealed:			
	-He was notified of Re 11/13/19 and 11/17/19	9.			
	 -He was scheduled to hospital follow-up visit 	see Resident #2 today for today.			
	-He was not sure wha Resident #2 to fall.	t exactly had caused			
	-Resident #2 was being nursing, physical there	ng seen by Home Health apy and occupational			
	therapy since Resider	nt #2 fall on 11/13/19. If by the facility of Resident			
		ne gave an order for Home			
	Health to treat and ev	aluate.			
	· · · · · · · · · · · · · · · · · · ·	more supervision and ies of daily living to prevent			
			1		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		c	
		HAL023045	B. WING		11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI SHELBY, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	22	D 270			
		interview with Resident #2's 11/25/19 at 2:30pm was				
	T	interview with Resident #2's st on 11/25/19 at 2:45pm				
	Refer to interview with Coordinator on 11/22					
	Refer to interview with on 11/22/19 at 12:00p	n the Resident Care Director om.				
	Refer to interview with 11/22/19 at 1:30pm.	n the Administrator on				
	03/18/19 revealed: -Diagnoses included bladder, hypothyroidis	sm, deafness, depression, on, and anxiety disorder. oriented constantly. evel of care was the y.				
	Review of Resident # revealed the resident on 07/31/17.	3's Resident Register was admitted to the facility				
	screening upon admis	3's record revealed no initial ssion to the facility to t may contribute to possible				
	Review of Resident # revealed: -Resident #3 was forgreminders.	3's care plan dated 11/28/18 getful and needed				

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					c	
		HAL023045	B. WING		11/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARD				
		SHELBY,	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 23	D 270			
	toileting, ambulation, and transfers. -There were no updated 11/28/18.	I supervision with eating, dressing, grooming, bathing, tes to the original care plan				
	10/04/19 at 7:00pm re	nd in his room without injury				
	-Resident #3 had no	injuries requiring first aid. It to the emergency room on				
	was 132/80, respiration	nined and blood pressure ons 20, and pulse 76. hysician were notified.				
	instructions were initial instructions: check vit shift.	ated with the following cal signs for three days every				
	assessment.	d not contain a post fall on indicated Resident #3's				
	care plan did not requ					
	summary dated 10/04	3's hospital discharge I/19 revealed: is was a fall with closed				
	-Resident #3 had a fa possibly hitting her he -Resident #3 denied a	any pain, no distress, was				
	alert and orientated a facility.	nd released to return to the				
	-On 10/04/19 at 10:4	3's progress notes revealed: 9pm, "Resident fell in room and became responsive esident was taking to				

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Division of Health Service Regulation

Division (of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED	
			A. BOILDING.			
						;
		HAL023045	B. WING		11/2	25/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARI	DIN DRIVE			
CLEVELA	ND HOUSE	SHELBY,	NC 28150			
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(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 270	Continued From page	e 24	D 270			
	emergency by emerg	ency medical services, all				
		otified, medtech/sic by				
	•					
	. ,,	rned to facility at 10:35pm,				
		nt back themselves, no				
	•	e, will continue to monitor				
	resident."					
	-On 10/07/19 at 12:05	5am "Resident had a good				
	night and blood press	sure was good."				
	-On 10/07/19 at 12:56	6pm "Resident was				
		care physician today related				
	to fall on 10/04/19, no	· ·				
	-There were no additi					
		onitoring that was required				
	according to the facili	ty's Fail Prevention				
	Program.					
		nentation indicating an				
	increase in supervision	on.				
	Review of Resident #	3's October 2019 electronic				
	Medication Administra	ation Record (eMAR)				
	revealed resident's vi	tal signs had been				
	documents every shif	ft for three days from				
	10/04/19 to 10/07/19.	-				
	Interview with Reside	ent #3's responsible party				
	(RP) on 11/21/19 at 9	, , ,				
		en last month, he did not				
		en last month, he did not				
	recall the date.	: d = #0 b = d f =				
		ident #3 had fallen and was				
	unresponsive.					
	-When he came to the					
		services (EMS) to take her to				
	the hospital.					
		took her to the hospital				
	Resident #3 became	more responsive.				
	-Resident #3 returned	d to the facility the same				
	evening.	-				
	-	she fell because she was				
	attempting to move to					
		v often staff visited Resident				
	-i ie did fiot kilow flow	V OILGIT SLATE VISILEU FLESIUETIL				1

Division of Health Service Regulation

STATE FORM 6899 IJRD11 If continuation sheet 25 of 67

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND FLAN OF CORRECTION ADJUDING	DIVISION OF FICARLY SERVICE REGULATION							
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every two hoursShe had not been told to check on every resident every two hours or more frequently after her falls. Interview with a first shift medication aide (MA) on 11/21/19 at 10:30am revealed: -She did not know Resident #3 had a fall on 10/04/19She was not able to remember all the resident's falls in the past monthShe did not check on Resident #3 every two hoursShe was not told to check on Resident #3 every two hours or more frequently after her falls. Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.			check on every resident					
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-She did not check on Resident #3 every two hoursShe was not told to check on Resident #3 every two hours or more frequently after her falls. Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.								
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two hours or more frequently after her falls. Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.			sheck on Resident #3 every					
Interview with a second shift medication aide (MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.			-					
(MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.		two flours of filore fre	equently after their fails.					
(MA) on 11/21/19 at 2:00pm revealed: -She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.		Interview with a secon	nd shift medication aide					
-She knew Resident #3 had a fall last monthShe had not been told to do anything differently for Resident #3 to prevent falls.								
-She had not been told to do anything differently for Resident #3 to prevent falls.								
for Resident #3 to prevent falls.								
shift when she worked.			_					
-She did not check on Resident #3 every two								
hours.			Tresident #5 every two					
-She was not told to check on Resident #3 every			check on Resident #3 every					
two hours or more frequently after her falls.								

