PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIL	LILD
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6	4 EAST A, NC 27925			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
D 000	Initial Comments		D 000			
		sure Section conducted an implaint investigation on 17/19.				
D 079	10A NCAC 13F .0306 Furnishings	S(a)(5) Housekeeping and	D 079			
	10A NCAC 13F .0306 Furnishings (a) Adult care homes (5) be maintained in orderly manner, free of hazards; This Rule shall apply facilities.	s shall an uncluttered, clean and of all obstructions and				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa environment free of h unit as evidenced by bed bug infestation th days and a broken wi	ns, interviews and record illed to maintain an azards in the special care Resident #9's room having a nat was left untreated for 7 ndow in resident room 209 for more than 6 weeks.				
	The findings are:					
	05/07/19 at 4:48am a -There was a bedbug the special care unit (-She found 2 bedbug month ago while she	infestation at the facility in				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL H	IOUSE	950 HWY (64 EAST			
COLUMBI			A, NC 27925			
(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	(X5) COMPLETE DATE
D 079	Continued From page	: 1	D 079			
	duty but she could no working at that time. She had not seen an rooms until this past Stresident #9 came outlight and said someth Another PCA went in discovered there were. The other PCA came into Resident #9's room. They saw multiple be pillows, sheets, and be They did not see any. They removed the bewashed it all in hot washed because the resident. The other PCA also conceived the seen assisted living (AL) side about the bedbugs. She had never seen assisted living (AL) side and said she was 15/04/19. She found three bed shere were bed bugs. There approximately the pillow and along the same of the pillow and along the pillow and along the same of the pillow and along the pillow and along the same of the pillow and along the pillow an	y bedbugs in residents' Saturday night (5/04/19). It of her room on Saturday ning was biting her. Ito Resident #9's room and be bedbugs in the room. It and got her and they went om together. It bedbugs on Resident #9's bedbugs on the mattress. It bedbugs on the deet the room next to out the PCA did not see any It on duty reported the Manager (CM). In the Manager (CM). In the front desk on the It to the resident #9's arm. It to the resident #9's arm. It to bed bugs on the sheet, It he seams of the pillow. It bed bugs because she	D 079			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 2 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		11-100000	B WING		05/45	7/0040
		Hal089002	D: 111110		05/1/	7/2019
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
			IA, NC 27925			
(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	(X5) COMPLETE DATE
D 079	Continued From page	2	D 079			
	-She checked the sea not find any bed bugs -She had read online bugsShe and the PCA rer pillows, stuffed anima and dried them three -She saw bed bug eg knew what they looked -It was hard to tell if Fibefore 05/05/19Resident #9 had dry always scratching bed -She had administered #9 every morning and bugs before 05/05/19 -She was told the day 05/05/19 cleaned Resident #9 roomShe could not rement finding the bed bugsThe process for man facility was for staff to reported to the Administrator worth the computer and mat to the facility and tread -Resident #9's room in bugs as of 05/08/19 bugs was taged to the pest con-Resident #9 was staged until the room had be staged to the post of the staged to the pest con-Resident #9 was staged the room had be staged to the pest con-Resident #9 was staged the room had be staged to the pest con-Resident #9 was staged to the pest con-Resident #9 was staged the pest con-Resident #9 was staged to the pest con-Resident #9 was staged the pest con-Resident #9 was staged to the pe	ams of the mattress but did at that heat killed the bed moved the bed linens, als and blankets and washed times. It is an an an at least times and blankets and washed times. It is an at least times are at like from online images. It is also that the fore of				
	Observations of Resid	dent #9's room on 05/07/19				

Division of Health Service Regulation

at 4:44am revealed:

STATE FORM STATE FORM If continuation sheet 3 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6	4 EAST		
		COLUMBIA	, NC 27925		
(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 079	Continued From page	3	D 079		
	-The mattress was turand leaned against the bedThere were no linensThere were personal blanket on the recline storage bins and clott drawersNone of the clothing, were sealed in plasticThe recliner had fine of the chair that reserThere was dirt and dithe carpet on the flooThere was no reside.	rned up on the box spring le wall at the head of the s on the mattress. Items in the room such as a r, throw pillows, plastic ning in the closet and blanket or throw pillows bags. white particles in the folds hable bed bug eggs. ust build up on and around r. nt in the room. dent #9's room on 05/09/19			
	bug excrement aroun outlet, a picture hange and around a small he above the headboard -There were two sma picture hanger and fo the headboard.	ack specks resembling bed d the call bell, electrical er on the wall above the bed bole in the wall in the corner. Il pale bed bugs next to the ur small pale bed bugs on			
	12:47pm revealed: -Bed bug management process and time frame-When staff found been the staff sent photos of cell phoneShe sent the bed bug staff and he sent the pest control comp	d bugs in a resident's room, of the bed bugs to her via g photos to her maintenance photos to his supervisor and			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 4 of 267

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					1	
		Hal089002	B. WING		05/1	17/2019
NAME OF D	DOVIDED OD CURRUED	OTDEET AS	ADDECC CITY CTA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ATE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
111111111111111111111111111111111111111	110002	COLUMB	IA, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) BE	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 079	Continued From none	- 4	D 079			
טטופ	Continued From page	: 4	0079			
	and heat treat the roo	om.				
		e work order she put in for				
	the bed bugs in Resid					
		of the evidence of bed bugs				
	on the walls in Reside	ent #9's room.				
	Review of a compute	rized work order dated				
	05/06/19 revealed:					
	-There was documen	tation of a "Life safety" work				
	order for bed bugs in	Resident #9's room.				
		from the Administrator and				
	assigned to the canin					
	accigned to the carmin	o nanalor.				
	Davious of amaila hat	waan tha tha Administrator				
		ween the the Administrator,				
		rict Manager (MDM) and the				
	canine Manager date	d 05/07/19 and 05/08/19				
	revealed:					
	-On 05/07/19 at 10:43	Bam, there was				
	documentation an image	age was sent from the the				
	Administrator to the N	•				
	-On 05/07/19 at 10:46					
		DM forwarded the image to				
		Divi forwarded the image to				
	the canine Manager.					
		7am, the canine Manager				
	·	would be scheduled for after				
	05/08/19.					
	-On 05/08/19 at 8:54a	am, the MDM forwarded the				
	canine Manager's rep	oly to theAdministrator.				
	Interview with the ma	intenance staff on 05/09/19				
	at 5:07pm revealed:					
		I by the Administrator on	1			
		ed bugs in Resident #9's	1			[
	room.					
	-He followed up with	his supervisor on 05/06/19 to				
	coordinate pest contr	ol treatment of the room.				
		m, so no one was able to	1			[
	enter the room.	, 13 112 1112 1130 4310 10				
		lse he could do to prevent				
	the spread of the bed	bugs.				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 5 of 267

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ´	- CONSTRUCTION	COMPL	
			A. BOILDING.			
		11-1020002	B. WING		05/4	17/2040
		Hal089002			05/1	17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
		COLUMB	IA, NC 27925			
(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	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 079	Continued From page	e 5	D 079			
	Observation on 05/13	3/19 at 11:30am revealed				
	Resident #9's room w					
		/19 at 4:44am; all personal				
		un-bagged and in the room.				
		ekeeper on 05/14/19 at				
	1:15pm revealed:	***				
		ility for a couple of weeks on				
	the AL side.	bed bugs in the facility.				
		Regional Clinical Director				
	_	dents clothing in the dryer at				
		eit for one hour if bed bugs				
	were found.	-				
		v to clean a room after				
	finding bed bugs					
	-He knew the room no	eeded to be wiped down; he				
	uld flot know what ch	erricals to use.				
	Interview with the Ho	usekeeping Supervisor on				
	05/14/19 at 1:35pm re					
	_	bed bugs while cleaning				
	rooms on the SCU.					
	•	responsible for spraying and				
		rooms where bed bugs the pest control company				
	came.	the pest control company				
		rith a chemical that was				
	already mixed.					
	-	nal belongings were bagged				
	up and taken to the la	aundry room where it was				
	dried several times, w	vashed and dried again.				
	Intorvious with the Ad-	ministrator on OE/1E/10 at				
	2:55pm revealed:	ministrator on 05/15/19 at				
	-Resident #9's room 2	203 suite A had been				
	cleared out.	200 Callo / Frida Doori				
		ig was placed in plastic				
		en outside and placed by the				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 6 of 267

DIVISION	i Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	: IED
		Hal089002	B. WING		05/4	7/2019
		1101003002			1 05/1	112013
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TTINKLLL	HOUSE	COLUMB	IA, NC 27925			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETIGIENCY)		
D 079	Continued From page	e 6	D 079			
	storage unit.					
	The family member w	vas going to nick up				
	Resident #9's clothing					
	,	said to throw away the				
	<u>-</u>	r furniture belonging to				
	Resident #9.	i lullillule belonging to				
		ard and bed frame were				
		yed with rubbing alcohol. sealed off and was awaiting				
		9				
	•	pest control company.				
		ed clearing Resident #9's				
	room out on 05/12/19					
	-The last pieces of pe					
	discarded on 05/14/19					
		eturn to the facility following				
		ment of the resident's room.				
		ne corporate office at the				
		k (05/13/19) to have the pest				
	• •	e out and treat for bed				
	bugs.					
		npany would not be available				
	until the end of the we	•				
		s waiting for the pest control				
	•	s, staff were expected to				
	•	n immediately and place in				
	the dryer.	to take the regident to				
	•	to take the resident to				
		spital gown and dry the				
	removed clothes.	to wine down furniture in the				
		to wipe down furniture in the				
	room and spray rubbi					
		to check for bed bugs in the				
	adjoining suite.	- for head because				
		s for bed bugs were done by				
	the canine inspector a	and/or pest control				
	company.					
		the family members of the				
		e week (05/13/19) related to				
	the bed bugs.					

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 7 of 267

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/20	019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 64 COLUMBIA				
(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 C	(X5) COMPLETE DATE
D 079	Continued From page	27	D 079			
	11:53am revealed: -He was contacted at on 05/08/19Staff sent the location bugs that were found -He forwarded the infethe canine inspectorThe canine inspector identify which rooms I -The canine inspector him and the facility; the company was contacted. Observation on 05/13 there was a dog going with the canine handled. Interview with the can 11:30am revealed the	went out to the facility to bed bugs were active in. Then emailed a report to be the pest control ted to treat for the bed bugs. 1/19 at 11:20am revealed groom to room in the facility er. 1/19 at were findings that he				
	05/13/19 revealed: -An inspection was confacility including 60 round -Concerns were identified and another roomNext step were listed company and rechect reatment was on 04/10. Telephone interview with the pest control company revealed: -A technician would g	inspection report dated completed on all areas of the coms. ified in Resident #9's room I as notify pest control o in 30 days. tation the facility's last 08/19. with a representative of the con 05/14/19 at 3:30pm o out to the facility and and determine what type of				

Division of Health Service Regulation

-Canine inspection was also used to inspect for

STATE FORM STATE FORM ZE7D11 If continuation sheet 8 of 267

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	,
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		11-100000	B. WING		05/47/004	
		Hal089002			05/17/201	9
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TVDDELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	A, NC 27925			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	l ((X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COM	MPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE D	DATE
				DEI IGIENGT)		
D 079	Continued From page	e 8	D 079			
	bed bug activity.					
		vere the most effective way				
	of finding bed bug act					
	-The pest control com	-				
		ng, treating or preventing				
	bed bugs.	ng, acating or preventing				
		npany would get out to treat				
		acted, as soon as possible.				
	-	treated for bed bugs seven				
	times by the pest con					
		npany required permission				
	from the facility to rele					
	information.					
		contacted the pest control				
		ug treatment for May 2019.				
	, , ,	3				
	Interview with the pes	st control technician on				
	05/16/19 at 2:24pm re					
	-	to heat treat furniture from				
	Resident #9's room.					
		ove the wall receptacles				
	•	ces and general area of				
	Resident #9's room.					
		e entire facility, only rooms				
	adjacent to the room					
	-	erday by his Supervisor to				
	treat for bed bugs at t					
		call center out of another				
	·	It to determine when the call				
		ore going to the Supervisor.				
		left with the facility were to				
	·	off overnight with any staff				
	or residents entering	the following day.				
	Interview with the Adr	ministrator on 05/15/19 at				
	12:30pm revealed:	initiation on oo/10/19 at				
		r contacted the pest control				
	company on behalf of					
		r gives the pest control				

Division of Health Service Regulation

company information on where bed bug activity

STATE FORM STATE FORM ZE7D11 If continuation sheet 9 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
	Hal089002	B. WING		05	5/17/2019
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
TYRRELL HOUSE	950 HW	Y 64 EAST			
	COLUM	BIA, NC 27925			
PREFIX (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 TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
contact with the pest of treatment of the bed by a facility by the end of the facility by the end of the facility by the end of the facility by the for bed bug manager followed it. Review of the facility's revealed: -Until bed bugs were were to be followed for of residents and to probugs. -Carefully remove bed into bags and tie close into bags and tie close into bags and tie close into bags and the dryer addryerdo not leave be area. -Remove bag and sea carry the bag out of the immediately. -Do not move the resident another room. -Suspected rooms mual beds must be taken acrevice, cleaned thorough the control can treat. -Pictures, purses, per wheelchairs and walk. -Housekeeping must wipe down all surface.	anine inspector to request control company for ougs. In told the Administrator he est control company to the he week. Don 05/14/19 at 4:50pm and a policy and procedure ment; the staff had not sundated bed bug protocol confirmed the following step or the safety and well-being event the spread of bed dding and clothing and place end. ags to the laundry and place end dump items into the ags sitting in the laundry all it inside another bag; he facility to the dumpsters ident or their belongings to ust be cleaned thoroughly, apart, vacuumed crack and oughlyand isolated until sonal items including ers must be cleaned, thoroughly vacuum and is to include baseboards, out), beds, closets, pictures, out), beds, closets, pictures,	D 079			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 10 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY			
	OLUMBA DV OT		A, NC 27925		
(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 079	Continued From page	÷ 10	D 079		
	Resident #16 dated 0 -Resident #16 "went is and pulled the window window." - "When staff heard no resident, the resident window and the window pare the lower window pare. The window pain was cardboard and black is linterview with a house 2:47pm revealed he could be window in resident to the window in resident to the window in resident with the window in the lawnmower of the lawnmower is she wasn't sure. Interview with the Care 105/08/19 at 3:12pm resident with the Care 105/08/19 at 3:12pm resident with the window in Administrator would know in the window in the win	nto another resident's room v up and looked out the oise and approached the came from under the ow cracked." //19 at 2:47pm revealed: epair technician removing lee in resident room 209. It is fully covered with stape. ekeeper on 05/08/19 at lid not know what happened lent room 209. onal care aide (PCA) on evealed: w long the window had been ened. It is window last week, but the window last week, but the Wanager (CM) on evealed she was not sure left what happened and in resident room 209; the show.			
	Interview with the Adr	ninistrator on 05/08/19 at			

Division of Health Service Regulation

-Resident #16 was seeking to get out of the

STATE FORM STATE FORM ZE7D11 If continuation sheet 11 of 267

STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE	-	
TYRRELL	HOUSE	950 HWY	64 EAST			
		COLUMB	IA, NC 27925			
(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	(X5) COMPLETE DATE
D 079	Continued From page	e 11	D 079			
ם פ פיע	window in another's raround the first of Api -The resident tried to through the screen, babout four inchesThe staff found the resident, which staff a occurredShe would have to cincident reports. Upon request on 05/0 no incident report for attempted elopement. Interview with a concution resident had 209 over a month agountil this week (05/06) -The Care Manager (was upset and wanteresident" busted the varied that the concution of the time the window with the concution of	resident room (room 209) ril 2019. lift the window and get out but the window only opened resident at the window. Independent the details of which and when the incident resident when the incident resident resident. 108/19 at 3:12pm, there was the broken window and the reby a resident. 108/19 at 3:12pm, there was the broken window and the reby a resident. 108/19 at 3:12pm, there was the broken window in room to and they did not repair it				
	(209) at the window.	The window was cracked.				

Division of Health Service Regulation

-Resident #16 had pulled the window up and was

STATE FORM STATE FORM ZE7D11 If continuation sheet 12 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST A, NC 27925			
OUMANDY OTATEMENT OF DEFINITION		ID	PROVIDER'S PLAN OF CORRECTION	N (X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 079	Continued From page	e 12	D 079			
	windowThe resident refused window, so she left the -When she and the C the resident was still a -She and the CM ass the window and the b the groundThe maintenance state a piece of cardboard with clear plastic. The taped by maintenance tape remained on the days ago.	and shoulders through the I to move away from the the room to get the CM. M came back into the room, the attempting to get out. The isted the resident away from the roken window fell out onto aff covered the window with the and covered the cardboard the plastic and cardboard was the and the cardboard and the window until repaired 2 on the special care unit				
	(SCU) on 05/14/19 at -Resident #16 was try and kicked the windor month (May 2019) bu date.	10:10am revealed: ying to get out of the facility w out in room 209 last It she did not remember the				
	-The resident had pulled the window up and could not get out. - Another staff and she observed her with part of her body out of the window (her head and shoulders), but she got stuck. -Maintenance tape cardboard over the window and the cardboard remained over the window until last week. Interview with the Administrator on 05/14/19 at 3:45pm revealed: -Resident #16 broke the window in room 209 and pushed the screen out and was observed with her head out of the window. -Staff heard noise in room 209 and when they went in the room, Resident #16 had already broke the window and had her head out of the window.					

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 13 of 267

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING: COMPLE			
			A. BOILDING.	A. BUILDING:	
		Hal089002	B. WING		05/17/2019
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6	4 EAST A, NC 27925		
(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 079	Interview with the mai at 3:13 pm revealed: -The window in room out around the 1st of resident who was trying. -He taped a temporary which were cardboard to the window. -The window was reprepair company. -The facility was respuglass company and set the window. The facility failAdministenvironment free of hand broken windows special care unit (SCU prevent the spread of prevent possible elop un-repaired broken windows was detrimental well-being of resident constitutes a Type B. The facility provided as	d not know why there was a window. intenance staff on 05/16/19 209 was broken and kicked last month (May 2019) by a ng to get out of the window. y cover over the window d and plastic covering taped laced last week by a glass onsible for contacting the cheduling replacement of strator to maintain an azards related to bed bugs in resident rooms on the J). The facility's failure to bed begs for 7 days and ement and/or injury from an indow for more than 6 al to the health, safety and violation.	D 079	DET IOLENOT)	
		DATE FOR THE TYPE B IOT EXCEED JULY 1, 2019.			
D 113	10A NCAC 13F .0311	(d) Other Requirements	D 113		
	10A NCAC 13F .0311 (d) The hot water sys	Other Requirements stem shall be of such size to			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 14 of 267

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
		11.100000				
		Hal089002	B. WIIVO	· · · · · · · · · · · · · · · · · · ·	05	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
IIKKELL	HOUSE	COLUME	BIA, NC 27925			
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 113	kitchen, bathrooms, la closets and soil utility temperature at all fixt be maintained at a m (38 degrees C) and s	supply of hot water to the aundry, housekeeping room. The hot water ures used by residents shall inimum of 100 degrees F hall not exceed 116 degrees	D 113			
	existing facilities. This Rule is not met Based on observatior reviews, the facility fatemperatures were multi-degrees Fahrenh	ns, interviews and record iiled to assure hot water aintained between 100 - neit (F) as evidenced by hot ower than 100°F from five				
	4:35am and 1:14pm r -At 4:35am, the hot w bathroom sink in roor -At 4:40am, the hot w bathroom sink in roor -At 4:45am, the hot w bathroom shower in r -At 1:11pm, the hot w bathroom sink in roor -At 1:14pm, the hot w shower in room 207 v Interview with the Adr 1:40pm revealed: -She was not aware t	rater temperature at the m 209 was 88 degrees F. rater temperature at the m 212 was 88 degrees F. rater temperature at the rater temperature at the rater temperature at the m 207 was 83 degrees F. rater temperature at the rater temperatures at the rater temperature at the rater temper				
		CU back hall were cold. aff checked the hot water and documented the				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 15 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	Hal089002	B. WING		05/47/2040	
NAME OF PROVIDER OR CURRUER			TE 710 CODE	05/17/2019	
NAME OF PROVIDER OR SUPPLIER	950 HWY	DRESS, CITY, STA 84 FAST	TE, ZIP CODE		
TYRRELL HOUSE		A, NC 27925			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
would follow-up and so to the facility to check to the staff had not reportemperatures to the Accomplete with the residual of the shower) was crunning for several mire. The water temperature and the shower) was crunning for several mire. The water temperature. He did not know how cold. The staff either assiste the big bathroom (Spawith water in a pan. Interview with the residual of the staff either assiste the big bathroom (Spawith water in a pan.) Interview with the residual of the staff either assiste the big bathroom (Spawith water temperature) was "off", it was coldual either temperature was "off", it was coldual either temperature was too coldual either temperature was too coldual either water. The water has been countered the staff either assiste the staff either assiste the staff either assiste the big bathroom earlier today. Interview with a persounce of the staff either assiste the sink and support of the staff either assiste the sink and support of the staff either assiste the sink and support of the staff either assiste the sink and support of the staff either assiste the sink and support of the staff either assiste the sink and support either eith	t Water Log." e maintenance staff and he chedule a plumber to come the hot water heater. Orted cold water dministrator. dent in room 207 on vealed: e in the bathroom (the sink cold even if the water was nutes. The needed to be "fixed". Ilong the water had been dents in room 212 on vealed: e at the sink and shower as shower because the water he cold water to the staff hing had been done to fix cold for a few weeks. I had been in their or looking at the water weeld: e had care aide (PCA) on vealed: pecial care unit had cold shower fixtures. ined of cold water when	D 113			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 16 of 267

Division of	<u>of Health Service Regu</u>	ılation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		TED
			·	A. BOILDING.		
		11-100000	B WING	B. WING		7/0040
		Hal089002	B: Wii(0		05/1/	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		IA, NC 27925			
			·			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	<u> </u>	(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	<u> </u>	DATE
			,,,,,	DEFICIENCY)		
D 113	Continued From page	e 16	D 113			
	-She did not know ho	w long the water				
		back hall had been cold.				
	temperatures on the t	back frail frau beeff cold.				
	Interview with the Adr	ministrator on 05/08/19 at				
	3:45pm revealed:	Tillistrator on 05/00/19 at				
	•	checked the hot water heater				
		ovided hot water to the				
	•	ck hall on the SCU on				
	5/07/19.	ck fiall off the SCO off				
		aced and was ordered by				
		•				
		ıld return and repair the hot				
	water heater.	dentel bethere one on the				
		dents' bathrooms on the				
		remained cold and staff				
		bathe the residents in the				
	spa on the front hall in	n the SCU.				
	Indian decreasing the theory	:t				
		intenance staff on 5/08/19 at				
	11:35am revealed:	the het water heater (CCL)				
		the hot water heater (SCU				
	•	. The "motherboard" needed				
	to be replaced.					
		d and will be installed when				
	the part was delivered	•				
		v long the water had been				
	cold on the SCU back					
		ed hot water temperatures on				
	the SCU weekly.					
		water at the fixtures and the				
	•	as cold (87 degrees F) at the				
	bathroom sink in room					
		d a plumber but had planned				
	to when he returned t					
		formed him on 5/07/19 of the				
		temperatures on the SCU				
	back hall.					
	Review of the facility's					
	Temperature Checks'					
	-On 4/3/19 the hot wa	ater temperature at a				

STATE FORM 6899 ZE7D11 If continuation sheet 17 of 267

Division of	of Health Service Regu	lation			
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
TVDDELL	HOUSE	950 HWY	64 EAST		
TYRRELL HOUSE COLUM		BIA, NC 27925			
(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 113	Continued From page	= 17	D 113		
		om 212 was 103 degrees F.			
		water temperature at a			
		om 209 was 87 degrees F.			
	There was no docum				
	temperatures in room temperatures in room	•			
	temperataree in reem	10 2 12 01 200.			
	Review of an invoice	from a plumbing service			
	dated 5/07/19 revealed				
		e was called by the facility to			
	determine problems v				
	-Heater had a bad co	nding one to the plumber.			
	-As soon as the contr				
	plumber would return				
D 167	10A NCAC 13F .0507	•	D 167		
	Cardio-Pulmonary Re	esuscitation			
	10A NCAC 13F .0507	7 Training On			
	Cardio-Pulmonary Re	•			
		e shall have at least one			
	staff person on the pr	emises at all times who has			
	I	last 24 months a course on			
		uscitation and choking			
		ng the Heimlich maneuver,			
	·	rican Heart Association,			
		, National Safety Council, Health Institute or Medic			
	First Aid, or by a train				
	1	er on these procedures			
	from one of these org	•			
		ding to this Rule shall have			

access at all times in the facility to a one-way valve pocket mask for use in performing

cardio-pulmonary resuscitation.

This Rule is not met as evidenced by:

STATE FORM STATE FORM If continuation sheet 18 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	Hal089002		B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00/11/2010
TYRRELL	HOUSE	950 HWY			
		COLUMBI	A, NC 27925		
(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 167	Continued From page	e 18	D 167		
	facility failed to assur- was on the premises completed within the cardio-pulmonary res choking management in April 2019 and May	last 24 months a course on uscitation (CPR) and tfor 3 of 27 shifts sampled			
	The findings are:				
	Review of personnel records, resident census reports, staffing schedules, and time punch detail reports revealed: -The facility had 3 shifts: first shift was 7:00am - 3:00pm, second shift was 3:00pm - 11:00pm, and third shift was 11:00pm - 7:00am. -There were no staff on duty with CPR training on Saturday, 04/27/19, during third shift from 11:39pm - 6:59am. -There were no staff on duty with CPR training on Friday, 05/03/19, during third shift from 11:15pm - 6:59am. -There were no staff on duty with CPR training on Saturday, 05/04/19, during first shift from 7:00am - 8:29am.				
	Review of Staff A's personnel record revealed: -Staff A was hired as a personal care aide (PCA) and medication aide (MA) on 06/15/17. -There was no documentation of Staff A having training on cardio-pulmonary resuscitation (CPR). Review of time punch detail reports and				
	(from 11:39pm - 6:59a -Staff A worked on thi -No other staff on dut	rd shift on 04/27/19. y with Staff A on 04/27/19 am) had training on CPR.			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 19 of 267

DIVISION	n Health Service Regu	iation	_		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					
			P WING		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
		950 HWY		,	
TYRRELL	HOUSE		A, NC 27925		
		COLUMBI	A, NC 2/925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG			IAG	DEFICIENCY)	
D 167	Continued From page	e 19	D 167		
	-Staff A worked on firs	ot shift on 05/04/10			
		y with Staff A on 05/04/19			
	(from 7:00am - 8:29ai	m) had training on CPR.			
	-	gional Clinical Director			
	(RCD) on 05/16/19 at	•			
		nad CPR training but there			
	was no documentatio	•			
	-Staff A told the RCD	that she had CPR training at			
	another facility in the	past (did not know time			
	frame).				
	-They were trying to o	contact the other facility to			
	get a copy of Staff A's	CPR training.			
	•	•			
	No further information	n was provided regarding			
	CPR training for Staff	· · · · · · · · · · · · · · · · · · ·			
	Ü				
	Refer to interview with	n the Administrator on			
	05/16/19 at 5:18pm.				
	Refer to interview with	h the RCD on 05/17/19 at			
	4:15pm.	1 110 1 102 011 00/11/10 01			
	ор				
	2 Review of Staff C's	personnel record revealed:			
		a personal care aide (PCA)			
	on 01/15/19.	a personal care alue (1 OA)			
		nentation of Staff C having			
	training on cardio-pull	monary resuscitation (CPR).			
	Davious of time assach	dotail reports and			
	Review of time punch				
	personnel records rev				
		ird shift on 04/27/19 until			
	2:24am.				
		y with Staff C on 04/27/19			
	(from 11:39pm - 2:24a	am) had training on CPR.			
		gional Clinical Director			
	(RCD) on 05/15/19 at	: 2:50pm revealed:			
	-Staff C no longer wo	rked at the facility as of last			

week.

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 20 of 267

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
			A, NC 27925			
(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 167	Continued From page	e 20	D 167			
	-Staff C did not have -Staff C was no longe and unavailable for in	r employed by the facility				
	Refer to interview with 05/16/19 at 5:18pm.	n the Administrator on				
	Refer to interview with 4:15pm.	n the RCD on 05/17/19 at				
	3. Review of Staff E's personnel record revealed: -Staff E was hired as a personal care aide (PCA) on 03/18/19There was no documentation of Staff E having training on cardio-pulmonary resuscitation (CPR).					
	Review of time punch detail reports and personnel records revealed: -Staff E worked on third shift on 04/27/19No other staff on duty with Staff E on 04/27/19 (from 11:39pm - 6:59am) had training on CPRStaff E worked on third shift on 05/03/19No other staff on duty with Staff E on 05/03/19 (from 11:15pm - 6:59am) had training on CPR.					
	Interview with the Reg (RCD) on 05/15/19 at -Staff E no longer wor -Staff E did not have	rked at the facility.				
	Staff E was no longer was unavailable for in	employed by the facility and atterview.				
	Refer to interview with 05/16/19 at 5:18pm.	n the Administrator on				
	Refer to interview with 4:15pm.	n the RCD on 05/17/19 at				

Division of Health Service Regulation

4. Review of Staff F's personnel record revealed:

STATE FORM STATE FORM If continuation sheet 21 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	950 HWY 6	DRESS, CITY, STA 64 EAST A, NC 27925	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	(X5) COMPLETE DATE
D 167	on 03/29/19. -There was no docum training on cardio-pull Interview with the Reg (RCD) on 05/15/19 at not have CPR training. Refer to interview with 05/16/19 at 5:18pm. Refer to interview with 4:15pm. Interview with the Adr 5:18pm revealed: -When she worked as Manager (BOM) prior Administrator, she wa aides (MAs) had to ha resuscitation (CPR) training because there duty. -The CPR certificates in the personnel files. -The facility's previous the facility on 04/26/1 responsible for makin completed by all MAs-She and the Care Maresponsible for makin always made sure a Nash ad CPR training at all times be MAs had CPR training.	a personal care aide (PCA) mentation of Staff F having monary resuscitation (CPR). gional Clinical Director 2:50pm revealed Staff F did g. In the Administrator on the RCD on 05/17/19 at ministrator on 05/16/19 at strained that all medication ave cardio-pulmonary raining. equired to have CPR e should always be a MA on were supposed to be kept and would have been g sure CPR training was and kept on file. anager (CM) were g the schedule and they MA was on duty. ity was covered with CPR ecause she thought all of the	D 167	DEFICIENCY		

Division of Health Service Regulation

allowed to leave the premises while on break.

STATE FORM STATE FORM If continuation sheet 22 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		950 HWY (•	
TYRRELL	HOUSE		A, NC 27925		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-)
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
D 167	Continued From page	22	D 167		
	the premises for brea was on the premisesShe did not have a spersonnel files to ass and up-to-date. Interview with the Reg (RCD) on 05/17/19 at-The BOM was respotraining was on file for A new BOM just star about a week ago and on responsibilities with including CPR training	ystem in place to check the ure CPR training was on file gional Clinical Director 4:15pm revealed: nsible for assuring CPR r staff. ted working at the facility d had not been trained yet th the personnel files, g. ocate documentation of any			
		e CPR classes at the facility			
D 188	10A NCAC 13F .0604 Other Staffing	(e) Personal Care And	D 188		
	Staffing (e) Homes with capa shall comply with the home is staffing to ce below 21 residents, the ahome with a census (1) The home shall high the needs of the residuty hours on each 8 be at least: (A) First shift (morning for facilities with a census desired in the center of the shall hours of aid additional hours of aid shall complete the shall be also shall be also shall be at least:	city or census of 21 or more following staffing. When the nsus and the census falls ne staffing requirements for s of 13-20 shall apply. ave staff on duty to meet dents. The daily total of aide -hour shift shall at all times or capacity of 21 to 40 urs of aide duty plus four de duty for every additional for facilities with a census			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 23 of 267

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Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		ETED	
		11-100000	B. WING		0=//	I=(00.40
		Hal089002	D. WING		05/1	17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	A, NC 27925			
24.5.1=	CLIMMADY CT	ATEMENT OF DEFICIENCIES		DDOV/DEDIS DI AN OF CODDECTIO	\NI	2/20
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 188	Continued From page	23	D 188			
2 .00	. •					
		nore residents. (For staffing				
	chart, see Rule .0606	• •				
		ernoon) - 16 hours of aide				
	•	a census or capacity of 21				
		6 hours of aide duty plus				
	four additional hours	•				
		residents for facilities with a				
		40 or more residents. (For				
	•	le .0606 of this Subchapter.)				
	, ,	ng) - 8.0 hours of aide duty				
		ents (licensed capacity or				
		or staffing chart, see Rule				
	.0606 of this Subchap	•				
		have additional aide duty to				
	meet the needs of the					
	•	amount of time reimbursed				
	-	d in this Rule, the term,				
	"heavy care resident"					
	~	are home who is defined as				
		caid and for which the facility				
	is receiving enhanced					
	•	shall require additional staff				
		eds of residents cannot be				
	met by the staning re	quirements of this Rule.				
	This Rule is not met	as evidenced by:				
		ns. interviews. and record				
		iled to assure aide hours				
	-	uirements on 15 of 27 shifts				
	-					
	resulting in inadequat	April 2019 and May 2019				
	_					
	supervision and perso	onal care needs of residents.				
	The findings are:					
	Review of the facility's	s 2019 license for adult care				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 24 of 267

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co			E SURVEY PLETED
		Hal089002	B. WING		0	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
TYRRELL	. HOUSE		Y 64 EAST BIA, NC 27925			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF	E CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 188	Continued From page	e 24	D 188			
	homes revealed: -The facility was licer including 24 beds lice (SCU)The capacity for the the facility was 26. Review of a resident 04/19/19 revealed the on the AL side was 2. Review of the punch 04/19/19 revealed: -There were 12.34 st shift on the AL side, liby 3.26 hours -There were 15.25 st	ased for a capacity of 50, ensed as special care unit assisted living (AL) side of census report dated e facility's in-house census				
	Review of a resident 04/20/19 revealed the on the AL side was 2	e facility's in-house census				
	04/20/19 revealed the	time detail report dated ere were 6.32 staff hours on the AL side, leaving the 1.28 hours.				
	Review of a resident 04/21/19 revealed the on the AL side was 2	e facility's in-house census				
	04/21/19 revealed: -There were 13.98 st shift on the AL side, le by 2.02 hoursThere were 7.15 star	aff hours provided on first eaving the shift short staffed ff hours provided on third eaving the shift short staffed				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 25 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00/11/2010
TYRRELL	HOUSE	950 HWY	64 EAST		
THREEL	110002	COLUMB	IA, NC 27925		
(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 188	Continued From page 25		D 188		
	by 0.85 hours.				
	Review of incident log reports and interviews -Resident #14 had a while the facility was -[Refer to Tag 270, 10 Personal Care and Street Review of a resident 04/22/19 revealed the on the AL side was 24 Review of the punch 04/22/19 revealed the 04/22/19 revealed the	fall on first shift at 10:00am short staffed. DA NCAC 13F .0901(b) upervision]. census report dated e facility's in-house census 4 residents. time detail report dated ere were 14.28 staff hours on the AL side, leaving the 1.88 hours. census report dated evealed the facility's			
	04/27/19 (Saturday) r -There were 13.5 statshift on the AL side, leby 2.5 hoursThere was one medithe facility for first shiwere assigned to the -There was no punch aideThere were two coole 6:31pmThere were 3.5 staff on the AL side, leavin 4.5 hours.	ff hours provided on first eaving the shift short staffed cation aide (MA) on duty for ft; seven of the MA's hours			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 26 of 267

	i Health Service Regu				т —	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLE		E I E D			
			B. WING			_,_,
		Hal089002	D. WING		05/1	7/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY				
TYRRELL	HOUSE		IA, NC 27925			
		COLUMB	IA, NC 27925			
(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 APPROP		COMPLETE DATE
TAG	NEODEMONT ON	is in the	TAG	DEFICIENCY)	WIL	
D 188	Continued From page	e 26	D 188			
	Review of a resident	conque report dated				
		•				
		e facility's in-house census				
	was 25 residents.					
	Davious of the reserve	time detail report detail				
	· ·	time detail report dated				
	04/28/19 (Sunday) re					
		nours provided on first shift				
		g the shift short staffed by 1				
	hour.					
	-There was one MA o	n duty for the facility on first				
	shift.					
	-There was no punch	time detail for a dietary				
	aide.					
	-There were two cook	s on duty from 6:25am until				
	6:15pm.					
	Interview with a secon	nd MA on 05/14/19 at				
	5:50pm revealed:	1 848				
		nly MA on duty in the facility,				
	her time was spent ru	•				
	between the SCU and					
	_	st one side and probably				
	=	f the shift on the SCU and				
	50% on the AL side.					
	•	y did not help with the care				
	•	sidents; they were in the				
	office.					
	-Staff felt burnt out an	nd too tired to respond due				
		s in a row and short staffed.				
	-"It was like you see,	but you don't see and you				
	hear, but you don't he	ear."				
	•					
	Review of a resident	census report dated				
		facility's in-house census				
	on the AL side was 24					
	Review of the employ	ee punch time cards dated				
	05/03/19 revealed:	,				
		hours provided on second				
		p	1	I .		