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					c	
HAI 022045		B. WING		1		
HAL023045		B. WC		11/2	5/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HARD	IN DRIVE			
CLEVELA	ND HOUSE	SHELBY,				
		SHELDT,	NC 20150			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
		,	17.0	DEFICIENCY)		
			1			
D 270	Continued From page	e 26	D 270			
	Telephone interview v	with Home Health Nurse on				
	11/25/19 at 2:01pm re					
	-She opened Resider					
	services after she fell					
		ng seen by Home Health				
	Nursing (HHN) and P	•				
		ident #3 weekly to educate				
	the resident and staff.	-				
		ating the staff and Resident				
		nd symptoms of recurrent				
	urinary tract infection	• •				
	•	As and PCAs to check				
		nment to keep pathways				
		to use her call bell, and slow				
	_	lating to prevent tripping				
	during every visit.	lating to prevent inpping				
	during every visit.					
	Interview Resident #3	B's primary care provider				
	(PCP) on 11/25/19 at					
	-He was notified of Re	esident #3's fall on 10/04/19.				
	-He saw Resident #3	on 10/07/19 to assess her				
	after the hospitalization	on from the fall.				
	-He was not sure wha					
	Resident #3 to fall.	•				
	-He had treated her fo	or a urinary tract infection				
	and consulted home I	-				
		d more supervision and				
		ties of daily living to prevent				
	falls.	, , ,				
	Attempted telephone	interview with Resident #3's				
		11/25/19 at 2:30pm was				
	unsuccessful.	·				
	Refer to interview with	h the Resident Care				
	Coordinator on 11/22	/19 at 11:33am.				
	Refer to interview with	h the Resident Care Director				
	on 11/22/19 at 12:00p					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDIEAN	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE		DIN DRIVE NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 270	11/22/19 at 1:30pm. 4. Review of Residen 09/19/19 revealed: -Diagnoses included hip fracture, and mus -The resident was sero of a wheelchairThe recommended leads a sisted Living Facility Review of Resident # revealed the resident on 10/01/19. Review of Resident # screening upon admit determine factors that falls. Review of Resident # revealed: -Resident #4 was forgremindersResident #4 required ambulation, dressing, -Resident #4 required ambulation, dressing, -Resident #4 required ambulation, dressing, -Resident #4 required and 10/14/19. Review of Resident # 11/01/19 at 12:52pm -On 10/31/19 at 3:10a in her room with abra and skin tear after an -Resident #4's injury her headResident #4 stated "single resident #4 stated"	t #4's current FL2 dated unspecified dementia, right cle weakness. mi-ambulatory with the use evel of care was the ty. 4's Resident Register was admitted to the facility 4's record revealed no initial ssion to the facility to t may contribute to possible 4's care plan dated 10/14/19 getful and needed d assistance with grooming, and bathing. d supervision with transfers. tes to the original care plan 4's incident report dated revealed: am, Resident #4 was found sions, bruising, a laceration,	D 270		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETE	J
		HAL023045	B. WING	B. WING		019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI	N DRIVE			
CLEVELAND HOUSE SHELBY, N		IC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 270	-Resident #4 was sen 10/31/19 at 3:10amVital signs were obta was 99/48, respiration pulse 83The Fall Prevention I instructions were initial instructions: check vit shift, monitor for 72 homental status or conditional related to the fallThe Fall Prevention I instructions included a document any "change-The notes section did assessmentThe evaluation section care plan did not requiver Review of Resident #4 summary dated 10/31-Resident #4 diagnos hematoma to left side forearm with a skin teresident #4 was treat and returned to the fall returned to the fall resident #4 on 10/31/19 at 5:122 and it started bleeding the right arm, she slide-On 10/31/19 at 2:38 propelling up and down	ar, and head was bleeding. Into the emergency room on sined and blood pressure ins 18, temperature 98.6, and in Program directive ated with the following its lasigns for three days every ours for bruising, change in lition, pain, and other injuries in Program directive special instructions to ges or no changes". Ind not contain a post fall on indicated Resident #4's aire updating. 4's hospital discharge life included a fall with the of head, knot to right ar. In ated in the emergency room incility. 4's progress notes revealed: In any "Resident hit her head in the head in the has a skin tear on incility.	D 270			
	-On 11/01/19 at 9:03p and started presenting eye.	om, Resident denied pain g with bruising to her left cam, Resident has bruising				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL023045 B. WING		C 11/25/2019	
	ROVIDER OR SUPPLIER			TE, ZIP CODE	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	pain, she said no it had on 11/03/19 at 6:31a Tylenol, blood pressu 96.9, respirations 18, on 11/04/19 at 4:24a Tylenol for right arm permered temperature 97.6, resident 72-hour maccording to the facility program. There was no documin supervision during Review of Resident #November 2019 elect Administration Record resident's vital signs have shift for three days from the permered they are sident supervision during Program. There was no documin supervision during Review of Resident #November 2019 elect Administration Record resident's vital signs have shift for three days from the permered they are she fell on her face we dege of her bed attention. She did not call out for because they did not help. The staff did not cheafter she fell. Interview with Reside (RP) on 11/21/19 at 9-Resident #4 told her not check on Resider more frequently since	when asked if she had any asn't bothering her too bad. Im, Resident requested re 121/72, temperature and pulse 90. Im, Resident requested pain, blood pressure 117/54, pirations 18, and pulse 80. Important of the pressure 117/54, pirations 18, and pulse 80. Important of the pressure 117/54, pirations 18, and pulse 80. Important of the pressure of th	D 270	DELIGITION 1)	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLEVELAND HOUSE		950 HARDI SHELBY, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	11/21/19 at 2:45pm re-She knew Resident because she saw the She helped Resident helpShe did not check or hoursNo one had told her every two hoursInterview with a first some saw the bruising on heshe did not check or hoursShe was not told to compare two hours or more free linterview with a second (MA) on 11/21/19 at 2-She knew Resident some saw the saw the bruising on heshe was not told to compare two hours or more free linterview with a second (MA) on 11/21/19 at 2-She knew Resident some she had not been told for Resident some she was not told to compare two hours or more free linterview was not told to compare two hours or more free two hours or more free linterview was not told to compare the was not told t	onal care aide (PCA) on evealed: #4 had a fall on 10/31/19 bruising on her face. #4 when she asked for In Resident #4 every two to check on the residents #4 had a fall because she er face. In Resident #4 every two Check on Resident #4 every quently after falls. #6 hift medication aide #7 had a fall last month. #8 hift medication aide #8 hod a fall last month.	D 270	DEFICIENCY)	
	Nursing (HHN) and P	iting the staff and Resident gns and symptoms of			

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	i rieaitii Service Regu				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COWIFLETED
					С
		HAL023045	B. WING		11/25/2019
		111.12020010			11/20/2010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		950 HARI	OIN DRIVE		
CLEVELA	ND HOUSE	SHELBY,	NC 28150		
(VA) ID	SLIMMADV STA	ATEMENT OF DEFICIENCIES	15	PROVIDER'S PLAN OF CORRECTION	V (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 270	Continued From page	. 21	D 270		
D 210	Continued From page	: 31	D 270		
	-She educated the MA	As and PCAs to check			
	Resident #4's environ	ment to keep pathways			
	clear, encourage her	to use her call bell, and lock			
		transferring during every			
	visit.				
	Interview Resident #4	l's primary care provider			
	(PCP) on 11/25/19 at	1:00pm revealed:			
	-He was notified of Re	esident #4's fall on 10/31/19.			
	-He saw Resident #4	to assess her after the			
	hospitalization from th	ne fall.			
	-He was not sure wha				
	Resident #4 to fall.	•			
	-He wrote an order fo	r home health nursing and			
	physical therapy.	3			
		I more supervision and			
	•	ties of daily living to prevent			
	falls.	accordany named to brosom			
		interview with Physical			
	Therapist on 11/25/19				
	unsuccessful.	o at 2.00pm was			
	unouoocoorui.				
	Refer to interview with	h the Resident Care			
	Coordinator on 11/22				
	000141114101 011 11722	To at Thouann			
	Refer to interview with	h the Resident Care Director			
	on 11/22/19 at 12:00p				
	011 11/22/10 dt 12.00p	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Refer to interview with	h the Administrator on			
	11/22/19 at 1:30pm.	Title / tallimotrator on			
	<u></u> 2.10 at 1.00piii.				
	5 Review of Residen	t #5's current FL2 dated			
	11/28/18 revealed dia				
		reakness, memory deficit,			
	•	rebral vascular accident.			
	hypertension, and cer	iebiai vascuidi accidelli.			
	Povious of Posidont #	S's Posidont Posistor			
	Review of Resident #				
		was admitted to the facility			
	on 04/27/17.		1		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
			B. WING		C
		HAL023045	D. WIITO		11/25/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD			
		SHELBY,	NC 28150		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 32	D 270		
	screening upon admis	5's record revealed no initial ssion to the facility to t may contribute to possible			
	revealed:	5's care plan dated 07/05/19			
	 -Resident #5 used a wheelchair for ambulation. -Resident #5 required limited assistance with toileting. 				
	-Resident #5 required extensive assistance with ambulation and locomotion, dressing, grooming and transfers.				
	a. Review of Residen 10/27/19 at 7:00am re	t #5's incident report dated			
		nd in her bathroom, sitting			
	on the toilet holding o	onto the bar, with a small			
		er an unwitnessed fall.			
	· ·	d a bump to the forehead			
	which did not require				
	-Resident #5 was ale				
		he, "didn't feel good and her			
	head was hurting".	obtained and Resident #5			
	was transported to the				
		charged from the hospital on			
		osis of dehydration and to			
	follow up with the prin	nary care provider (PCP).			
		hysician were notified.			
	-The Fall Prevention I				
		an order with the following			
		for 72 hours with special			
	•	orogress notes daily 10/27/19			
	to 11/13/19.	d not contain a neet fell			
		d not contain a post fall			
	assessment. -The evaluation section	on indicated Resident #5's			
	care plan did not requ				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD	IN DRIVE		
CLEVELA	IND HOUSE	SHELBY, I	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	33	D 270		
	-There were no progre 11/13/19 documented available. -There was no docum in supervision during b. Review of Residen	5's progress notes revealed: ess notes for 10/27/19 to in Resident #5's record or eentation indicating increase the 72-hour monitoring.			
	first on the floor, after -Resident #5 had no i -Resident #5 was aler complaint of pain. -Vital signs were obta	nd in her room, lying face an unwitnessed fall. njuries requiring first aid. t and verbal and had no ined and temperature 97.9,			
	pulse 66Resident #1 was not emergency roomThe family and the pl	hysician were notified.			
	instructions was initial instructions: check vit shift, monitor for 72 homental status or conditional related to the fall. -The Fall Prevention F	ted with the following al signs for three days every ours for bruising, change in ition, pain, and other injuries Program directive			
	assessment.	on indicated Resident #5's			
	-There were no progre 11/07/19 documented available.	5's progress notes revealed: ess notes for 11/04/19 to in Resident #5's record or			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD	IN DRIVE		
SHELBY,		NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 34	D 270		
	in supervision during	the 72-hour monitoring.			
	(eMAR) revealed: -The staff did not cher per their policyThe staff did not doc changes for 2 out of 9 Review of Resident # revealed Resident #5 related to the falls. Telephone interview v 11/21/19 at 9:50am re -Resident #5 was being	Administration Record ck vitals for 1 out of 9 shifts ument changes or no 9 shifts per their policy. 5's record on 11/21/19 expired on 11/13/19, not with Home Health Nurse on evealed: ng seen by Home Health			
	Nursing for nursing set-She opened Resider 11/04/19 after her last 11/04/19 for nursing some Therapy to evaluate of She was seeing Reselabs, neuro checks, some seducated the Market about checking on Research was removed from her clear, and assistive deference of the second s	ervices. nt #5 to Home Health on			
	reachOn 11/07/19 Resider Hospice services and	nt #5 was evaluated for approved.			
	provider (PCP) on 11/2-He was notified of Re 10/27/19, 10/28/19 ar -He informed the Res Resident #5 required assistance with activities.				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL023045	B. WING		C 11/25/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD	IN DRIVE		
CLEVELA	ND HOUSE	SHELBY,	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 35	D 270		
	of his visits with the re- Resident #5's last se	RCD was present during all esidents at the facility). eizure was on 10/04/19.			
	at 2:34pm revealed:	cation aide (MA) on 11/21/19			
	•	vere performed on the			
		irs unless there was a			
	behavioral issue or fa Resident Care Coord	ills as instructed by the			
		oral issues or falls then the			
		O minute as instructed by the			
	RCC.	•			
	-	checks were documented			
	in the white book at the				
	instructed by the RCC	ok at the nurses station had			
	one hour checks at th	ne top but she was instructed out the "one hour" and write			
		ks included observing the ther than" the resident's			
	normal behaviors or is				
	some of the time and check on Resident #5	Resident #5 every 2 hours some of the time she would more often, because that			
	the amount of care re	s could handle because of equired for all of the			
	residentsShe was told by the	RCD after Resident #5's			
	scans on 10/04/19 Re	esident #5 would continue to			
		ures and needed more			
		an every 2 hours), and			
		ties of daily living (ADL's). Resident #5 falls on 10/27/19			
	and 10/28/19 and 11/	04/19 by another MA at shift			
	change.				
		d Resident #5's vital signs			
	• .	nour checks, because that s could handle because of			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	I ' '	A. BUILDING:		COMPLETED	
		HAL023045	B. WING		11/2	25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
CLEVFI A	ND HOUSE		DIN DRIVE				
OLLVLLA	ND 11000E	SHELBY	, NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
D 270	Continued From page	e 36	D 270				
	the amount of care re residentsShe had not docume to Resident #5 on 10/11/04/19.	ented vitals and any changes					
	11/22/19 at 3:39pm re-She knew Resident after shift reportShe helped Resident her get dressed and a-She was told by the (RCC), Resident #5 re with transfers becaus seizure at any time ar-She did not check or every two hoursShe had been told to every two hoursShe was not trained hours after falls, just the	#5 had a fall on 11/04/19 It #5 with a bath, she helped assisted with transfers. Resident Care Coordinator equired 2 persons assist e Resident #5 could have a nd would fall. In Resident #5 any more than or check on every resident It to check more than every 2 to make sure the floor was sident's room and always 2					
	member on 11/22/19 -She was informed at -She was informed by would have 2 people seizure she would no -With the falls on 10/2 Resident 5 was "foun -If Resident #5 was constituted at least less falls."	oout Resident #5's falls. If the MAs that Resident #5 assist her so if she had a t get hurt. If the massisted and 11/04/19 If and not being assisted, hecked on every 30 minutes could have been avoided or alls other than 10/27/19, If the massisted and massisted are also only the ma					

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			74. 501251140.		c	
		HAL023045	B. WING		11/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
01 = 1 = 1	ND 1101105	950 HARD	IN DRIVE			
CLEVELAND HOUSE SHELBY,		NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 37	D 270			
	11/23/19 at 12:00pm -She was trained by to (RCD) and RCC there computer to "alert" the documentation on "chevitals every shift post -The every 30 minute on the resident and donurses station what the issues. The book had -She did not do the endocumented Resident checks" because she residents -She was made awar 10/28/19, during shift -On 10/27/19, she found her bathroom toilet work-resident #5 complaint was not sent out to the -She was alerted where eMAR to document vorter her falls on 10/2 -On 11/04/19, she found her bedroom floor. and was not sent to the -She checked Resider 72-hour checks and control to 10 to	revealed: he Resident Care Director e were orders put in the em to do the every shift hanges or no changes" and fall for 72 hours. checks were to "lay eyes" ocument in the book at the he resident was doing or any not been used in awhile. very 30 minute checks just t #1 was "still on 30 minute was too busy with the e Resident #5 had falls on report. und Resident #5 sitting on ith a knot on her forehead. hed of her head hurting but he hospital. en logging into Resident #5's itals every shift for 72 hours 7/19. und Resident #5 face down Resident #5 denied pain he hospital. ent #5's vital signs during the documented "no change" for he worked. hot document was because in the residents during her lis, vitals, meals and	D 210			
	at 4:00pm revealed: -She was informed at	oout Resident #5's falls on a fall on 11/04/19 during				

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DIVISION	of Health Service Regu	liation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		HAL023045	B. WING		11/25/2019
		HALU23045			11/25/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		950 HAR	DIN DRIVE		
CLEVELA	ND HOUSE		NC 28150		
			110 20100		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 070	0 " 15	00	D 070		
D 270	Continued From page	e 38	D 270		
	shift report.				
	-	ntion Program was initiated			
		the eMAR that required you			
		nift vital signs and if there			
	were changes or no c	•			
	~	en logging into Resident #5's			
		itals every shift for 72 hours			
	after her falls on 10/2	_			
	11/04/19.	1719, 10/20/19 and			
	-She did not docume	nt any changes or no			
		2-hour checks for Resident			
	#5 at all during the m	onth of October of			
	November.				
	•	sy" with her medication for			
	residents and other ta				
		doing the 30-minute checks			
	on Resident #5 on 10	0/27/19, 10/28/19 and			
	11/04/19.				
	-	ced on the 72 hours fall			
		after her fall on 10/27/19,			
	10/28/19 and 11/04/1				
	•	Resident #5's vital signs			
		shift and documented.			
	-She was told to repo	ort and document if anything			
	changed for Resident				
	-She did not know sh	e had to document if the			
	resident had no chan	9			
		n Resident #5 every two			
	hours because she w	as always "busy" as stated			
	above.				
	Refer to interview with	h the Resident Care			
	Coordinator on 11/22	/19 at 11:33am.			
	Refer to interview with	h the Resident Care Director			
	on 11/22/19 at 12:00p	om.			
	Refer to interview with	h the Administrator on			
	11/22/19 at 1:30pm.				