Division of Health Service Regulation

shift on the AL side, leaving the shift short staffed

STATE FORM STATE FORM If continuation sheet 27 of 267

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05	5/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
TYRRELL	HOUSE		64 EAST				
			BIA, NC 27925				
(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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 188	8 Continued From page 27		D 188				
		ff hours provided on third eaving the shift short staffed					
	Review of a resident census report dated 05/04/19 revealed the facility's in-house census was 24 residents. Review of the punch time detail report for the AL side dated 05/04/19 revealed: -There were 7 hours 55 minutes of staff hours provided on first shift on the AL side, leaving the shift short staffed by 8 hours 5 minutesThere was one PCA on duty for the facility for first shiftThere were 13 hours 3 minutes of staff hours provided on second shift on the AL side, leaving the shift short staffed by 2 hours 57 minutesThere was one MA on duty for the facility for second shift and 1 PCA on duty for a partial shift.						
	5:05pm revealed: -She had enough starday to complete increses residents with increasesShe was not aware of for the SCU, one PCA	ff on duty each shift every eased safety checks on sed supervision needs. of any shifts having one PCA A for the AL side and one ring both the SCU and AL					
	dated 05/05/19 reveal census was 24 reside Review of the punch 05/05/19 revealed:	time detail report dated					
		s 23 minutes of staff hours shift on the AL side, leaving					

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 28 of 267

Hal089002 B. WING O5/17/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURY	
11000002							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			Hal089002	B. WING		05/17/2	2019
AND LUMB AND THE STATE OF THE S	NAME OF PRO	ROVIDER OR SUPPLIER			TE, ZIP CODE		
TYRRELL HOUSE 950 HWY 64 EAST COLUMBIA, NC 27925	TYRRELL H	HOUSE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PREFIX	(EACH DEFICIENC	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X5) COMPLETE DATE
the shift short staffed by 37 minutes. -There was one PCA on duty for the facility, two PCAs on duty for a partial shift and one MA on duty for a partial shift. -There were 27 minutes of staff hours provided on third shift on the AL side, leaving the shift short staffed by 7 hrs 33 minutes. -There was one MA on duty for the facility for second shift with 1 PCA on duty for a partial shift. Confidential interview with a resident revealed: -There was not enough staff at the facilityThe resident needed help pulling up incontinence briefs but the resident did not ask for help because staff was too busy and it took too long for staff to comeSometimes it took '2 days maybe" for staff to come and helpThe resident had urinated on themselves "a few times" while waiting for staff to come. Confidential interview with a resident revealed: -The resident had to bathe self at times because staff said they were coming to help but never came. Confidential interview with a resident revealed: -The resident had to wait a long time for staff to come to assist the resident with careWhen the resident rang the call bell, the resident sometimes waited "an hour" before any staff came to assist the resident for toileting. Confidential interview with a resident revealed: -Her shower days were Tuesdays, Thursdays, and Saturdays -It was hard to get a shower on Saturdays because of the facility being short staffed. Confidential interview with a family member		the shift short staffed -There was one PCA PCAs on duty for a partial shift -There were 27 minut on third shift on the A staffed by 7 hrs 33 m -There was one MA o second shift with 1 Po Confidential interview -There was not enoug -The resident needed incontinence briefs bu for help because staff too long for staff to co -Sometimes it took "2 come and helpThe resident had urin times" while waiting fo Confidential interview resident had to bathe said they were comin Confidential interview -The resident had to v come to assist the res -When the resident re sometimes waited "ar came to assist the res -Confidential interview -Her shower days we and Saturdays -It was hard to get a s because of the facility	ed by 37 minutes. A on duty for the facility, two partial shift and one MA on iff. Inutes of staff hours provided AL side, leaving the shift short minutes. A on duty for the facility for PCA on duty for a partial shift. Ew with a resident revealed: Engh staff at the facility. End help pulling up but the resident did not ask aff was too busy and it took come. "2 days maybe" for staff to arrinated on themselves "a few of for staff to come. Ew with a resident revealed the ne self at times because staff ing to help but never came. Ew with a resident revealed: Ew with a resident revealed: Ew with a resident revealed: Ew with a long time for staff to resident with care. For wait a long time for staff to resident with care. For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting. Ew with a resident revealed: For wait a long time for staff to resident for toileting.	D 188			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 29 of 267

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		11-100000	B. WING		05/47/0040
		Hal089002			05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
T./DDE.L		950 HWY	64 EAST		
TYRRELL	HOUSE	COLUMB	IA, NC 27925		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(* /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 188	Continued From page	29	D 188		
	Commission Fugo 25				
		would take too long and the			
	resident would almost urinate on themselves.				
		with a family member			
	revealed:	5.90 1 3 .10			
	-	visited 7 days a week at			
		re was usually only 1 PCA			
	on the AL side of the				
	•	d to the family member that			
		ait at least 30 minutes or			
	longer when they call	ea for neip.			
	Interview with a PCA	on 05/07/19 at 4:23am			
	revealed:	011 03/01/13 at 4.23am			
		ne facility for 3 months and			
	she usually worked or				
	•	staff on duty on third shift			
	for the entire facility.				
	_	PCAs and 1 MA with 2 staff			
	in the AL side and 2 s				
	-The MA usually stay	ed on the AL side for most of			
	•	dications in the SCU if			
	needed.				
	-If "lucky" and fully sta	affed, there would be 5 staff			
	on duty, but they rece	ently had "a lot" of call outs			
	or no shows.				
	-The facility managen	nent was aware, but she did			
	not know if anything v	vas being done.			
		gh staff to keep a check on			
		e sure residents were dry			
	and "not laying in urin				
	-Staff usually got their				
		due to being short staffed.			
	•	esidents up as early as			
	_	a bath in order to have			
	-	I tasks completed during the			
	shift.				
		hour shifts sometimes and			
	double shifts to help v	with the shortage.			

STATE FORM 6899 ZE7D11 If continuation sheet 30 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/4	7/2019
NAME OF D					05/1	112019
NAME OF PI	ROVIDER OR SUPPLIER	950 HWY 6	RESS, CITY, STA 4 FAST	TE, ZIP CODE		
TYRRELL	HOUSE		A, NC 27925			
(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	(X5) COMPLETE DATE
D 188	Continued From page	30	D 188			
	Second interview with 05/17/19 at 3:44pm re- She was responsible scheduleShe used the "regular determine staff need -She or the CM would short shiftsIf they were unable to lead Supervisor, CM of the shiftWhen she or the CM providing direct care, clock"Clocking in" meant of the shift working on the shift shift working on the shift working on the shifts; "if staff were for terminated on the spot terminated on the spot the CM was not avai 05/16/19 and 05/17/1 10A NCAC 13F .0901 Supervision 10A NCAC 13F .0901 Supervision (a) Adult care home care to residents accorplans and attend to all	a the Administrator on evealed: for making the staff atory" staffing grid to by resident census. If make calls to staff to cover of find staff to work, then the or the Administrator covered worked on the floor they "clocked in" on the time working on the floor. ght and monitoring of staff floor. at random times on all three und sleeping they were ot." lable for interview on 9. (a) Personal Care and	D 269			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 31 of 267

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6	64 EAST			
TTRRELL	COLUME					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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	(X5) COMPLETE DATE
D 269	Continued From page	: 31	D 269			
	This Rule is not met a TYPE A2 VIOLATION					
	Based on observations, interviews and record reviews, the facility failed to provide assistance for the personal care needs 7 of 8 sampled residents (#1, #2, #4, #5, #6, #8 and #15) who were unable to attend to themselves including incontinence care, toileting, bathing and dressing.					
	The findings are:					
	the time that you all (s	with a resident revealed "for survey team) are here, we ted right and might even get				
	03/06/19 revealed: -Diagnoses included of corpus collosum, hypothypoosmolality, hypothypothypoosmolality, hypothypoosmolality, hypothyp	t #4's current FL-2 dated central demyelination of comagnesia, candidiasis, natremia, alcohol abuse, comnia and hypertension. tation Resident #4 was the aide of a wheelchair. tation Resident #4 needed and and dressing.				
	03/05/19 revealed: -Resident #4 was aml and had no upper exti-Resident #4 needed transfers and eating.	staff supervision with limited assistance with				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 32 of 267

DIVISION	n nealth Service Regu	iation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
			1			
			P WING			
		Hal089002	B. WING		05/17	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		950 HWY 6	M FAST	•		
TYRRELL	HOUSE		A, NC 27925			
		COLUMBI	4, NC 2/925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	KLOOLATOKT OK	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	NAIL	5,2
			+	,		
D 269	Continued From page	2 32	D 269			
	Review of Resident #	4's current Licensed Health				
		(LHPS) evaluation dated				
	03/04/19 revealed:	(En G) evaluation dated				
		tasks included transfer				
	assistance and assist					
		pelled her wheelchair and				
	was able to bath and					
	-Resident #4 required					
	transfers in and out of					
	-Resident #4 had occ	asional urgency				
	incontinence.					
		note dated 03/08/19 at				
	10:06pm for Resident					
		days she act as if she can't				
	do anything, then other	er days she was fine."				
		vith a medication aide (MA)				
	on 05/15/19 at 9:40pr					
	-She had documented	d the charting note dated				
	03/08/19 for Resident	t #4 .				
	-The MAs were respo	nsible for documenting what				
	type of assistance a r	esident needed.				
	-Resident #4 had retu	rned to the facility after				
	being gone for severa	al months in the hospital and				
	a rehabilitation center					
	-When Resident #4 re	eturned she was different,				
		the resident "get back to				
	routine."	-				
	-Getting back to the re	outine meant Resident #4				
	-	ecause "she could hardly				
	use her left arm."	,				
		assistance with bathing,				
		p her incontinence brief.				
		any staff being demeaning				
	or rude to Resident #4					
	assistance.	- about providing				
	นออเอเตทอน.					
	Interview with Reside	nt #4 on 05/08/19 at 3:28pm				

Division of Health Service Regulation

revealed:

STATE FORM STATE FORM If continuation sheet 33 of 267

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D. WING		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
			64 EAST	,	
TYRRELL	HOUSE				
		COLUME	BIA, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG	NEODEMIONI ONE	200 IDEIXTII TIIVO IIXI OTAAMATION,	TAG	DEFICIENCY)	W. (1) E
			+		
D 269	Continued From page	e 33	D 269		
	0	6			
	-She had been gone from the facility from				
	September 2018 thro	_			
	_	from a life threatening low			
		n caused her to have a			
	metabolic brain injury				
		nt with toileting, showering,			
		ting prior to leaving the			
	facility in September 2				
		d for several months and			
	then in a rehabilitation	n center for several months.			
	-She tried to keep her	rself clean but was not			
	always able to manag	ge on her own.			
		raise and use her left arm,			
		n her legs and her balance			
	was off.	•			
	-She was usually able	e to transfer herself and			
	used a wheelchair for				
		a hard time getting up from			
	the recliner.	G 10. G 2. G 2.			
		ock back and forth to get			
		o raise up from sitting.			
		ded help with bathing,			
	-	of the chair and cleaning			
	after toileting.	or the orian and oleaning			
	. •	o have to ask for assistance			
	because of how staff				
		her and called her lazy			
	behind her back.	nor and dance nor lazy			
		d her a wad of toilet paper			
		rd you can do it yourself,"			
	and then walked awa				
		opened two or three weeks			
	ago and she reported	· ·			
	Administrator.	tile stall to the			
		mber the staff's name.			
		e point where she did not			
		th cleaing after having			
I	repeated episodes of	diarrhea.			

-She developed an infection to her groin, rectum and buttocks because she was not able to clean

STATE FORM 6899 If continuation sheet 34 of 267 ZE7D11

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	Hal089002	B. WING		05/17/2019	
ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	E, ZIP CODE		
HOUSE					
		IA, NC 27925			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD) BE COMPLETE	
Continued From page	e 34	D 269			
well enough by herseShe saw her primary week (04/30/19) and I because her bottom v -Her bottom started fe (05/07/19). Observation of Reside 4:10pm revealed: -Resident #4 rocked is several times before it	If. care provider (PCP) last he prescribed a cream vas "raw". seling better yesterday ent #4 on 05/08/19 at				
-Resident #4's left arm she had limited range -Resident #4 was una assist with getting out -Resident #4 took sev turn and transferred ir -Resident #4 was una guide herself into sittii -Resident #4 sat down	of motion. able to use her left arm to the chair. Weral small shuffling steps to the wheelchair. able to use her left arm to the wheelchair. In forcefully into the				
O5/10/19 at 11:43am resident #4 had not resident was at the faneed assistanceResident #4 needed bottom after she had resident #4 also nee washing her back and bottoms pulled up who Interview with a secon 11:52am revealed: -Resident #4 went be	revealed: always needed help; the cility in 2018 and did not assistance with wiping her a bowel movement. eded help in the shower d feet and help getting her en getting dressed. and MA on 05/10/19 at tween constipation and				
	SUMMARY STI (EACH DEFICIENCY REGULATORY OR LE Continued From page well enough by herse -She saw her primary week (04/30/19) and le because her bottom v -Her bottom started for (05/07/19). Observation of Reside 4:10pm revealed: -Resident #4 rocked to several times before to standResident #4's left arm she had limited range -Resident #4 was una assist with getting out -Resident #4 took sev turn and transferred in -Resident #4 was una guide herself into sitti -Resident #4 sat down wheelchair on her bot Interview with a perso 05/10/19 at 11:43am -Resident #4 had not resident was at the fa need assistanceResident #4 needed bottom after she had -Resident #4 also nee washing her back and bottoms pulled up wh Interview with a secon 11:52am revealed: -Resident #4 went be diarrhea due to pain re-	Hal089002 ROVIDER OR SUPPLIER STREET AL BOS HWY COLUMB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 well enough by herselfShe saw her primary care provider (PCP) last week (04/30/19) and he prescribed a cream because her bottom was "raw"Her bottom started feeling better yesterday (05/07/19). Observation of Resident #4 on 05/08/19 at 4:10pm revealed: -Resident #4 rocked back and forth in her recliner several times before being able to push up and standResident #4's left arm was limp at her side and she had limited range of motionResident #4 was unable to use her left arm to assist with getting out of the chairResident #4 was unable to use her left arm to guide herself into sitting down in the wheelchairResident #4 was unable to use her left arm to guide herself into sitting down in the wheelchairResident #4 sat down forcefully into the wheelchair on her bottom. Interview with a personal care aide (PCA) on 05/10/19 at 11:43am revealed: -Resident #4 had not always needed help; the resident was at the facility in 2018 and did not need assistanceResident #4 needed assistance with wiping her bottom after she had a bowel movementResident #4 also needed help in the shower washing her back and feet and help getting her bottoms pulled up when getting dressed. Interview with a second MA on 05/10/19 at	ROVIDER OR SUPPLIER Hal089002 STREET ADDRESS, CITY, STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 well enough by herself. She saw her primary care provider (PCP) last week (04/30/19) and he prescribed a cream because her bottom was "raw". Her bottom started feeling better yesterday (05/07/19). Observation of Resident #4 on 05/08/19 at 4:10pm revealed: Resident #4 rocked back and forth in her recliner several times before being able to push up and stand. Resident #4 was unable to use her left arm to assist with getting out of the chair. Resident #4 took several small shuffling steps to turn and transferred into the wheelchair. Resident #4 was unable to use her left arm to guide herself into sitting down in the wheelchair. Resident #4 sat down forcefully into the wheelchair on her bottom. Interview with a personal care aide (PCA) on 05/10/19 at 11:43am revealed: Resident #4 had not always needed help; the resident #4 needed assistance with wiping her bottom after she had a bowel movement. Resident #4 also needed help in the shower washing her back and feet and help getting her bottoms pulled up when getting dressed. Interview with a second MA on 05/10/19 at 11:52am revealed: Resident #4 went between constipation and diarrhea due to pain medications and laxatives.	The correction in the prescription of the chair. Resident #4 rocked back and forth in her recliner several times before being able to push up and she had limited range of motion. Resident #4 was unable to use her left arm to assist with getting down in the wheelchair. Resident #4 sat down forcefully into the wheelchair. Resident #4 sat down forcefully into the wheelchair own with a second MA on 05/10/19 at 11:43am revealed: Resident #4 had not always needed help; the resident #4 also needed help in the shower washing her back and feet and help getting her bottoms aged. Interview with a second MA on 05/10/19 at 11:52am revealed: Resident #4 also needed help in the shower washing her bottom after she had a bowel movement. Resident #4 also needed help in the shower washing her bottom after she had a bowel movement. Resident #4 also needed help in the shower washing her bottom after she had a bowel movement. Resident #4 also needed help in the shower washing her bottom after she had a bowel movement. Resident #4 also needed help in the shower washing her botk and feet and help getting her bottoms after she had a bowel movement. Resident #4 also needed help in the shower washing her botk and feet and help getting her bottom after she had a bowel movement. Resident #4 also needed help in the shower washing her botk and feet and help getting her bottoms after she had a bowel movement. Resident #4 also needed help in the shower washing her botk and feet and help getting her bottoms and taxetives.	

Division of Health Service Regulation

after toileting.

STATE FORM STATE FORM If continuation sheet 35 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/	2019
NAME OF P	ROVIDER OR SUPPLIER	950 HWY	DRESS, CITY, STA 64 EAST A, NC 27925	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	(X5) COMPLETE DATE
D 269	and wipe herself well. Resident #4 had exp and "got raw down th getting cleaned well. Resident #4 would a needed help; she help when she was workin Resident #4 had told help her with cleaning She did not report th did not name the staf Review of a primary of 04/30/19 revealed the Lotrisone cream (an a daily to erythematous infection or inflammat and groin until resolve Telephone interview w 05/15/19 at 9:55am re He did not see the ex erythema (red) on Re Resident #4 did not w privacy. He prescribed an oin empirically because F diarrhea and rectal bu He did not know of a assisting Resident #4 Interview with the Adr 4:45pm revealed: She did not know Re humiliated and develo wanting to ask for hel	able to reach her bottom perienced diarrhea recently ere (bottom)" from not sk for assistance when she ped Resident #4 herself gg. I her that some staff did not g after toileting. e staff because Resident #4 f. care provider order dated ere was an order for antifungal) apply three times is (redness due to injury, iion) rash in perirectal area ed. with Resident #4's PCP on evealed: excoriation (raw) and/or esident #4's bottom. want him to see the area for attment to treat the area Resident #4 reported having urning. ny issue with staff not is with cleaning after toileting. ministrator on 05/09/19 at esident #4 had felt so oped a rash due to not	D 269			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 36 of 267

ווטופוזיום	n Health Service Regu	iation	1		1		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			` '	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	בובט	
		Hal089002	B. WING		05/1	7/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE			
	NOTIBELL OIL OC. 1 EIEN	950 HWY (, ,	, 000_			
TYRRELL	HOUSE		A, NC 27925				
0/0.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	N	0/5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE	
			 	DEFICIENCY)			
D 269	Continued From page	2 36	D 269				
	Refer to interview with 05/08/19 at 3:02pm.	n a medication aide (MA) on					
	Refer to telephone int 05/15/19 at 9:40pm.	erview with a second MA on					
	Refer to interview with 05/07/19 at 7:41am.	n the Care Manager (CM) on					
	Refer to interview with 05/08/19 at 4:40pm.	n the Administrator on					
	Refer to second interview with the Administrator on 05/17/19 at 3:44pm.						
	01/22/19 revealed: -Diagnoses included a osteoarthritis, Lewy b deficiency, gastro-esc peripheral edemaResident #8 was con ambulatory and wand	·					
	08/27/18 revealed: -Resident #8 was alw significant memory log redirectedResident #8 had black required limited assistant dressing.	ss and needed to be dder incontinence and tance with toileting, bathing					
		8's current Licensed Health (LHPS) evaluation dated tasks included use of					

Division of Health Service Regulation

assistive devices for ambulation.

STATE FORM STATE FORM ZE7D11 If continuation sheet 37 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF D			ADDECC CITY CTA	TE 7/D 000E	03/11/2019
NAME OF PI	ROVIDER OR SUPPLIER	950 HWY	DRESS, CITY, STA	ILE, ZIP CODE	
TYRRELL	HOUSE		IA, NC 27925		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 269	Continued From page	: 37	D 269		
	-There was no documentation of Resident #8's ability to complete activities of daily living (ADLs)There was no documentation of ADL assistance required for Resident #8. Observations on 05/07/19 from 6:18am until 6:33am revealed: -There was a urine odor at the entrance of Resident #8's roomA personal care aide (PCA) entered Resident #8's room at 6:18am and began waking the residentThere was a brown stain on the recliner in Resident #8's roomWhen Resident #8 stood from the bed there was				
	an area of wetness aplarge watermelonThe PCA took Resideremoved the incontine	oproximately the size of a ent #8 to the bathroom and			
		A on 05/07/19 at 6:30am			
	revealed: -Resident #8 would g sometimes think the r the toilet.	et up at night and would ecliner or the foot stool was incontinence brief, but the			
	5:32am revealed: -The 2nd shift comple 11:00pm to make sun dry; second shift was third shift was 11:00p -The 3rd shift staff ch	ecked residents on the J) every two hours by "just			

Division of Health Service Regulation

incontinence or need for changing until 5:00am

STATE FORM STATE FORM If continuation sheet 38 of 267

Division o	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		0:	5/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
TYRRELL	HOUSE	950 HWY	64 EAST				
		COLUMB	IA, NC 27925				
(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 ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 269	Continued From page	≥ 38	D 269				
	the day. -They did not check at the SCU for incontine 3rd shift, just the eigh bathed and dressed. Interview with a second 5:09am revealed: -She had been working weeksThere were 22 reside additional residents were checked for know which residents. Review of Resident # (ADL) record dated 00 revealed: -There was an entry foolieting/incontinenceThere were 8 of 45 of documentation of association between 1:00am and supposed to beShe visited Resident out to the hair salon of the resident #8's hair has her scalp had a thick was still there after we linterview with a third revealed:	w often residents on the or incontinence; she did not a were incontinent. 8's activities of daily living 3/25/19 through 05/08/19 for hygiene after days where there was sistance being provided 5:00am. erned citizen on 05/10/19 at a cleaned the way she was at #8 every week and took her once a month. and been oily and unwashed; build up oil and dandruff that ashing. PCA on 05/17/19 at 3:15pm					
	-Resident #8 was able	e to go to the bathroom on					

Division of Health Service Regulation

her own.

STATE FORM STATE FORM If continuation sheet 39 of 267

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		IA, NC 27925			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	RIATE	DATE
				DEFICIENCY)		
D 269	Continued From page	e 39	D 269			
	-Resident #8 needed	staff assistance with				
	cleaning after toileting] .				
	-Resident #8 wore inc	continence briefs.				
	-Staff also showered	Resident #8 and assisted				
	with dressing and me	als.				
	Interview with a medic					
	05/17/19 at 3:25pm revealed:					
	-Resident #8 was inco					
	assistance with incon					
		of months, Resident #8 had				
	•	fussing and resisting care."				
		ated and aggressive when				
	staff tried to help her.					
	Telephone interview v	vith Resident #8's primary				
	-	on 05/15/19 at 3:28pm				
	-He last saw Residen	t #8's on 05/04/19.				
		dressed in her pajamas;				
	her hair was not partic					
	-Staff had reported Re					
	refusing personal care	e assistance, was				
	aggressive and struck	k staff.				
	Rased on observation	ns, interviews and record				
		nined Resident #8 was not				
	interviewable.	miled Nesident #0 was not				
	interviewable.					
	Refer to interview with	h a medication aide (MA) on				
	05/08/19 at 3:02pm.					
	 					
	Refer to telephone int 05/15/19 at 9:40pm.	terview with a second MA on				
	Refer to interview with 05/07/19 at 7:41am.	h the Care Manager (CM) on				
	Refer to interview with	h the Administrator on				

Division of Health Service Regulation

05/08/19 at 4:40pm.

STATE FORM STATE FORM ZE7D11 If continuation sheet 40 of 267

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6	4 EAST		
TTINKELL	HOUSE	COLUMBIA	A, NC 27925		
(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 269	Continued From page	e 40	D 269		
	Refer to second inter- on 05/17/19 at 3:44pr	view with the Administrator m.			
	02/05/19 revealed:	t #2's current FL-2 dated Alzheimer's disease, high			
	pre-renal diseaseThe resident was con	•			
	-The resident was ser	mi-ambulatory but assistive			
	device used was not documented. -The resident required assistance with bathing,				
	dressing, and feeding -The resident was inc	ontinent of bladder and			
	bowel.				
	Review of Resident # care plan dated 02/12	2's current assessment and 2/19 revealed:			
	-The resident had dai	nbulatory with a wheelchair. Iy incontinence of bladder			
	and bowel.-The resident was totagrooming, and toileting	ally dependent for bathing,			
		d limited assistance with			
		onal care aide (PCA) on			
	05/07/19 at 4:23am re				
	3 PCAs and 1 medica	staff on duty on third shift, ation aide (MA).			
		CA currently working on the			
	assisted living (AL) si	de and the MA was on the			
	AL side.	ata an tha Albaide (L. C			
		nts on the AL side that			
	required 2-hour incon	inence cnecks. The staff to keep the residents			
	_	rs and make sure they were			
	dry and "not laying in				
		ner incontinence checks			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 41 of 267

Division o	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/	/17/2019	
NAME OF PE	ROVIDER OR SUPPLIER	STREET ΔΓ	DDRESS, CITY, STAT	TE ZIP CODE			
TO WILL OF TH	TO VIDEN ON OUT FEET	950 HWY	, ,	12, 211 0002			
TYRRELL	HOUSE		SIA, NC 27925				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
D 269	Continued From page	÷ 41	D 269				
	around 1:00am deper pulled their call bells a residentIf she was bathing a while (10 minutes or I bellIt was "stressful" trying and there was sometic incontinence care bed staff. Interview with the same 5:15am revealed: -Resident #2 was on was just going to chard dressedResident #2 required of daily living. Observation of Resides: -There was strong od -Resident #2 was lying and she was lying on -The PCA removed the bottomsThe PCA assisted the the resident walked we bathroomThe resident was we briefsWhen the PCA remothere was a large bow briefs were saturated	resident, it could take a longer) to respond to a call ing to get all of the care done imes a delay in providing cause there was not enough the day shift bath list so she inge her and get her diassistance with all activities assistance with all activities assistance with pajamas on top of an incontinence pad. The resident to the shower in bathroom. In the day shift sagged while with assistance to the saring two incontinence briefs, well movement and both with urine. The resident in the bathroom the resident in the bathroom.					

Division of Health Service Regulation

-The bowel movement was stuck to the resident's

STATE FORM STATE FORM ZE7D11 If continuation sheet 42 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		3) DATE SURVEY COMPLETED 05/17/2019 (X5) COMPLETE DATE	
		11-1000000	B WING		05/47/0		
		Hal089002			05/17/2	019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
TYRRELL	HOUSE		IA, NC 27925				
(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 C	COMPLETE	
D 269	Continued From page	e 42	D 269				
D 269	skin and was difficult -There was no skin by Resident #2At 5:28am, the PCA shower and assisted back to her bedThe PCA finished dre the resident to the what 5:46am. Based on observation review, it was determ interviewable. Interview with the sam 5:15am - 5:46am reve -She bathed Residen had "messed up" her -She thought she had around 3:00am (not shad two incontinence -She did not know wh briefs on Resident #2 -She put two incontine because that was the did it. Interview with a secon	to clean. reakdown or irritation on got the resident out of the the resident with walking essing the resident, assisted eelchair, and left the room as, interviews, and record ined Resident #2 was not the PCA on 05/07/19 from ealed: the #2 because the resident incontinence briefs. I last checked the resident ure of time) and the resident briefs on at that time. by they put two incontinence	D 269				
	incontinence care usubriefs for "extra protecthe next change it wo-Resident #2 had alw briefs because she reincontinence care.	quired assistance with ally wore two incontinence ction" so if they wet before uld not go through and leak. ays worn two incontinence equired assistance with					
	Interview with a MA /	supervisor on 05/08/19 at					

Division of Health Service Regulation

5:35pm revealed:

STATE FORM STATE FORM If continuation sheet 43 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR' COMPLETE	
			D WING			
		Hal089002	B. WING		05/17/2	2019
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6	4 EAST A, NC 27925			
(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 269	Continued From page	2 43	D 269			
	-Resident #2 should woriefStaff had been told (work to put two incontinence) -She had not had a control of the put two incontinenceShe had not had a control of the put two incontinence works and the put two incontinence briefs or staff were not support of the put to put the put t	wear only one incontinence within the last 2 months) not be briefs on residents. hance to check behind the ere still putting two briefs on If not have two briefs on the skin breakdown. The Manager (CM) on evealed: staff were putting two in Resident #2. sed to put two incontinence staff to do incontinence rounds with Resident #2's primary on 05/15/19 at 10:44am				
	incontinence briefs at -There was a potentia	time on Resident #2. all for the resident to develop edness and irritation if left in				
	Resident #2.	, S 199900 Mill				
	Refer to interview with 05/08/19 at 3:02pm.	n a medication aide (MA) on				
	Refer to telephone int 05/15/19 at 9:40pm.	terview with a second MA on				
	Refer to interview with 05/07/19 at 7:41am.	n the Care Manager (CM) on				

Division of Health Service Regulation

Refer to interview with the Administrator on

STATE FORM STATE FORM ZE7D11 If continuation sheet 44 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	1 00/11/2010
			64 EAST	112, 211 0002	
TYRRELL	HOUSE		SIA, NC 27925		
(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 269	Continued From page	e 44	D 269		
	05/08/19 at 4:40pm.				
	Refer to second inter- on 05/17/19 at 3:44pr	view with the Administrator m.			
	4. Review of Residen 07/13/18 revealed:	t #6's current FL-2 dated			
	-Diagnoses included dementia, hypertension, chronic anxiety, hyperlipidemia, and glaucomaThe resident was intermittently disorientedThe resident was semi-ambulatory but assistive				
	device used was not	documented. was functionally limited.			
	_	d assistance with bathing,			
	-The resident was conbladder.				
	Review of Resident # care plan dated 12/27	6's current assessment and 7/18 revealed:			
	-The resident was am -The resident was con	bulatory with a wheelchair. ntinent of bladder and			
	•	d extensive assistance with			
	bathing, grooming, dr -The resident required	essing, and toileting. d limited assistance with			
	eating, transferring, a				
	Interview with a person 05/07/19 at 4:23am re	onal care aide (PCA) on evealed:			
	-There were usually 4 3 PCAs and 1 medica	staff on duty on third shift, ation aide (MA).			
	-She was the only PC	A currently working on the de and the MA was on the			
		nts on the AL side that			
	-There was not enoug	gh staff to keep the residents and make sure they were			

Division of Health Service Regulation

dry and "not laying in urine".