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Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			D WINO		C	
		HAL023045	B. WING		11/2	5/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			DIN DRIVE	,		
CLEVELA	ND HOUSE					
		SHELBT,	NC 28150			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
IAG		,	170	DEFICIENCY)		
			+			
D 270	Continued From page	e 39	D 270			
	Interview with the Res	sident Care Coordinator				
	(RCC) on 11/22/19 at					
	, ,	er seeing the Fall Prevention				
	Program policy until to					
		no reported a fall completed				
		nen a resident had a fall.				
	-She reviewed the Inc					
	completeness and as					
	completing the report					
	-She did not instruct t					
		of residents who had falls.				
		ected to check on residents				
	· · · · · · · · · · · · · · · · · · ·	residents with personal				
	care.	residents with personal				
	-She initiated the Fall	Prevention Program				
		s to document vital signs and				
	parameter notes ever					
	=	cument vital signs every shift				
	for 72 hours.	ourners that eight every erms				
		oort and document any				
		ents during the 72 hours.				
	-She did not check or					
	72-hour checks to rev	•				
		ne MAs documentation				
	during the 72-hour ch					
	0	sident Care Director and				
		iss resident falls monthly.				
		of a formal training for the				
	staff for fall prevention					
	·	,				
	Interview with the Res	sident Care Director (RCD)				
	on 11/22/19 at 12:00p					
		e Fall Prevention Program				
	policy until today.	-				
		ed a fall screening upon				
		s to determine factors that				
	may contribute to falls	S.				
	-	she was responsible for				
		reening upon admission.				
		C, Physical Therapist, and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		GOWII ELTED
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
01 = 1/= 1 4	ND 1101105	950 HARD	IN DRIVE		
CLEVELA	ND HOUSE	SHELBY,	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 40	D 270		
	past month. -The RCC reviewed In the falls during the first -She did visits resider residents and put interfuture falls. -The PCAs and MAs revery resident every Interview with the Adra 1:30pm revealed: -She knew the resided: -She had met with the discuss monthly falls. -During the monthly falls. -During the monthly falls. -During the monthly falls. -During the monthly falls. -She did not review expeach resident. -She did not visit the infall with them. -She did not have a second resident and review as a second resident.	nts who had falls. e RCD, RCC, and PT to alls meeting the clinical staff of the residents who had fall was preventable and n would implement to assist			
	sampled residents, ba needs and facility poli falls in one week with fractures in her right wathree falls within a two resulting in a hospital subarachnoid hemorr fallen and was hospital injury, Resident #4 withinner and was sent a diagnoses of traum	rovide supervision for 5 of 5 ased on their assessed icy, Resident #1 who had 4 one resulting in two wrist. Resident #2 who had be week time period with one ization with a diagnosis of hage, Resident #3 who had alized with a closed head no had fallen on a blood to the emergency room with natic hematoma of forehead or extremity, and Resident			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		C
		HAL023045	B. WING		11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARDII			
		SHELBY, N	C 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 270	Continued From page	· 41	D 270		
	to a head injury. This supervision to resider				
	The facility provided a accordance with G.S.	plan of protection in 131D-34 on 11/22/19.			
	CORRECTION DATE VIOLATION SHALL N 25, 2019	FOR THE TYPE A1 OT EXCEED DECEMBER			
D 273	10A NCAC 13F .0902	(b) Health Care	D 273		
	• •	Health Care assure referral and follow-up ad acute health care needs			
	This Rule is not met a				
	reviews, the facility fa follow-up to meet the 1 of 5 sampled reside treatment for a reside stools, dizziness and	nt who had black tarry weakness and in regard to two fractures of the right			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED	
		HAL023045 B. WING		C 11/25/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARD	IN DRIVE			
OLLVLLA	TOOOL	SHELBY,	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 42	D 273			
	The findings are:					
	07/08/19 revealed dia middle cerebral artery artery), coronary arte	e1's current FL2 dated agnoses included acute y stroke (the largest cerebral ry disease, gastrointestinal aditioning and anxiety.				
	revealed: -Resident #1 used a v -Resident #1 required	walker for ambulation. If supervision with toileting, notion, dressing, grooming				
	Review of Resident #1 incompetent.	1's Guardianship document was adjudicated				
	11/06/19 at 9:45pm, r found in her room, sit	t #1's Incident Report dated revealed Resident #1 was ting on her bottom, after an ident #1 stated she was				
	physical dated 11/09/ -Resident #1 was adr 11/08/19 at 11:05 pm -Resident #1 had falle deformity was noted for the right di forearm bones locate fracture of the right ul projection located on bones located on the -Resident #1's princip	mitted to the hospital . en 2 days ago and a to the right wrist. mitted on 11/08/19 for istal radius (one of two d on the thumb side) and a lnar styloid (a bone one of the two forearm				

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Division of Health Service Regulation						
	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
	l	1141 0000 45	B. WING		C	
		HAL023045	D. WING		11/2	5/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
			DIN DRIVE			
CLEVELA	ND HOUSE		NC 28150			
	OLUMBA DV OT					
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 070	IE		D 070			
D 273	Continued From page	∍ 43	D 273			
	fracture of the right di	istal radius and ulnar styloid,				
	and hypokalemia.					
		charged from the hospital to				
	a skilled nursing facili					
		ty 51. 1.7.15.15.				
	Telephone interview v	with Resident #1's Guardian				
	on 11/25/19 at 8:30an					
		about the fall that occurred				
	on 11/06/19.	about the fall that see and				
		as contacted by the family				
		er Resident #1 fell a few days				
		right wrist pain and swelling				
	and an x-ray was orde					
	_	ne family member to come to				
		them send Resident #1 out				
	_	n, swelling and unable to				
	move right wrist.	i, owoming and analysis to				
	_	istory of falls but she was				
	never told about any i					
		ity on 11/08/19 and told the				
		ent #1 to the hospital for the				
	x-ray.	γ				
		nsported to the hospital on				
		d for GI bleed and fracture				
		us and fracture of the right				
	ulnar styloid.					
	,	hospital told her Resident				
		b) was dangerously low and				
		to dizziness and falls (Hgb,				
	_	for transporting oxygen in				
		rmal range is 11.5-15.0).				
		aff to follow up on concerns				
		laints from Resident #1 as				
	soon as they were giv					
		ff had responded to their				ı
		1 may not have ended up				
		ness and fractures from the				
	fall.					
	Telephone interview v	with Resident #1's family				

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MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HARDIN DRIVE SHELBY, NC 28150 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 44 member on 11/25/19 at 10:16am revealed: -She was informed of Resident #1's falls when she visitedShe was informed by the medication aide (MA) on 11/06/19, Resident #1 fell earlier and during the shower noticed Resident #1's right wrist was swollen and "crooked"She asked the MA to send Resident #1 out to the hospital and was told again could not do anything until told by the GuardianShe tried to call the Guardian again, there was no answer and she left a voice mail to call her backOn 11/107/19, she reported to 2 different MAs that Resident #1's rarm was broken and needed to be seenShe was told by one MA the x-ray would be done		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HARDIN DRIVE SHELBY, NC 28150 (X4) ID PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 44 member on 11/25/19 at 10:16am revealed: -She was informed by the medication aide (MA) on 11/06/19, Resident #1's fight wrist was swollen and discolored and Resident #1 could not move her fingersShe saw Resident #1's right wrist and noticed it was swollen and "crooked"She saked the MA to send Resident #1 out to the hospital and was told again could not do anything until told by the GuardianShe tried to call the Guardian again, there was no answer and she left a voice mail to call her backOn 11/07/19, she reported to 2 different MAs that Resident #1's ram was broken and needed to be seen.				A. BUILDING	A. BUILDING.		
CLEVELAND HOUSE 950 HARDIN DRIVE SHELBY, NC 28150 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 44 member on 11/25/19 at 10:16am revealed: -She was informed of Resident #1's falls when she visitedShe was informed by the medication aide (MA) on 11/06/19, Resident #1's right wrist was swollen and discolored and Resident #1 could not move her fingersShe saw Resident #1's right wrist and noticed it was swollen and "crooked"She tried to call the Guardian again, there was no answer and she left a voice mail to call her backOn 11/07/19, she reported to 2 different MAs that Resident #1's arm was broken and needed to be seen.			HAL023045	B. WING		1	
SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OTHER APPROPRIATE DEFICIENCY) D 273 Continued From page 44 D 273 D 273	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 44 member on 11/25/19 at 10:16am revealed: -She was informed of Resident #1's falls when she visitedShe was informed by the medication aide (MA) on 11/06/19, Resident #1's right wrist was swollen and discolored and Resident #1's right wrist was swollen and "crooked"She asked the MA to send Resident #1 out to the hospital and was told again could not do anything until told by the GuardianShe tried to call the Guardian again, there was no answer and she left a voice mail to call her backOn 11/07/19, she reported to 2 different MAs that Resident #1's arm was broken and needed to be seen.	CLEVELAND HOUSE						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 44 member on 11/25/19 at 10:16am revealed: -She was informed of Resident #1's falls when she visitedShe was informed by the medication aide (MA) on 11/06/19, Resident #1 fell earlier and during the shower noticed Resident #1's right wrist was swollen and discolored and Resident #1 could not move her fingersShe saw Resident #1's right wrist and noticed it was swollen and "crooked"She asked the MA to send Resident #1 out to the hospital and was told again could not do anything until told by the GuardianShe tried to call the Guardian again, there was no answer and she left a voice mail to call her backOn 11/07/19, she reported to 2 different MAs that Resident #1's arm was broken and needed to be seen.		1	SHELBY, N	IC 28150			
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-She was informed of Resident #1's falls when she visitedShe was informed by the medication aide (MA) on 11/06/19, Resident #1 fell earlier and during the shower noticed Resident #1's right wrist was swollen and discolored and Resident #1 could not move her fingersShe saw Resident #1's right wrist and noticed it was swollen and "crooked"She asked the MA to send Resident #1 out to the hospital and was told again could not do anything until told by the GuardianShe tried to call the Guardian again, there was no answer and she left a voice mail to call her backOn 11/07/19, she reported to 2 different MAs that Resident #1's arm was broken and needed to be seen.	D 273	Continued From page	e 44	D 273			
on 11/08/19. She asked why the x-ray was taking 2 days when Resident #1 was in pain and she was told by one MA it was because "that's when it could be done". -On 11/08/19, while visiting Resident #1 still had no x-ray so she called the Guardian again and was able to talk to get on the phone. -She informed the Guardian about Resident #1's falls and arm with pain swelling and unable to move the right wrist and the x-ray was ordered 2 days ago and still had not been done. -The Guardian came and had the facility send Resident #1 to the hospital. -On 11/08/19, while at the hospital she was told Resident #1 was admitted for a GI bleed and broken wrist and arm. Review of Resident #1's progress notes revealed: -On 11/07/19 at 5:08pm, Resident #1 complained		member on 11/25/19 -She was informed of she visitedShe was informed by on 11/06/19, Residen the shower noticed R swollen and discolore move her fingersShe saw Resident # was swollen and "cro-She asked the MA to hospital and was told until told by the Guard-She tried to call the on answer and she le backOn 11/07/19, she repressident #1's arm was seenShe was told by one on 11/08/19. She ask 2 days when Residen was told by one MA it could be done"On 11/08/19, while v no x-ray so she called was able to talk to ge-She informed the Guardian came Resident #1 to the ho-On 11/08/19, while a Resident #1 to the ho-On 11/08/19, while a Resident #1 was adm broken wrist and arm	at 10:16am revealed: Resident #1's falls when the medication aide (MA) t #1 fell earlier and during esident #1's right wrist was d and Resident #1 could not t's right wrist and noticed it oked". Send Resident #1 out to the again could not do anything dian. Guardian again, there was fit a voice mail to call her borted to 2 different MAs that as broken and needed to be MA the x-ray would be done ed why the x-ray was taking at #1 was in pain and she was because "that's when it disiting Resident #1 still had d the Guardian again and t on the phone. lardian about Resident #1's in swelling and unable to and the x-ray was ordered 2 d not been done. and had the facility send ispital. t the hospital she was told initted for a GI bleed and c'1's progress notes revealed:				

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Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					С
		HAL023045	B. WING		11/25/2019
					11/20/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
CI EVELA	ND HOUSE	950 HAR	DIN DRIVE		
		SHELBY	, NC 28150		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
TAG	REGOLATOR OR	in ordination,	TAG	DEFICIENCY)	W 11 E
5.070					
D 273	Continued From page	e 45	D 273		
	right wrist. The medic	ation aide (MA) faxed the			
		er. The PCP gave an order			
		oile x-ray was notified, and			
	•	e was a high volume and			
	they would get there a	_			
		am, the Resident Care			
		nented she spoke with			
	, ,	wice after family member			
		: Resident #1's x-ray. The			
		inator (RCC) called to make			
		s coming. Mobile x-ray			
		be at the facility today			
		#1 did not complain of pain,			
	•	velling in Resident #1's right			
		ly elevated. There was no			
	documentation Resid				
		or of the delay with the			
	mobile x-ray on 11/08				
	-	om, the RCC spoke with the			
		assured they would be at			
	the facility today (11/0				
	• • • • • • • • • • • • • • • • • • • •	delay with the mobile x-ray			
		reported to the PCP on			
	11/08/19.				
	-On 11/08/19 at 4:58p	om, the RCC spoke with			
	Resident #1's Guardia	an to inform the Guardian			
	Resident #1 was goin	ng to be sent to the hospital			
	to receive an x-ray of	the wrist. There was no			
	documentation of the	delay with the mobile x-ray			
	for Resident #1 was r	reported to the PCP on			
	11/08/19.				
	-On 11/08/19 at 5:30p	om, (recorded as a late entry			
	on 11/09/19 at 2:11pm	n) Resident #1 was sent to			
	the emergency room	due to swelling and pain of			
	the right arm. PCP no	otified, Guardian notified.			
	Resident #1 was hosp	pitalized due to a broken			
	wrist and GI bleed.				
	-On 11/13/19, Reside	nt #1 would not return from			
	the hospital and woul	d go to another facility.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
74101 1244	or connection	A. BUILDING:		OOMII EETEB	
		HAL023045	B. WING		C 11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	,
		950 HAR	DIN DRIVE		
CLEVELA	ND HOUSE	SHELBY	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 273	Continued From page	e 46	D 273		
	Review of a picture of taken on 11/06/19 by member revealed: -The picture was of Rand handThere was moderate: #1's right wrist from the approximately 4 inchess Review of Resident #1 revealed an order recomplaints of right	n 11/25/19 at 10:46am, Resident #1's family desident #1's right arm, wrist a swelling noted to Resident the wrist up the arm es. at 's orders dated 11/07/19 questing a mobile x-ray due wrist pain, swelling and ated she could not move it. ok to the request,			
	A telephone interview with Resident #1's primary care provider (PCP) on 11/21/19 at 1:52pm revealed: -He was not notified of Resident #1's falls on 10/31/19 and 11/02/19 and 11/06/19. -He was received a fax on 11/07/19 requesting a mobile x-ray because Resident #1 was complaining of right wrist pain, swelling, bruising and unable to move it. There was no mention of the fall on 11/06/19 documented on the fax. -He gave an order to give as needed Tylenol for pain and approved the request for the mobile x-ray. -The staff was to notify him if there was increased pain, swelling, tenderness or the resident could not move the arm, wrist or fingers and he would send Resident #1 to the hospital. -He did not receive any additional information until after Resident #1 was hospitalized on 11/08/19. -He was not aware that mobile x-ray was going to take 2 days to get to Resident #1. -He did not receive any notifications about				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		HAL023045	B. WING		11/25/2019
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIR CODE	
NAME OF T	NOVIDEN ON 301 1 EIEN		DIN DRIVE	II., ZII CODE	
CLEVELA	ND HOUSE		NC 28150		
	QUILLA DIV OT	·			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	÷ 47	D 273		
	or nain other than wh	en he ordered the x-ray on			
	11/07/19.	en ne ordered the x-ray on			
		ed about Resident #1's x-ray			
		he would have sent her out			
	to the hospital.				
	Telephone interview v				
	11/23/19 at 12:00pm				
	-She was made aware Resident #1 had falls on 10/31/19, 11/02/19 and 11/06/19 during shift				
	report.	id 11/06/19 during shift			
		ve Resident #1 a shower			
	_	plained of right wrist pain.			
	-She noticed Residen				
		lue, Resident #1 could not			
	move her fingers on r	ight hand and the right wrist			
	was painful to the tou				
		d RCD about Resident #1			
		discoloration and Resident			
	#1 was unable to mov				
		er "they already knew that". nt #1 complained of pain and			
	swelling in right wrist.	·			
		all physician received order			
		n and continue to monitor			
	and to call if there we	re any changes.			
	-She asked the RCD				
		gain and was told to request			
	an x-ray from the phy				
		to the physician for an x-ray			
		" the request on 11/07/19. led the mobile x-ray and			
		2 days because they were			
	backed up.	2 days because they were			
	•	hysician and let him know			
	the x-ray was going to				
		and RCD know about the			
	x-ray taking 2 days be	efore it could be done.			
	Interview with the RC	C on 11/22/19 at 11:33am			