STATE FORM STATE FORM If continuation sheet 45 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6	4 EAST A, NC 27925		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 269	Continued From page	e 45	D 269		
D 269	-She usually started haround 1:00am deper pulled their call bells a a residentIf she was bathing a while (10 minutes or I bellIt was "stressful" trying and there was sometic incontinence care beautined there was sometic incontinence care beautined. Observation of Reside 5:52am - 6:24am reversesident #6 was lying and had an incontinence parallel for the incontinence parallel for the PCA assisted the and pushed her to the copenThe PCA unclothed the with the door openThe resident was we briefs and both were strength the same and beautiful for the PCA assisted the transferring back to the The PCA pushed the bedroom and left the linterview with the same pulled the same	ner incontinence checks ading on if any residents had and she was busy assisting resident, it could take a onger) to respond to a call and to get all of the care done mes a delay in providing cause there was not enough ent #6 on 05/07/19 from ealed: g in bed, wearing pajamas, nce pad underneath her. d was dry. e resident to the wheelchair e suite bathroom. and the bathroom were left the resident in the bathroom aring two incontinence saturated with urine. ong odor of urine. and no breakdown or e resident with dressing and ne wheelchair. e resident back to her room at 6:24am. ne PCA on 05/07/19 from	D 269		
	because that was the -Resident #6 needed dressing, transferring	aring two incontinence briefs			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 46 of 267

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
	110002	COLUMB	IA, NC 27925			
(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	(X5) COMPLETE DATE
D 269	Continued From page	e 46	D 269			
	Resident #6 for incon	tinence care on this shift.				
	6:13am and 05/13/19 -She wore two incontinated to wait for staff to want to wether bed of sometimes she waite to come and assist he enough staffThe resident was legs shadows so she need shadows so she need shadows so she need to the day but staff did not night. A third interview with 4:10pm revealed she night anymore because the interview with a second 5:35pm revealed: -The residents that residents that residents are staff to wait	ed "about an hour" for staff er because there was not gally blind and could only see ded assistance. If about every 2 hours during not check on her during the Resident #6 on 05/15/19 at edid not use the call bell at se staff "won't come". Ind PCA on 05/08/19 at equired assistance with				
	briefs for "extra proted the next change it wo -Resident #6 "liked" to briefs.	ually wore two incontinence ction" so if they wet before old not go through and leak. o wear two incontinence have any skin breakdown.				
	5:35pm revealed: -Staff had been told (' to put two incontinent -She had not had a cl PCAs to see if they w residents.	supervisor on 05/08/19 at within the last 2 months) not ce briefs on residents. hance to check behind the vere still putting two briefs on not have two briefs on se skin breakdown				

Division of Health Service Regulation

-Resident #6 might be wearing two incontinence

STATE FORM STATE FORM ZE7D11 If continuation sheet 47 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
			A, NC 27925			
(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	(X5) COMPLETE DATE
D 269	Continued From page	e 47	D 269			
	briefs because she was a "heavy wetter" and the resident had requested to wear two briefsResident #6 did not have any skin breakdown.					
	Interview with the Car 05/07/19 at 2:05pm re -She was not aware s	evealed: staff were putting two				
	incontinence briefs on Resident #6Staff were not supposed to put two incontinence briefs on the residentsStaff were supposed to do incontinence rounds					
	every 2 hours.					
	Telephone interview with Resident #6's primary care provider (PCP) on 05/15/19 at 10:44am revealed: -He was not aware staff were putting two					
	skin issues such as reurine or feces.	al for the resident to develop edness and irritation if left in				
	-He was not aware of Resident #6.	any skin issues with				
	Refer to interview with 05/08/19 at 3:02pm.	n a medication aide (MA) on				
	Refer to telephone int 05/15/19 at 9:40pm.	terview with a second MA on				
	Refer to interview with 05/07/19 at 7:41am.	n the Care Manager (CM) on				
	Refer to interview with 05/08/19 at 4:40pm.	n the Administrator on				
	Refer to second intervolution 05/17/19 at 3:44pr	view with the Administrator m.				

Division of Health Service Regulation

5. Review of Resident #15's current FL-2 dated

STATE FORM STATE FORM ZE7D11 If continuation sheet 48 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
			23.25		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STRFFT A	DDRESS, CITY, STA	TE, ZIP CODE	-
			Y 64 EAST	,	
TYRRELL	HOUSE		BIA, NC 27925		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG	NEODE HORT ORT		TAG	DEFICIENCY)	
D 269	Continued From page	<u> </u>	D 269		
2 200		3 40			
	07/18/18 revealed:	atrial fibrillation			
	 -Diagnoses included hypertension, chronic 				
	hyperlipidemia, chron	•			
	bilateral knees, lumba	•			
	degenerative joint dis				
		nbulatory with a walker.			
	-	d assistance with bathing			
	and dressing.	postinget of bladder			
	-The resident was inc	continent of bladder.			
	Review of Resident #	15's current assessment			
	and care plan dated (08/27/18 revealed:			
		nbulatory with an aide or			
	device (type not spec				
		casionally incontinent of			
	bladder and bowel.	d extensive assistance with			
	bathing, grooming, ar				
		d limited assistance with			
	toileting and transferr	ing.			
	-The resident require	d supervision with			
	ambulation.				
	Interview with a nerse	onal care aide (PCA) on			
	05/07/19 at 4:38am re				
	-Resident #15 got up				
	because she liked to	get up and get bathed and			
	dressed at 4:00am.				
		5-minute delay over the			
	weekend in assisting				
	 Sne was on ner way to get her up. 	to Resident #15's room now			
	to get her up.				
	Observation of Resid	ent #15 on 05/07/19 at			
	4:41am revealed:				
	-	ing in bed with her night			
	clothes on		1		

Division of Health Service Regulation

-The PCA provided standby assist to the resident

with transfer from bed to wheelchair.

STATE FORM STATE FORM If continuation sheet 49 of 267

DIVISION	n nealth Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			P WING		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	
		950 HWY 6		•	
TYRRELL	HOUSE				
		COLUMBIA	A, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG	REGOEMONT ON E	EGG IBENTII TING IN GRAMMITON,	IAG	DEFICIENCY)	
D 269	Continued From page	e 49	D 269		
	The DCA pushed the	regident from her room to			
	the shared suite bath	e resident from her room to			
		e resident with transferring			
	from wheelchair to the				
		ne resident's clothing and			
		vith water, soap, and a			
		esident was sitting on the			
	toilet without clothes	****			
		e resident with standing so			
		the resident's private area			
		ent put on clean incontinence			
	briefs and clothing.				
		e resident back to her			
		esident's bed, and then left			
	the room.				
		ent #15 on 05/07/19 at			
	•	at 11:28am revealed:			
		nce with bathing and she			
		h every day since she did			
	not take showers.				
		to get her up at 4:00am			
	every day to bathe an				
		come at 4:00am otherwise			
	she would have to wa				
		up at 4:00am anymore and it			
		Dam lately when staff came.			
		d dress herself on at least			
	two occasions because	se staff were either late or			
	never came to assist				
		ere the only ones on duty			
	and they had to assis	t residents in the special			
	care unit (SCU).				
	-It was difficult to bath	ne and dress herself			
	because she could no	ot reach her back and she			
	had a hard time trying	g to put on her socks.			
	, ,	-			
	Telephone interview v	with Resident #15's family			
	member on 05/15/19				

Division of Health Service Regulation

-Resident #15 needed assistance with bathing

STATE FORM STATE FORM ZE7D11 If continuation sheet 50 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
			A. BOILDING.			
		Hal089002	B. WING		05	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
ITRRELL	. HOUSE	COLUME	BIA, NC 27925			
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 269	Continued From page	e 50	D 269			
	so she was supposed morning. -There had been a "fe missed her bath in the The most recent time a Sunday. -There was one time missed her bath becanot know the bath scl. Interview with a MA / 5:35pm revealed: -Resident #15 should she was at risk for fal She was not aware herself without staff all the facility had been	last year the resident ause staff was new and did nedule. supervisor on 05/08/19 at not bathe herself because ls. Resident #15 had to bathe				
	Refer to interview wit 05/08/19 at 3:02pm.	h a medication aide (MA) on				
	Refer to telephone in 05/15/19 at 9:40pm.	terview with a second MA on				
	Refer to interview wit 05/07/19 at 7:41am.	h the Care Manager (CM) on				
	Refer to interview wit 05/08/19 at 4:40pm.	h the Administrator on				
	Refer to second inter on 05/17/19 at 3:44pr	view with the Administrator m.				
	revealed diagnoses in	t #1's FL-2 dated 10/17/18 ncluded Alzheimer's dementia, right hip joint				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 51 of 267

Division of Health Service Regulation					1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
	Hal089002 B. WING				05/17/2019	
		0.70557.45		TE 7/0 0005		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	I E, ZIP CODE		
TYRRELL HOUSE 950 HWY						
		COLUMB	IA, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
17.0		,	17.0	DEFICIENCY)		
D 200	0 " 15		D 200			
D 269	Continued From page	9 51	D 269			
	replacement, hyperte	nsion, depression, anxiety,				
	osteoarthritis.					
		#1's care plan dated				
	12/19/18 revealed:					
		ted with the use of a device				
	(walker).					
		soriented at times, forgetful				
	and needed reminder	d limited assistance with				
	bathing and dressing					
	battling and dressing.	•				
	Observation made or	n 05/07/19, in the special				
	care unit (SCU), at 4:					
		ner room asleep in a recliner				
	with her feet elevated	l.				
	-The resident was full	ly dressed in a pair of pants,				
	a pullover blouse and	I socks.				
		1 1:0 004 05/07/40				
		I shift PCA on 05/07/19 at				
	4:57am revealed;	t in their "street clothes".				
		ere responsible for getting				
		or bed, including changing				
	into bed clothes.	or bod, mordanig orianging				
	-Resident #1 slept in	her recliner and sometimes				
		he resident maybe "cold				
	natured".	•				
		d to assist the resident with				
	changing into her bed	d clothes.				
		1.114 05/07/40 1.4.55				
		ent #1 on 05/07/19 at 1:55pm				
	revealed:	or with her beth and				
	-The staff assisted he	er with her bath and				
	changing clothes.	nes at times because her				
	•					
	clothes were warm at					

Division of Health Service Regulation

warm and the staff helped her change.
-She did not remember if she slept in her

STATE FORM STATE FORM If continuation sheet 52 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
Hal089002		B. WING		05/1	7/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 64	4 EAST ., NC 27925			
(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	(X5) COMPLETE DATE
D 269	Continued From page	: 52	D 269			
	pajamas or her clothe night.	s last night or any other				
	with other residentsThe resident was drepants, the same pullor linterview with two of Finembers on 5/09/19 are They expected the strain with her personal care dressing and changing-Even though the resistence should not sleep all day. Refer to interview with 05/08/19 at 3:02pm. Refer to telephone int 05/15/19 at 9:40pm.	ressed in the same pair of ver blouse. Resident #1's family at 6:50pm revealed: resident e, which included bathing, g into bed clothes at night. dent slept in her recliner, in her clothes she had worn e a medication aide (MA) on erview with a second MA on				
	05/07/19 at 7:41am.	n the Care Manager (CM) on				
	Refer to interview with 05/08/19 at 4:40pm.	n the Administrator on				
	Refer to second intervon 05/17/19 at 3:44pm	view with the Administrator n.				
	revealed diagnoses of	t #5's FL-2 dated 3/6/19 f cirrhosis, hypertension, osteoarthritis, dementia with r.				

Division of Health Service Regulation

Review of the resident's care plan dated 6/19/18

STATE FORM STATE FORM ZE7D11 If continuation sheet 53 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZID CODE	1 03/1	1/2019
			64 EAST	TE, 211 GODE		
TYRRELL HOUSE		IA, NC 27925				
(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	(X5) COMPLETE DATE
D 269	Continued From page	e 53	D 269			
	with bathing, dressing					
	revealed; -Staff usually spend a with her bath/shower hair, washing her bac -The resident only rec week but wanted to s weekA PCA told the reside	ceived a shower one time a hower at least two times a ent if she had the time, she dent with more showers.				
	Interview with a PCA revealed: -She tried to give Restime a weekAll the resident's work but we usually work s	on 05/16/19 at 5:59pm sident #5 a shower at least 1 uld get more showers/bathes short and if she was the only could not give showers 3				
	05/08/19 at 3:02pm.	h a medication aide (MA) on terview with a second MA on				
	05/15/19 at 9:40pm.					
	Refer to interview with 05/08/19 at 3:02pm.	h a medication aide (MA) on				
	Refer to telephone into 05/15/19 at 9:40pm.	terview with a second MA on				
	Refer to interview with 05/07/19 at 7:41am.	h the Care Manager (CM) on				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 54 of 267

	ROVIDER OR SUPPLIER	Hal089002			
	ROVIDER OR SUPPLIER	Hai009002	B. WING		05/47/2040
	ROVIDER OR SUPPLIER	OTDEET			05/17/2019
TYRRELL			DDRESS, CITY, STAT 7 64 EAST	TE, ZIP CODE	
TYRRELL HOUSE		SIA, NC 27925			
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 269	Continued From page	e 54	D 269		
	Refer to interview with 05/08/19 at 4:40pm.	n the Administrator on			
	on 05/17/19 at 3:44pr	view with the Administrator n.			
	(ADLs) they complete throughout the shiftThe MA printed, revier report and gave the re-Upon review the MA area that did not have Telephone interview v 05/15/19 at 9:40pm re-Bathes were done to days for 3rd shiftOn the new compute staff had to document	evealed: ne activities of daily living ed on the computer ewed and signed the ADL eport to the Administrator. had to follow up with any e 100% documentation. with a second MA on evealed: no early on some bathing er documentation system, t activities of daily living			
	(ADL) tasks within a constant would rush to go not want to be late do	et done because they did			
Interview with the Care Manager (CM) on 05/07/19 at 7:41am revealed: -PCAs were expected to monitor for incontinence care needs every two hours for all incontinent residents on the SCU and the AL sideMost residents on the SCU required some type of incontinence careThe 3rd shift was responsible for bathing and dressing eight residents between 5:00am and 7:00amResidents were bathed every day and received a shower three times a week.					

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 55 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation	1			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		11-100000	B. WING			- /0040
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY 6	4 EAST			
TYRRELL	HOUSE	COLUMBIA	A, NC 27925			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 269	Continued From page	2.55	D 269			
	. •	. 66				
	4:40pm revealed:					
		s process to not perform				
	incontinence checks I	between 11:00pm and				
	5:00am.					
	-If a resident needed	assistance then staff should				
	be helping.					
		to offer toileting assistance				
	-	ence checks on all residents				
		o hours on every shift.				
	in the identity every th	o noure on every erma				
	Second interview with	the Administrator on				
	05/17/19 at 3:44pm re	evealed:				
		mpleted assistance tasks				
	on the computer.	p.otou uoolotuiloo tuolio				
	-	compliance with providing				
		ng and bathing four hours at				
	a time on all shifts.	ing and batting loar nours at				
		to provide incontinence care				
	and bathing assistance					
		providing assistance by				
		care unit (SCU) for 20				
	minutes at random tin	,				
	residents.	aff checking incontinent				
		onitored for incontinence				
	care was one week a	go.				
	The facility failed to p	rovide personal care				
		continence care, toileting,				
	bathing and dressing					
	_	's failure to provide residents				
	with personal care as					
	T	ng a rash on the buttocks				
		ng a medicated ointment for				
	one week before impr					
		ident #6 at risk for skin				
	breakdown. The facili	=				
		ious neglect and physical				
	harm and constitutes	a Type A2 Violation.				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 56 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	•		
TYRRELL	HOUSE		/ 64 EAST BIA, NC 27925				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST 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	(X5) COMPLETE DATE	
D 269	Continued From page	= 56	D 269				
	The facility provided a accordance with G.S. this violation.	a plan of protection in . 131D-34 on 05/10/19 for					
		DATE FOR THE TYPE A2 NOT EXCEED JUNE 16,					
D 270	10A NCAC 13F .0901 Supervision	1(b) Personal Care and	D 270				
		e supervision of residents in nesident's assessed needs,					
	This Rule is not met TYPE A1 VIOLATION	-					
	reviews, the facility fa was provided to 3 of #14, #16) including to out of the special card service hall and kitch	observations, and record ailed to assure supervision 11 sampled residents (#1, wo residents who wandered e unit unsupervised into a en (#1, #16) and a resident ths resuliting in injuries and cy room (#14).					
	The findings are:						
	1.Review of Resident	t #1's FL-2 dated 10/17/18					

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 57 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE		64 EAST		
		COLUMB	IA, NC 27925		
(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 57	D 270		
	replacement, hyperte osteoarthritis.	dementia, right hip joint nsion, depression, anxiety,			
	Review of Resident # 12/19/18 revealed:	#1's care plan dated			
		istory of wandering and se of a device (walker).			
		oriented at times, forgetful			
	and needed reminder				
	Review of Resident 12/19/18 revealed:	#1's care plan dated			
		istory of wandering and			
		se of a device (walker).			
	and needed reminder	oriented at times, forgetful s.			
	a.Observation made revealed;	on 05/07/19 at 4:37am			
		eep in a recliner in her			
	bedroom with her fee -There were massive	t elevated. dark purplish facial bruises			
		f of the resident's face which			
	_	ehead, under her right eye,			
	brow above the left e	ner left eye, and on her left ye.			
		d shift PCA on 5/7/19 at			
	4:57am revealed:				
	-On 5/03/19 around 5 the resident on the flo	:00am, another PCA found			
		vas bruised and the resident			
	complained of knee p				
	 The resident was tra evaluation and came 	nsported to the ER for			
		w long the resident was on			
	the floor.	-			
	-The resident's super	vision did not change, the			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 58 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	Hal089002	B. WING		05/17/2019	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL HOUSE 950 HWY 6 COLUMBIA		64 EAST IA, NC 27925			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
hoursAll residents on thours when in beThe resident fell She fell again on -The resident was on third shift. and right knee which I fall. The resident -She thought the was not sure. Interview with Rerevealed: -The resident fell to go to the bathreShe did not use I right side of her falls and the sheet of the staff called him of the staff called him of the staff called him of the staff did not on the floorThe staff did not on the floorThe staff should	ecked on the resident every two the SCU was checked every 2 d. one more time since 05/03/19. 5/6/19 (3rd shift). Is found on the floor on 05/03/19 complained of pain of her "bad" had blisters from the previous was not sent to the ER. If all was reported to the MA but sident #1 on 05/07/19 at 1:55pm while getting out of her recliner from 3 or 4 nights ago. her walker and fell and hit the lace, nose and right knee. Inted to the ER but there were no lises on her face and a blister on the time about 1-2 days ago but livies. In of Resident #1's family 19/19 at 6:50pm revealed: lat 5:45am last week on orted the resident had fallen and	D 270			

Division of Health Service Regulation

subsequent falls since 05/03/19

STATE FORM STATE FORM ZE7D11 If continuation sheet 59 of 267

STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE		64 EAST			
	T		BIA, NC 27925			
(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	Continued From page	e 59	D 270			
	9:20am revealed; -She was working the 05/03/19She was found by th sent to the ERThe PCAs should ch 30 minutes on the SC Review of an Event R 05/03/19 revealed: -On 05/03/19 revealed: -On 05/03/19 at 5:15a unwitnessed fall in he-The resident compla bruising of the right fo pain to her back, eye -The resident was transfer an accidental fallThe resident #1 was transfer of an accidental fallThe resident was dia contusion of the right knee, and contus	Report (incident report) dated arm the resident had an er bedroom. Inced of pain. There was prehead, and complained of and forehead. Insported to the local ER. Summary dated 05/03/19 Insported to the ER because agnosed with periorbital eye, contusion of the right of the lower right leg. Instead walker at all times for ant further falls. On 05/07/19 at 10:05am om the SCU patio to the cked. It, which was an entrance				

Division of Health Service Regulation

was an entrance to the SCU dining room had a

STATE FORM STATE FORM ZE7D11 If continuation sheet 60 of 267

DIVISION	n nealth Service Regu	iation	_			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	LETED
			1			
			D. WING	D. MINO		
		Hal089002	B. WING		05/1	17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE. ZIP CODE		
		950 HWY		,		
TYRRELL	HOUSE		A, NC 27925			
			A, NC 2/925	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE A		DATE
iAO		,	IAG	DEFICIENCY)		
			+			
D 270	Continued From page	e 60	D 270			
	key pad.					
	key pau.					
	Interview with a dietai	ry aide on 05/07/19 at				
	10:15am revealed:	ry alae on oeron to at				
		d assisted with delivering				
		n to the special care unit				
	(SCU).					
		ervice hall used by kitchen				
	staff to deliver meals					
		ndered into the kitchen				
		the service hall recently,				
	but she did not remer					
	-The residents, from t					
		secured outside patio on the				
	SCU.	secured outside patio on the				
	-The door from the pa not have a lock.	atio into the service hall did				
	-Residents had made	their way to the kitchen				
	several times or got s	tuck in the hallway.				
	-On average, kitchen	staff found a resident in the				
	hallway or kitchen twi	ce a week.				
	-The kitchen door was					
		-				
	Interview with a perso	onal care aide (PCA) on				
	05/07/19 at 1:29pm re	evealed:				
	-Residents could go o	out to the enclosed patio				
	throughout the day.					
	-The staff "kept an ey	e on" residents while they				
	were outside in the er	nclosed patio area.				
		e residents out on the patio				
	from inside the comm					
	through the windows.					
	~	ught residents back to the				
		J) from the service hall.				
		uld see the residents in the				
		ring the residents back to				
	the SCU.	g and residents back to				
	-The kitchen door was	s usually locked.				
		he exit door from the SCU				

Division of Health Service Regulation

dining room to the enclosed patio was supposed

STATE FORM STATE FORM If continuation sheet 61 of 267

Division o	of Health Service Regu	lation				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			B. WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY 6		•		
TYRRELL	HOUSE					
		COLUMBIA	A, NC 27925			
(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 APPROPF		COMPLETE DATE
iAo		,	17.0	DEFICIENCY)		
D 270	Continued From page	e 61	D 270			
	to be locked.					
	to be locked.					
	Interview with the Eve	coutive Director (ED) on				
	05/08/19 at 4:40pm re	ecutive Director (ED) on				
	•	to accompany residents to				
	· ·	The state of the s				
	outside on patio.	d supervise residents while				
	•	to do "look in" checks every				
	30 minutes for all resi	-				
		t of sight" then staff knew to				
	check the service hal					
		ent 30 minute checks on				
	residents.					
		ver walk into the service hall				
	unsupervised.					
		door the entrance door into				
		the SCU patio did not lock.				
		e a lock when the building				
	was constructed.					
		3/19 at 2:40pm revealed:				
	-There were two resid	dents outside on the				
	enclosed patio area.					
		outside with the residents.				
	•	care aides (PCAs) in the				
	common area with se	even residents.				
		ility's cook on 05/16/19 at				
	10:00am revealed:					
		go, the cook was preparing				
		of soup was cooking on the				
	stove.					
		working alone) left the facility				
	while on her break (a	,				
		Resident #1 was standing				
	next to the stove over	r the pot of soup. She had				
	turned the stove off.					
	-The cook eased up t	o her to keep from startling				

Division of Health Service Regulation

the resident and took her back to the SCU.
-The staff did not know she was off the unit; they

STATE FORM STATE FORM If continuation sheet 62 of 267

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1			
		Halosooos	B. WING		05/47/0040	
		Hal089002			05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUM	BIA, NC 27925			
()(4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID 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	62	D 270			
5210	Continued From page	5 02	5270			
	had not missed her.					
	-The dietary staff hav	e complained about the				
	service hall to the Exe	ecutive Director (ED).				
	-The kitchen door wh	ich entered the service hall				
		hile the dietary staff was on				
	duty and preparing m	-				
	-If the door was locke					
		all from the SCU patio just				
		ice hallway until the dietary				
		ccompanied them back to				
	the SCU.	companied them back to				
		om the SCU walked in the				
	-	ice hall and were often				
		he stove with the burners				
	and the oven on and					
	•	ently started taking those				
		ffice instead of back to the				
		vas nothing being done to				
		its on the patio and they				
	come and go through	the service hall as they				
	pleased.					
	•	different and resident's				
	continued to walk in t	he service hall and in the				
	kitchen.					
	-The SCU staff were	always sitting at the nurse's				
	station and not super	vising the residents in the				
	commons area or on	the patio.				
	-The cook only worke	ed part-time (1-2 a week)				
	_	observed a resident in the				
		en was about one month				
	ago.					
	-					
	Interview with a PCA	on 5/16/19 at 5:59pm				
	revealed:	r				
		ndered into the kitchen from				
		al times before the staff				
	realized she was gon					
	_	e last time the resident				
		chen but the wandering had				

Division of Health Service Regulation

occurred since January or February 2019.

STATE FORM STATE FORM If continuation sheet 63 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
TYRRELL	HOUSE	950 HWY	64 EAST			
TIRRELL	HOUSE	COLUMBI	A, NC 27925			
(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	(X5) COMPLETE DATE
D 270	Continued From page	e 63	D 270			
	-The staff knew where the service hall from to the service hall, but back to the SCUThere were residents into the service hall, but them backShe was aware the country the pation was not lockWhen the residents warea, the SCU staff where the dining room window the residents. Interview with the Excu 05/17/19 at 5:15pm reshe was Resident #1 to the service hall and unsupervisedThe cook had repeate either back to the SCI kitchen. Resident #1 was on 3 checks and she was a continued to wander in the service hall and continued to wander in the service of Resident #2. Review of Resident #3 checks and she was a continued to wander in the service hall and the service hall	e the resident wandered into the secured patio. The secured patio. The secured patio. The secured pation was brought the resident out the dietary staff brought door to the service hall from stable. The were outside in the pation as able to watch them from the secutive Director (ED) on the every staff brought the door dientered the kitchen the secutive Director (ED) on the every staff brought the resident of the ordered the kitchen the secutive Director (ED) on the every staff brought the resident of the the secutive Director (ED) on the every staff brought the resident of the kitchen the secutive supervisory unaware the resident of the kitchen. The secutive of the secutive different the kitchen of the secutive of the secutiv				
	Observation made on revealed:	05/07/19 at 10:05am				

Division of Health Service Regulation

-The entrance door from the SCU patio to the

STATE FORM STATE FORM ZE7D11 If continuation sheet 64 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: A. BUILDING:	(X3) DATE SURVEY COMPLETED
Hal089002 B. WING	05/17/2019
1101000002	09/1//2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TYRRELL HOUSE 950 HWY 64 EAST COLUMBIA, NC 27925	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIME DEFICIENCY)	BE COMPLETE
D 270 Continued From page 64 service hall was unlockedThe door on the right, which was an entrance into the kitchen from the service hall was unlocked and the dietary staff was in the kitchen preparing a mealThe door on the left end of the service hall which was an entrance to the SCU dining room had a key pad. Interview with a dietary aide on 05/07/19 at 10:15am revealed: -She was a server and assisted with delivering meals from the kitchen to the SCUThe hallway was a service hall used by kitchen staff to deliver meals to the SCUThe residents, from the SCU, entered the service hall from the secured outside patio on the SCUThe door from the patio into the service hall did not have a lockResidents had made their way to the kitchen several times or got stuck in the hallwayOn average, kitchen staff found a resident in the hallway or kitchen twice a weekThe kitchen door was locked at night. Interview with a personal care aide (PCA) on 05/07/19 at 1:29pm revealed: -Residents could go out to the enclosed patio throughout the dayThe staff "kept an eye on" residents while they were outside in the enclosed patio areaThe staff "kept an eye on" residents while they were outside in the enclosed patio from inside the common area/dining room through the windowsKitchen staff had brought residents back to the special care unit (SCU) from the service hallThe kitchen staff would see the residents in the	

Division of Health Service Regulation

the SCU.

STATE FORM STATE FORM If continuation sheet 65 of 267

	n rieaitii Service Regu					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	IΕD
						ļ
		11-1000003	B. WING		05/47	/0040
		Hal089002	1		05/17	12019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		A, NC 27925			
	OLIMANA DV OT		1	DDOV/DEDIO DI ANI OF CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 070	0 (; 15	05	D 270			
D 270	Continued From page	9 65	D 270			
	-The kitchen door was	s usually locked.				
		he exit door from the SCU				
		closed patio was supposed				
	to be locked.	ciosca pallo was supposed				
	to be locked.					
	Observation on 05/08	3/19 at 2:40pm revealed:				
	-There were two resid	•				
	enclosed patio area.	derits outside on the				
		outside with the residents.				
	•	care aides (PCAs) in the				
	common area with se	even residents.				
	Intorvious with the Eve	ecutive Director (ED) on				
	05/08/19 at 4:40pm re					
	-	to accompany residents to				
	-					
	•	d supervise residents while				
	outside on patio.	to do "look in" checks every				
	30 minutes for all resi					
		t of sight" then staff knew to				
	check the service hall	• •				
		ent 30 minute checks on				
	residents.					
		ver walk into the service hall				
	unsupervised.					
		door the entrance door into				
		the SCU patio did not lock.				
	-The door did not hav	e a lock when the building				
	was constructed.					
		ility's cook on 5/16/19 at				
	10:00am revealed:					
		red through into the service				
	hall door repeatedly.					
	-The kitchen staff alw	ays watched her because				
	she would try to esca					
	-She would try to ope					
		uld not get in the kitchen.				
		the resident back to the				

Division of Health Service Regulation

special care unit (SCU) or to the Administrator's

STATE FORM STATE FORM ZE7D11 If continuation sheet 66 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	Hal089002		B. WING		05/17/2019
	ROVIDER OR SUPPLIER	STREET AD 950 HWY	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	. HOUSE	COLUMB	IA, NC 27925		
(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	service hall to the Exc. The kitchen door wh was kept unlocked widuty and preparing melf the door was locked entered the service he wandered in the service staff saw them and at the SCU. Multiple residents from the service found standing near the and the oven on and the continued to walk in the kitchen. The ED did nothing continued to walk in the kitchen. The SCU staff were station and not super commons area or on the cook only worked and the last time she service hallway/kitched ago. Interview with a person of the staff knew the reservice hall from the service h	e complained about the ecutive Director (ED). ich entered the service hall nile the dietary staff was on eals. Id, the residents who all from the SCU patio just ice hallway until the dietary ecompanied them back to the stove with the burners food cooking. In the stove with the burners food cooking. In the stove with the burners food tooking. In the store hall and were often the stove with the burners food tooking. In the service hall as they the service hall as they the service hall and in the salways sitting at the nurse's the service hall and in the the patio. In the service hall and in the service hall and in the the patio. In the service hall and in the service hall before the staff the service hall the service	D 270		

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 67 of 267

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	950 HWY	DDRESS, CITY, STA 64 EAST IA, NC 27925	TE, ZIP CODE		
(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	into the service hall, I them back. -She was aware the of the patio was not lock. -When the residents area, the SCU staff with the dining room winds the residents. Interview with the Exc 05/17/19 at 5:15pm reshe knew Resident adoor to the service has unsupervised becaus secured patio) did noto the cook had repeate either back to the SC kitchen. Resident #16 was on checks and she was continued to wander as continued to wander as the policy of the monitored and identification. Fall Risk Assessment residents admitted to staff would receive to the same admitted to staff would complete entirety for any fall. -Staff would complete entirety for any fall. -Staff would complete entirety for any fall. -Staff would complete resident falls to invest circumstances contributed ocument observation.	s who occasionally walked out the dietary staff brought door to the service hall from cable. were outside in the patio ras able to watch them from ows, and not go outside with ecutive Director (ED) on evealed: #16 routinely opened the all and entered the kitchen e the service door (from the tock. redly brought the resident U or to her office from the an incident expervisory unaware the resident into the kitchen. Ty's Falls Management the facility for residents to be died for risk of falls. The facility of the facility of the facility. The facility of the facility o	D 270			

Division of Health Service Regulation

initially and every shift for 72 hours and

STATE FORM STATE FORM If continuation sheet 68 of 267

DIVISION	of fleatin Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
			D 14//10			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE ZIP CODE		
TO WILL OF TH	NOVIDER OR OUT FEEL	950 HWY				
TYRRELL	HOUSE					
		COLUMBI	A, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORT OR E	130 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	NAIL	5,2
D 270	Continued From page	e 68	D 270			
	accomment of possib	de riek / contribution feators				
	T =	le risk / contribution factors				
	for falls.					
		lls within a 4 weeks period,				
		be contacted requesting an				
		rapy (PT) evaluation or other				
	treatment / intervention					
	-The resident was to I	be placed in Hot Box / Alert				
	Charting for 72 hours	for follow up and				
	monitoring.					
	-The Healthcare Qual	lity Assurance Team would				
	review incident report	s on a monthly basis.				
	·	·				
	Review of Resident #	14's current FL-2 dated				
	02/26/19 revealed:					
	-Diagnoses included I	Huntington's disease and				
	_	on's disease is a genetic				
		uncontrolled movement of				
		face, and upper body.)				
	-The resident was ser					
	wheelchair.	The difficulties of white d				
	-The resident's speed	h was slurred				
	· ·	d assistance with bathing				
	-	a assistance with bathing				
	and dressing.	are on her albem				
	-The resident had sca					
		casionally incontinent of				
	bowel and bladder.					
	Daview of Decident #	14's current assessment				
	and care plan dated 0					
		bulatory with a wheelchair.				
		ntington's disease and was				
	unsteady.					
		ited range of motion in her				
	upper extremities.					
		casional incontinence of				
	bowel and bladder.					
	-The resident was orion	ented and her memory was				
	adequate.					
	-The resident's speed	h was slurred.				

Division of Health Service Regulation

-The resident was a fall risk and had to be

STATE FORM STATE FORM If continuation sheet 69 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BOLLDING.	
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATI	E, ZIP CODE	
TYRRELL	HOUSE	950 HWY	64 EAST		
THRICEL		COLUMB	BIA, NC 27925		
(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 COMPLETE
D 270	Continued From page	e 69	D 270		
	bathing, grooming, dr	d limited assistance with			
	charting notes, and h -The resident had 29 05/14/19. -The resident went to for evaluation of injuri	the emergency room (ER) les for 6 of the 29 falls.			
	abrasions/lacerations injury, post-traumatic of neck muscle, bruis abrasion lower left an left side of body, bruis	es included scalp hematoma, to elbows, minor head headache, pain and strain ing and knot on head, ikle, scratch and bruise on se on right hand, reddened ratch on left side of face.			
	area on back, and scratch on left side of face. Interview with Resident #14 on 05/13/19 at 11:53am revealed: -The resident had slurred speech and was difficult to understandThe resident had falls but she did not have any falls over the past weekendThe resident went to the hospital sometimes because of falls.				
		ne last time she fell, the ould not be understood.			
	11/04/18 at 7:41am re -The resident was for closet on her bottomThere were no appar signs were goodThe resident had a seleft side from an old for the resident and the selection of the resident and the selection of the resident and the selection of the resident was selected.	rent injuries and her vital cratch and a bruise on her			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 70 of 267

DIVISION OF Fleath Service Regulation							
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
		11-100000	B. WING		054	7/0040	
		Hal089002	1		₁ 05/1	7/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
		950 HWY	64 EAST				
TYRRELL	HOUSE	COLUMB	IA, NC 27925				
040.15	STIMMADV ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTIO	iNI	0/5)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE	
				DEFICIENCY)			
D 270	Continued From page	270	D 270				
D 210	Continued From page	. 10	D 210				
	throughout the shift.						
	-The primary care pro	ovider (PCP) and guardian					
	were aware of the situ	uation.					
	Review of Resident #	14's accident/injury reports					
	revealed there was no	o report completed for the					
	resident's fall on 11/04	4/18.					
	Review of Resident #	14's 72 hour falls follow-up					
		e was no form documented					
	· · ·	w-up for the fall on 11/04/18.					
	3						
	Review of Resident #	14's accident/injury report					
	dated 11/07/18 at 6:2						
		en on the rocks, next to the					
	sidewalk.	•					
		chair was sideways on the					
	ground.						
	-The resident stated h	ner wheelchair went					
	backwards with her in						
		abrasion (location not					
	specified).						
	-The resident was tak	en to the FR					
		ignosed with a minor head					
	injury.	.geeea mara minor noda					
		for the resident's PCP and					
	guardian.	of the resident 31 of and					
	gaaraiari.						
	Review of Resident #	14's charting note dated					
	11/07/18 at 7:13pm re						
	•	of her wheelchair on the					
	rocks while outside w						
		cratch on her lower left					
	back.	CIALOIT OIT HEI TOWEL TEIL					
		she hit her head and she					
		one nit nei neau anu sne					
	was sent to the ER.	an ware contacted					
	-The PCP and guardi	an were contacted.					
	Paview of Posidont #	14's hospital ED notes					
	Meview of Resident #	14's hospital ER notes	1				

Division of Health Service Regulation

dated 11/07/18 revealed:

STATE FORM STATE FORM ZE7D11 If continuation sheet 71 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	A. BOILDING.		
		Hal089002	B. WING		05/1	7/2019
NAME OF PROVIDER OR	SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL HOUSE 950 HWY 6						
			A, NC 27925		1	
1 1 ()	CH 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	(X5) COMPLETE DATE
D 270 Continued	d From page	e 71	D 270			
-The residence of the resident's Review of reports resident's Review of reports resident's Re	dent was secan and an dent was dia an abrasion of Resident # vealed there or ing or folloof Resident had fall dent later state was give dent's vital secand of shift. If Resident # there was no fall on 11/1 or Resident # vealed there or ing or folloof Resident # 25/18 at 3:3 dent was lay dent stated secand of shift.	en for a fall. x-ray of the left ankle were agnosed with a minor head n of the left ankle. 14's 72 hour falls follow-up e was no form documented w-up for the fall on 11/07/18. 14's charting note dated revealed: en out of her wheelchair. ated her head was hurting a en some Tylenol (for pain). igns were taken again t and the resident was to monitor the resident	D 270			
backward -No injurie to the ER	s, and she I es were note	anded on the floor. ed but the resident was sent for the resident's PCP and				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 72 of 267

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	,
			64 EAST		
TYRRELL	. HOUSE	COLUME	BIA, NC 27925		
(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 72	D 270		
	dated 11/25/18 revea -The resident was ser -The resident fell out head, and complainer the neck and a heada -Scans of the cervica -No acute abnormaliti scanThe resident was ad the pain and sent back Review of Resident # reports revealed there for monitoring or follo Review of a physician dated 12/12/18 revea for the resident's whe positioning. (A lap bu snugly into the wheel that provides upper b assistance.) Review of Resident # dated 01/02/19 at 1:1 -The resident was out her wheelchairNo injuries were pres -Messages were left if guardian. Review of Resident # 01/02/19 at 3:29pm re -The resident was out wheelchair.	en for a fall. of the wheelchair, hit her d of pain to the right side of ache. I spine and head were done. lies were noted with either ministered medication for ek to the facility. 14's 72 hour falls follow-up e was no form documented w-up for the fall on 11/25/18. 1's order for Resident #14 led an order for a lap buddy elchair for safety and uddy is a cushion that fits chair frame about the lap ody support and posture 14's accident/injury report Opm revealed: tside on the ground out of sent. for the resident's PCP and			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 73 of 267

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TIMALLE	110002	COLUMBI	A, NC 27925			
(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 270	Continued From page	e 73	D 270			
	Review of Resident # dated 01/02/19 at 11: -The resident was lay the bedThe resident stated sher headNo injuries were noted to the hospitalMessages were left figuardian. Review of Resident # dated 01/03/19 reveative -The resident was seed -Scans of the cervical -The resident was dia headache and strain of -The resident was given medications; a muscle and a medication for information of the resident was seed seed to resident was seed seed to resident was seed seed to resident was to remotive the remoti	14's accident/injury report 17pm revealed: ing on her left side beside she rolled off the bed and hit ed but the resident was sent for the resident's PCP and 14's hospital ER notes led: en for a fall. I spine and head were done. ignosed with post-traumatic of neck muscle. en orders for 3 new e relaxer, a pain medication, nausea. 14's charting note dated revealed the resident's book the lap buddy back with pecified). 14's after visit summary with 01/04/19 at 11:00am en for a Huntington's impaired balance or eased the dosage of a eat involuntary movements ington's disease. return to the neurologist in 6				
	Review of Resident #	14's accident/injury report	1		ļ	ı

Division of Health Service Regulation

dated 01/04/19 at 6:30pm revealed:

STATE FORM STATE FORM If continuation sheet 74 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY (
	CLIMMADV CT		A, NC 27925	DROVIDEDIS DI AN OF CORRECTIO	N age	
(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 APPROP DEFICIENCY)	BE COMPLE	ETE
D 270	Continued From page	e 74	D 270			
	the floor beside the baseline -No injuries were pres					
	01/04/19 at 6:31pm re -The resident was in I slipped out of the who on her bedThe resident's vital s -The resident's PCP a	e14's charting note dated evealed: her room and stated she eelchair when trying to get eigns were in normal range. and guardian were notified. her throughout the shift.				
	report dated 01/04/19 -"Section B" for asses including questions resigns, wearing proper device, or taking psychological properties."	esing the resident was blank elated to the resident's vital shoes, using an assistive chotropic medications. signs each shift was blank				
	dated 01/08/19 revea -The resident was senew patient. -Staff reported the resand was sent to the E	en to be established as a sident had a fall on 01/03/19				
	dated 01/24/19 at 3:0 -The resident rolled to -The resident was lay wheelchairNo injuries were pres	oo far back and flipped over. ring back on rocks in the				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 75 of 267

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		0:	5/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
TYRRELL	HOUSE		' 64 EAST BIA, NC 27925				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
D 270	Continued From page	e 75	D 270				
	dated 02/05/19 reveal -The resident was be follow-up visitThe resident wanted something to keep he coughThe PCP ordered me coughThere was no docume resident's falls. Review of Resident # dated 02/18/19 at 12: -The resident was in bathroom and slid ou on the floorNo injuries were president.	to see the PCP to request er calm and something for a edications for anxiety and mentation regarding the e14's accident/injury report e49pm revealed: the wheelchair in the tof the wheelchair and fell					
	02/18/19 at 1:16pm re-The resident had "a state of the resident was in bathroom and slid ou on the floorStaff would continue throughout the shift. Review of Resident # dated 02/24/19 at 10:10-The resident was lay -The resident stated she was sleeping.	fall today at 12:49pm". her wheelchair in the t of the wheelchair and laid to monitor the resident 14's accident/injury report 30pm revealed: ving by the bed. she fell out of the bed while an old cut on her right and put some triple					

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 76 of 267

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			·			
			D WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE ZIP CODE		
TYRRELL	HOUSE		64 EAST			
		COLUME	BIA, NC 27925			1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DATE
				,		
D 270	Continued From page	e 76	D 270			
	-A massage was left y	with the resident's guardian.				
	-Staff spoke with the					
	-Stall spoke with the	resident's FOF.				
	Review of Resident #	14's charting note dated				
	02/25/19 at 1:41am re					
	-The resident fell off h					
	sleeping.	iei bed toriigiit wrille				
		she was "alright" but her				
	right elbow was bleed					
	0	ed an old cut that was on				
	•	ed all old cut that was off				
	her right elbowStaff did first aid on h	nor olbow, called all				
		nd notified them on what				
	was going on with the					
	-The resident's vital s					
		to monitor the resident's				
	behaviors throughout	. triat sinit.				
	Review of Resident #	14's accident/injury report				
	dated 02/25/19 at 12:					
		ving on the floor on her back				
	beside the bed.					
	-The resident stated s	she fell off the bed				
	-No injuries were pres					
	-	with the resident's guardian.				
	-Staff spoke with the					
	отан ороно на на					
	Review of Resident #	14's charting note dated			ĺ	
	02/25/19 at 1:44pm re					
	-	ner bed and was laying by				
	her bed on the floor.	-, 3 -,				
		to monitor the resident				
	throughout the shift.					
	3				ľ	
	Review of Resident #	14's accident/injury report				
	dated 02/26/19 at 6:3				ĺ	
	-The resident was lay					
	-The resident stated s	_				
	wheelchair and fell ou					
		aceration on her right elbow				
		and a second sec	1			

STATE FORM 6899 ZE7D11 If continuation sheet 77 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17	7/2019	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	, 00		
TYRRELL	HOUSE	950 HWY 6	4 EAST				
			A, NC 27925				
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 270	Continued From page	: 77	D 270				
	and it was bandagedMessages were left v guardian.	vith the resident's PCP and					
	dated 02/26/19 revea						
		ng seen for a follow-up visit. ne resident had 3 falls in a					
	transfer to her wheeld						
	 -No injuries noted fror -The resident stated s any pain. 	m any of the falls. she was okay and denied					
	-The PCP ordered ph	ysical therapy (PT) and (PT) evaluate and treat.					
	02/26/19 at 10:33pm						
	ne resident fell getti morning.	ng in her wheelchair this					
	-Vital signs were take were called.	n and the PCP and guardian					
	Review of PT visit not revealed:	es for Resident #14					
	02/28/19.	mitted to PT services on					
		charged from PT services ck of progress towards PT					
	-The resident was add 03/01/19.	n for Resident #14 revealed: mitted to OT services on					
	on 04/16/19 due to more potential being achiev						

Division of Health Service Regulation

Review of Resident #14's charting note dated

STATE FORM STATE FORM ZE7D11 If continuation sheet 78 of 267

DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE ZIP CODE	
3					
TYRRELL	HOUSE		64 EAST		
		COLUMB	IA, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(* /
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				22.18.2.18.1	
D 270	Continued From page	e 78	D 270		
	03/01/19 at 8:50am re				
	-The resident fell out	of her wheelchair this			
	morning.				
	-Vital signs were take	n and were normal.			
		re left for the resident's PCP			
	and guardian.				
		to monitor the resident for			
	the next 72 hours.	to mornior the regident for			
	the field 72 flours.				
	Review of Resident #	14's accident/injury reports			
		o report completed for the			
		•			
	resident's fall on 03/0	1/19.			
	D : (D :1 1#	441			
		14's accident/injury report			
	dated 03/07/19 at 10:				
		ting in her wheelchair.			
	-There was blood on	the wall and air conditioner			
	unit.				
	-The resident stated s	she fell out of bed the night			
	before and got back ι	ıp on her own.			
	-The resident had a la	aceration on her right elbow.			
	-It was cleaned, ointm	nent applied, and wrapped			
	with gauze.	11 / 11			
	•	with the resident's guardian.			
	-Staff spoke with the				
	otali opolio iliai alo				
	Review of Resident #	14's 72 hour falls follow-up			
		e was no form documented			
		w-up for the fall on 03/07/19.			
	ioi monitoring or iono	w up for the fail off 05/0//19.			
	Paview of Posidont #	:14's accident/injury report			
	dated 03/09/19 at 12:				
		ring on the floor in the			
	hallway.				
	-The resident stated s	sne tell out of the			
	wheelchair.				
	-No injuries were pres				
		with the resident's PCP and			
	guardian.				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 79 of 267

	i Health Service Regu		<u> </u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
		11-1090002	B. WING		05/4	7/0040
		Hal089002			05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		IA, NC 27925			
	CLIMMA DV CT		<u> </u>	DDOVIDEDIC DI ANI OF CODDECTIO	NI.	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
D 270	Continued From page	270	D 270			
D 210	Continued From page	e 79	D 270			
	Review of Resident #	14's charting note dated				
	03/09/19 at 4:02pm re					
	-The resident fell out	of her wheelchair this				
	afternoon.					
	-No injuries were four	nd, and vital signs were				
	taken.	-				
	-The resident's PCP a	and guardian were notified.				
		to monitor throughout shift.				
	Review of Resident #	14's 72 hour falls follow-up				
		e was no form documented				
	•	w-up for the fall on 03/09/19.				
		ap				
	Review of Resident #	14's accident/injury report				
	dated 03/13/19 at 6:2					
		ting on the floor in the dining				
	room.	g				
	-The resident stated s	she slipped out of her				
	wheelchair.	one employ eat or no.				
	-No injuries were pres	sent				
		with the resident's PCP and				
	guardian.	with the resident 31 of and				
	gaaraiari.					
	Review of Resident #	14's 72 hour falls follow-up				
		e was no form documented				
	- I	w-up for the fall on 03/13/19.				
	ioi monitoring or iono	w-up for the fall off 03/13/19.				
	Review of Resident #	14's accident/injury report				
	dated 03/15/19 at 6:5					
		ring on the floor next to her				
	bed.	ing on the hoor heat to her				
	-The resident stated s	she rolled off the hed				
	-No injuries were pres					
		with the resident's PCP and				
		with the resident's PCP and				
	guardian.					
	Interview with a perso	onal care aido (PCA) on				
		onal care aide (PCA) on				
	05/14/19 at 6:30pm re					
	-Resident #14 needed	d assistance with showers				

Division of Health Service Regulation

and dressing.

STATE FORM STATE FORM If continuation sheet 80 of 267

DIVISION	n Health Service Regu	iauon				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	E I E D
		11.100000	B. WING			_,
		Hal089002	D. WIING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
	-	950 HWY				
TYRRELL	HOUSE					
		COLUMBI	A, NC 27925			
(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 APPROP		COMPLETE DATE
TAG	REGULATORT OR L	LOC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	NATE	D/(IL
				,		
D 270	Continued From page	e 80	D 270			
	Ctoff also sociated th					
		ne resident with transferring				
		om with her, otherwise the				
	resident could transfe					
		ilet herself and would use				
	the call bell if she nee					
	-The resident was on	2-hour routine checks and				
	no one had instructed	d staff to monitor the resident				
	more frequently.					
	-When the PCA works	ed, the resident fell about				
	twice a week.					
	-She thought the resid	dent fell because the				
	resident got in a hurry					
	resident had involunta					
		ent on the floor about 1 and				
		ing to 03/15/19) when the				
	resident had fallen ou	-				
		have injuries or go to the				
		-				
	hospital on that occas					
		ent while doing routine				
		e did not know how long the				
	resident was on the fl					
	· · · · · · · · · · · · · · · · · · ·	to the medication aide (MA)				
	on duty.					
		it was checked every 30				
		then back to routine 2-hour				
	checks.					
		14's 72 hour falls follow-up				
	•	e was no form documented				
	for monitoring or follo	w-up for the fall on 03/15/19.				
		14's accident/injury report				
	dated 03/18/19 at 8:5					
	-The resident was sitt	ting in her wheelchair.				
	-The resident stated s	she fell out of the wheelchair				
	while trying to put her	shoes on.				
	-No injuries were pres					
	-	with the resident's PCP and				
	guardian.					

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 81 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
		950 HWY		,		
TYRRELL	HOUSE		IA, NC 27925			
(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	Continued From page	e 81	D 270			
	reports revealed there for monitoring or follo	14's 72 hour falls follow-up e was no form documented w-up for the fall on 03/18/19.				
	dated 03/20/19 revea	14's current PCP visit notes led: en today for multiple falls.				
	-The care staff reporte	ed the resident had falls				
	about every day.	other than the "came anot"				
	on her elbow.	other than the "same spot"				
	-The resident stated s	she was okay.				
		lls occurred when the				
	resident had uncontro					
		ary movements including				
		, twisting, and writhing). pen when the resident got				
	-The resident required ways not feasible with	d positioning of the body in an ordinary bed.				
	success.	had been tried with no				
	semi-electronic hospi					
	-The resident was to I	be rechecked in 2 weeks.				
		ent #14 on 05/14/19 at				
	2:10pm - 2:20pm reve					
	 The resident was in I wheelchair. 	-				
	mattress in her room.					
		legs, and torso had near				
	body to jerk and her a	movements causing her arms and legs to flail in				
	random directions. -The resident could be	ropel the wheelchair with				
	her feet, but the whee	elchair jerked and rolled iple directions because of				

Division of Health Service Regulation

the resident's sudden involuntary movements.

STATE FORM STATE FORM If continuation sheet 82 of 267

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
			A, NC 27925			
(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 82		D 270			
	dated 03/21/19 at 12: -The resident was sitt -The resident stated s incontinence briefNo injuries were pres	ing up on bathroom floor. she fell while pulling up her				
	03/21/19 at 12:35am -The resident fell in th -The resident's vital s normal range.					
	reports revealed there for monitoring or follo	14's 72 hour falls follow-up was no form documented w-up for the fall on 03/21/19.				
	Review of a physiciar dated 03/22/19 revea semi-electric hospital mattress.					
	dated 03/28/19 at 6:4 -The resident was lay bathroom by her whe -The resident stated stathroomNo injuries were noted.	ing on the floor in the elchair. She fell trying to go to the				
	dated 03/30/19 at 11:	balance and fell while trying				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 83 of 267

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	SI GORREOTION	IDENTIFICATION NOMBER.	A. BUILDING: _		JOHN EETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY	64 EAST IA, NC 27925		
0(0.15	CHMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 83	D 270		
	-The resident's PCP	and guardian were notified.			
	dated 04/02/19 at 10: -The resident was lay in her room, then she -The resident stated s -No injuries were note	ring on her back on the floor sat up. she fell.			
	revealed: -Resident #14's involugotten worse over the -Staff helped the resident groomingThe resident could s and she could transferif staff pushed the reher room, staff would transferring or toiletin -Resident #14 had "a tried to get up by hershelpShe thought the resishe was discharged fishe was "too far gone -The resident had a honcave mattress are this month.	tand holding onto something er herself. sident in her wheelchair to assist the resident with g. lot" of falls because she self and would not call for dent had PT last month but from PT services because			
	dated 04/21/19 at 10: -The resident was sittledroomThe resident did not	ting on the floor in her			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 84 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE S	
			7.1. 20.22.110.			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY (
			A, NC 27925			
(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	(X5) COMPLETE DATE
D 270	270 Continued From page 84		D 270			
	bit".	ell, "it made it bleed a little				
	and bandaged it.	e bruise, put ointment on it, and guardian were notified.				
		on 05/14/19 at 5:21pm				
	revealed: -Resident #14 had fa falls.	lls but "not really" a lot of				
	-Resident #14 needed assistance with bathing and dressing.					
		ped the resident with toileting				
		ent did not call for help but call staff for assistance.				
	• •	routine 2-hour checks,				
	•	nstructions to monitor				
	Resident #14 more fr	equently than every 2 hours.				
	Review of Resident # dated 05/02/19 at 1:5	:14's accident/injury report 5pm revealed:				
	side with her hands u					
	-The resident stated stated states					
		oump on the back of her				
	-The resident was tak	en to the ER. arge diagnosis was scalp				
	hematoma.					
	-The resident's PCP	and guardian were notified.				
	Review of Resident # 05/02/19 at 3:17pm re	:14's charting note dated evealed:				
	-The resident was for	and in her room on the floor.				
		she fell out of her wheelchair				
	trying to go to the bat -The resident's vital s	hroom. igns were checked, and the				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 85 of 267

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		Hal089002	B. WING	·····	05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		950 HWY	64 FAST		
TYRRELL	HOUSE		A, NC 27925		
			A, NO 27925	T	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG			IAG	DEFICIENCY)	
D 270	Continued From page 85		D 270		
	resident was sent to t	ho ED			
	residerit was serit to t	He ER.			
	Pavious of Posidont #	14's hospital ER notes			
	dated 05/02/19 revea				
	-The resident was see				
	-A head scan was do				
	-The resident was dia	ignosed with a scalp			
	hematoma.				
	Deview of Decident #	4.415 abouting water dated			
		14's charting note dated			
	05/03/19 at 1:30pm re				
		and sitting on the floor in her			
	room.				
	-The resident did not				
		she was getting a cookie that			
	fell on the floor.				
	-The resident's vital s	-			
		for the resident's guardian.			
	-Staff spoke with som	eone at the PCP's office			
	and they would call be	ack if there were any orders			
	from the PCP.				
	Review of Resident #	14's accident/injury reports			
	revealed there was no	o report completed for the			
	resident's fall on 05/0	3/19.			
		14's charting note dated			
	05/05/19 at 10:20am				
	-The resident was fou	and sitting on the floor in her			
	bathroom and she wa	as crying.			
	-The resident stated s	she hit her head on the toilet.			
	-The resident had a k	not on the top of her head			
	and a scratch on the I	left side of her face near her			
	eye.				
	-The resident asked to	o go to the hospital.			
		-			
	Interview with a MA o	n 05/15/19 at 3:57pm (who			
	wrote the charting not	te on 05/05/19) revealed:			
		on second shift from 3:00pm			

Division of Health Service Regulation

to 11:00pm.

STATE FORM STATE FORM ZE7D11 If continuation sheet 86 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/201	9
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE		64 EAST			
			IA, NC 27925			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	X5) PLETE ATE
D 270	Continued From page	e 86	D 270			
	own but the resident of the resident would try lean over in the chair resident #14 was or checks until yesterda start doing 30-minute right of the chair start doing 30-minute right of the chair right of the chair right of the chair resident was lay bathroom. The resident stated so the chair resident had brusent to the ER.	ed something on the floor, to pick it up, causing her to and fall at times. n routine 2-hour monitoring y, when staff was told to checks on the resident. sident #14 in common areas ore often. 14's accident/injury report 00am revealed:				
	dated 05/05/19 reveal -The resident was see -Scans of the head at -The resident was dia	en for a fall. nd spine were done. ignosed with abnormal bry of Huntington's disease.				
	dated 05/07/19 reveal. The resident was be -Care staff reported the -The only injury obtains of her head, which had -The resident stated is been falling out of betathroom.	ing seen for multiple falls. ne resident had several falls. ned was a knot on the back id resolved. she was "good" but she had				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 87 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	Hal089002	B. WING		05/·	17/2019	
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STAT	FE, ZIP CODE		20.10	
TYRRELL HOUSE		7 64 EAST BIA, NC 27925				
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
dated 05/08/19 at 2:28 -The resident was sitti hallwayThe resident stated siner wheelchairNo injuries were note. A message was left for Information was relay. Review of Resident #1 05/08/19 at 4:50pm re. The resident slid out of hallwayThere were no injurie taken. Review of Resident #1 05/08/19 at 9:50pm re. The resident saw the several fallsThe PCP stated the replaced somewhere els. Staff would continue to the Review of Resident #1 dated 05/09/19 at 12:3 -The resident was trying fell in the dining roomThe resident's PCP anotified. Review of Resident #1 dated 05/13/19 at 8:20 -The resident was sitti hallway.	14's accident/injury report Bpm revealed: ing on the floor in the he was trying to sit back in ad. or the resident's guardian. wed to the PCP's nurse. 14's charting note dated evealed: of her wheelchair in the as and vital signs were 14's charting note dated evealed: PCP on 05/07/19 for resident needed to be se. to monitor. 14's accident/injury report 30pm revealed: ng to pick up her shoe and and guardian were not 14's accident/injury report 0 am revealed: ing on the floor in the he was trying to get her	D 270				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 88 of 267

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			/ DOILDING			
Hai089002 B. WING			05/17/2019			
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TINKLLL	11003L	COLUMB	IA, NC 27925			
(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 88	D 270			
	05/13/19 at 9:47am re- The resident was on -The resident's vital s -The resident's PCP a Interview with a PCA revealed: -Staff helped Resident dressingThe resident sometiment on but would fall out of the resident tried to but if staff where check resident was in the baseThe resident was on -She thought Resident	the floor in the hallway. igns were taken. and guardian were notified. on 05/14/19 at 5:35pm It #14 with bathing and mes tried to put her shoes of the wheelchair because of tary movements. transfer and toilet herself cking on her and the athroom, staff would assist routine 2-hour checks. It #14 may have been on 72 hours after a fall about a				
	revealed: -Resident #14 needed and dressing.	on 05/14/19 at 6:20pm d assistance with bathing t incontinent and she could				
	assisted because the going to fall".	n her own. transfer herself but staff y were "afraid she was or assistance at times but				
	not all of the timeMost of the resident's resident's involuntary wheelchair.	s falls were caused by the movements while in the				

Division of Health Service Regulation

because she needed assistance.

STATE FORM STATE FORM ZE7D11 If continuation sheet 89 of 267

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
			P WING			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
				,		
TYRRELL	HOUSE	950 HWY				
		COLUMBI	A, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	, · ·	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE DAI	_
D 270	Continued From page 89		D 270			
		f were supposed to do				
		72 hours after a fall then the				
	resident went back or	n routine 2-hour checks.				
		14's current PCP visit notes				
	dated 05/14/19 revea					
	-The resident was bei	ing seen for multiple falls.				
	-Care staff reported th	ne resident had 5 falls in a				
	week.					
	-The resident had sev	veral abrasions of her				
	elbows.					
	-The PCP ordered a r	neurology consult for				
	repeated falls.					
	•	consult for evaluation of a				
	specialized wheelcha					
	resident's falls.	ii to help control the				
	resident's fails.					
	Interview with the Car	ro Managor (CM) on				
	05/13/19 at 4:20pm re					
	-					
	-Resident #14 had fre					
		falls and one day she had 2				
	or 3 falls the same da	-				
	-Resident #14 tried to					
	instead of getting ass					
	-Resident #14 could s					
	independently but she	e needed standby				
	assistance at least.					
	-The resident also slid	d out of her wheelchair and				
	fell out of bed someting	mes.				
	-The resident got a co	oncave mattress (could not				
	recall when) and that	helped some with falls from				
	her bed.					
	-The resident also ha	d a lap buddy for her				
	wheelchair but it did r					
		e it so the lap buddy was				
		s guardian (could not recall				
	when).	guardian (could not recail				
		and OT about a result are				
	- ine resident had PT	and OT about a month ago				

Division of Health Service Regulation

but they were told PT and OT could not do

anything else for the resident.

STATE FORM STATE FORM If continuation sheet 90 of 267

	i Health Service Regu				ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	=D
		Hal089002	B. WING		05/17/2	2019
					1 00/11//	2013
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE		64 EAST			
		COLUME	IA, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DAIL
				,		
D 270	Continued From page	e 90	D 270			
	-There was not much	improvement after the				
	resident had PT/OT.					
	-Resident #14 was or	n routine 2-hour checks like				
	the other residents.					
	-Staff should try to ch	eck on Resident #14 every				
	time they walked by t					
		rvision checks had not been				
	increased to her know	•				
		minute checks, it would be				
	documented.					
		nt vital signs and monitoring				
		ours after each fall on the 72				
	hours falls follow-up r	ероп.				
	A second interview w	ith the CM on 05/14/19 at				
	2:35pm revealed:					
	_	new wheelchair last year but				
	the resident broke it.					
	-The resident's guard	•				
		sident which was the one				
	she currently used.	asidamtla DCD vastandav				
		esident's PCP yesterday				
	specialty wheelchair b	of getting the resident a				
		Decads the regional D) had mentioned it to the				
	CM.	o) had mentioned it to the				
	-Resident #14 was or	2-hour incontinence				
	checks.					
		y the resident's door, they				
		door and look in on the				
	resident.					
	-Staff "just know" to c	heck on Resident #14.				
		do for herself but she				
	needed assistance.					
	Intomious sitte the A. I.					
		ministrator on 05/14/19 at				
	4:57pm revealed:	II stoff wore supressed to				
	-ii a resident nad a fa	II, staff were supposed to				

Division of Health Service Regulation

get the MA so the MA could assess the situation

and check the resident's vital signs.

STATE FORM STATE FORM ZE7D11 If continuation sheet 91 of 267

DIVISION	n Health Service Regu	lation			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		Hal089002	B. WING		05/1	7/2019
			ı		1 00/1	772010
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
		COLUMBI	A, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
IAG	NEODE WORLD	iso BENTIL TINO IN GRAW, WIGHT,	IAG	DEFICIENCY)	WIL	
			 			
D 270	Continued From page	91	D 270			
	-If there was obvious	pain, blood, or injury,				
		ervices (EMS) should be				
	called.	,				
	-If a resident hit their	head but there was no knot				
	or other obvious injury	y, staff should follow				
	protocol of 72 hour re call EMS.	porting but they would not				
		to check vital signs and				
		nd pain on all 3 shifts for 72				
	hours after each fall.	ta pain on an o orinto for 72				
		e in a resident's status, the				
	•	I and the resident sent to the				
	hospital.					
	•	n meant more checks than				
	-	ecks with options for 1-hour				
	or 30-minute checks.					
	-All residents in the A	L side of the facility including				
	Resident #14 were or	routine 2-hour checks.				
	-She thought Resider	nt #14 was put on hourly				
		ıt it had "been a while" and				
	she could not recall w					
		nt hourly checks because				
	staff were entrusted to					
		if Resident #14 had ever				
	been on 30-minute ch					
		concave mattress, PT/OT, a				
		as supervised while outside				
	(could not recall when					
	-	fall mat but had recently gement meeting (not sure				
	date).	gement meeting (not sure				
	•	ed to fall, after 1-hour checks				
		y would keep trying by				
	•	n such as 30-minute checks.				
		r such as 50-minute checks.				
	checks.					
	-She could not explain	n why Resident #14's				
		een increased even though				
	the resident continued					

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 92 of 267

DIVISION	i Health Service Regu	I			T
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		11-100000	B. WING		05/47/0040
		Hal089002			05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		950 HWY	64 EAST		
TYRRELL	HOUSE	COLUMB	IA, NC 27925		
040.15	STIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N OVE
(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 APPROP	RIATE DATE
				DEFICIENCY)	
D 270	Continued From page 92		D 270		
22.0	. •		52.0		
		D on 05/14/19 at 4:55pm			
	revealed:				
		he resident's PCP had			
	recently discussed (co	ould not recall date)			
	upgrading Resident #	14 to a skilled nursing			
	facility.				
	-She was not sure ho	w the resident would			
	respond to that becau	use this was the first facility			
	the resident had resid	led in and it was the			
	resident's home.				
	-She was not sure the	e status of upgrading the			
		ave to check with the CM.			
		vith Resident #14's current			
	PCP on 05/15/19 at 1	0:23am revealed:			
		deterioration in functional			
	-	2019 and was getting worse.			
	-The resident's speed	ch was more slurred and she			
	was difficult to unders				
		se process (Huntington's			
	disease) was "relative				
	-He was aware Resid	ent #14 had several falls but			
	he was not sure if he	was notified each time the			
	resident fell.				
	-He received a text from	om the CM yesterday			
	(05/14/19) about the r	resident falling out of her			
	wheelchair.				
	-There was a care pla	anning meeting for the			
	resident about 6 weel	ks ago and staff reported the			
	resident was falling or	n a daily basis.			
	-A lot of the falls were	related to the resident			
	falling out of bed beca	ause the resident had a			
	difficult time reposition	ning and moving around in			
	bed.				
	-They got a hospital b	ed with concave mattress			
		change in her wheelchair at			
	some point (could not				
	-He thought the reside	· ·			
		ot the hospital bed and			

Division of Health Service Regulation

concave mattress.

STATE FORM STATE FORM If continuation sheet 93 of 267

STATEMENT OF DEPICIENCES AND PLAN OF CORRECTION DEPICE CONTRICATION NUMBER AND PLAN OF CORRECTION DEPICE CONTRICATION DEPICE CONTRICATIO	Division of	of Health Service Regu	ilation				
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE SUMMARY STATEMENT OF DETOCIONATES (PACH DEPOCHATIVE MUST BE PRECEDED BY VAIL. PREFIX TAG. PREFIX (PACH DEPOCHATIVE OF DETOCIONATES OF TAG. D. 270 Continued From page 93 - He thought most of the resident's falls now were out of the wheelchair. - The resident was trying to maintain her independence and their do to drings for herself. - The facility had not been able to lessen or improve the resident's falls. - It was reasonable that more supervision may help the resident. - He was currently thinking a skilled nursing facility would be able to "keep more eyes" on the resident and provide more supervision and that may decrease the resident's facility was the resident the resident being moved because this facility was the resident. - Interview with the RCD on 05/16/19 at 12:40pm revealed they contacted the resident #14's Department for the resident #14's Department for the resident #14's Department of Social Services (DSS) guardian and the guardian was working on finding placement for the resident #14 so Department of Social Services (DSS) guardian on 05/14/19 at 11:58am revealed: - She was concerned about the resident because the session of the resident to the battroom. - The resident was going to the bathroom. - She was not sure how often they assisted the resident foll. - She was onto sure how often they assisted the resident to the battroom. - She was not sure how often they assisted the resident to the battroom. - She was not sure how often they assisted the resident to the battroom. - The resident needed assistance with bathing,	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		
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-The resident needed assistance with bathing,			and needed to go to the				
			Lassistance with hathing				
-The resident could propel the wheelchair with							

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 94 of 267

Division of	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AIND PLAIN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		11-1000000	B. WING		
		Hal089002	D. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE		64 EAST		
	I		BIA, NC 27925		
(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	BE COMPLETE
				DEFICIENCY)	
D 270	Continued From page 94		D 270		
	her feet.				
		sident trying to stand up but			
	-She had not seen the	bbly" when she did that. e resident walk			
		Γ (could not recall when) but			
		v long the resident took PT.			
		re independent when she vbe made her stronger"			
	physically.	be made her stronger			
	-A lap buddy was ord				
		se they thought it would			
	helpThe resident could re	emove the lap buddy and			
		t a different wheelchair, the			
	lap buddy no longer f				
		ider wheelchair (between mber 2018) so she could			
	lean back more and t	· ·			
	-She did not know ho	w often staff checked on or			
	monitored the resider	• • •			
		ed to have multiple falls and resident needed a higher			
	level of care because				
		oking for a skilled facility to			
	move the resident.				
	A third interview with	the CM on 05/16/19 at			
	11:55am revealed:				
		minute supervision checks 05/14/19 as part of the			
	facility's plan of prote				
		ting the 30-minute checks on			
	a spreadsheet that was	as kept at the nurses'			
		ed Supervision - Every 30			
		for Resident #14 revealed nting 30-minute checks on			
	the resident on 05/14	•			

STATE FORM 6899 ZE7D11 If continuation sheet 95 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		Hal089002	B. WING		05/17/20	119
	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	COLUMBIA	A, NC 27925			
(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 CC	(X5) DMPLETE DATE
D 270	for 3 of 11 sampled reresident (#14) sustain resulting in injuries ar and another resident the SCU unsupervise the facility's kitchen repot of soup cooking. in serious physical haconstitutes a Type A1 The facility provided a accordance with G.S. this violation. THE CORRECTION I VIOLATION SHALL N 2019.	rovide adequate supervision esidents resulting in one hing 29 falls in 6 months and emergency room visits; (#1) wandering away from d into a service hall and into ear a hot stove with a large. The facility's failure resulted from and neglect and Violation. The plan of protection in a plan of protection in a plan of protection in a plan of protection in the protection i	D 270			
D 271	an accident or incider provide care and interfacility's policies and provide a	Personal Care and d immediately in the case of at involving a resident to resolvention according to the procedures. as evidenced by: ews and interviews, the and to incidents immediately th the facility's established	D 271			

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 96 of 267

Division c	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		Hal089002	B. WING		05/47	7/2040
		Пановии2			05/17	7/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	IA, NC 27925			
(V4) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	VI I	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 271	Continued From page	<u> </u>	D 271			
			52			
	sampled (#1) who fell	l in the facility.				
	The findings are:					
	Review of the facility's	s Falls Management				
	Program revealed:	facility for regidents to be				
		he facility for residents to be				
	monitored and identifi					
		nts were completed for all				
	residents admitted to	raining on Fall Prevention				
		raining on Fail Prevention				
	Awareness.	as incident report in its				
	entirety for any fall.	e an incident report in its				
	, ,	e the 72 Hour Follow Up on				
	resident falls to invest					
	circumstances contrib	•				
		ns for 72 hours after the fall.				
		Up included vital signs				
	initially and every shif					
		ole risk / contribution factors				
	for falls.	70 11011.7 55.11.154.11.11.11.11.11				
		alls within a 4 weeks period,				
		be contacted requesting an				
		rapy (PT) evaluation or other				
	treatment / intervention					
	-The resident was to	be placed in Hot Box / Alert				
	Charting for 72 hours	for follow up and				
	monitoring.					
	-The Healthcare Qual	lity Assurance Team would				
	review incident report	ts on a monthly basis.				
		t1's FL-2 dated 10/17/18				
	revealed diagnoses ir					
		dementia, right hip joint				
		nsion, depression, anxiety,				
	osteoarthritis.					
	l					
		hift personal care aide				
	(PCA) on 05/07/19 at	: 4:57am revealed:				

STATE FORM 6899 ZE7D11 If continuation sheet 97 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		Hal089002	B. WING		05/1	7/2019
NAME OF D					05/1	112019
NAME OF PI	ROVIDER OR SUPPLIER	950 HWY 64	RESS, CITY, STA 1 FAST	TE, ZIP CODE		
TYRRELL	HOUSE		, NC 27925			
(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	(X5) COMPLETE DATE
D 271	-Resident #1 had two employed at the facilities. The resident was four she had fallen on floor 3rd shift last Friday (5 transported to the location and shift). The fall (5/06/19). -She found Resident is knees. -The resident complaint knee (right knee). -She assisted the resident reminded the resident falls were the medication aides resident for injuries.	cility for about 1½ months. falls since she had been ty. Ind by another PCA after or and had hit her head on 1/03/19). The resident was al emergency room (ER). Indicate the 5/03/19 occurred yesterday #1 on the floor on her or and the floor on her or and the pain of her bad of the pain of her bad of the to use her walker. Indicate the floor on the required to be reported to or (MA) who assessed the	D 271			
	fall to the fall to the M reported it. Interview with another at 5:05am revealed start's second fall but we to the MA. Interview with Reside revealed: -She had fallen about out of bedShe hit her right kneed face.	r 3rd shift PCA on 05/07/19 ne was aware of Resident as not sure it was reported nt #1 on 5/07/19 at 1:55pm 4 nights ago while getting e and the right side of her ago, but did not remember v she fell.				