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	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
, and i but of contraction	BERTII 10/11/01/11/01/NBERT	A. BUILDING: _			
	HAL023045	B. WING		11/2	25/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE		
CLEVELAND HOUSE		DIN DRIVE NC 28150			
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
revealed: -Resident #1 sustained two-Resident #1 complained of swelling and pain around of could not remember when -She did not notify the PCF swellingShe did not call the PCP to have handled thatShe did not address the factoncerns because she was -She told the RCD about the concern afterwards. Interview with the RCD on revealed: -Resident #1's family mem 11/06/19 and informed her having right arm swelling a x-ray for Resident #1She informed the family m guardian for Resident #1, a discuss any issues with the -On 11/07/19, she requested physician for an x-rayShe did not speak with the falls, swelling or pain of Refor the 2 day delay of the manual transport of the Polysician after falls or compression response she or the RCC of the RCC and RCD were affollowing up with the physician were not taken care of the physician.	of right arm and wrist one of the falls but she it was. Pabout the pain and or opecause the MAs would amily members on the guardian. The family members on the guardian. The family members on about Resident #1 and pain, requesting an another there was a and she would need to be guardian. The guardian of the esident #1's right wrist, sobile x-ray. The for notifying the aplaints and if no would call. The for notifying the ass. The sponsible for cians with concerns	D 273			

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Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HARDIN DRIVE	AND PLAN OF COR	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HARDIN DRIVE	AND I LAN OF OOI	JORREOTION	BENTI IOATION NOMBER.	A. BUILDING: _		J COIVII EL	-120
CLEVELAND HOUSE 950 HARDIN DRIVE			HAL023045	B. WING		1	
CLEVELAND HOUSE	NAME OF PROVID	/IDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SHELBY, NC 28150	CLEVELAND H	HOUSE					
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
D 273 Continued From page 49 She was not aware the x-ray for Resident #1 was going to take two days to receive. She expected the MAs to follow up on the complaints and x-ray for Resident #1 with the physician and the RCC or RCD to follow up if there were issues. b. Review of Resident #1's current FL2 dated 07/08/19 revealed diagnoses included gastrointestinal bleeds (GI bleed) (a bleed from the stomach or intestines in which symptoms include black tarry stools, dizziness and weakness). Review of Resident #1's progress notes revealed: -On 10/31/19 at 10:27am, Resident #1 complained of dizziness and then fell, she was sent to the hospital. The PCP and Guardian was notified about the fall. There was no documentation Resident #1's dizziness was reported to the PCP on 10/31/19On 11/01/19 at 9:02am, Resident #1 stated she felt dizzy. There was no documentation Resident #1's dizziness was reported to the PCP on 10/10/19On 11/04/19 at 10:28pm, Resident #1 complained of dizziness, her blood pressure was 139/70, and pulse 66. There was no documentation Resident #1's dizziness was reported to the PCP on 11/04/19On 11/07/19 at 12:09am, Resident #1 fell at 9:45pm after standing up, turned too quickly and fell on her bottom. There was no documentation Resident #1's dizziness was reported to the PCP on 11/07/19On 11/07/19 at 12:20pm, Resident #1 was observed with a very unsteady gait, her blood pressure was 113/63 while stitting and 116/71 while standing. Resident #1's dated she was not	-Shi goir -Shi com phy ther b. F 07/0 gas the inclusive and the i	She was not aware to oing to take two days she expected the Momplaints and x-ray hysician and the RC here were issues. Review of Resident 7/08/19 revealed dia astrointestinal bleed astrointestinal bleed he stomach or intest include black tarry store akness). Review of Resident # On 10/31/19 at 10:22 complained of dizzine and to the hospital. To otified about the fall ocumentation Reside ported to the PCP on 11/01/19 at 9:02 at dizziness was resident 4/101/19. On 11/04/19 at 10:28 complained of dizzine and policy and pulse 86 coumentation Reside ported to the PCP of 11/07/19 at 12:09 at 45pm after standing all on her bottom. The esident #1's dizzine in 11/07/19. On 11/07/19 at 1:52p bserved with a very ressure was 113/63	the x-ray for Resident #1 was as to receive. As to follow up on the for Resident #1 with the CC or RCD to follow up if It #1's current FL2 dated agnoses included is (GI bleed) (a bleed from ines in which symptoms bols, dizziness and It's progress notes revealed: Tam, Resident #1 Tess and then fell, she was the PCP and Guardian was then the fell, she was on 10/31/19. There was no lent #1's dizziness was on 10/31/19. There was no lent #1 stated she no documentation Resident to the PCP on the ported to quickly and lere was no documentation ress was reported to the PCP on the ported to the PCP on the ported to quickly and lere was no documentation ress was reported to the PCP on the ported to the ported to the ported to the PCP on the ported to	D 273			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL023045	B. WING		C 11/25/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CI EVELA	ND HOUSE	950 HARDI	N DRIVE		
CLEVELA	ND HOUSE	SHELBY, N	C 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 50	D 273		
5 273	for a urinalysis after a Resident #1's urine (Care Director). There Resident #1's gait wa 11/07/19On 11/08/19 at 5:30p on 11/09/19 at 2:11pr the emergency room the right arm. PCP no Resident #1 was hosy wrist and GI bleedOn 11/13/19, Reside the hospital and woul	of foul order was noted with documented by the Resident was no documentation is reported to the PCP on the properties of	5210		
	concerns about Residuand complaining of di	n revealed: member reported her dent #1 having dark stools zziness about a week prior acility had not sent Resident			
	-The family member i had a history of GI ble Resident #1's (hemog-She was the new Gu was not aware of Resident #1 to the facility to send Reside evaluation of the dark pain from a fallResident #1 was tran 11/08/19 and admitted fractures of the right of the right ulnar styloidThe physician at the	iardian for Resident #1 and sident #1's health history. ity on 11/08/19 and told the ent #1 to the hospital for a stools, dizziness and wrist insported to the hospital on d for a GI bleed and distal radius and fracture of hospital told her Resident			
	transporting oxygen in range is 11.5-15.0) we low Hgb could lead to	o, a protein responsible for in the blood and the normal as dangerously low and a o dizziness and falls. aff to follow up on concerns			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
			D WING		С
		HAL023045	B. WING		11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CI EVELA	ND HOUSE	950 HARD	IN DRIVE		
OLLVLLA		SHELBY, I	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 51	D 273		
	of the family or compl soon as they were giv -It was possible if staf concerns, Resident #	aints from Resident #1 as			
	member on 11/25/19 -On 10/31/19, after R a MA Resident #1 fell confused and weakne -On 11/01/19, during a told the MA and the A was confused and dis -On 11/03/19, Reside she visited Resident # dizzyShe reported it to the Guardian but was uns -On 11/03/19, during a weak, and dizzy. She noticed dark stool and dizziness and weakne -The MA told her she things with the Guard discuss anything with the GuardianOn 11/03/19, she as send Resident #1 to t Resident #1 could no to the weakness but t -On 11/04/19, Reside	esident #1 fell twice she told because her "Hgb was low, ess". a visit with Resident #1 she dministrator Resident #1 soriented. nt #1 had another fall. When #1 was still weak and still e MA and tried to contact the successful. a visit Resident #1 was still changed Resident #1 and d reported the dark stools, ess to the MA. needed to discuss these ian and the staff could not her because she was not ked the night shift MA to he hospital because t do anything for herself due			
	concerns about Residulation of low Hgb, falls and parties. The Administrator tol	nistrator and voiced her dent #1's weakness, history			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		UAL 022045	B. WING		C	
NAME OF D		HAL023045			11/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER	950 HARDI	RESS, CITY, STA N DRIVE	TE, ZIP CODE		
CLEVELA	ND HOUSE	SHELBY, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
	#1's stools were dark still confused and wear -On 11/08/19, while vinformed the Guardia confusion, weakness, -The Guardian came Resident #1 to the horous -On 11/08/19, while a Resident #1 was admit broken wrist and arm -Resident #1's Hgb wright -If Resident #1 had be when she initially informay not have fallen and the Interview with a medicat 2:34pm revealed:	isiting Resident #1 she in about Resident #1's in dark stools. In and had the facility send spital. It the hospital she was told initted for a GI bleed and It as 9 on admission.				
	at 9:15am, she notice left leg. She remember stroke in the past, so #1 was transported to -Resident #1 complai dizziness but her spe -She reported the dizziness but her spe -She reported the dizziness but her spe -She reported the RCD through the RCD and the RCD through the resident #1's rece -On 11/04/19, after be member informed her -She informed the RCD family's complaint.	ed Resident #1 dragging her ered Resident #1 had a she called 911 and Resident to the hospital. Index over the next week of each was good. Iziness and weakness to the roughout the week because not fall. Ising off for 2 days, a family Resident #1's was dizzy. In about Resident #1's In the family member was the RCC would contact the with a second MA on				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
					l c	
		HAL023045	B. WING		1	5/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
CLEVEL A	ND HOUSE	950 HARI	IN DRIVE			
CLEVELA	ND HOUSE	SHELBY,	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROFED DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 273	complained about Re stools" but she had ju shower and did not not resident #1's family about Resident #1's Hgb was but it was a hard situal member was not the goy the RCD and the Adiscuss issues about member. It was a difficult posit family members concide Administrator. Telephone interview was a 4:00pm revealed: On 11/04/19, Reside thought, because of hwas experiencing and because Resident #1 dark colored stools. She was concerned informed the RCC and #1's dizziness and blaces he was instructed to bathroom, increase fluent ate. She was still concern the RCD to report issue the RCD. On 11/06/19, Reside to the facility for a visit was in pain, dizzy, ha "bleeding inside".	at #1's family member had sident #1 having "dark st given Resident #1 and office any dark stools. In member had complained as dizzy and thought as low and causing the falls ation because the family guardian and she was told administrator she could not Resident #1 with the family from she was in but made the erns know to the RCD and with a third MA on 11/24/19 and #1's family member for history, Resident #1's other GI bleed because low was dizzy, falling and had about Resident #1 and dithe RCD about Resident	D 273	DEFICIENCY)		
	RCDShe was off the next					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			
,	o. 001.11.2011011	152.** 167.1.16.**.	A. BUILDING:			
		1141 000045	B. WING			C
		HAL023045	B. WIITO	· · · · · · · · · · · · · · · · · · ·	11	/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	E, ZIP CODE		
CLEVELA	ND HOUSE	950 HAR	DIN DRIVE			
CLLVLLA	IND HOUSE	SHELBY	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 54	D 273			
	that Resident #1 was wrist and a GI bleed.	in the hospital for a broken				
	Interview with the RC revealed:	C on 11/22/19 at 11:33am				
	dizziness, dark stools	complain to her about s or pain and swelling to right				
		esident #1's family member				
	dark stools and swell	ent #1 having dizziness, ing and pain of the right wrist				
	on and after 10/31/19 to 11/08/19She did not call the physician because the MAs					
	would have handled t -She did not address					
		e was not the guardian.				
		out the family members				
		#1's dizziness, dark stools				
		g of the right wrist after the				
	conversation with the					
	Interview with the RC revealed:	D on 11/22/19 at 12:00pm				
	-Resident #1's family	member called her on d her about Resident #1				
	having dark stools, di hemoccult for Reside	zziness, and requesting a nt #1.				
		mily member there was a t #1, and she would need to				
	discuss any issues w	ith the guardian.				
		quested an order from the				
	physician for a hemo					
		ith the physician about the				
	dark stools or dizzine					
	-	onsible for notifying the				
		r complaints and if no				
	response she or the F	KUU Would call.				
	Review of Resident # 11/08/19 a faxed requ	1's orders revealed on uest to the PCP for a				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLE	ובט
		HAL023045	B. WING		11/2	5/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1172	0/2013
			DIN DRIVE			
CLEVELA	ND HOUSE		NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 55	D 273			
	hemoccult stool due to dark stools per family with a return fax on 11/08/19 with an "ok" to the request.					
		1's progress notes revealed related to hemoccult or				
	Resident #1's gastroe 3:15pm revealed: -Resident #1 was bei gastrointestinal bleed related to ulcersIf the Hgb dropped b dizzinessIf the Hgb dropped b would need to be per -If Resident #1's Hgb could cause dizziness	was low (9 or below) it s and could contribute to				
	care physician (PCP) revealed: -Resident #1 had a hi anemiaOn 11/08/19, was the about Resident #1 ha stools when the staff hemoccult test to be because of a report of the hemoccult was relif he had been notified complaint about dizziout to the hospital	with Resident #1's primary on 11/21/19 at 1:52pm istory of GI bleeds and e first time he was informed aving dizziness, and black called and requested a done on Resident #1 if "dark stools". not completed. ed about Resident # 1's ness he would have sent her				
	Interview with the Adr 1:00pm revealed: -She spoke to Reside	ministrator on 11/22/19 at ent #1's Guardian on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SUR COMPLETE	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETE	-0
		HAL023045	B. WING		C 11/25/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI SHELBY, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	family member of Res reports by the family having dark stools an -The family member of dizziness or dark stool -The family member of dizziness or dark stool -The MAs were responsive to the MAS were responsive to the RCC and RCD of following up with the physician. -She expected the Macomplaints for Reside the RCC or RCD to form a resident with a have dizziness which result for a diagnosed GI blowhich was dangerous report 4 falls, the last her right wrist in which move her fingers, explored the medical medical and constitute. The facility provided a accordance with G.S. CORRECTION DATE	9 after speaking with the sident #1 concerning the member of Resident #1 d dizziness. did not voice anything about of at that time. Insible for notifying the incerns or the requesting were responsible for physicians with concerns are of after the MAs notified As to follow up with the ent #1 with the physician and follow up if there were issues. Trovide referral and follow-up history of GI bleeds and rry stools, weakness, and ted in a delay of treatment eed and a hemoglobin level sty low. The facility failed to fall resulted in 2 fractures to the Resident #1 could not be perioned pain and swelling perioned p	D 273			
D 338	10A NCAC 13F .0909	Resident Rights	D 338			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL023045	B. WING		11	C / 25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
CLEVELA	AND HOUSE		DIN DRIVE			
		SHELBY	, NC 28150			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 338	10A NCAC 13F .0909 An adult care home is all residents guarante Declaration of Reside and may be exercise. This Rule is not met TYPE B VIOLATION Based on record revifacility failed to assur (#2 & #4) was treated the staff on second a speaking to and prov (#4) and related to the items from his room viresident present (#2) 1. Review of Resident og/19/19 revealed: -Diagnoses included hip fracture, and musimality fracture	P Resident Rights shall assure that the rights of seed under G.S. 131D-21, ents' Rights, are maintained d without hindrance. as evidenced by: ews and interviews the e 2 of 5 sampled residents d with respect and dignity by and third shifts when iding care for the residents e Administrator removing without permission and the current FL2 dated unspecified dementia, right acle weakness. mi-ambulatory with the use et's incident report dated revealed: am Resident #4 was found in ons, bruising, a laceration,	D 338			