Division of Health Service Regulation

Observation of Resident #1's right knee on

STATE FORM STATE FORM ZE7D11 If continuation sheet 98 of 267

DIVISION	of Health Service Regu	lation	_		_	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D 14//10			
		Hal089002	B. WING		05/17/2019	
NAME OF D		OTDEET AS	DDRESS, CITY, STA	TE 710 000E		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	ILE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
THREEL	110002	COLUMB	IA, NC 27925			
(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)		
5.0=4			5.074			
D 271	Continued From page	e 98	D 271			
	05/07/19 at 2:00pm re	evesled a dark bruise				
	_	d a blister, the size of a half				
	dollar, filled with clear	r fluid.				
	Interview with a 3rd s	hift MA on 05/14/19 at				
	9:20am revealed:					
	-She was aware of Ro	esident #1's fall on 3rd shift,				
	on 05/03/19, but she	was not aware of another				
	fall since then.					
	-Staff had not reporte	d a second fall				
	-	whether injuries or not, staff				
	-	- · · · · · · · · · · · · · · · · · · ·				
		the fall to the MA and an				
	-	ort would be completed after				
		essed for injuries. The fall				
	would have beem rep	orted the the resident's				
	primary care provider	· (PCP).				
	Interview with the Adr	ministrator on 05/14/19 at				
	3:45pm revealed:					
	•	of Resident #1 sustaining a				
	second fall this month					
		had not reported a second				
	fall.	nad not reported a second				
		norted to the NAA or Core				
		ported to the MA or Care				
		would assess the resident for				
	injuries.					
		nented on an incident report				
	and reported to the re	esident's primary care				
	physician (PCP). The	resident would be sent to				
	the emergency room					
	o ,	,				
	Interview with the CM	l on 05/14/19 at 5:50pm				
	revealed:					
		Resident #1 had fallen again				
	since 05/03/19.	Concert #1 Had falleri ayalif				
		sident nement de come e				
		cident report documenting a				
	second fall.					
	-She expected staff to					
	-The PCAs should re	port resident falls/incidents				

Division of Health Service Regulation

to the MA or CM and the MA/CM would assess

STATE FORM STATE FORM If continuation sheet 99 of 267

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		Hal089002	B. WING		0:	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
TYRRELL	HOUSE		Y 64 EAST BIA, NC 27925			
(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 T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 271	resident's PCP or se Review of an Event I 05/03/19 revealed: -On 05/03/19 at 5:15 unwitnessed fall in he -The resident compla bruising of the right f pain to her back, eye -The resident was tra	es and report the fall to the nd the resident to the ER. Report (incident report) dated am the resident had an er bedroom. ained of pain. There were orehead, and complained of and forehead. ansported to the local ER.	D 271			
D 273	1		D 273			
	reviews the facility fa follow up for routine a for 6 of 10 sampled r #10, and #17) as evi routine and weekly la	-				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 100 of 267

<u>Division c</u>	<u>of Health Service Regu</u>	lation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		11-100000	B. WING		0=/4	- /0040
		Hal089002	D. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 FAST			
TYRRELL	HOUSE		IA, NC 27925			
			A, NC 21925			
(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 273	Continued From page	∍ 100	D 273			
	obtain a proceure rele	ease cushion for a resident's				
	T	erral to podiatry (#3); obtain a				
		red due to diarrhea and to				
ļ	-	P for a recheck visit after a				
		t (#2); report a fall with injury				
		rtment visit to the physician				
		esident received ordered				
	testing (#4).					
		it #10's current FL-2 dated				
	10/29/18 revealed:					
ļ	-Diagnoses included	congestive heart failure,				
	atrial fibrillation, chror	nic anticoagulation therapy,				
	hypertension, and dia					
	-There was document					
ļ	prothrombin time and	I international normalized				
	•	until stable then monthly as				
		blood tests to measure the				
		tes and used to determine				
ļ	safe dosing of Couma					
	_	s coagulation to prevent				
		coagulation to prevent				
	clots).	for Coumadia 1 milliaram				
		for Coumadin 1 milligram				
	(mg) take two tablets	•				
		for Coumadin 5mg take one				
		ng with 1mg to equal 7.5mg				ı
	daily".					ı
	There was an order f	for Coumadin 7.5mg daily.				
	 					ı
	Review of Resident #					
	revealed an admissio	n date of 11/01/18.				ı
	Review of Resident #	10's subsequent orders				
	dated 11/15/18 revea	lled there was an order for				
	Coumadin 2.5 mg tak	ce three tablets (7.5mg) daily				
	(check PT/INR every					ı
	, 	,				ı
	Review of an addition	nal subsequent order for				
	Resident #10 dated 1					

-There was an order for Coumadin 7.5mg daily.

STATE FORM 6899 ZE7D11 If continuation sheet 101 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74121 2741	or dorate of the transfer of t	IDEITH IOMONOMETA.	A. BUILDING: _		COMIT LETES
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY COLUMBI	64 EAST A, NC 27925		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	73 Continued From page 101		D 273		
	-There was an order to check the PT/INR weekly.				
		(LHPS) dated 11/13/18 ocumentation to obtain a			
	Review of Resident #10's 11/07/18 - 11/30/18 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Coumadin 5mg daily. "Take 5mg with 1mg to equal 7.5mg". The origination date was 11/08/18There was documentation Coumadin 5mg "take 5mg with 1mg to equal 7.5mg" was administered from 11/09/18 - 11/10/18 and 11/12/18 at 5:00				
	2.5mg take 3 tablets every week. The original	onic entry for Coumadin (7.5mg) daily. Check PT/INR nation dated was 11/11/18.			
	administered from 11.	tation Coumadin 7.5mg was /11/18 - 11/30/18 at 5:00 pm. onic entry for Coumadin T/INR weekly. The			
	origination date was	11/10/18. tation Coumadin 7.5mg was			
	Review of Resident # revealed:	10's December 2018 eMAR			
	2.5mg take 3 tablets PT/INR weekly.				
		tation Coumadin 7.5mg was 8 - 12/05/18 at 5:00 pm.			
	November and Decer was no documentation	s transportation log for mber 2018 revealed there n Resident #10 was cal facility for lab work.			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 102 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		Hal089002	B. WING		0	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
IIRKELL	. HOUSE	COLUME	BIA, NC 27925			
(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 273	Continued From page	e 102	D 273			
	notes, physician note Emergency Departmenthere were no PT/INF 12/06/18 other than 1 went to the ED for dia 12/06/18 when the Rehospital for a hemorrh Review of Resident # Services (EMS) patie 12/06/18 revealed: -Staff reported when Resident #10 was slounable to walk like no -"Last night's staff sai but was fine when I le	ent (ED) notes revealed R's obtained from 11/07/18 - 11/29/18 when the resident abetic polyneuropathy and esident was admitted to the hagic stroke. 210's Emergency Medical and care notes dated coming on shift at 7:00 am puching to the side and primal. and they noticed him slouching eff here at 7 pm." e was found sitting in a fused, and difficulty rm and leg. as positive.				
	-He presented to the weakness at 8:42 am -He was treated in the complained of right h -He reported he may of 12/05/18 but was a -There was a prothro (A blood test to deter Coumadin. The norn 11.1 seconds)There was an interna (INR) result of 6.2 (A	ord dated 12/06/18 revealed: ED with right sided e ED 12/05/18 for a fall and ip pain. have fallen again the night able to get back into bed. mbin time (PT) result of 59.4 mine the effectiveness of hal reference range is 9.1 - ational normalized ratio blood test that measures and is used to determine				

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 103 of 267

Division of	of Health Service Regu	lation			1 Ordivi	ALLINOVED
STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	SIA, NC 27925			
(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	(X5) COMPLETE DATE
D 273	Continued From page	: 103	D 273			
D 273	intraparenchymal hen brain). -His mental status der (a tube placed in the la respiratory failure). -He had a "high probadeterioration in conditation or during intercranial hemorrhathe was transferred beneurosurgery at a high records from 12/06/18. -He was given KCenturgently reverse the entry reverse the entry received a trache for breathing tube plather received a percutation to high records in the stomach for medications) on 12/22. -His condition continuation in the was made a doin life-saving mechanism	ith an acute left thalamic norrhage (a bleed in the clined, and he was intubated ungs to secure the airway in ability of life-threatening ions at the initial the ED course related to ge". by air ambulance to her-level hospital. 10's higher-level hospital. 10's higher-level hospital. 13 - 12/30/18 revealed: ra in the ED (a medication to effects of Coumadin) on tion pneumonia on 12/11/18. ostomy (incision to trachea cement) on 12/21/18. aneous gastrostomy tube (a or feedings and 1/18. ed to decline. ot resuscitate [DNR (no	D 273			
		s 12/30/18 at 11:57 pm.				
	on 12/06/18.					

stroke.

Resident #10 was sitting in his recliner.
-Resident #10 looked as if he was having a

-Resident #10 was drooping, leaning to the side, "

STATE FORM E899 ZE7D11 If continuation sheet 104 of 267

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	LDING:		
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYPPELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMBI	A, NC 27925			
(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 APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 104	D 273			
D 2/3	looked funny to me slurred"She notified the MA. who the MA wasThe morning of 12/00 had seen Resident #2 Interview with the Adr 2:45 pm revealed: -The facility would tak hospital for labsWhoever received the a hospital lab requisition we Care Provider (PCP) hospital lab to schedue. The lab appointment documented in the cheabs were done were. When the resident we labs a copy of the lab the resident's facility of the remainder the resident whose a transposition with the resident facility of the resident facility of the resident facility of the resident facility chart. Interview with the Regulation of the PCP would sign or electronicallyThe CM was responsitions.	She could not remember 8/18 was the first time she 10 in that condition. ministrator on 05/17/19 at we residents to the local we lab order would complete ion. was signed by the Primary then they would call the wile the lab work. Information would be warting notes. Welly, no specific day. was taken to the hospital for requisition would be filed in chart. Intation log that was used to lents were taken for medical WR results should be filed in gional Clinical Director on revealed: CM) was responsible for s onto the hospital lab the lab requisition manually sible for faxing the lab	D 2/3			
	requisition to the hosp the ordered labs.	pital or calling to schedule				

Division of Health Service Regulation

#10's PT/INR results.

STATE FORM E899 ZE7D11 If continuation sheet 105 of 267

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		Hal089002	B. WING	·····	05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY (S4 FAST			
TYRRELL	HOUSE		A, NC 27925			
	OLUMBA DV OT		1	DD0//DEDI0 DLAN 05 00DD507101		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(-)	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 070	0 (15	405	D 070			
D 273	Continued From page	2 105	D 273			
	-She expected reside	nts to be taken for labs as				
	ordered.					
	Telephone interview v	vith a representative for the				
	facility's contracted pl	harmacy on 05/17/19 at 4:00				
	pm revealed:					
	-The pharmacy had re	eceived a medication list				
	with three different or	ders for Coumadin on				
	11/8/18.					
		call Resident #10's PCP to				
	clarify the correct order					
	-The order was for Co	. .				
	-They dispensed 70 to	ablets of Coumadin 2.5mg				
	tablets on 11/10/18 w	ith instruction to take 3				
	tablets daily to equal	7.5 mg daily.				
		vith a nurse for Resident				
		19 at 4:15 pm reveled:				
		n because of atrial fibrillation				
		action of the heart that				
		ool in the heart and can				
	contribute to blood clo	The state of the s				
		ered weekly to monitor the				
		ave a therapeutic control.				
		e for the INR was between				
	2.0 - 3.0.	on in the ED on 11/20/19				
	and had an INR of 3.9	een in the ED on 11/29/18				
		le thin" with an INR of 3.9. rould have adjusted down				
	-	She could not say to what				
	dose.	one could not say to what				
		een in the ED on 12/06/18				
	and had an INR of 6.2					
		thin with an INR of 6.2.				
	_	PT/INR's obtained for				
		n 11/07/18 - 12/06/18.				
		nentation the facility had				
	- mere was no docum	ioniation the facility flau	1		1	

Division of Health Service Regulation

were not obtained.

notified Resident #10's PCP that the PT/INR's

STATE FORM E899 ZE7D11 If continuation sheet 106 of 267

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		Hal089002	B. WING		05/17/2019
		Пагоозоог			05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TVDDELL		950 HWY	64 EAST		
TYRRELL	HOUSE	COLUMB	A, NC 27925		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	e 106	D 273		
	Continuou i rom page				
	-	vith a physician who worked			
		PCP on 05/17/19 at 4:30 pm			
	revealed:	- los out the INID het was a 0.0			
	•	o keep the INR between 2.0			
	- 3.0.-The higher the INR to	he higher the risk of			
	bleeding.	ne nigher the risk of			
	-She expected the PT	[/INR's to be done as			
	ordered.				
	-Resident #10's thin b	blood could make him more			
	prone to bleeding.				
	-	reekly to monitor the blood			
	and prevent a combin	nation of things such as			
	gastrointestinal bleed	ing, hemorrhagic strokes,			
	and hematomas with	falls.			
		ith the ED on 05/17/19 at			
	5:18pm revealed:				
		Resident #10's INR lab work			
	had not been done as				
		CM) was responsible for			
	ensuring lab work was	s obtained as ordered.			
	The CM was not avail	lable for interview on			
	05/16/19 or 05/17/19.				
	05/10/19 01 05/17/19.				
	Attempted interview w	vith a MA on 05/16/19 at			
	8:30 pm was unsucce				
	5.50 pm mad andadoc				
	Attempted interview v	vith Resident #6's PCP on			
	05/17/19 at 4:15 pm v				
	•				
	2. Review of #6's curr	rent FL-2 dated 07/13/18			
	revealed:				
	-Diagnoses included I	hypertension, dementia,			
		rlipidemia, and glaucoma.			
		for Amlodipine 10 milligrams			
	(mg) at bedtime (a me	edication used to lower			

Division of Health Service Regulation

blood pressure that could also lower the heart

STATE FORM E899 ZE7D11 If continuation sheet 107 of 267

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PEFFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			H-1080002	B. WING		05/47/004	
TYRRELL HOUSE 950 HWY 64 EAST COLUMBIA, NC 27925 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						05/17/201	9
TYRRELL HOUSE COLUMBIA, NC 27925 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	NAME OF PRO	OVIDER OR SUPPLIER			TE, ZIP CODE		
(AT) IS	TYRRELL HOUSE						
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE CON	IPLETE
rate)There was an order for Losartan Potassium 100mg daily (a medication used to lower blood pressure that could also lower the heart rate). Review of Resident #6's subsequent orders dated 01/02/19 revealed: -There was an order for Amlodipine 10 milligrams (mg) at bedtimeThere was an order for Losartan Potassium 100mg daily. Observation of Resident #6 on 05/09/19 at 9:07 am revealed: -She was alaying in her bedShe was alaying in her bedShe was alert, cooperative, and conversed appropriatelyThe medication aide (MA) assessed her left radial pulseThe MA returned to the medication cart and proceeded to the next resident for medication administration. Interview with the MA on 05/09/19 at 09:08 am revealed Resident #6's pulse was 38 beats per minute (bpm). Review of Resident #6's physician notes dated 01/08/19 revealed: -She was being seen for visual hallucinationsThere was an order for a weekly heart rate (HR)There were HR parameters to call if HR greater than (>) 140 or less than (<) 50. Review of Resident #6's 05/01/19 - 05/09/19 electronic medication administration record (eMAR) revealed: -The resident was receiving two medications to lower blood pressure that may also lower HR.		rate)There was an order of 100mg daily (a medicipressure that could all Review of Resident # 01/02/19 revealed: -There was an order of (mg) at bedtimeThere was an order of 100mg daily. Observation of Resideam revealed: -She was laying in heshe was alert, cooperated and pulseThe medication aider radial pulseThe MA returned to the proceeded to the next administration. Interview with the MA revealed Resident #6 minute (bpm). Review of Resident #01/08/19 revealed: -She was being seen there was an order of the the there was an order of the there were HR parated than (>) 140 or less the Review of Resident #6 minute (bpm). Review of Resident #6 minute (bpm) revealed: -There were HR parated than (>) 140 or less the Review of Resident #6 minute (bpm) revealed: -The resident was recommendation (eMAR) revealed: -The resident was recommendation was resident was recommendation of the process of the proces	for Losartan Potassium ration used to lower blood Iso lower the heart rate). 6's subsequent orders dated for Amlodipine 10 milligrams for Losartan Potassium ent #6 on 05/09/19 at 9:07 or bed. erative, and conversed (MA) assessed her left the medication cart and the resident for medication a on 05/09/19 at 09:08 am by pulse was 38 beats per 6's physician notes dated for visual hallucinations. For a weekly heart rate (HR), meters to call if HR greater man (<) 50. 6's 05/01/19 - 05/09/19 administration record deiving two medications to	D 273			

Division of Health Service Regulation

-There was an electronic entry to call for pulse <

STATE FORM E899 ZE7D11 If continuation sheet 108 of 267

DIVISION OF Fleatin Service Regulation				1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1		1
			5 14/11/0		
		Hal089002	B. WING		05/17/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	ATE ZID CODE	
NAME OF T	TOVIDER OR SOLT LIER		, ,	KIE, ZII GODE	
TYRRELL	HOUSE	950 HWY			
		COLUMBI	A, NC 27925		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
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TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	100	D 273		
B 210	Continued i Tom page	: 100	5270		
	50.				
	-There was no docum	nentation the resident had a			
	HR of 38 on 05/09/19				
		tation the resident had a HR			
	of 98 at 8:00 am on 0				
	-There was document				
		vas "late administration:			
	charted late" at 9:5	5am on 05/09/19.			
		6's progress and care notes			
		o documentation informing			
	the residents Primary	Care Provider (PCP) of a			
	pulse of 38 bpm.				
	A second interview wi	ith the MA on 05/09/19 at			
	10:35 am revealed:				
	-A HR of 38 was "too	low"			
		Resident #6's HR was low			
	because she was dist				
		pecause she did not "feel			
	•	ous" because she had "a lot"			
	of things to do on her	·			
	-She did not know if F	Resident #6 had HR			
	parameters.				
	-She should have not	ified the resident's PCP she			
	had a pulse of 38.				
	-She did not know if the	he facility had a policy for			
	HR's.				
	-She would recheck F	Resident #6's HR and if still			
	low "38" she woul				
10W STIC WOULD CALL LITE I OI .					
	Interview with the care manager (CM) on				
	05/09/19 at 11:15 am	• , ,			
		CP to be notified of a HR of			
	38 within 5 to 10 minu				
	•	R to be rechecked within 15 -			
	20 minutes.				
		ad HR parameters to be			
	notified for HR's > 140	0 or < 50.			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 109 of 267

	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: _		COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY	64 EAST		
THRICEL	110002	COLUMBI	A, NC 27925		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 273	73 Continued From page 109		D 273		
	5:55 pm revealed: -Resident #6 had HR medication administra -The MA should have	parameters in the electronic ation record (eMAR). looked at the parameters ified the PCP "right away"			
	05/15/19 at 4:34 pm r -He expected the wee Resident #6 as ordere -A HR of 38 was not g life-threateningHe had not been not Resident #6He expected to be not -If he had of been not	ekly HR to be obtained for ed. good and was ified of a HR of 38 for otified as soon as possible. ified of a HR of 38 he would supervisor recheck the HR			
	02/07/19 revealed: -Diagnoses included infection and inflamm acquired absence of hypertension, atheros history of falling, histofractureHe was semi-ambula-He had a right hip wo-Wound care to the risher was incontinent of	ound. ght hip was ordered. of bowel and bladder. 3's Resident Register			
	a. Review of Residen dated 05/03/19 revea	n date of 02/07/19. t #3's physicians order led an order for a pressure resident's wheelchair (a			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 110 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TVDDELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	IA, NC 27925		,	
(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 273	Continued From page	e 110	D 273			
	cushion that decreases the amount of sitting pressure by air cells that increase and decrease in air volume).					
	Observation of Resident #3's wheelchair on 05/15/19 at 2:20 pm revealed: -There was a light blue foam cushion in the					
	wheelchair. -The cushion did not fit fully in the wheelchair seat. -There was approximately a two-inch gap from each side of the cushion to the wheelchair. -There was approximately a three-inch gap from the end of the cushion to the end of the wheelchair seat where the resident's legs rested. -The cushion position was not fixed in the wheelchair. Interview with Resident #3's family member on 05/10/19 at 11:50 pm revealed: -Resident #3 could not walk. -Resident #3 spent a lot of time in the wheelchair. -The left back thigh wound was new and had developed since he had been at the facility. -He thought the wound was caused from the resident sitting in the wheelchair. Interview with Resident #3 on 05/14/19 at 10:35 am revealed he needed assistance with transfers, bathing, and dressing. Interview with the care manager (CM) on 05/14/19 at 4:45 pm revealed: -The pressure relief cushion for Resident #3 had not been ordered. -She had tried to order the pressure relief cushion but the durable medical equipment (DME) company did not carry the pressure relief cushion.					

Division of Health Service Regulation

-The DME company only carried gel cushions.

STATE FORM E899 ZE7D11 If continuation sheet 111 of 267

Division C	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		Hal089002	B. WING	· · · · · · · · · · · · · · · · · · ·	05/1	17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	EA EAST	·		
TYRRELL	HOUSE					
		COLUMBI	A, NC 27925			T
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGOEMONT ON	is in the initial or	TAG	DEFICIENCY)	W (1 L	
			-			1
D 273	Continued From page 111		D 273			
	The DMC common with	ald has the assessintion				
		old her the prescription				
	needed to be written	•				
		nen she tried to order the				
	ROHO cushion.					
	-She did not contact I	Resident #3's wound care				
	provider to inform the	m the ROHO cushion had				
	not been ordered.					
	-The facility transport	er was to contact Resident				
		rider because it was easier				
		provider when transporting				
	residents.	,				
	-The transporter was	unable to contact the				
	provider.	and to contact the				
	provider.					
	Interview with the Adr	ministrator on 05/14/19 at				
	4:53 pm revealed:	Timiotrator or oo, 1 ii 10 at				
		essure relief cushion for				
	Resident #3 to have b					
	-She expected the pro-					
		if there was a delay with				
	ordering the pressure					
		as required she expected				
	the CM to have conta	icted the provider				
	immediately.					
	 She did not expect a 	ny delays in ordering any				
	DME.					
	Interview with Resident #3's home health registered nurse (HHRN) on 05/15/19 at 2:19 pm					
	revealed:					
	-The resident had a w	vound to the back of his left				
	thigh that developed	after admission to the				
	facility.					
	-The resident would s	scoot forward in his				
	wheelchair.	COST POLYMAN III 1110				
		ion would slide towards the				
	back of the wheelcha					
	- I ne back of the resid	dent's leg would hit the front				

Division of Health Service Regulation

of the wheelchair seat.

-She thought the resident's wound on the back of

STATE FORM E899 ZE7D11 If continuation sheet 112 of 267

DIVISION	or riealin Service Regu	iation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			D WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
			, ,			
TYRRELL	HOUSE	950 HWY				
		СОГОМВІ	A, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETICIENCY)		
D 273	Continued From page	e 112	D 273			
	commutation page					
	his left thigh was caus	sed by the wheelchair.				
	-The wound on the ba	ack of the resident's left				
	thigh would heal but v	would possibly reoccur				
		of the leg resting on the front				
	of the wheelchair sea					
		ushion would fit in the				
	•	Resident #6's current				
	cushion.	The side ii #0 s current				
		and between the manner.				
	_	aps between the pressure				
	relief cushion and the	wneeichair.				
	I	with a nurse for Resident				
	#3's wound care prov	rider on 05/15/19 at 3:35 pm				
	revealed:					
	-The pressure relief of	ushion was ordered				
	I	sident #3 spent a lot of time				
	in the wheelchair.					
	-The pressure relief of	ushion would help to				
	improve Resident #3'					
	-The pressure relief of					
		nt of new pressure ulcers.				
		e relief cushion Resident #3				
		se in the stage or worsening				
	of the pressure ulcer.					
	· •	cility to initiate orders the				
	same day as received					
	·	ovider be notified within one				
	to two days maximum	n if there were any problems				
	getting the pressure r	elief cushion for Resident				
	#3.					
	-There was no contact from anyone regarding the pressure relief cushion for Resident #3 until					
	05/14/19 by the HHR					
	Sort in to by the filling					
	Telephone intonious	with a second nurse for				
		with a second nurse for				
		care provider on 05/16/19 at				
	12:52 pm revealed:					
		CM) called either 05/14/19 or				
		e need for and delay of the				
	pressure relief cushio	on for Resident #3.				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 113 of 267

STATEMENT OF DEPOCHMENTS HaldS002 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NO 2729S TYRRELL HOUSE SUMMARY STATEMENT OF DEPICIENCIES (CACH DEPICIENCY MUST BE PRECEDED BY FULL PLAY TAG CONSMICT ON 15 CONTROL OF SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES (CACH DEPICIENCY MUST BE PRECEDED BY FULL PLAY TAG CONSMICT ON 15 CONTROL OF SUPPLIER CACH DEPICIENCY MUST BE PRECEDED BY FULL PLAY TAG CONSMICT ON 15 CONTROL OF SUPPLIER OF SUP	Division (Division of Health Service Regulation						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 SUMMARY STATEMENT OF DEPOSITIONS (EACH DEPTICENCY MUST BE PRECEDED BY FILL) PRETIX HEOULATORY OR ISC IDENTIFYING INFORMATION) D 273 Continued From page 113 —There was no contact regarding the pressure relief cushion for Resident #3's wound care physician on 05/15/19 at 12:52 pm was unsuccessful. D. Observation of Resident #3's toenalls on both feet on 05/06/19 at 5:00 pm revealed: His toenalis on both feet were thick, yellow, discolored, and jagged. —The right 2nd - 5th toenalis extended beyond the tips of his toes from approximately 0.5 - 1 millimeters (mm). —There were nidges in the right and left 1st - 5th toenalis. —The skin to both feet, toes, and cuticles were dry, thin, and flaking. —When his socks were removed flakes of skin fell from his socks and feet. Interview with Resident #3 on 05/08/19 at 5:00 pm revealed: He had not had his toenalis cut since he had been at the facility. His family member used to bring him to have his toenalis cut. He was going to ask his family member to take him to have his railis cut. His toenalis cut. His toenalis cid not bother him. Interview with a personal care aidle (PCA) on 05/14/19 at 11:04 am revealed:	STATEMEN	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 CALLED CONTROL CONTROL CONTROL CALLED CONTROL	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 CALLED CONTROL CONTROL CONTROL CALLED CONTROL								
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 COLUMBIA, NC 27925				B WING				
TYRRELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES ID PREPIX EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTED BY FLAT ID PREPIX EACH CORRECTIVE ACTION SHOULD BE CONSTRUCTED BY TAG ID PREPIX TAG CROSS-REFERENCED TO A PROPRIED BY FLAT TAG CROSS-REF			Hal089002	B. WING		05/17/2019		
TYRRELL HOUSE COLUMBIA, NC 27925 Continued From page 113 D 273	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
TYRRELL HOUSE COLUMBIA, NC 27925 Continued From page 113 D 273			950 HW)	/ 64 FAST				
Mail D SUMMARY STATEMENT OF DEFICIENCES D PREFIX SEARCH OFFICENCY MUST OF RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG SEARCH OORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE OF THE APPROPRIATE DATE OF THE APP	TYRRELL	HOUSE						
ERECULATORY OR USE CIRCHITEYING INFORMATION) D 273 Continued From page 113 -There was no contact regarding the pressure relief cushion for Resident #3's wound care physician on 05/15/19 at 12:52 pm was unsuccessful. b. Observation of Resident #3's toenalis on both feet on 05/08/19 at 5:00 pm revealed: -His toenalis on both feet were thick, yellow, discolored, and jaggedThe right 2nd - 5th toenalis extended beyond the tips of his toes for approximately 0.5 - 1 mmThere were ridges in the right and left 1st - 5th toenalisThe skin to both feet, toes, and cuticles were dry, thin, and flakingWhen his socks were removed flakes of skin fell from his socks and feet. Interview with Resident #3 on 05/08/19 at 5:00 pm revealed: -He had not had his toenalis cut since he had been at the facilityHis family member used to bring him to have his toenalis did not bother him. Interview with a personal care aide (PCA) on 05/14/19 at 10-40 am revealed:				JIA, NO 21323				
D 273 Continued From page 113 -There was no contact regarding the pressure relief cushion for Resident #3's wound care physician on 05/15/19 at 12:52 pm was unsuccessful. b. Observation of Resident #3's toenails on both feet on 05/08/19 at 5:00 pm revealed: -His toenails on both feet were thick, yellow, discolored, and jaggedThe right 2nd - 5th toenails extended beyond the tips of his toes from approximately 0.5 - 1 mmThere were ridges in the right and left 1st - 5th toenailsThe skin to both feet, toes, and cuticles were dry, thin, and flakingWhen his socks were removed flakes of skin fell from his socks and feet. Interview with Resident #3 on 05/08/19 at 5:00 pm revealed: -He had not had his toenails cut since he had been at the facilityHis family member used to bring him to have his toenails cutHe was going to ask his family member to take him to have his nails cutHis toenails did not bother him. Interview with a personal care aide (PCA) on 05/14/19 at 10-40 am revealed:						(- /		
D 273 Continued From page 113 -There was no contact regarding the pressure relief cushion for Resident #3 before the CM called. Attempted interview with Resident #3's wound care physician on 05/15/19 at 12:52 pm was unsuccessful. b. Observation of Resident #3's toenails on both feet on 05/08/19 at 5:00 pm revealed: -His toenails on both feet were thick, yellow, discolored, and jaggedThe right 2nd - 5th toenails extended beyond the tips of his toes from approximately 0.5 - 1 millimeters (mm)The left 3rd - 5th toenails extended beyond the tips of his toes for approximately 0.5 - 1 mmThere were ridges in the right and left 1st - 5th toenailsThe skin to both feet, toes, and cuticles were dry, thin, and flakingWhen his socks were removed flakes of skin fell from his socks and feet. Interview with Resident #3 on 05/08/19 at 5:00 pm revealed: -He had not had his toenails cut since he had been at the facilityHis family member used to bring him to have his toenails cutHe was going to ask his family member to take him to have his nails cutHis toenails did not bother him. Interview with a personal care aide (PCA) on 05/14/19 at 10-40 am revealed:								
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05/14/19 at 10:40 am revealed:		to the time and the time						
05/14/19 at 10:40 am revealed:		Interview with a perso	onal care aide (PCA) on					
Lisque nau nevel Diovideo hali Cale lo Resident #3								
-She had never bathed Resident #3.								

Interview with a medication aide (MA) on

STATE FORM 6899 ZE7D11 If continuation sheet 114 of 267

DIVISION	Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY 6	S4 FAST			
TYRRELL	HOUSE		A, NC 27925			
			1, 110 27323			
(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 APPROPR		
iAO		,	170	DEFICIENCY)		
D 273	Continued From page	e 114	D 273			
	05/14/19 at 10:45 am	rovealed:				
		Resident #3 saw a podiatrist.				
		nentation in Resident #3's				
	charting notes that he	•				
		CM) would know if Resident				
	#3 saw a podiatrist.	Alaina aland Danidant #0la				
		ything about Resident #3's				
	toenails.					
	Intomious with a const	nd DCA on 05/44/40 at 40:55				
		nd PCA on 05/14/19 at 10:55				
	am revealed:					
		ved to trim the toenails of a				
	diabetic resident.					
		any nailcare to diabetic				
	residents.					
		m nailcare to diabetic				
	residents.					
	-She had never bathe	ed Resident #3				
	Interview with the Adr	ministrator on 05/14/19 at				
	1:00 pm revealed:					
		oodiatrist that was available				
	to see the residents.					
		esident #3's toenails were				
	thick, vellow, and lone					
	, , - , - ,	ve a referral from their				
		er (PCP) before they could				
	see the podiatrist.	(, ,				
	-The care manager (CM) was responsible for scheduling residents to see the podiatristShe expected Resident #3 to already have seen					
		e he was a diabetic with				
	•	ed, and jagged toenails.				
	unok, yonow, discolor	oa, ana jaggoa toonana.				
	Interview with the CM	l on 05/14/19 at 1:28 pm				
	revealed:	- r				
	-Resident #3 had not	seen a podiatrist.				
		need a referral from his PCP				

Division of Health Service Regulation

to see the podiatrist.

-She did not know Resident #3 needed to see a

STATE FORM E899 ZE7D11 If continuation sheet 115 of 267

DIVISION	n nealth Service Regu	lation	_			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					1	
		Hal089002	B. WING		05/17/201	9
NAME OF D	ROVIDER OR SUPPLIER	STDEET AD	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF FI	NOVIDER OR SUFFLIER		, ,	TE, ZIF GODE		
TYRRELL	HOUSE	950 HWY				
		COLUMBI	A, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		IPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE D	ATE
			1	DEFICIENCY)		
D 273	Continued From page	115	D 273			
5 210	Continued From page	, 110	52.0			
	podiatrist.					
	-She would schedule	Resident #3 to see the				
	facility podiatrist.					
		ware not allowed to do noil				
		were not allowed to do nail				
	care to diabetic reside	ents.				
		nt #3's PCP on 05/14/19 at				
	4:00 pm revealed:					
	-She Resident #3 onc	ce on 03/15/19 for a right hip				
	wound.					
	-She had referred Re-	sident #3 to the wound care				
	center on 03/15/19.					
	-Resident #3 did not h	nave a return appointment				
	scheduled.	ave a retain appointment				
		or any guartians related to				
		er any questions related to				
		in for the right hip wound				
	because she had not	seen him for anything else.				
	4 Review of Residen	t #17's current FL-2 dated				
	01/22/19 revealed:	t // 17 o darrolle i E Z dated				
	-Diagnoses included	vascular dementia				
	•	depression and malnutrition.				
		tation Resident #17 was				
	constantly disoriented	1.				
		t/incident report dated				
	05/06/19 at 11:38am	revealed:				
	-Resident #17 was for	und sitting on the floor in the				
		special care unit (SCU) on				
	05/05/19 at 10:00am.	, , , , , , , , , , , , , , , , , , , ,				
	-No injury was noted and the resident's primary					
		and Guardian were notified.				
		tation Resident #17 was to				
	_	ked and monitoring for				
	bruises, mental status	s change, condition change,				
		every shift for 72 hours.				
	, , , , , , , , , , , , , , , , , , , ,	•				
	Interview with a perso	onal care aide (PCA) on				
	05/14/19 at 1:48pm re					
	at 1. 10piii 10	- · · ·	1	I .	ı	

Division of Health Service Regulation

-On 05/05/19, Resident #17 did not "fall-fall," the

STATE FORM E899 ZE7D11 If continuation sheet 116 of 267

DIVISION	Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
			1				
		Hal089002	B. WING		05/17/2019		
					1 00:		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE			
TYRRELL	TYRRELL HOUSE 950 HWY						
		COLUME	BIA, NC 27925				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	()		
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF			
				DEFICIENCY)			
D 273	Continued From page	116	D 273				
2 2.0			2 2.3				
	~ .	the chair in the common					
	area and lost her bala						
		d of caught" Resident #17.					
	-Resident #17's arm	•					
		esident's side "kind of hit" the					
	foot rest that was turn						
	-Resident #17 did not	#17 if she was hurt and					
		; she said she was not hurt.					
	· · · · · · · · · · · · · · · · · · ·	to the medication aide (MA)					
	· · · · · · · · · · · · · · · · · · ·	could not remember which					
	MA.	codia not remember which					
	-Resident #17 did not	t complain of any pain until					
	two days later.	, ,,,					
	Observation on 05/07	7/19 at 5:48am revealed:					
		tting on the edge of her bed					
	facing the window.	ung on the eage of her bea					
		e PCA, "I'm hurting on my					
		left side near the rib cage.					
	-The PCA said she w	•					
		3/19 at 5:07pm revealed					
		turning to the facility on a					
	ambulance stretcher.						
	Interview with the Adv	ministrator on 05/08/19 at					
		sident #17 was sent to the					
	•						
	hospital because her stomach was hurting.						
	Review of hospital re	cords dated 05/08/19 for					
	Resident #17 revealed: -She was seen in the emergency room (ER) fall						
	of unknown mechanis						
	•	with left rib fractures and					
	acute cystitis.						
	Davidson of the Control						
		note dated 05/07/19 at					
	1:01pm for Resident	# I I I TEVEAIEU SIAII	- 1				

Division of Health Service Regulation

documented leaving a message for the resident's

STATE FORM E899 ZE7D11 If continuation sheet 117 of 267

STATEMENT OF CERCICIONS (XI) PROVIDERS MADERAL DENTIFICATION NUMBER: (BARD DAMP CONTROLLED (STATEMENT OF CORRECTION) (NAME OF PROVIDER OR SUPPLIER SHARED AND ESSA CITY, STATE, APP CODE SHARED AND ESSA CITY,	Division of Health Service Regulation						
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE SUMMARY STATEMENT OF DEPICIENCES 950 HWY 64 EAST COLUMBIA, NO. 27925 DAY, ID PRECINA (RACH DEPICIENCY MUST ER PRECIDED BY PILL) PRECINA IAG D 273 Continued From page 117 primary care provider (PCP) regarding concern for the resident having a breathing issue. Review of charting notes dated 05/08/19 for Resident #17 revealed: -A1 75 fpm, the CM documented Resident #17 stiting on the floor in the common area with no apparent injuriesA1 75 fpm, the CM documented Resident #17 was complaining of stomach pain and wheezing baddyResident #17 returned to the facility with a closed left in fracture. Interview with a medication aide (MA) on 05/14/19 at 9:10am revealed: -She did not remember hearing anything about Resident #17 falling on 05/06/19; there was no 72 hour monitoring on the electronic medication administration record (eMAR)The first she knew about Resident #17 experiencing a fall was when the resident complained of pain on her sideShe had given Resident #17 libuprofen for the pain: she did not remember what day that wasIncidents and accidents were not always reported by outgoing staff to the next shiftSometimes she might find out about a resident falling the next day, and sometimes not at all. Review of Resident #17 SM May 2019 eMAR revealed: -There was an entry for Fall Prevention ProgramThere was an entry for Monitor status for 72	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
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was complaining of stomach pain and wheezing badly. -Resident #17's PCP was notified and told the CM to send the resident to the ERResident #17 returned to the facility with a closed left rib fracture. Interview with a medication aide (MA) on 05/14/19 at 9:10am revealed: -She did not remember hearing anything about Resident #17 falling on 05/05/19; there was no 72 hour monitoring on the electronic medication administration record (eMAR)The first she knew about Resident #17 experiencing a fall was when the resident complained of pain on her sideShe had given Resident #17 ibuprofen for the pain; she did not remember what day that wasIncidents and accidents were not always reported by outgoing staff to the next shiftSometimes she might find out about a resident falling the next day, and sometimes not at all. Review of Resident #17's May 2019 eMAR revealed: -There was an entry for Fall Prevention ProgramThere was documentation of vital signs every shift 05/06/19 through 05/09/19There was an entry for Monitor status for 72		• • •					
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-Resident #17 returned to the facility with a closed left rib fracture. Interview with a medication aide (MA) on 05/14/19 at 9:10am revealed: -She did not remember hearing anything about Resident #17 falling on 05/05/19; there was no 72 hour monitoring on the electronic medication administration record (eMAR)The first she knew about Resident #17 experiencing a fall was when the resident complained of pain on her sideShe had given Resident #17 ibuprofen for the pain; she did not remember what day that wasIncidents and accidents were not always reported by outgoing staff to the next shiftSometimes she might find out about a resident falling the next day, and sometimes not at all. Review of Resident #17's May 2019 eMAR revealed: -There was an entry for Fall Prevention ProgramThere was documentation of vital signs every shift 05/06/19 through 05/09/19There was an entry for Monitor status for 72							
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falling the next day, and sometimes not at all. Review of Resident #17's May 2019 eMAR revealed: -There was an entry for Fall Prevention Program. -There was documentation of vital signs every shift 05/06/19 through 05/09/19. -There was an entry for Monitor status for 72		reported by outgoing	staff to the next shift.				
Review of Resident #17's May 2019 eMAR revealed: -There was an entry for Fall Prevention Program. -There was documentation of vital signs every shift 05/06/19 through 05/09/19. -There was an entry for Monitor status for 72		-Sometimes she migh	nt find out about a resident				
Review of Resident #17's May 2019 eMAR revealed: -There was an entry for Fall Prevention Program. -There was documentation of vital signs every shift 05/06/19 through 05/09/19. -There was an entry for Monitor status for 72		<u> </u>					
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revealed: -There was an entry for Fall Prevention ProgramThere was documentation of vital signs every shift 05/06/19 through 05/09/19There was an entry for Monitor status for 72		Review of Resident #	17's May 2019 eMAR				
-There was an entry for Fall Prevention ProgramThere was documentation of vital signs every shift 05/06/19 through 05/09/19There was an entry for Monitor status for 72			•				
-There was documentation of vital signs every shift 05/06/19 through 05/09/19There was an entry for Monitor status for 72			for Fall Prevention Program.				
shift 05/06/19 through 05/09/19There was an entry for Monitor status for 72							
-There was an entry for Monitor status for 72							

STATE FORM 6899 ZE7D11 If continuation sheet 118 of 267

DIVISION	Division of Health Service Regulation						
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND I LANC	O CONTROLON	IDENTIFICATION NOWIDEN.	A. BUILDING: _			0	
			B. WING				
		Hal089002	D. WING		05/1	7/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
TYRRELL	HOUSE	950 HWY					
	COLUMI						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 273	Continued From page 118		D 273				
D 2/3	status/condition, pain fallStaff documented lef to 7:00am shift on 05There was an entry f four hours as needed -There was documen administered on 05/00 05/07/19 at 6:21am for the condition of the conditio	or other injuries related to it side pain on the 11:00pm /06/19. for ibuprofen 600mg every for pain. tation ibuprofen was 6/19 at 6:08am and or left side pain. erview with the MA on was unsuccessful. and MA on 05/14/19 at on 05/07/19. Id by the prior shift MA mplaining of left sided pain at the second MA on 05/14/19 ed on 72 hour monitoring consible for checking and for any new pain or ment every shift on the ing was automatically and came up on the screen MA on 05/14/19 at 12:42pm came and told her Resident	D 273				
	· ·	urting and she was					

Division of Health Service Regulation

resident pointed to her left side.

STATE FORM E899 ZE7D11 If continuation sheet 119 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/20	19
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE. ZIP CODE		
		950 HWY	, ,			
TYRRELL HOUSE COLUMBIA		IA, NC 27925				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CO	(X5) MPLETE DATE
D 273	Continued From page	e 119	D 273			
D 2/3	-She called the PCP of #17 to the ERShe did not know Re of left sided pain on 0 -MAs reported off to to MA was off for a day of know what happened -There was no comm Telephone interview of Guardian on 05/14/19 -Resident #17 had no -Monday of last week voicemail from staff sfallenThe staff said they cl signs and she was ok send her to the ERStaff had not said ReanywhereShe had not been cabeing sent to the ER with rib fractures. Telephone interview of 05/15/19 at 9:55am re-He did not have a real Resident #17's fall on pain after the fall on 0 -Resident #17 was fin 05/14/19.	who said to send Resident esident #17 had complained 15/06/19 and 05/07/19. he oncoming shift, but if a or two there was no way to those days. unication book to review. with Resident #17's 0 at 12:10pm revealed: by been having any falls. (05/06/19) she received a aying Resident #17 had thecked Resident #17's vital say so they did not need to esident #17 was hurting fulled about Resident #17 on 05/08/19 and diagnosed with Resident #17's PCP on evealed: cord of being notified for 105/05/19 or complaints of 105/06/19 and 05/07/19. st seen for a fall on	D 273			
	PCP on 05/15/19 at 3 -He was at the facility residents. -The CM was able to	erview with Resident #17's 3:28pm revealed: v every Tuesday to see add residents to the weekly spital follow up and other				

Division of Health Service Regulation

-The normal protocol was for staff to notify him

STATE FORM E899 ZE7D11 If continuation sheet 120 of 267

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		Hal089002	B. WING		05/17/2019
		11003002			05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HW	64 EAST		
TINKLLL	HOUSE	COLUMI	BIA, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	\ - /
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NATE DATE
			+		
D 273	Continued From page	e 120	D 273		
	within one hour of an	event, incident or acute			
	changes in a resident's condition.				
	•	I provider on call 24 hours a			
	day from his office.	i provider on dan 2 i nodro d			
	day from the office.				
	Interview with the CM	l on 05/14/19 at 2:00pm			
	revealed:	·			
	-The MA who was on	duty 05/05/19 reported			
	Resident #17 did not	fall.			
	-The MA said Reside	nt #17 was going to fall, but			
	staff caught her and s				
	-The MAs had not rep				
	•	nt #17 on 05/06/19 and			
	05/07/19 for left sided				
		ially report administering			
		ss three consecutive doses			
	had been given.				
	_	required three consecutive			
	doses she would follo	ow up with the PCP.			
		our monitoring after a fall			
	was to monitor for ne	w pain and changes in			
	condition.				
	-Staff "should have ha	ad the common sense to			
	report the pain and w	e could have gone from			
	there."				
	-She would have con	tacted the PCP about			
	Resident #17's left sid	ded pain.			
		ministrator on 05/14/19 at			
	2:15pm revealed:				
		esident #17 had complained			
	of left sided pain each	•			
		turning from the emergency			
	room on 05/08/19 wit				
	-She did not know the				
		r 05/07/19 about Resident			
	#17's left side pain.				
	-The MA should have	notified the CM and			

administered the pain medication.
-The 72 hour monitoring was specifically to

STATE FORM 6899 ZE7D11 If continuation sheet 121 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		Hal089002	B. WING		05/17	/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6	64 EAST A, NC 27925			
0/4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 121	D 273			
	monitor for pain; if the pain continued after 72 hours then the CM would have contacted the PCPStaff would be educated to call the PCP immediately or send the resident to the ER when there was new pain after a fall. 5. Review of Resident #4's current FL-2 dated					
	03/06/19 revealed: -Diagnoses included corpus collosum, hyphypoosmolality, hypothypoosmolality, hypothypoosmolalit	t #4's current FL-2 dated central demyelination of omagnesia, candidiasis, natremia, alcohol abuse, omnia and hypertension.				
		y care provider (PCP) visit or Resident #4 revealed r bilateral breast				
	revealed: -She had a mass in h was supposed to hav in September 2018She was seriously ill medical issues in Sep when to a rehabilitatic -She never had the fo 2018, so her PCP orc	er left breast last year and e a follow up mammogram and hospitalized with other otember 2018 and then on facility for several months. Ollow up from September lered the mammogram.				
	at 3:20pm revealed: -The day after she go mammogram for Res local provider to sche -She did not remembe 2019.	ident #4 she contacted a				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 122 of 267

DIVISION	i Health Service Regu	I			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
			B. WING			_,_,
		Hal089002	D. WING		05/1	7/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 FAST			
TYRRELL	HOUSE					
		COLUMB	IA, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
D 273	Continued From page	e 122	D 273			
	had a mammagram in	March 2010				
	had a mammogram in					
	•	nid the insurance company				
	• • •	mammogram every six				
	months.	. 5				
	-She did not have acc	cess to Resident #4's				
	electronic record.					
		anager (CM) that she could				
		nmogram for Resident #4.				
		sible for getting referral				
	orders to her, then sh	e scheduled the				
	appointment, took the	e resident to the appointment				
	and brought the visit f	form back to the CM.				
	-If there were any issu	ues with scheduling				
	appointments or takin	ig residents to appointments				
	she let the CM know.	•				
	Telephone interview v	vith Resident #4's PCP on				
	05/15/19 at 9:55am re					
		ammogram on 04/02/19 for				
		she had prior female issues				
	that needed follow up					
		ing that the mammogram				
	had been done.	ing that the manimogram				
	naa been done.					
	h Review of a primar	y care provider (PCP) visit				
		or Resident #4 revealed				
		r a pelvic ultrasound for				
	•	the resident's right fallopian				
	tube.					
	Intendeur with Device	mt #4 am 05/40/40 -t 0:05:				
		nt #4 on 05/16/19 at 3:35pm				
	revealed:					
		talized in September 2018				
		her right fallopian tube.				
		zed with a serious illness				
	· · · · · · · · · · · · · · · · · · ·	follow up for the fallopian				
	tube mass.					
	-Her PCP ordered a p	pelvic ultrasound to finally				
	get some follow up or					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 123 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6			
			A, NC 27925		
(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 123	D 273		
	Interview with the transportation staff on 05/16/19 at 3:20pm revealed she did not know anything about scheduling a pelvic ultrasound for Resident #4.				
	05/15/19 at 9:55am re -He had ordered a pe	elvic ultrasound on 04/02/19 use she had prior female ellow up. ing that the pelvic			
	on 05/15/19 at 9:40pr who was responsible	with a medication aide (MA) m revealed she did not know for making referral d by a resident's PCP.			
	(RCD) on 05/10/19 at -The Care Manager (giving appointment re staff. -The transportation st scheduling the appoin	CM) was responsible for eferrals to the transportation saff was responsible for entment, documenting in the sheduling book and entering			
	The CM was not avai 05/16/19 and 05/17/1				
	3:44pm revealed: -She did not know the for a mammogram ar 04/02/19 for Resident scheduled.				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 124 of 267

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		Hal089002	B. WING		05/17/2019
			1		1 00/1//2010
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY	64 EAST		
		COLUMB	IA, NC 27925		
(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 APPROPR	
TAG	REGULATORI ORT	100 IDENTIFY TING INFORMATION)	TAG	DEFICIENCY)	JANE
D 273	Continued From page		D 273		
		sible for putting all PCP			
	orders in the compute				
	-The CM was respons	•			
	documentation of refe				
		e transportation staff each			
	month.				
	-	aff was responsible for			
		rogress notes about resident			
	appointments.	aible for reporting any issues			
	-The CM was responsible for reporting any issues with scheduling or keeping appointments to the				
	PCP.	eping appointments to the			
	FOF.				
	6. Review of Residen	t #2's current FL-2 dated			
	02/05/19 revealed:				
	-Diagnoses included	Alzheimer's disease, high			
	blood pressure, Vitan	nin D deficiency, and			
	pre-renal disease.	and the second of			
	-The resident was con				
	-The resident was ser				
	dressing, and feeding	d assistance with bathing,			
		ontinent of bladder and			
	bowel.	onlinent of bladder and			
	bowci.				
	a. Review of Residen	t #2's charting note dated			
	02/06/19 at 4:39pm re	-			
	-	ew bowel movements but			
	did not seem to be in	any pain.			
	-Staff would continue	to monitor throughout the			
	shift.				
		2's primary care provider			
	(PCP) visit notes date				
	•	sident had diarrhea for the			
	past 3 days.	uhito olimu outstana-			
		vhite, slimy substance			
	present.	stool culture O. 8. D. (ave. and			
	- me FOF ordered a s	stool culture O & P (ova and	1		

Division of Health Service Regulation

parasite) difficile toxin. (O & P testing and difficile

STATE FORM E899 ZE7D11 If continuation sheet 125 of 267

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	FIED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
TYPPELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMBI	A, NC 27925			
(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 APPROFIDEFICIENCY)) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 125	D 273			
	toxin testing are used to determine if there are infections in the intestines that could cause symptoms such as diarrhea.)					
	notes, and provider n	2's charting notes, lab otes revealed no ool culture was done as				
	04/25/19 at 4:35pm re	2's charting note dated evealed the resident was al for loose stool with very				
	dated 04/25/19 at 4:4	nt to the hospital for very dor.				
	05/10/19 at 1:42pm re -Resident #2's diarrhe					
		evealed she did not know if ulture had been done but				
		ns, interviews, and record ined Resident #2 was not				
	12:40pm revealed:	ith the CM on 05/10/19 at cal hospital and there was ulture being done for				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 126 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	Hal089002	B. WING		05/17	7/2019
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
	950 HWY (64 EAST			
TYRRELL HOUSE	COLUMBI	A, NC 27925			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E TAG REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273 Continued From page 126		D 273			
-The CM was responsible for appointments including any -The residents at the facility the local hospital for labwork stool samples were obtained taken to the local hospital for lf a stool sample was needed notify the MAs when a reside movement and the MA was getting the sample. -The facility staff would then the lab at the local hospital for Resident #2's stool culture of was not done because she of the lab at the local hospital for Resident #2's stool culture of was not aware of Resident #2's stool culture of laborated Resident #2's stool culture of laborated Resident #2's stool culture done. A third interview with the CM 4:10pm revealed: -A stool sample was collected stool culture over the weeke 05/12/19). -She would file a copy of the resident's record when received at 10:00am revealed. The ordered a stool culture for February 2019 because she and he was concerned the reconcerned the reconstruction of the content of the intestines caused. He was not aware the stool done until facility staff notified. He had them to get the stool done until facility staff notified.	labwork. had to be taken to to be completed or if If, the samples were resting. ed, the PCAs would ent had a bowel responsible for take the sample to or testing. ordered on 02/12/19 overlooked the order. dent #2 having any ne was seen in the 9. s PCP this morning d the resident to I on 05/13/19 at I of or Resident #2's and (05/11/19 or I results in the order. I or Resident #2's and (05/11/19 or I results in the order. I or Resident #2's and (05/11/19 or I results in the order. I or Resident #2 in was having diarrhea esident might have a c (Clostridium difficile sing diarrhea.) culture had not been d him last week.	D 2/3			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 127 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6 COLUMBIA	4 EAST A, NC 27925			
(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	(X5) COMPLETE DATE
D 273	Continued From page	: 127	D 273			
	Review of Resident #2's labwork dated 05/11/19 revealed the resident's stool sample was negative for Clostridium difficile toxin.					
	report dated 03/13/19 -The resident was sittle her bedroom doorThe resident had a sthat was cleaned and -The resident's family	ing on the floor in front of kin tear on her lower left leg bandaged.				
	03/20/19 revealed: -The resident was be -Staff reported the resolution obtained a small abra	sident had a fall and sion on her lower left leg. on on her lower left leg with on noted. the resident to be				
	in 4 weeks after the v	nentation of a follow-up visit				
		ns, interviews, and record ined Resident #2 was not				
	Interview with the Cal 05/10/19 at 12:40pm -She was responsible residents to be seen	revealed:				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 128 of 267

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					
			P WING		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		950 HWY	64 FAST		
TYRRELL	HOUSE		A, NC 27925		
			IA, NC 27925		
(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 APPROPR	
1710		,	1,710	DEFICIENCY)	
D 070	0 " 15	100	D 070		
D 273	Continued From page 128		D 273		
	weekly visits.				
		sit with the PCP was on			
	03/20/19.				
		the PCP's note to have the			
		weeks from the visit on			
	03/20/19.				
		lent #2 on the list to be seen			
	by the PCP on his ne				
	05/14/19.	At visit on ruesday,			
		esident #2 had no falls since			
	the fall in March 2019				
	the fall in March 2018	·			
	Telephone interview v	vith Resident #2's PCP on			
	05/15/19 at 10:00am				
		residents at the facility at			
	least every 90 days ro				
		seeing residents once a			
	week.	seeing residents once a			
		him of any residents that			
	needed to be seen fo	-			
		m with a resident, he would			
	•	for them to be rechecked in			
	4 weeks.	for them to be rechecked in			
		sident to be put book on the			
		sident to be put back on the			
	,	e seen in 4 weeks as noted.			
		nave been seen in 4 weeks			
		0/19 to follow-up on her			
	status after a fall.				
		yesterday (05/14/19) during			
	his routine visits.	:41			
	-He was not aware of				
	anymore falls since M	iarch 2019.			
	o Dovious of Dociders	t #2's primary care provider			
		t #2's primary care provider			
	(PCP) visit notes date				
		en today to establish as a			
	new patient.	according to the CDO (
		owork for a CBC (complete			
	blood count) and CMI	P (comprehensive metabolic			

Division of Health Service Regulation

panel) at next blood draw and every 4 months.

STATE FORM E899 ZE7D11 If continuation sheet 129 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	950 HWY 6	ORESS, CITY, STA 64 EAST A, NC 27925	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	(X5) COMPLETE DATE
D 273	Continued From page	: 129	D 273			
	notes, and provider n documentation the CI ordered on 01/08/19. Based on observation review, it was determ interviewable. Interview with the Car 05/10/19 at 12:40pm -She contacted the lono record of CBC or CResident #2. -The CM was respons appointments includin -The residents at the the local hospital for I -When the CM receiv communicate with the coordinate at time to hospital lab. -An appointment was lab so the transporter without making an ap -Resident #2's CBC a 02/12/19 were not do the order. -She contacted Resid (05/10/19) and he told done today, 05/10/19 A second interview wid:10pm revealed:	as, interviews, and record ined Resident #2 was not re Manager (CM) on revealed: cal hospital and there was CMP being done for sible for setting up any labwork. facility had to be taken to abwork to be completed. ed an order for labwork, she a facility's transporter to take the resident to the not needed for the hospital could take a resident pointment. and CMP ordered on the because she overlooked them to get the labwork. The the CM on 05/13/19 at				
	•	of the results in the				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 130 of 267

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMIT LETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TTRRELL	HOUSE	COLUMB	IA, NC 27925			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET	Ë
D 273	Continued From page	e 130	D 273			
	Review of Resident #2's labwork revealed a CMP and CBC were completed on 05/10/19.					
	O5/15/19 at 10:00am -Resident #2 was est during the visit in Jan -He routinely ordered patients to establish a monthsHe was not aware R had not been comple 2019 until the facility -He had them to get t and he would rechect wanted to monitor the potassium supplement The facility failed to a obtained weekly for 4 was on Coumadin 7.5 had a blood sugar of hospital with a hemor intubated, given med level of 6.2, develope received a tracheosto died. The facility also primary care provider	ablished as a new patient uary 2019. CBC and CMP for all new a baseline and then every 4 esident #2's CBC and CMP ted as ordered in January staff notified him last week he labwork done last week k the CMP in 4 weeks as he e resident's response to a nt he discontinued. ———————————————————————————————————				
	days after the fall who department 3 days af					
	ensure a resident havultrasound that had b This failure resulted in	rib fracture; and failed to ye a mammogram and pelvic een ordered for 45 days. n death, serious physical d constitutes a Type A1				
		. 131D-34 on 05/10/19 with				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 131 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		Hal089002	B. WING		0.9	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	. ZIP CODE		<i></i>
			Y 64 EAST	, 2.11 0002		
TYRRELL	HOUSE	COLUM	BIA, NC 27925			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 131	D 273			
	revision on 05/14/19.					
		DATE FOR THE TYPE A1 NOT EXCEED JUNE 15,				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276			
	10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.					
	reviews the facility fai implemented for 2 of #6) for a daily postura blood pressure and h	as evidenced by: ns, interviews, and record iled to assure orders were 10 sampled residents (#4, al vital signs (#4); and daily eart rate checks (#6). rent FL-2 dated 07/13/18				
	revealed: -Diagnoses included chronic anxiety, hype -There was an order (mg) at bedtime (Aml	hypertension, dementia, rlipidemia, and glaucoma. for Amlodipine 10 milligrams odipine is a medication used essure by relaxing the blood				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 132 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE S		
7.1.15 . 27.11 .	5. G5.W.E6.W6.W	ISENTING TO THE STATE OF THE ST	A. BUILDING: _		""	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY (64 EAST A, NC 27925			
	OLIMANA DV. OT		·	DDO//DEDIO DI ANI OF CODDECTIO	NA 1	
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 276	Continued From page 132		D 276			
	vessels which could lower the heart rate)There was an order for Losartan Potassium 100mg daily (Losartan Potassium is a medication used to treat high blood pressure by relaxing the					
		could lower the heart rate).				
	Review of Resident #6's subsequent orders dated 01/02/19 revealed: -There was an order for Amlodipine 10 milligrams (mg) at bedtimeThere was an order for Losartan Potassium 100mg daily.					
	100mg daily. Review of Resident #6's physician notes dated 01/08/19 revealed: -She was having visual hallucinationsThere was an order for weekly blood pressure (BP) and heart rate (HR)There were BP parameters to call if systolic blood pressure (SBP) greater than 220 or less than 90, or diastolic blood pressure (DBP) greater than 110There were HR parameters to call if HR greater than 140 or less than 50.					
	2019 electronic medic (eMAR) revealed: -The resident was rec lower blood pressure	6's January 2019 - April cation administration record reciving two medications to that may also lower HR. nentation that revealed HR was obtained.				
		6's monthly weight and vital 2019 - April 2019 revealed BP and HR were not				
		6's charting notes revealed: itten entry on 01/18/19				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 133 of 267

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
		11-100000	B. WING		0.7/4	
		Hal089002	B: Wiito		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMBI	A, NC 27925			
0(0)15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECTION	J	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 276	Continued From page	133	D 276			
D 210	Continued From page	: 133	5270			
	regarding foot and na	il care.				
	-There was a handwr	itten entry on 03/29/19				
	regarding foot and na	il care.				
	-There was no docum	nentation that revealed				
	Resident #6's BP or H	HR heart rate was obtained.				
	Interview with the car	e manager (CM) on				
	05/09/19 at 5:39 pm r	revealed:				
	-She was responsible	for printing physician notes,				
	reviewing for orders,	and faxing to pharmacy to				
	be entered on the eM	• .				
	-She would attach the	e fax confirmation to the				
		to pharmacy until pharmacy				
	entered the orders on					
		s to enter orders on the				
	eMAR.					
	-	ed Resident #6's 01/08/19				
	_	the order for weekly BPs and				
	HRs to the pharmacy					
		y the order for weekly BP				
	and HR did not popul	-				
	and the did not popul	ate on the own are.				
	Interview with the Adr	ministrator on 05/09/19 at				
	5:55 pm revealed:	Time trater on octoor to at				
	•	sible for reviewing physician				
	notes for orders.	olore terretung projection				
		ders to the pharmacy and				
		out the orders on the eMAR.				
		enter orders on the eMAR.				
		M to enter orders on the				
	-					
	eMAR if not entered by pharmacy.					
	-She did not know there were 01/08/19 orders for Resident #6's BP and HR to be obtained weekly.					
	NOSIDELL #0 5 DF dHO	This to be obtained weekly.				
	Telephone interview w	vith Resident #6's PCP on				
	05/15/19 at 4:34 pm r					
		gnosis of hypertension for				
	Resident #6.	griodia of hypoticilatori for				
		he ordered a weekly BP				
	The did not know willy	no ordered a weekly Di	1		I	

Division of Health Service Regulation

and HR on Resident #6.