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DIVISION	n nealth Service Regu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	D
			B. WING		C	
		HAL023045	B. WING		11/25/2	019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
		950 HARD	, ,	,		
CLEVELA	ND HOUSE					
		SHELBY,	NC 28150			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
TAG	REGOLATORI ORT	EGO IDENTIL TING IN GRANATION	TAG	DEFICIENCY)	WAY E	
D 338	Continued From page	e 58	D 338			
	She did not like to as	sk the staff to help her				
		s not nice to her on many				
	occasions.	s not nice to her on many				
		an accord and third shift to				
		on second and third shift to				
		the floor because she could				
		m in her wheelchair, and				
	•	did not hear her request for				
	help.					
		help, she had to wait a long				
		ne had gone ahead and				
	done it herself.					
		vith the staff one evening				
	•	e they were being very loud.				
	-She told the staff the	y were being too loud, and				
	they told her to mind	her own business when				
	things don't involve he	er.				
	-One of the second sl	hift staff members came into				
	her room sat on her b	ed after the incident				
	laughed at her and to	ld her she was not going				
	home.					
	-She felt "shunned" b	y a personal care aide				
	(PCA) on night shift.					
	-During the evening h	ours after dinner the staff				
		er when she was in the living				
	room with other reside	ents.				
	-The staff would look					
		ude her in a conversation.				
		nsible party had gone to the				
	Administrator and rep					
	-	d not come to speak to her				
	about a complaint she					
	•	Administrator even knew				
	her name.	A COMMISSION OF CIT KITCW				
	nei name.					
	Interview with anothe	r resident on 11/22/19 at				
	9:00am revealed:	1 TOORGOIT OIT TITZZ/10 At				
		Resident #4 when she				
		etting things she dropped on				
	the floor.	at #4 in the commercial				
	-one sat with Resider	nt #4 in the common area	1			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74401 2744	SI COMMEDITION	BERTH TO ATTOM NOW BERT	A. BUILDING: _		JOHN EETEB
					С
		HAL023045	B. WING		11/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
01 = 1/= 1 4	ND 1101105	950 HARD	IN DRIVE		
CLEVELA	ND HOUSE	SHELBY, I	NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 338	Continued From page	: 59	D 338		
		enings and noticed staff did t #4. rator was not an			
	at 9:15am revealed: -She heard Resident: staff membersResident #4 said she staff members to help -Resident #4 told her members were as kin -She did not report the because she took it a her because she liked members. Interview with Reside (RP) on 11/22/19 at 9	she wished all the staff d as her. e conversations to anyone s a compliment directed at d her better than other staff nt #4's responsible party			
	staff members that sh Administrator a couple -Resident #4 had bec staff members becaus being very loud after 9 weeks ago. -The staff member tol our business that wha involve her. -Later in the evening a member came into Re her bed to discuss the	e had reported to the e of weeks ago. ome angry with one of the se the staff member was 9:00pm one evening a few d Resident #4 to mind her at was going on did not effect the interaction the staff esident #4's room sitting on e interaction and ended the			
	you're not going home -Resident #4 told her additional times she h staff.	about this interaction and lad felt alienated by the ministrator and she told her			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL023045	B. WING		1:	C 1/ 25/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
CLEVELA	AND HOUSE		RDIN DRIVE 7, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	reprimandedResident #4 had be interactions between -Resident #4 was de to ask the staff to he -She was very conce not been checking or resulting in a fall. Interview with the Ad 2:30pm revealed: -Resident #4's RP in member had an inapresidentShe reprimanded th RPShe did not discuss with Resident #4 to rincident had been ad -She did not want Resincident. 2. Review of Resident 12/31/18 revealed didisorientation, seizur vitamin D deficiency, history of hip fracture. Review of Resident 10/10/17 revealed hi roommate. Interview with Resident revealed items below roommate had been without their permiss. Interview with Resident 11/22/19 at 1:35pm resident resident with Resident revealed items below roommate had been without their permiss.	en unforgiving of the her and the staff. termined she was not going up her unless she needed it. erned the staff members had in Resident #4 enough ministrator on 11/08/19 at formed her that a staff propriate interaction with the e staff member and told the the incident and follow up teassure the resident the ddressed. Esident #4 to dwell on the edisorder, osteoporosis, vitamin B12 deficiency, and existence with the edisorder of	D 338			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				С		
		HAL023045	B. WING		11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARDI				
	I	SHELBY, N	C 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	e 61	D 338			
	shared with Resident -She was not asked prom their roomThere were items of roomShe did not know whete When she had asked was taken, they didn't -She did not feel this Administrator to remoin the room. Interview with the me 11/22/19 at 2:00pm re-The Administrator en from Resident #2's ropermission last weekIt was difficult to get roommate to clean up Interview with the Adr 2:30pm revealed: -She had removed so #2's roomShe had removed the visited the building last-She did not ask pernand clear out clutter from the removed the item of the she room.	#2 last week. Dermission to remove items Clothing missing from their Dere the items were moved. If the staff where her stuff it know. Developed items without her being Developed items without her being Developed items on without asking Developed items De				
	facility failed to assure dignity and respect re alienated by staff that and did not provide he The behavior led to R for help and attemptir	ews and interviews the e residents were treated with egarding Resident #4 feeling spoke to her inappropriately elp when she asked for it. lesident #4 not willing to ask ag to act independently injuries and Resident #2's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _			
HAL023045		B. WING		C 11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CLEVELA	ND HOUSE	950 HARD SHELBY	OIN DRIVE 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 338	items being removed permission and the refailures of the facility was detrimental to the of the residents and oviolation. A plan of protection win accordance with G CORRECTION DATE VIOLATION SHALL N 2020.	from his room without esident present. These to assure residents rights to health, safety, and welfare constitutes a Type B ras provided from the facility S. 131D-34.	D 338		
	10A NCAC 13F .1208 (g) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (g) With regard to any resident death under circumstances described in G.S. 130A-383, a facility shall notify the appropriate law enforcement authorities so the medical examiner of the county in which the body is found may be notified. Documentation of such notification shall be maintained by the facility and be made available for review by the Division upon request. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to assure notification of local law enforcement for 1 of 1 resident (Resident #6) who was found unresponsive on her bed. The findings are:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
HAL023045		B. WING		11	C 11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	ZIP CODE	•	
CLEVEL A	ND HOUSE	950 HAR	DIN DRIVE			
CLEVELA	IND HOUSE	SHELBY	NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 444	D 444 Continued From page 63		D 444			
	Review of Resident #6's current FL2 dated 05/17/19 revealed diagnoses included non-insulin diabetes, sleep apnea, hypertension, major depression and lupus. Review of Resident #6's Accident/Incident Reports revealed there were no reports documented or available.					
	Review of Resident #6's electronic progress notes revealed there were no progress notes documented on 10/22/19 when Resident #6 expired.					
	Interview with Resident #6's Provider on 11/25/19 at 2:00pm revealed: -He was notified about Resident #6 after the Paramedics pronounced her deceased on the sceneResident #6 had a history of hypertension and possibly died of a cardiac eventHe fill out the death certificate and the cause of death was a myocardial infarction.					
	on 11/25/19 at 2:15pr -On 10/22/19, she for unresponsive at 8:00/ -She had another MA -She notified the phys Coordinator (RCC), F (RCD), and the Admir -The RCD notified the -Resident #6 was pro EMSResident #6's death expected and surprise even been sick.	und Resident #6 in her bed pm. I call 911 and started CPR. Sician, Resident Care Resident Care Director histrator.				

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
			R WING		С	
		HAL023045	B. WING		11/25/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE	950 HARD				
		SHELBY, N	NC 28150		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 444	4 Continued From page 64		D 444			
	revealed: -She was called by the coded and 911 was of the coded and 911 was incident in police were not called family because she do the Police. Interview with a second 3:30pm revealed: -On 10/22/19 around a second MA that Resided to call 911The RCC, RCD and by the second MAResident #6's death was enforcement. Interview with the Adra 3:40pm revealed: -On 10/22/19 she was Resident #6 coded are awaiting 911 to get the She notified the famiting Resident #6's death and not expected at a She did not call local	the facility the paramedics ident #6 deceased. eport filled out and the dignst the physician and the id not think she had to call and MA on 11/25/19 at 8:00pm she was alerted by sident #6 coded and she the Administrator was called was unexpected. It she had to call the local and the identification on 11/285/19 at it is notified by the MA and CPR was in progress ere. Ily. was a surprise and sudden,				
D911	G.S. 131D-21(1) Dec	laration of Residents' Rights	D911			
		ration of Resident's Rights nave the following rights:				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		, 23 i.b. 113		С		
HAL023045			B. WING		11/25/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE		DIN DRIVE , NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D911	1. To be treated with dignity, and full recog individuality and right. This Rule is not met Based on observation reviews, the facility fareceived care and set appropriate, and in confederal and state laws related to Resident R. The findings are: Based on record reviet facility failed to assured dignity and respect realienated by staff that and did not provide h. The behavior led to R for help and attempting resulting in a fall with items being removed permission and the real Tag 338, 10A NCAC (Type B Violation)].	respect, consideration, nition of his or her to privacy. as evidenced by: ns, interviews, and record illed to ensure residents rvices which were adequate, ompliance with relevant is and rules and regulations	D911			
	G.S. 131D-21 Declar Every resident shall h	ration of Residents' Rights nave the following rights: al and physical abuse,				
	This Rule is not met	as evidenced by:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
						С
		HAL023045	B. WING		11/	/25/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CLEVELA	ND HOUSE		DIN DRIVE , NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D914	reviews, the facility fawere free of neglect r supervision and healt The findings are: 1. Based on observatinterviews, the facility for 5 of 5 sampled results, and #5) related to NCAC 13F .0901(b) F Supervision (Type A1 2. Based on observatine reviews, the facility family for 5 sampled reside treatment for a reside stools, dizziness and delayed treatment for wrist after a fall, (Results)	ciled to ensure residents elated personal care and ch care. cions, record reviews, and failed to provide supervision sidents (Resident #1, #2, #3, falls. [Refer to Tag 270, 10A Personal Care and	D914			

Division of Health Service Regulation

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