STATE FORM E899 ZE7D11 If continuation sheet 134 of 267

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S COMPLI	
			R WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST IA, NC 27925			
	SLIMMADV ST	FATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	<u></u>	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 276	Continued From page	e 134	D 276			
	-He ordered weekly BP checks if he was concerned about a resident's BPHe did not know Resident #6 had not had weekly					
	BP's and HR's obtain					
		ekly BPs and HRs for				
		been obtained as ordered.				
	C Deview of Donidon	CUAL SUSSESSEE O detect				
	2. Review of Residen 03/06/19 revealed:	nt #4's current FL-2 dated				
		central demyelination of				
	corpus collosum, hyp	oomagnesia, candidiasis,				
		onatremia, alcohol abuse,				
	major depression, ins	somnia and hypertension.				
	Review of a primary of	care provider (PCP) visit				
	note dated 03/20/19 i	reveal an order for postural				
		vo weeks. (Postural vital				
	signs are a check of l	heart rate and blood down, sitting up and then				
	standing consecutive	- ·				
	Review of a PCP ord	ler dated 03/26/19 revealed				
		vital signs daily for one				
	week.					
		#4's March and April 2019				
		administration record				
	vital signs.	re was no entry for postural				
	Upon request on 05/	14/19, documentation of				
	postural vital signs for Resident #4 were not					
	available for review.					
	Interview with Reside revealed:	ent #4 on 05/16/19 at 3:35pm				
		her PCP ordered blood				
		g, sitting and standing.				
	-Staff did not do bloo	d pressure checks except				

Division of Health Service Regulation

once right before the PCP returned for the next

STATE FORM E899 ZE7D11 If continuation sheet 135 of 267

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6 COLUMBIA	4 EAST A, NC 27925			
(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 276	05/15/19 at 9:55am re -He had ordered post Resident #4 was expense when she stoodHe did not recall see -Getting vital signs re problem at the facility The Care Manager (Counterview on 05/16/19) Interview with the Adra 3:44pm revealed: -She did not know the postural vital signs or the postural vital signs or the postural vital sign Resident #4The facility PCP sits over each resident selThe PCP gives all the	with Resident #4's PCP on evealed: ural vital signs because eriencing balancing issues ing any vital signs results. sults was a common . CM) was not available for and 05/17/19. ministrator on 05/17/19 at ere was a PCP order for 03/20/19 and 03/26/19, and is were not documented for down with the CM and goes een each week.	D 276			
D 310	orders in the computed 10A NCAC 13F .0904 Service 10A NCAC 13F .0904 (e) Therapeutic Diets (4) All therapeutic diesupplements and thick served as ordered by This Rule is not met Based on observation reviews, the facility far	er system. He(e)(4) Nutrition and Food Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.	D 310			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 136 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE		A, NC 27925		
(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
	meats diet who cough while eating food that ordered. The findings are: Review of Resident # 02/05/19 revealed: -Diagnoses included blood pressure, Vitam pre-renal diseaseThe resident was cou-The resident required -There was an order to diet. Review of the facility's revealed Resident #2 meats diet.	2's current FL-2 dated Alzheimer's disease, high nin D deficiency, and nstantly disoriented. d assistance with feeding. for a regular chopped meats s diet list dated 02/28/19 was listed as a ground			
	-				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 137 of 267

Division (of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		Hal089002	B. WING		05/4	7/2040
		Hai009002			05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	A, NC 27925			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 310	Continued From page 137		D 310			
	fish and assisted Res	sident #2 with eating				
	teaspoon sized piece	•				
		esident #2 with eating one to				
	one and half inch pied	•				
		nt #2 coughed twice while				
	chewing food.	3				
	•	to assist Resident #2 with				
	eating teaspoon sized	d pieces of the baked fish				
	-	were one to one and half				
	inch in length.					
	_	eating the lunch meal at				
	12:24pm with no furth	ner coughing.				
	Interview with the PC revealed:	A on 05/10/19 at 12:43pm				
		nt to make the food small ent could eat the food.				
	-Resident #2 was abl					
	-Coughing during the Resident #2.	meal was normal for				
	-The medication aide	s (MAs) knew Resident #2				
	•	meals because the MAs				
	were usually in the di	ning room during the meals.				
		nd PCA on 05/10/19 at				
	12:31pm revealed:	on a thoronoutic distribe				
		on a therapeutic diet; the				
	ground food.	ered to have chopped or				
		erything," and was able to				
		crytillig, and was able to				
	chew the food. -She had never paid attention to it before, but Resident #2 did cough regularly while eating					
	meals.					
	, , , , , , , , , , , , , , , , , , , ,					
	Interview with a MA or revealed:	on 05/10/19 at 12:44pm				
		ed Resident #2 coughing				
	while eating a meal.	5 0				
		e process for diet orders,				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 138 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COWIFE	ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6	64 EAST			
	110002	COLUMBI	A, NC 27925			
(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	(X5) COMPLETE DATE
D 310	ground a resident's for Interview with the Die 05/10/19 at 12:38pm up Resident #2's food resident with eating. Interview with the Car 05/10/19 at 12:50pm - The primary care prodiet order sheet for th gave the diet order she-The kitchen staff followy the PCP. -A chopped diet mean to pick up with a utensenough so as not to colf a resident experier she expected staff to immediately. -Tending to the resider resident's mouth to mother and standing the helped food to go down-PCAs were expected residents coughing will interview with Reside 05/09/19 at 12:55pm - Resident #2's PCP to	bund food. In the staff would chop or and if that was the order. Itary Manager/Cook on revealed the PCAs chopped if when they assisted the re Manager (CM) on revealed: Itary Manager/Cook on revealed the measure then she she had be resident while eating, attend to the resident with the sake sure there was no food the resident up because that with the report any incidents of the manager (CM) on report any incidents of the manager (CM) on revealed the resident up because that with the sake sure there was no food the resident up because that with the report any incidents of the manager (CM) on revealed the resident up because that with the sake sure there was no food the resident up because that with the resident up the r	D 310			
	took the resident a lor -The resident's food v -Staff were cutting the but not always in sma -She had asked the k	esing several teeth and it and time to chew her food. It was not being chopped. It resident's food with a knife, all pieces. It itchen staff several times told the facility did not have				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 139 of 267

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		Hai089002	B. WING		05/	17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
TYRRELL	HOUSE		Y 64 EAST BIA, NC 27925			
			DIA, NC 21925			
(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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 310	Continued From page 139		D 310			
	the proper equipment to chop the foodShe was not aware of the resident coughing or					
	choking while eating.	or the resident coughing of				
	choking write caulig.					
	Telephone interview v	with Resident #2's PCP on				
	05/15/19 at 10:00am					
		ered a chopped meats diet				
	due to bad dentition.	asidant #2aa nat baina				
	served a chopped die	esident #2 was not being				
	-He was not aware R					
	coughing while eating					
		oughed while eating, there				
		f aspiration pneumonia.				
		pe notified if Resident #2				
	aspiration.	due to possible risk of				
	Interview with the Adr 3:44pm revealed:	ministrator on 05/17/19 at				
		sible for entering diet orders				
	into the computer sys					
		order report every month				
	and gave a copy to the					
		e diet orders in Resident #2's				
	chart and on the diet	order report did not match.				
	Based on observation	ns, interviews, and record				
		ined Resident #2 was not				
D 312	10A NCAC 13F .0904 Service	4(f)(2) Nutrition and Food	D 312			
	10A NCAC 13F .0904	Nutrition and Food Service				

Homes:

(f) Individual Feeding Assistance in Adult Care

(2) Residents needing help in eating shall be assisted upon receipt of the meal and the

STATE FORM E899 ZE7D11 If continuation sheet 140 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDIEAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		OOMII EETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY (COLUMBI	64 EAST A, NC 27925		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 312	Continued From page 140		D 312		
		nhurried and in a manner ances each resident's			
	reviews, the facility fa with eating two obser maintained Resident	as evidenced by: ns, interviews and record illed to provide assistance ved meals in a manner that #21's dignity and respect by e resident during each meal.			
	The findings are: Review of Resident #21's current FL-2 dated 12/08/18 revealed: -Diagnoses included vascular dementia, frontal temporal lobe degeneration, hypothyroidism, osteoporosis and back painResident #21 was constantly disorientedResident #21 required assistance with eating meals.				
	03/05/19 revealed the	r assistance with eating			
		r sheet dated 01/08/19 for d there was an order for a			
	from 5:30pm until 5:5 -A personal care aide Resident #21 with ea lasagna, mixed veget -Resident #21 was se wheelchairThe PCA stood at the	(PCA) was assisting ting a plate of baked ables and a dinner roll.			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 141 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		1 '	E CONSTRUCTION (X3) DATE SURVE COMPLETED		
		Hal089002	B. WING		05/1	7/2019
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00	
TYRRELL	HOUSE	950 HWY	64 EAST			
TIRRELL	HOUSE	COLUMBI	A, NC 27925			
(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 312	Continued From page	e 141	D 312			
	eating.					
	from 5:38pm until 5:4 -A PCA was assisting while the resident was wheelchairThe PCA stood at the Resident #21 while as eating. Interview with the PC revealed: -She did not want a c Resident #21 with eas -In response to feedir she said, "I'm fine." -Resident #21 was "o	Resident #21 with eating seated in a high back eside of the wheelchair over esisting the resident with A on 05/13/19 at 5:45pm hair to sit and assist ting her meal. In the resident at eye level, was with standing over her."				
	05/17/19 at 3:44pm re -She did not know sta Resident #21 with ear -Staff were expected assist residents with e	off were standing to assist ting meals. to sit down at eye level to				
		ns, interviews and record nined Resident #21 was not				
D 358	10A NCAC 13F .1004 Administration	e(a) Medication	D 358			
	10Δ NCΔC 13E 100Δ	Medication Administration				

Division of Health Service Regulation

(a) An adult care home shall assure that the

STATE FORM E899 ZE7D11 If continuation sheet 142 of 267

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Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74157 2747	or definition	ISERTII IO/RIGITATIONISER	A. BUILDING: _			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY (COLUMBI	64 EAST A, NC 27925			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 142	D 358			
	preparation and admi prescription and non- by staff are in accorda (1) orders by a licens which are maintained	nistration of medications, prescription, and treatments				
	reviews, the facility farmedications as ordered the facility's policy for observed during the rerrors with a vitamin I and for 3 of 10 sample including errors with a used to treat low potal acid reflux, and treat a	ns, interviews, and record iled to administer ed and in accordance with 2 of 11 residents (#18, #19) medication passes including D supplement (#18, #19); ed residents (#3, #2, #4) a diuretic (#3), medications essium, treat and prevent and prevent stomach ulcers in to treat chronic obstructive				
	opportunities during the medication passes or	ror rate was 7% as ervation of 2 errors out of 27 he 6:00 am, and 7:00 am n 05/07/19; 9:00 am and passes on 05/09/19; and				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 143 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST A, NC 27925			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET	ΓE
D 358	a. Review of Residen 01/23/19 revealed dia Alzheimer's dementia dysphagia, iron defici disorder, history of fe coordination, and abroximation, and abroximation of Resident # 101/23/19 revealed and phosphorus and bone disorders). Observation of the 8: 05/10/19 revealed Vitadministered to Resident # 105/10/19 revealed: -There was an entry for take 1 tablet daily. -Vitamin D3 was doct 05/01/19. -Vitamin D3 was not administered from 05-10/19. Review of a physician revealed: -There was an order multivitamin).	at #18's current FL-2 dated agnoses included and muscle weakness, ency anemia, thyroid mur fracture, lack of normal gait and mobility. E18's physician order dated order for Vitamin D3 1,000 min D 3 is a vitamin as the body absorb calcium is used to treat and prevent O0 am medication pass on tamin D3 1000 units was not dent #18. E18's 05/01/19 - 05/10/19 administration record For Vitamin D3 1,000 units Scontinue date of 05/01/19. Sumented as administered on documented as 102/19 - 05/10/19. In documented why Vitamin	D 358	DEFICIENCY)		

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 144 of 267

Division of	<u>of Health Service Regu</u>	lation				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HW	64 EAST			
ITKKELL	HOUSE	COLUMI	BIA, NC 27925			
(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)	D BE COMPLETE	
D 358	Continued From page	2 144	D 358			
D 358	attached to the order "Vitamin D3"Resident #18's name post it note. Review of Resident # revealed there was no Vitamin D3 1000 units Interview with the Car 05/10/19 at 12:20 pm -She called Resident (PCP) to clarify the 04 discontinue theragran -Resident #18's PCP should have been dis -She received a verba Vitamin D3 for Reside -She did not write a v Vitamin D3 for Reside -She could not remen verbal order to discon	which read to discontinue was handwritten on the 18's physicians orders order to discontinue s daily. The Manager (CM) on revealed: #18's primary care provider 14/22/19 physician order to n. told her the Vitamin D3 continued also. al order to discontinue ent #18. erbal order to discontinue ent #18. her when she received the other when be been written when	D 358			
	facility's contracted pl 12:25 pm revealed:	R there was not a				
		ceive a discontinuation				

Interview with the Regional Clinical Director (RCD) on 05/10/19 at 1:45 pm revealed: -The physician order dated 04/22/19 for Resident

STATE FORM 6899 If continuation sheet 145 of 267 ZE7D11

DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019	
			1		1 00/11/2013	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TTRICELL	HOUGE	COLUMB	A, NC 27925			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	IAIE DAIL	
				,		
D 358	Continued From page	e 145	D 358			
	#18 was to discontinu	ue theragram not Vitamin				
	D3.	ic theragram not vitamin				
		Resident #18's PCP (as she				
	pointed at the post it	`				
	discontinue the Vitam	•				
		order written to discontinue				
	the Vitamin D3 for Re					
		ct Resident #18's PCP for				
	clarification.					
	-She expected verbal	orders to be written when				
	•	r faxed to the provider to				
	sign.	·				
	Interview with the Exe	ecutive Director (ED) on				
	05/09/19 at 5:55 pm r	revealed:				
	-At the end of each sh	nift the medication aides				
	(MAs) pulled a medic	ation administration				
		check for missed medication				
	administration to resid					
	-If missed medication					
		and CM or ED would be				
	notified.					
		ne where orders were pulled				
	•	eMAR and medications in				
	the medication cart.					
	Telephone interview v	vith Resident #18's PCP on				
	05/10/19 at 4:48 pm r					
	-	ner requesting an order to				
	discontinue Resident	. •				
		ther provider wanted the				
	Vitamin D3 discontinu	•				
		order to discontinue the				
	_	she did not write the order				
	for Resident #18.					
	-Another provider for	Resident #18 at her office				
	=	tamin D3 and would not be				
	back to the facility un					

Division of Health Service Regulation

-Vitamin D3 deficiency could worsen and cause a decrease in the metabolism and bone health in

STATE FORM E899 ZE7D11 If continuation sheet 146 of 267

Division (of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
TYPPELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	SIA, NC 27925			
(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 SHOULI CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 146	D 358			
	the elderlyShe expected the fact writtenIf a provider gave ord medication that was a she expected the fact provider for clarification the order. b. Review of Residen 07/13/18 revealed dia hypertension, heart or dementia in chronic s Review of Resident # 01/02/19 revealed an units take 2 tablets (8 is a vitamin supplement absorb calcium and preat and prevent bon of the 11 05/19/19 revealed: -The medication aide D3 400 unit tablet into cupResident #19 was act 400 unit tablet. Interview with the MA revealed: -Resident #19 should two Vitamin D3 400 unit did not look at the medication card or on #19's Vitamin D3.	ders to discontinue a ordered by another provider, lity to call the ordering on instead of discontinuing of the second of discontinuing of the				
	_	ent #19 and administered				

Division of Health Service Regulation

-She normally would read the medication

STATE FORM E899 ZE7D11 If continuation sheet 147 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
0/0/15	SHIMMADV ST.	ATEMENT OF DEFICIENCIES	A, NC 27925	PROVIDER'S PLAN OF CORRECTION	NI I	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 147	D 358			
	directions on the med- She would tell the Ca Executive Director (E administered the corr- She was not sure if s #19's primary care pri dose of Vitamin D3. Interview with the CM revealed: -She expected the Ma soon as a medication -She expected the Ma as orderedShe would inform Re resident did not receively Vitamin D3. Interview with the ED revealed: -She expected the Ma compare the eMAR to times before administ residents to ensure the medication, dose, rou administeredShe expected the Ma or ED of medication e -At the end of each sh medication administration check for missed medication discovered the PCP, notifiedCart audits were don and compared to the	dication card and eMAR. are Manager (CM) or the D) Resident #19 was not ect dose of Vitamin D3. The would notify Resident ovider (PCP) of the incorrect I on 05/09/19 at 1:07 pm A to inform the CM or ED as error was noted. A to administer medications asident #19's PCP the we the correct dose of On 05/09/19 at 5:55 pm A's to review the eMAR and of the medication card three the correct resident, ate, and time was A to notify the PCP, and CM errors. The main the main to the fire compliance report to dication administration to				
	notifiedCart audits were don	e where orders were pulled				

Division of Health Service Regulation

Telephone interview with Resident #19's PCP on

STATE FORM E899 ZE7D11 If continuation sheet 148 of 267

AND DI AN OF CORDECTION IDENTIFICATION NUMBER:	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: I	(X3) DATE SURVEY	
AND FLAN OF CONNECTION DENTIFICATION NOWIGEN. A. BUILDING:	E I E D	
HaI089002 B. WING	17/2040	
Hal089002 B. WING 05/	17/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
950 HWY 64 EAST		
TYRRELL HOUSE COLUMBIA, NC 27925		
(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	COMPLETE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE	DATE	
DEFICIENCY)		
D 358 Continued From page 148 D 358		
05/45/40 at 4.40 are accepted Withoutin DO		
05/15/19 at 4:40 pm revealed Vitamin D3 was		
ordered for Resident #19 due to previously		
documented low Vitamin D levels.		
2. Review of Resident #3's current FL-2 dated		
2. Review of Resident #3's current FL-2 dated 02/07/19 revealed:		
-Diagnoses included type 2 diabetes mellitus,		
infection and inflammatory reaction to left hip,		
acquired absence of left upper limb above elbow,		
hypertension, atherosclerotic heart disease,		
history of falling, history of healed traumatic		
fracture.		
Review of an electronic order dated 03/15/19 for		
Resident #3 revealed:		
-There was an order for Lasix 20mg take 1/2		
tablet daily for 10 days. (Lasix is a diuretic used to		
high blood pressure).		
-The quantity was 10 tablets.		
- The quantity was to tablets.		
Review of one of Resident #3's March 2019		
electronic Medication Administration Records		
(eMARs) revealed:		
-There was an entry for Lasix 20 milligrams (mg)		
take "1/2 tablet" daily for 10 days.		
-There was documentation Lasix was		
administered from 03/16/19 - 03/31/19.		
auministricu nom oo, no na - oo, o n na.		
Review of Resident #3's April 2019 eMAR		
revealed:		
-There was an entry for Lasix 20mg take "1/2		
tablet" daily for 10 days.		
-There was documentation Lasix was		
administered from 04/01/19 - 04/30/19.		
daministored from 04/01/10 - 04/00/10.		
Review of Resident #3's May 2019 eMAR		
revealed:		
-There was an entry for Lasix 20mg take "1/2		
tablet" daily for 10 days.		

Division of Health Service Regulation

-There was documentation Lasix was

STATE FORM E899 ZE7D11 If continuation sheet 149 of 267

Division o	of Health Service Regu	lation				
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
		COLUMB	IA, NC 27925			
(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 APPROFIDENCY)	D BE COMPLETE	
D 358	Continued From page	e 149	D 358			
	administered on 05/0	1/19.				
	Review of Resident #3's medications on hand on 04/29/19 revealed there was no Lasix available for administration.					
	facility's contracted ph 12:30 pm revealed: -Resident #3 did not h Lasix on file at the ph -They had never filled	with a pharmacist from the harmacy on 05/14/19 at have a current order for larmacy. If an order for Lasix for a admission date of 02/07/19.				
	Resident #3's previou 12:42 pm revealed: -Resident #3's had ar milligrams (mg) take days.	1/2 tablet daily (10mg) for 10 insed ten Lasix 20mg tablets 3/15/19. o Resident #3's Lasix				
	-Ten whole tablets of dispensed for Reside	sident #3's previous 9 at 3:32 pm revealed: Lasix 20mg tablets were int #3 on 03/15/19. rovider (PCP) wrote an order				
	eMAR for Resident #3	revealed: tering the Lasix order on the				

Division of Health Service Regulation

-The start date was "03/18/19" which was the

STATE FORM E899 ZE7D11 If continuation sheet 150 of 267

STATEMENT	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
			A, NC 27925			
(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 358	Continued From page	e 150	D 358			
	-She should have ent stop date for 03/28/19 -She entered a stop of #3's Lasix instead of She did not rememb #3's PCP of the extra administered to Resid daysThe MA would not have no 03/28/19 for Resid date on the eMAR be Interview with the Exe 05/14/19 at 1:00 pm r-She expected the MawrittenIt was unacceptable administered Lasix foorderedShe did not know whhave come fromThe CM should have Resident #3's Lasix a days from the start darkesident #3's son brigacilityThe CM would transithe eMAR when outsiresident medications.	date of 05/01/19 for Resident 03/28/19. er if she notified Resident days Lasix was dent #3 past the ordered 10 dave known to stop the Lasix lent #3 because of the ending 05/01/19. ecutive Director (ED) on revealed: A's to follow orders as Resident #3 was remore days than it was dere the extra Lasix would be entered the end date for s 03/28/19 which was 10 ate of 03/18/19. ought the Lasix to the cribe medication orders on ide facilities provided				
	on 03/28/19 because was 05/01/19. Telephone interview v PCP on 05/14/19 at 4	with Resident #3's current soon pm revealed:				
	Resident #3's Lasix o	rder because she did not				

Division of Health Service Regulation

order the Lasix.

-Resident #3 saw a previous provider that

STATE FORM E899 ZE7D11 If continuation sheet 151 of 267

DIVISION	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019
		Haloobooz	1		1 03/11/2013
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
TVDDELL	HOUSE	950 HWY 6	64 EAST		
TYRRELL	HOUSE	COLUMBI	A, NC 27925		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	LIATE DATE
			-	DEI IOIENOT)	
D 358	Continued From page	e 151	D 358		
		d no longer worked at the			
	PCP office.				
	2. Daview of Desider	t #Ole accorded to a detect			
		t #2's current FL-2 dated			
	02/05/19 revealed dia	high blood pressure, Vitamin			
	D deficiency, and pre-	•			
	D deliciency, and pre-	-ieilai disease.			
	a Review of Residen	t #2's current FL-2 dated			
	02/05/19 revealed an				
		Eq/15ml take 10mEq (7.5ml)			
		6 ounces of water or juice.			
	(Potassium Chloride i				
	•	tassium Chloride Liquid			
	•	ore taking to prevent mouth,			
	throat, and stomach in				
		,			
	Review of Resident #	2's March 2019 - May 2019			
	electronic medication	administration records			
	(eMARs) revealed:				
	-There was an entry of				
		0mEq/15ml Liquid take			
		outh every day - dilute in 6			
	ounces of water or jui				
		Liquid was documented as			
	•	7:00am from 03/01/19 -			
	05/14/19.				
	Observation of Decid	ant #Ola madiantiana			
		ent #2's medications on			
	hand on 05/09/19 at 4	4:25pm revealed: of Potassium Chloride			
	Liquid on hand.	or Folassium Cilionae			
	•	ottle dispensed on 04/14/19			
		still contained 30ml (a 4-day			
	supply).	Still Contained Sollii (a 4-day			
		ottle dispensed on 05/07/19			
		still contained 30ml (a 4-day			
	supply).	Still Contained Sollii (a 4-day			
	σαρριγ <i>)</i> .				

Division of Health Service Regulation

Interview with a medication aide (MA) on

STATE FORM E899 ZE7D11 If continuation sheet 152 of 267

DIVISION	n nealth Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		, ,	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED	
			P WING			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
		950 HWY	, ,	,		
TYRRELL	HOUSE		A, NC 27925			
		COLUMBI	A, NC 2/925			_
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	\ ' ' /	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		-
IAG			IAG	DEFICIENCY)		
						\dashv
D 358	Continued From page	e 152	D 358			
	05/09/19 at 4:25pm re	avealed:				
	·	tered Potassium Chloride				
		because it was scheduled				
		7:00am and she thought the				
		supposed to administer it.				
	-There was no other s					
	Chloride Liquid on ha					
		usually refuse medications				
	to her knowledge.					
	Interview with the Co.	ro Managar (CM) an				
	Interview with the Car					
	05/09/19 at 5:45pm re					
		ty the pharmacy would have				
		of Potassium Chloride Liquid				
		ad of a month's supply.				
		osed to administer the				
	Potassium Chloride a					
		y the supplies of Potassium				
	Chloride Liquid on ha					
	administered to the re					
	-She would check with	h the MAs and the				
	pharmacy.					
		sident #2's primary care				
	. ,	otassium Chloride Liquid				
	had not been adminis	stered as ordered.				
	A accordints wis	ith the CM on 05/42/40 at				
		ith the CM on 05/13/19 at				
	4:12pm revealed:	iniatored modications to the				
		inistered medications to the				
	residents.	d the Detection Obleside				
		d the Potassium Chloride				
	•	but could not recall the last				
	time.	o Detection Objected Lieutid				
	•	ne Potassium Chloride Liquid				
		the resident to drink when				
		medications or when the				
	resident was eating b					
		osed to follow instructions				
	and mix the Potassiur	m Chloride Liquid in water or				

Division of Health Service Regulation

juice for administration.

STATE FORM E899 ZE7D11 If continuation sheet 153 of 267

ווטופועום	i Health Service Regu				(X3) DATE SURVEY	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019	
		1101003002			03/11/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TTKKLLL	HOUSE	COLUMB	IA, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (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 APPROPF DEFICIENCY)	RIATE DATE	
			_	- ,		
D 358	Continued From page	e 153	D 358			
	-The resident usually	drank all of it and had not				
	refused it to her know					
	-She notified Residen	nt #2's PCP on Friday,				
	05/10/19, about the P	otassium Chloride Liquid				
	not being administere					
	-	on 05/10/19 to check the				
	resident's potassium	level.				
	·					
	A second observation	of Resident #2's				
	medications on hand	on 05/13/19 at 5:55pm				
	revealed:					
	-The 2 bottles of Pota	assium Chloride Liquid that				
	were dispensed on 04	4/14/19 and 05/07/19 were				
	still on hand.					
	-Both of the bottles st	ill contained 30ml of 30ml				
	and none had been u	sed.				
	-There was no other s	supply of Potassium				
	Chloride Liquid on ha	nd for Resident #2.				
	A third interview with	the CM on 05/13/19 at				
	5:55pm revealed:					
	-She was not aware s	staff had not administered				
	any Potassium Chlori	de Liquid from 05/09/19 -				
	05/13/19.					
		osed to administer the				
	Potassium Chloride a					
	-She would check wit					
	because they would be					
	administering it since	it was scheduled for				
	7:00am.					
	Intension with	nd MA on 05/44/40 -+				
		nd MA on 05/14/19 at				
	9:25am revealed:					
		esident #2's Potassium				
		morning before third shift				
	ended at 7:00am.	15 () 011				
		d Potassium Chloride Liquid				
		ttle on Friday, 05/10/19.				
	- I here was a "little" li	quid left in the white bottle				

Division of Health Service Regulation

after that last dose she administered.

STATE FORM E899 ZE7D11 If continuation sheet 154 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
		COLUMBI	A, NC 27925			
(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 358	Continued From page	e 154	D 358			
	-After that, she was o	off for 3 days.				
		not in the medication cart				
		e a dose that morning (on				
		nall 30ml bottle in the cart.				
		ne she had used the small				
	brown bottle.					
		red the Potassium Chloride				
	=	red it to the resident without				
	diluting it.	the instructions on the				
		n label to mix and dilute the				
	Potassium Chloride w					
		swallow the medication and				
		rimace when taking it.				
		mentia and she had not				
	refused the Potassiur	m Chloride to her				
	knowledge.					
	Telephone interview v	with a third MA on 05/15/19				
	at 10:05pm revealed:					
		on third shift and she did not				
		nistering Potassium Chloride				
	Liquid to Resident #2	a white or brown bottle in				
	_	#2 but she could not recall				
	when she saw it.	Dat one codia not recail				
		if Potassium Chloride Liquid				
	was "popping" up on					
		n why she documented the				
		iquid as administered on the				
	eMAR when she never	<u> </u>				
		oo much" with one MA				
	_	tions for the whole facility.				
		ck and forth between the				
	-	U) and the assisted living				
	(AL), "something will	DE 111155EU.				
	Telephone interview v	with a pharmacist at the				
		harmacy on 05/15/19 at				

Division of Health Service Regulation

2:13pm revealed:

STATE FORM E899 ZE7D11 If continuation sheet 155 of 267

Division of	Health Service Regul	lation				
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPLI	
		Hal089002	B. WING		05/1	7/2019
NAME OF PRO	OVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	E, ZIP CODE		
TYRRELL H	OUSE	950 HWY	64 EAST			
		COLUMB	SIA, NC 27925			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 358 (Continued From page	: 155	D 358			
- the control of the	Liquid medications what to be reordered by dispensed. There was 473ml (a of 2's Potassium Chlorid 12/05/18. The facility did not recounty of 12/05/18. The facility did not recounty of 12/05/19. The facility did not recounty of 12/05/13/19. The facility did not recounty of 12/05/13/19. The facility did not recounty of 12/05/13/19. There was 225ml (a standard of 13/19). There was not sure whom 2 occasions unless was keyed into the synchon Potassium Chlorid of 13/19. The of 13/19 of 13/19 of 13/19 of 13/19. There were 3 bottles be on 13/15/19 of 13/19. There were 3 bottles be on 13/15/19 of 13/19. The 30ml bottle dispersion of 13/15/19. The 30ml bottle dispersion of 13/15/19.	rere not on a cycle fill and by the facility for refills to be 63-day supply) of Resident ide Liquid dispensed on equest another refill until ths later. -day supply) dispensed on equest another refill until ks later. -day supply) dispensed on equest another refill until ks later. -day supply) dispensed on equest another refill until for ano				

(a 30-day supply).

that had not been used and still contained 225ml

Interview with a fourth MA on 05/15/19 at 3:35pm

STATE FORM E899 ZE7D11 If continuation sheet 156 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6			
		COLUMBIA	, NC 27925		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	8 Continued From page 156		D 358		
	revealed: -She had never admit Liquid to Resident #2 worked first shift and that shiftThe MAs were responsed register in the period of the	nistered Potassium Chloride because she usually it was not administered on ensible for ordering were supposed to fax any			
		ns, interviews, and record ined Resident #2 was not			
	05/15/19 at 10:00am -Resident #2 was ord Liquid prior to establis January 2019Potassium Chloride I should be diluted for a -He was "surprised" ti it without it being dilut -Facility staff notified resident had not rece ordered.	ered Potassium Chloride			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 157 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
0/0.15	SHIMMADV ST	ATEMENT OF DEFICIENCIES	IA, NC 27925	PROVIDER'S PLAN OF CORRECTION	N OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	8 Continued From page 157		D 358			
	-He saw the resident (05/14/19) and decide Potassium Chloride L without it to see how l	ed to discontinue the iquid and try the resident				
	Review of Resident #2's labwork dated 05/10/19 revealed the resident's potassium level was 4.0, within normal limits (reference range 3.4 - 4.4). Review of Resident #2's physician's order dated 05/14/19 revealed an order to discontinue Potassium Chloride. b. Review of Resident #2's current FL-2 dated 02/05/19 revealed an order for Omeprazole 20mg 1 capsule twice daily. (Omeprazole is used to treat and prevent acid reflux.)					
	Omeprazole to once a was associated with \ magnesium levels, inc Clostridium difficile in -The primary care pro recommendation and	ed 04/05/19 revealed: mmended to decrease a day due to high dose use //itamin B12 deficiency, low creased incidence of fections and pneumonia. vider (PCP) accepted the				
	medication administrative revealed: -There was an entry for capsule twice daily so at 7:00am and 7:00pm	or Omeprazole 20mg 1 heduled for administration				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 158 of 267

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
		COLUMB	A, NC 27925			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 158		D 358			
	twice daily from 04/01/19 - 04/30/19The order dated 04/30/19 to decrease Omeprazole 20mg to once daily was not listed on the eMAR.					
	capsule twice daily so at 8:00am and 8:00pr -Omeprazole was door twice daily from 05/01 -The order dated 04/3 Omeprazole 20mg to the eMARThe resident continuous omeprazole 20mg two daily as ordered on 04 Interview with a media 05/09/19 at 4:25pm re-Resident #2's Omepratore a day because the eMARShe was not aware to	or Omeprazole 20mg 1 cheduled for administration n. cumented as administered /19 - 05/08/19. 60/19 to decrease once daily was not listed on ed to be administered ice daily instead of once 4/30/19. cation aide (MA) on evealed: razole was administered chat was how it "popped" on				
	pharmacy recommen- -She could not recall order dated 04/30/19 Omeprazole to the ph	re Manager (CM) on evealed: for faxing any orders from dations to the pharmacy. if she faxed Resident #2's to decrease the earmacy. pharmacy entered any new es onto the eMAR.				

system.

system on 03/25/19, the CM was the only staff at the facility who could enter orders into the eMAR

STATE FORM 6899 If continuation sheet 159 of 267 ZE7D11

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY	64 EAST		
		COLUME	BIA, NC 27925		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 159	D 358		
	-She did not know why Resident #2's order for Omeprazole 20mg once a day was not entered into the eMAR system. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -The most current order the pharmacy had on file for Resident #2's Omeprazole was dated 01/02/19 with instructions for twice a day.				
		received the order dated the Omeprazole to once			
	Telephone interview with Resident #2's PCP on 05/15/19 at 10:00am revealed: -He was not aware Resident #2's Omeprazole				
	ordered on 04/30/19He expected the faci	decreased to once a day as lity to implement the order			
	doses of Omeprazole	nat prolonged use of high could cause issues such as t could interfere with bone			
Based on observation		ns, interviews, and record ined Resident #2 was not			
	c. Review of Resident #2's current FL-2 dated 02/05/19 revealed an order for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime. (Carafate Oral Suspension is used to treat and prevent stomach ulcers.)				
	Review of Resident # medication administra	2's March 2019 electronic ation record (eMAR)			

Division of Health Service Regulation

revealed:

STATE FORM E899 ZE7D11 If continuation sheet 160 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUF COMPLET	
TYRRELL HOUSE 950 HWY 64 EAST COLUMBIA, NC 27925 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 100 PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			Hal089002	B. WING		05/17/	/2019
TYRRELL HOUSE COLUMBIA, NC 27925 (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 COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PRO	VIDER OR SUPPLIER			TE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	TYRRELL HO	OUSE					
	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
There was an entry for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime with scheduled administration times of 7:00am, 12:00pm, 5:00pm, and 8:00pm. -Carafate was documented as administered 4 times a day from 03/01/19 - 03/31/19 for a total of 124 doses (or 1,240ml). Review of Resident #2's April 2019 eMAR revealed: -There was an entry for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -Carafate was documented as administered 4 times a day from 04/01/19 - 04/30/19 for a total of 120 doses (or 1,200ml). Review of Resident #2's May 2019 eMAR revealed: -There was an entry for Carafate 1gm/10ml Oral Suspension, take 10ml (1gm) with meals and at bedtime with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -Carafate was documented as administered 4 times a day from 05/01/19 - 05/13/19 (5:00pm) for a total of 51 doses (or 510ml). Observation of Resident #2's medications on hand on 05/15/19 at 3:35pm revealed: -There were three 420ml bottles of Carafate Oral Suspension (total of 1,260ml) dispensed on 05/02/19. -Bottles 2 of 3 and 3 of 3 were unopened and each contained 420ml for a total of 840ml. -Bottle 1 of 3 contained approximately 300ml out of 420ml. -Approximately 120ml (a 3-day supply) had been used from the 1,260ml dispensed on 05/02/19.	Sb 57 - Citin 1 R resident 1 R	There was an entry for Suspension, take 10 moved time with schedule 7:00 am, 12:00 pm, 5:00 Carafate was documines a day from 03/01/24 doses (or 1,240 moved times and entry for Suspension, take 10 moved time with schedule 3:00 am, 12:00 pm, 5:00 Carafate was documines a day from 04/01/20 doses (or 1,200 moved times and the schedule 3:00 am, 12:00 pm, 5:00 Carafate was an entry for Suspension, take 10 moved time with schedule 3:00 am, 12:00 pm, 5:00 Carafate was an entry for Suspension, take 10 moved time with schedule 3:00 am, 12:00 pm, 5:00 Carafate was documines a day from 05/00 cor a total of 51 doses 2:00 cor a to	or Carafate 1gm/10ml Oral not (1gm) with meals and at ed administration times of (10pm, and 8:00pm. ented as administered 4 (11/19 - 03/31/19 for a total of not). 2's April 2019 eMAR or Carafate 1gm/10ml Oral not (1gm) with meals and at ed administration times of (10pm, and 8:00pm. ented as administered 4 (11/19 - 04/30/19 for a total of not). 2's May 2019 eMAR or Carafate 1gm/10ml Oral not (1gm) with meals and at ed administration times of (10pm, and 8:00pm. ented as administered 4 (11/19 - 05/13/19 (5:00pm)).	D 358			

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 161 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E. ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
			64 EAST	,		
TYRRELL	HOUSE	COLUME	BIA, NC 27925			
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
D 358	Continued From page 161		D 358			
	Suspension and did r was workingShe did not know whof Carafate Oral Suspension and they refill requests to the p-When liquid medications.	evealed: took the Carafate Oral not refuse it when the MA by there was an oversupply bension on hand. and MA on 05/15/19 at rafate Oral Suspension and a she was working. run out of Carafate Oral busible for ordering a were supposed to fax any				
	of Carafate Oral Susp Resident #2Resident #2 did not a medications to her kn -The MAs were support Carafate Oral Susper -She would check with pharmacy about the Oral Telephone interview of facility's contracted platesLiquid medications was	evealed: ny there was an oversupply pension on hand for refuse to take any lowledge. posed to administer the losion as ordered.				

Division of Health Service Regulation

dispensed.

-There were 420ml (a 10.5-day supply) of

STATE FORM E899 ZE7D11 If continuation sheet 162 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
					05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	950 HWY (DRESS, CITY, STA BAFAST	TE, ZIP CODE		
TYRRELL	HOUSE		A, NC 27925			
(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 358	Continued From page	e 162	D 358			
	Resident #2's Carafard dispensed on 01/02/11 -There were 420ml (a on 01/16/19) -There were 420ml (a on 01/27/19) -The facility did not re 02/27/19, 30 days late -There were 1,260ml dispensed on 02/27/11 -The facility did not re 05/02/19, over 2 mon -There were 1,260ml on 05/02/19No Carafate Oral Surequested or dispense because any back-up through the contracte Observations, intervier regarding Resident #2-There were 3,780ml Suspension dispense which was a 94.5-day period)There were approxing supply) used during the about half of the amount as ordered at 10ml 4 Telephone interview we care provider (PCP) or revealed: -He was not aware Resuspension was not broderedHe could evaluate the	te Oral Suspension 9. 10.5-day supply) dispensed 10.5-day supply) dispensed 10.5-day supply) dispensed 10.5-day supply) dispensed 10.5-day supply) until 10.5-day supply) 9. 10.5-day supply) 10.				

Division of Health Service Regulation

the Carafate.

STATE FORM E899 ZE7D11 If continuation sheet 163 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURY	
		Hal089002	B. WING		05/17/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
	COLUMBI					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 163	D 358			
	Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable.					
	03/06/19 revealed: -Diagnoses included corpus collosum, hyp hypoosmolality, hypo major depression, ins-There was an order daily. (Ellipta is used pulmonary disease (CReview of Resident #medication administratevealed: -There was an entry fidailyThere was document	4's March 2019 electronic				
	dailyThere was documen	4's April 2019 eMAR for an Ellipta inhaler one puff tation the Ellipta inhaler was /01/19 through 04/30/19.				
	dailyThere was documen administered daily 05 on 05/08/19.	tation the Ellipta inhaler was /01/19 through 05/06/19 and tation the Ellipta inhaler was /05/07/19 because the				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 164 of 267

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		Hal089002	B. WING		05/17/2019
		Па1009002			05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TVDDELL		950 HWY	64 EAST		
TYRRELL HOUSE COLUMBIA		A, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	AG REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPE	IATE DATE
			1	DEFICIENCY)	
D 358	Continued From page	e 164	D 358		
	. •				
	revealed:	nt #4 on 05/16/19 at 3:35pm			
		last week" without her			
	Ellipta inhaler.	last week without her			
	-She had "really bad"	COPD			
		orked well at controlling her			
	symptoms most of the				
		ne Ellipta inhaler then she			
		rol inhaler. (Albuterol is used			
	to treat asthma symp				
	• •	e needed the Albuterol			
	inhaler after taking the				
	•	·			
		ations on hand for Resident			
	#4 on 05/10/19 at 11:				
	 There was no Ellipta resident. 	inhaler on hand for the			
	-There was an Albute	rol inhaler with a			
	prescription label with	Resident #4's name and			
		uffs every four hours as			
	needed for shortness	of breath.			
	Interview with the me	` ,			
	05/11/19 at 11:21am				
	•	inhaler was on order from			
	the pharmacy.	en the inhaler had been			
	ordered.	ien the inhaler had been			
		le for requesting medication			
	refills when there was				
	remaining.				
		ve the sticker from the			
		e the sticker on the refill			
		the sheet to the pharmacy.			
	•	vith a MA on 05/15/19 at			
	9:40pm revealed:				
		inhalers in addition to the			
	Ellipta, Spiriva and ar	nother in a "red box" that she	1		

Division of Health Service Regulation

gave the resident whenever the Ellipta was not

STATE FORM E899 ZE7D11 If continuation sheet 165 of 267

			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TVDDELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUMB	IA, NC 27925			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page 165		D 358			
	available. (Spiriva is usethma)Resident #4 would a inhalers if the Ellipta vone of the other two Resident #4 on 05/08 Telephone interview vone facility's contracted place 2:00pm revealed: -The Ellipta inhaler foordered on 03/07/19The pharmacy dispee Ellipta for Resident #4 Review of a Medication 03/01/19 for Resident -The resident was addinhaler on admission.	sk for one of the two was not available. inhalers was what she gave i/19. with the Pharmacist from the harmacy on 05/15/19 at r Resident #4 was originally nsed a 30 day supply of 4 on 03/07/19 and 05/09/19. on Release form dated t #4 revealed: mitted with one Ellipta				
	puffs every four hours shortness of breath (\$03/06/19. Review of Resident # revealed: -There was an entry f puffs every four hours -There was no docum inhaler was administed 05/08/19There was document	: for Spiriva. for an Albuterol inhaler two s and needed (PRN) for SOB)/wheezing dated				

Division of Health Service Regulation

05/08/19 at 5:46pm.

STATE FORM E899 ZE7D11 If continuation sheet 166 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		Hal089002	B. WING		05	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
		950 HWY	64 EAST			
TYRRELL	HOUSE	COLUME	BIA, NC 27925			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	358 Continued From page 166		D 358			
	05/09/19 for Resider documentation abou	otes dated 03/01/19 through ht #4 revealed there was no t the resident's Ellipta inhaler.				
	Telephone interview with Resident #4's primary care provider (PCP) on 05/15/19 at 9:55am revealed: -The Ellipta inhaler was used to treat asthma and COPD.					
	prescribed because medication.					
	 -A controller medication was used to keep symptoms from occurring verses a rescue medication (Albuterol) which was used to control symptoms that were present. -Not taking the Ellipta inhaler as prescribed could 					
	cause symptoms to a	arise.				
	3:44pm revealed:	Iministrator on 05/17/19 at				
	her Ellipta inhaler for administered in place					
	medications when th supply left.	onsible for reordering ey saw there was a week's				
		request to the pharmacy.				
	ordered for 2 of 11 remedication passes a for record review. R	administer medications as esidents observed during the and 3 of 10 sampled residents esident #3 was administered (5 whole tablets) of Lasix				
	#2 was administered amount of Potassium the dosage ordered	without an order. Resident I approximately 40% of the Chloride Liquid needed for from 12/05/18 - 05/15/19, at risk for low potassium				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 167 of 267

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY 6	4 EAST			
TYRRELL	HOUSE		A, NC 27925			
24.0.15	CLIMMA DV CT	ATEMENT OF DEFICIENCIES	,		1 000	\dashv
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page 167		D 358			
	levels. Resident #2 wapproximately 50% of Oral Suspension need from 01/01/19 - 05/15 risk for stomach ulcer inhaler was unavailable least 4 days in May 2 risk of exacerbation of associated with asthmoulmonary disease. administer medication detrimental to the heat the residents and contract of the facility provided a accordance with G.S.	vas administered If the amount of Carafate ded for the dosage ordered If 19, putting the resident at Its. Resident #4's Ellipta Dele for administration for at 019, putting the resident at If breathing problems In and chronic obstructive In failure of the facility to Ins as ordered was In alth, safety, and welfare of Institutes a Type B Violation. In plan of protection in In 131D-34 on 05/16/19.				
D 367	(j) The resident's merecord (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa administered; (4) instructions for ad or treatment; (5) reason or justifical medications or treatm	Medication Administration dication administration e accurate and include the cation or treatment order; age or quantity of medication ministering the medication tion for the administration of nents as needed (PRN) and alting effect on the resident; dministration;	D 367			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 168 of 267

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Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		Hal089002	B. WING		0:	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ITRKELL	. HOUSE	COLUME	BIA, NC 27925			
(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 367	omission, including re (8) name or initials of the medication or trea signature equivalent documented and mai administration record	nents and the reason for the efusals; and, the person administering atment. If initials are used, a to those initials is to be ntained with the medication (MAR).	D 367			
	reviews, the facility farmedication administrator 2 of 5 residents satinaccurate document supplement (#2), an iobstructive pulmonar	illed to assure the ation records were accurate ampled (#2, #4) including ation of a liquid potassium				
	02/05/19 revealed: -Diagnoses included blood pressure, Vitan pre-renal diseaseThere was an order Liquid 20mEq/15ml taday, dilute in 6 ounce (Potassium Chloride potassium levels.)	for Potassium Chloride ake 10mEq (7.5ml) once a s of water or juice.				

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 169 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE ZIP CODE	1 00/11/2010	
			64 EAST	1., 2 0002		
TYRRELL	HOUSE	COLUMB	BIA, NC 27925			
(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	Ξ
D 367	Continued From page 169		D 367			
	7.5ml (10mEq) by mo ounces of water or juingly administered daily at 05/14/19. Observation of Reside hand on 05/09/19 at 4-There were 2 bottless Liquid on hand. -There was a 30ml bottlest hand not been used (a 4-day supply). -There was a 30ml bottlest hand not been used (a 4-day supply).	OmEq/15ml Liquid take buth every day - dilute in 6 ce. Liquid was documented as 7:00am from 03/01/19 -				
	05/09/19 at 4:25pm re-She did not administ Liquid to Resident #2 to be administered at were supposed to adreshe did not know whadministering Potassi occasions in April 20° administered it. Interview with the Car 05/09/19 at 5:45pm re-The MAs were not some dication was administered -She did not know what the Potassium Chloric	er Potassium Chloride because it was scheduled 7:00am and third shift MAs minister it. by she documented um Chloride Liquid on 3 19 since she had not re Manager (CM) on evealed: upposed to document a nistered on the eMAR if it by the the MAs documented de Liquid was administered up medication was still on				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 170 of 267

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S COMPLE		
		Hal089002	B. WING	B. WING		05/17/2019	
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STA		1 05/1	7/2019	
		950 HWY (, ,	TE, ZIP CODE			
TYRRELL	HOUSE		A, NC 27925				
(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	(X5) COMPLETE DATE	
D 367	Continued From page	e 170	D 367				
D 367	A second observation medications on hand revealed: -The 2 bottles of Pota were dispensed on 04 still on hand. -Both of the bottles st and none had been used. -There was no other stand choride Liquid on hand. A second interview with 5:55pm revealed: -She was not aware stany Potassium Chloride of the eMAR. -The MAs had been the on the eMAR and the document a medication of administered. Interview with a second 9:25am revealed: -She administered Recultary Chloride Liquid every ended at 7:00am. -She last administered that morning on 05/14. -She did not administ Liquid over the past work off and did not work. -She had not noticed eMAR and medication Potassium Chloride Leven though she init Potassium Chloride Leven thoug	assium Chloride Liquid that 4/14/19 and 05/07/19 were till contained 30ml of 30ml used. Supply of Potassium and for Resident #2. The CM on 05/13/19 at staff had not administered ide Liquid from 05/09/19 - anted it as administered on the rained on how to document by were not supposed to on was administered if it was administered it was administered it was administe	D 367				

Division of Health Service Regulation

Telephone interview with a third MA on 05/15/19

STATE FORM E899 ZE7D11 If continuation sheet 171 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 (A) ID PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (CONTINUED FROM THE APPROPRIATE DATE D 367 Continued From page 171 at 10:05pm revealed: -She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -There was 47sml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 04/14/19There was 30ml (a 4-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/07/19, -There was 225ml (a 30-day supply) dispensed on 05/07/19, -No Potassium Chloride Liquid had been	STATEMENT	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TYRRELL HOUSE 950 HWY 64 EAST COLUMBIA, NC 27925 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 367 Continued From page 171 at 10:05pm revealed: -She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -There was 473ml (a 63-day supply) of Resident #2/S Potassium Chloride Liquid dispensed on 12/05/18There was 30ml (a 4-day supply) dispensed on 04/14/19There was 225ml (a 30-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19).			Hal089002	B. WING		05/17/2019	
TYRRELL HOUSE COLUMBIA, NC 27925 (X4) ID PREFIX TAGE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE COMPLETE COMPLET	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
COLUMBIA, NC 27925 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 367 Continued From page 171 at 10:05pm revealed: -She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -There was 473ml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 04/14/19There was 30ml (a 4-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19).	TYRRELL	HOUSE	950 HWY 6	4 EAST			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 367 Continued From page 171 at 10:05pm revealed: -She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2. -She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -There was 473ml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 04/14/19. -There was 30ml (a 4-day supply) dispensed on 05/07/19. -There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19).		Г		A, NC 27925			
at 10:05pm revealed: -She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -There was 473ml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 12/05/18There was 30ml (a 4-day supply) dispensed on 04/14/19There was 30ml (a 4-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19).	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
-She usually worked on third shift and she did not remember ever administering Potassium Chloride Liquid to Resident #2She could not explain why she documented the Potassium Chloride Liquid as administered on the eMAR on 21 occasions from March 2019 - May 2019 when she never administered any. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/15/19 at 2:13pm revealed: -There was 473ml (a 63-day supply) of Resident #2's Potassium Chloride Liquid dispensed on 12/05/18There was 30ml (a 4-day supply) dispensed on 04/14/19There was 30ml (a 4-day supply) dispensed on 05/07/19There was 225ml (a 30-day supply) dispensed on 05/13/19 (delivered on 05/14/19).	D 367	Continued From page	e 171	D 367			
dispensed by the back-up pharmacy because any back-up request had to be processed by the contracted pharmacy. A third observation of Resident #2's medications on hand on 05/15/19 at 3:35pm revealed: -There were 3 bottles of Potassium Chloride Liquid on hand. -The 30ml bottle dispensed on 04/14/19 had not been used and still contained 30ml (a 4-day supply). -The 30ml bottle dispensed on 05/07/19 had 15ml (a 2-day supply) remaining. -There was a 225ml bottle dispensed on 05/13/19 that had not been used and still contained 225ml		at 10:05pm revealed: -She usually worked or remember ever admir Liquid to Resident #2 -She could not explain Potassium Chloride LeMAR on 21 occasion 2019 when she never Telephone interview of acility's contracted pt 2:13pm revealed: -There was 473ml (a #2's Potassium Chlori 12/05/18There was 30ml (a 4 04/14/19There was 30ml (a 4 05/07/19There was 225ml (a on 05/13/19 (delivered)-No Potassium Chlori dispensed by the bact back-up request had contracted pharmacy. A third observation of on hand on 05/15/19There were 3 bottles Liquid on handThe 30ml bottle dispensed and still consupply)The 30ml bottle dispensed on the supply)There was a 225ml between the supply) remains a 225ml between the supply) remains a 225ml between was a 225ml betwee	on third shift and she did not histering Potassium Chloride in why she documented the iquid as administered on the ns from March 2019 - May administered any. With a pharmacist at the narmacy on 05/15/19 at 63-day supply) of Resident ide Liquid dispensed on day supply) dispensed on day supply) dispensed on 30-day supply) dispensed on 30-day supply) dispensed on 40-day supply) dispensed on 80-day supply) dispensed on 80				

Division of Health Service Regulation

Observations, interviews, and record reviews

STATE FORM E899 ZE7D11 If continuation sheet 172 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	B. WING		05/17/2019
NAME OF PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
TYRRELL HOUSE		64 EAST		
		BIA, NC 27925		
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES / 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 367 Continued From page	Continued From page 172			
regarding Resident #2 Liquid revealed: -There were 758ml dis 05/15/19, which was a 162-day time period)There were 488ml (a the 162-day time perio amount required if adir 7.5ml per dayThe MAs had docume administered from 03/ 488ml were used from rendering the eMARs Based on observation review, it was determi interviewable. 2. Review of Resident 03/06/19 revealed: -Diagnoses included of corpus collosum, hypor hypoosmolality, hypor major depression, inse -There was an order for daily. (Ellipta is used to pulmonary disease (C) Review of Resident #4 medication administrat revealed: -There was an entry for dailyThere was document administered daily 05/ on 05/08/19.	2's Potassium Chloride spensed from 12/05/18 - a 101-day supply (for a 65-day supply) used during od, only about 40% of the ministered as ordered at ented 562.5ml were 01/19 - 05/14/19 but only in 12/05/18 - 05/14/19, inaccurate. s, interviews, and record ned Resident #2 was not a #4's current FL-2 dated central demyelination of omagnesia, candidiasis, natremia, alcohol abuse, omnia and hypertension. or an Ellipta inhaler one puff to treat chronic obstructive cOPD) and asthma). 4's May 2019 electronic ation record (eMAR) or an Ellipta inhaler one puff teation the Ellipta inhaler was 01/19 through 05/06/19 and ation the Ellipta inhaler was	D 367		

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 173 of 267

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			71. 501251110.			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
TYRRELL	HOUSE		64 EAST			
			BIA, NC 27925			
(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	(X5) COMPLETE DATE
D 367	Continued From page	e 173	D 367			
	Interview with Reside revealed: -She went four days 'Ellipta inhalerShe had "really bad" -If she did not have thad to use her albute -There were times shinhaler even after tak Observation of medic #4 on 05/10/19 at 11: -There was no Ellipta residentThere was an albute prescription label with instructions for two puneeded for shortness Interview with the me 05/11/19 at 11:21am	ent #4 on 05/16/19 at 3:35pm "last week" without her "COPD. The Ellipta inhaler then she erol inhaler. The needed the albuterol ing the Ellipta inhaler. The stations on hand for Resident extra revealed: The inhaler on hand for the erol inhaler with a the Resident #4's name and ouffs every four hours as				
	9:40pm revealed: -Resident #4 had two Ellipta, "Spiriva" and a she gave the resident not available. (Spiriva asthma)Resident #4 would a inhalers if the Ellipta v -One of the other two Resident #4 on 05/08 Review of primary ca Resident #2 revealed -There was no order	was not available. inhalers was what she gave 8/19. re provider orders for l:				

Division of Health Service Regulation

puffs every four hours and needed (PRN) for

STATE FORM E899 ZE7D11 If continuation sheet 174 of 267

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/11/2010
TYRRELL	HOUSE	950 HWY 6			
		COLUMBIA	A, NC 27925		
(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 367	Continued From page	e 174	D 367		
	shortness of breath (SOB)/wheezing dated 03/06/19.				
	Review of Resident #4's May 2019 eMAR revealed:				
	-There was an entry for an albuterol inhaler two puffs every four hours PRN for SOB/wheezing.				
	-There was no documentation the albuterol inhaler was administered on the morning of 05/08/19.				
	-There was documentation the albuterol inhaler was administered on 05/03/19 at 4:17pm and 05/08/19 at 5:46pm.				
	Review of charting notes dated 03/01/19 through 05/09/19 for Resident #4 revealed there was no documentation about the resident's Ellipta inhaler.				
	Interview with the Adr 3:44pm revealed:	ministrator on 05/17/19 at			
	when a medication wa				
		to document in the progress bout any medication that			
	-MAs were expected	to document administering en they administered PRN			
D 392	10A NCAC 13F .1008	3(a) Controlled Substances	D 392		
	(a) An adult care hon retrievable record of odcumenting the recedisposition of controller records shall be main	Controlled Substances ne shall assure a readily controlled substances by eipt, administration and ed substances. These tained with the resident's n order that there can be n.			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 175 of 267

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		Hal089002	B. WING		0.5	5/17/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET /	ADDRESS, CITY, STATE	ZIR CODE	,	
WANE OF T	NOVIDEN ON GOLT EIEN		Y 64 EAST	, ZII OOBL		
TYRRELL	HOUSE	********	BIA, NC 27925			
(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 ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 392	Continued From page 175		D 392			
	reviews, the facility fa readily retrievable rec receipt, administration	ns, interviews and record iled to assure there was a cord documenting the				
	for accurate reconcilia residents (#4).	olam in the resident's record ation for 1 of 6 sampled				
	The findings are: Review of Resident #4's current FL-2 dated 03/06/19 revealed diagnoses included central demyelination of corpus collosum, hypomagnesia, candidiasis, hypoosmolality, hyponatremia, alcohol abuse, major depression, insomnia and hypertension.					
		4's Resident Register was admitted to the facility				
	03/06/19 revealed the Oxycodone 5mg ever	t #4's current FL-2 dated ere was an order y six hours as needed s a controlled substance				
		care provider (PCP) order led an order to discontinue				
		with the Pharmacist with the harmacy on 05/15/19 at				

Division of Health Service Regulation

STATE FORM STATE FORM ZE7D11 If continuation sheet 176 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
TYRRELL	HOUSE	950 HWY				
		COLUMB	A, NC 27925			
(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 392	Continued From page	e 176	D 392			
	2:00pm revealed: -The pharmacy did no Oxycodone 5mg table 03/01/19 through 03/3-There were no return Oxycodone 5mg. Review of a Medication 03/01/19 for Resident Oxycodone 5mg table the time the resident Review of Resident # medication administrative revealed: -There was an entry fisix hours PRNThere was documentablets were administ 6:42pm through 03/03	ot have an order for ets for Resident #4 dated 31/19. Ins to the pharmacy of on Release form dated at #4 revealed there were 106 ets released to the facility at was admitted. 4's March 2019 electronic ation record (eMAR) for Oxycodone 5mg every tation 40 Oxycodone 5mg ered from 03/01/19 at				
	#4 on 05/10/19 at 11: no Oxycodone 5mg to Review of an controlle	21am revealed there were ablets. ed substance "Inventory				
	entry for Oxycodone	19 revealed there was no 5mg tablets for Resident #4.				
	Upon request on 05/0 controlled substance for Oxycodone 5mg for 0 controlled substance	record available for review				
	(RCD) on 05/17/19 at	gional Clinical Director : 4:00pm revealed she tronic record for Oxycodone				
	Based on review of R	esident #4's 03/01/10				

Division of Health Service Regulation

Medication release form, March 2019 eMAR and

STATE FORM E899 ZE7D11 If continuation sheet 177 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY COLUMB	64 EAST IA, NC 27925		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 392	Continued From page	e 177	D 392		
	controlled substance the facility's contracte there was insufficient	records; and interview with d pharmacy's Pharmacist, documentation to he record for Oxycodone			
	Refer to interview with a medication aide (MA) on 05/10/19 at 11:21am.				
	Refer to interview with the Regional Clinical Director (RCD) on 05/17/19 at 4:00pm.				
	Refer to telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm.				
	Refer to interview with 05/17/19 at 3:44pm.	h the Administrator on			
	b. Review of a primary care provider (PCP) visit note dated 03/06/19 revealed an order for Oxycodone 10mg every six hours as needed (PRN). (Oxycodone is a controlled substance used to treat pain.)				
		er dated 03/13/19 revealed ne 10mg every six hours			
	Review of a PCP order an order for Oxycodo 12:00pm and 6:00pm	_			
	Review of a PCP order Resident #4 revealed 10mg every six hours	an order for Oxycodone			
	I	with the Pharmacist with the harmacy on 05/15/19 at			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 178 of 267

Division of Health Service Regulation			_				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
			1				
		11-100000	B. WING		05/17/2019		
		Hal089002			05/1	7/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
		950 HWY	64 EAST				
TYRRELL	HOUSE		IA, NC 27925				
			17, 110 27323				
(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	
1710		,	,,,,,	DEFICIENCY)			
D 392	Continued From page 178		D 392				
	2:00pm revealed:						
	•	r Oxycodone 10 mg was					
	dated 03/06/19.	respectable reing was					
		r Oxycodone 10mg was for					
		s not covered by Resident					
	#4's insurance.	o not obvered by reoldent					
	-The pharmacy dispe	insed 20 tablets of					
		03/12/19, 100 tablets on					
	04/16/19 and 120 tab						
		ns to the pharmacy of					
	Oxycodone 10mg.	is to the pharmacy of					
	Oxycodone forng.						
	Review of Resident #	4's March 2019 electronic					
	medication administra						
	revealed:	ation record (emart)					
		for Oxycodone 10mg every					
	six hours PRN pain.	of Oxycodone foring every					
		tation 26 Oxycodone 10mg					
		tered PRN from 03/19/19 at					
	11:45am through 03/2						
	•	for Oxycodone 10mg three					
	times daily.	ior exycoderic rorng times					
	•	tation 13 Oxycodone 10mg					
		tered from 03/27/19 at					
	6:00pm through 03/3						
	o.oopiii airougii ooro	iii to at o.oopiii.					
	Review of an controll	ed substance "Inventory					
	Report" dated 03/24/						
	-There were 63 Oxyc						
		ining for Resident #4.					
		ocument the original delivery					
	date and amount deli						
	date and amount den	VO. 04.					
	Review of a Controlle	ed Substance Report for					
		3/01/19 through 03/31/19					
	revealed:	70 17 19 till Ough 00/01/19					
		for Oxycodone did not					
		-					
		f the tablets (5mg or 10mg).					
	-There was no docum	• •					
	administration and dis	sposition of Oxycodone prior					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 179 of 267

PRINTED: 06/18/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6-	4 EAST ., NC 27925			
(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	(X5) COMPLETE DATE
D 392	were received on 03/2 -There were eight tab documented as being controlled substance 7:24am and 03/27/19 -There was documen order: one tablet adm 7:24am, one tablet wa one tablet administered two tablets wasted (g system) on 03/26/19 administered on 03/26 (given/working with no 9:22am and one table at 12:16pm. Review of Resident # revealed on 03/25/19 administered at 7:24a on 03/26/19 at 2:05pr 03/27/19 at 12:16pm The Care Manager (C (MA) who documente 03/25/19 through 03/2 interview on 05/16/19 Attempted telephone 9:41pm with a second discrepancy on 03/37 unsuccessful. Review of Resident # revealed: -There was an entry f times daily at 6:00am -There was documenter was documenter of the control of	tation 63 Oxycodone tablets 25/19 at 12:49am. Plets of Oxycodone administered on the report between 03/25/19 at at 12:16pm. Plets of 03/25/19 at at 12:16pm. Plets of 03/25/19 at at 12:16pm. Plets of 03/25/19 at asted/dropped at 5:44pm, Plets of 03/26/19 at 2:05pm, Plets of 03/27/19 at 2:05pm, Plets of 03/	D 392			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 180 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COWII ELTED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
			IA, NC 27925			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE COMPLE	ETE
D 392	Continued From page	e 180	D 392			
	6:00amThere was an entry f six hours at 12:00am. 6:00pmThere was documen tablets were administ 04/04/19 at 12:00pm Review of Resident # revealed: -There was an entry f six hours at 12:00am. 6:00pmThere was documen	for Oxycodone 10mg every , 6:00am, 12:00pm and tation a total of 35 llets were administered from				
	Review of a Controlle Resident #4 dated 04 revealed: -The documentation of specify the dosage of -There was documen were received on 04/1-0n 04/10/19 at 3:52 documented two Oxy -The MA and CM documedication was alreadiscontinuedThe MA and the CM comment section "sysgiven." -There was document	com, a MA and the CM codone tablets were wasted. Sumented the reason was the dy prepped but was documented in the stem issues, medication tation 100 Oxycodone on 04/17/19 at 2:54pm.				
	Attempted interview of	on 05/16/19 at 9:41pm with				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 181 of 267

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: _	A. BUILDING:		EIED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
		COLUMBIA	A, NC 27925			
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	D 392 Continued From page 181		D 392			
	the MA who documen	nted the 04/10/19 waste of				
	two Oxycodone tablet					
	Observation of medic	ations on hand for Resident				
	#4 on 05/10/19 at 11:	21am revealed:				
	· ·	pack with a pharmacy label				
	for Oxycodone 10mg	44's name and instructions every six hours.				
	-The pharmacy label	indicated 120 tablets were				
	dispensed on 04/16/19, and there were 6 tablets remaining.					
	Interview with Reside revealed:	nt #4 on 05/16/19 at 3:35pm				
		g of Oxycodone prior to				
	coming to the facility i					
	Oxycodone 5mg table	y the prior facility sent ets.				
	-At the prior facility, so	ometimes she was given				
	two 5mg tablets of Ox 10mg tablets.	kycodone if there were no				
	Second interview with 3:04pm revealed:	n Resident #4 on 05/17/19 at				
		running out of Oxycodone				
	since March 2019.	lifer in March 2040 with				
	-She came to the faci "bunch" of Oxycodone	lity in March 2019 with a e tablets.				
		he Oxycodone was 5mg,				
	10mg, or both.					
	-	vith Resident #4's PCP on				
	05/15/19 at 9:55am re					
	management.	used for chronic pain				
	-He did not know of a	ny requests for prescription				
		the ordinary for Resident				
	#4. -He did not know of a	ny missed dosages of pain				
	medication for Reside					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 182 of 267

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D. MINIC			
		Hal089002	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
TYRRELL HOUSE 950 HWY						
	CLIMMADY CT		SIA, NC 27925	DDOWNERIC PLAN OF CORRECTION		
(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 392	Continued From page	e 182	D 392			
	Medication release for 2019 eMARs and correct and interview with the pharmacy's Pharmac documentation to accord for Oxycodone 10mg, where the 63 tablets of 03/25/19 on the Controlled Substance at 7:24am and 03/27/ of 179 Oxycodone 10 documented as admin	ist, there was insufficient curately reconcile the record. Discrepancies included documented as received on rolled Substance Report ancy of two Oxycodone in the March 2019 eMAR and report dated from 03/25/19 19 at 12:16pm; and a total lung tablets were inistered between 03/19/19 re were only 120 tablets				
	Refer to interview with 05/10/19 at 11:21am.	h a medication aide (MA) on				
	Refer to interview with Director (RCD) on 05.	h the Regional Clinical /17/19 at 4:00pm.				
	Refer to telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm. Refer to interview with the Administrator on 05/17/19 at 3:44pm.					
	dated 03/06/19 revea	y care provider (PCP) order led an order for Oxycontin . (Oxycontin is a controlled eat chronic pain.)				
	Review of a PCP orde	er dated 03/20/19 revealed				

Division of Health Service Regulation

an order to discontinue Oxycontin.

STATE FORM E899 ZE7D11 If continuation sheet 183 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	A. BUILDING.		
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6	4 EAST A, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
D 392	Continued From page 183		D 392			
	05/15/19 at 2:00pm re -The pharmacy dispe 10mg on 03/12/19The original order wa not covered by Resid -There were no return Oxycontin 10mg for R Review of Resident # medication administra revealed: -There was an entry f dailyThere was document	as for 60 tablets, but it was ent #4's insurance. as to the pharmacy of Resident #4.				
	Report" dated 03/24/	ed substances "Inventory 19 revealed there was no cycontin for Resident #4.				
	Review of a Controlled Substance Report for Resident #4 dated 03/01/19 through 05/09/19 revealed there was no documentation for Oxycontin.					
	(RCD) on 05/17/19 at	gional Clinical Director 4:00pm revealed she tronic record for Oxycontin				
	Observation of medications on hand for Resident #4 on 05/10/19 at 11:21am revealed there was no Oxycontin 10mg tablets.					
	revealed:	nt #4 on 05/17/19 at 3:04pm xycontin for one week				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 184 of 267

STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	·	
TYRRELL	HOUSE	950 HWY				
0/0/15	SHIMMADY ST	TATEMENT OF DEFICIENCIES	IA, NC 27925	PROVIDER'S PLAN OF CORRECTION	N.	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 184	D 392			
		ot tolerate the medication. e to sleep and the Oxycontin iin.				
	Telephone interview with Resident #4's PCP on 05/15/19 at 9:55am revealed: -He tried to change Resident to Oxycontin for					
	Oxycodone which wa -Resident #17 did not	g acting medication verses as short acting. t tolerate the Oxycontin due s, so he discontinued the				
	Based on review of Resident #4's 03/01/19 Medication release form, March 2019 eMARs and controlled substance records; and interview with the facility's contracted pharmacy's Pharmacist, there was no Controlled Substance Record for Oxycontin for Resident #4 and 10 tablets were documented as dispensed, but 15 tablets were documented as administered or refused on the eMAR.					
	Refer to interview with 05/10/19 at 11:21am.	h a medication aide (MA) on				
	Refer to interview with Director (RCD) on 05	h the Regional Clinical 5/17/19 at 4:00pm.				
	Refer to telephone inf from the facility's con 05/15/19 at 2:00pm.	terview with the Pharmacist tracted pharmacy on				
	Refer to interview with 05/17/19 at 3:44pm.	h the Administrator on				
	d. Review of Residen 03/06/19 revealed the	nt #4's current FL-2 dated ere was an order				

Division of Health Service Regulation

alprazolam 0.25mg twice daily. (Alprazolam is a

STATE FORM E899 ZE7D11 If continuation sheet 185 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			_		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6			
	CLIMMADY CT		, NC 27925	DROVIDEDIC DI ANI OF CODDECTION	
(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 392	Continued From page 185		D 392		
	controlled substance	used to treat anxiety.)			
	from the facility's cont 05/17/19 at 2:54pm re	evealed the pharmacy n 0.25mg 10 tablets on 9; and 60 tablets on			
	Review of a Medication Release form dated 03/01/19 for Resident #4 revealed there were 62 alprazolam 0.25mg tablets released to the facility at the time the resident was admitted.				
	Telephone interview with the Pharmacist from the facility's contracted pharmacy on 05/15/19 at 2:00pm revealed there were no returns to the pharmacy of alprazolam 0.25mg.				
	Review of Resident #4's March 2019 electronic medication administration records (eMARs) revealed: -There was an entry for alprazolam 0.25mg twice daily at 7:00am and 7:00pmThere was documentation a total of 61 alprazolam 0.25mg tablets were administered from 03/01/19 at 7:00pm through 03/31/19 at 7:00pm.				
	Resident #4 revealed -There were 16 alpra: remainingThe report did not do date and amount delir Review of Resident # revealed:	zolam 0.25mg tablets ocument original delivery vered. 4's April 2019 eMAR			
	-There was an entry f daily at 7:00am and 7	or alprazolam 0.25mg twice ':00pm.			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 186 of 267

		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		ETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF D	ROVIDER OR SUPPLIER	etdeet ad	DRESS, CITY, STA	TE ZIR CODE	•	
NAME OF PI	ROVIDER OR SUPPLIER	950 HWY	, ,	II E, ZIP CODE		
TYRRELL	HOUSE		A, NC 27925			
	CLIMMADY CT		,	DDOVIDEDIC DI AN OF CODDECTION	NI.	
(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	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
D 392	Continued From page	e 186	D 392			
	-There was documen					
		ablets were administered				
	-	am through 04/301/19 at				
	7:00pm.	am though 04/301/19 at				
	-There was documen	tation no doses were				
		3/19 at 7:00am, 04/07/19 at				
	7:00pm and 04/08/19					
	-There was documen	tation alprazolam 0.25mg				
	was administered on	04/02/19 at 7:00am and				
	7:00pm, and 04/07/19	9 at 7:00am.				
	Review of Resident #	4's May 2019 eMAR				
	revealed:	or alprazolam 0.25mg twice				
	daily at 7:00am and 7	for alprazolam 0.25mg twice				
	-There was documen	•				
		ablets were administered				
	-	am through 05/09/19 at				
	7:00am.	3				
		d Substance Report dated				
	03/01/19 through 05/0					
	-The documentation f					
	specify dosage of tab					
		tation 16 alprazolam tablets				
	were received on 03/2					
		zolam tablets documented een 03/25/19 at 7:19am and				
		he remaining count was				
	zero.	the remaining count was				
		tation one alprazolam tablet				
		04/02/19 at 6:43am leaving				
	a remaining count of	•				
		tation one alprazolam tablet				
		2/19 at 11:16am leaving a				
	remaining count of ze					
		tation one alprazolam tablet				
		04/02/19 at 7:01pm leaving				
	a remaining count of					
	- i nere was documen	tation one alprazolam tablet				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 187 of 267

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			7 50.25 (6.		
			D. MINO		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO WILL OF TH	TO VIDER OR OUT FEEL				
TYRRELL	HOUSE		64 EAST		
		COLUME	IA, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	\ -7
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIE
				,	
D 392	Continued From page	e 187	D 392		
		0/40 - 1 44 04 - 1 - 1			
		2/19 at 11:31pm leaving a			
	remaining count of ze				
		tation 10 alprazolam tablets			
	were received on 04/0				
	-There were 9 alprazo	olam tablets documented as			
	administered and one	e tablet documented as			
	wasted between 04/0	3/19 at 3:47pm and			
	04/06/19 at 6:05pm.				
	-There was documen	tation two alprazolam tablets			
		n 04/06/19 at 6:05pm and			
		eaving a remaining count of			
	negative one.	in the second se			
	~	tation one alprazolam tablet			
		04/07/19 at 6:28am leaving			
	a remaining count of				
	_	tation two alprazolam tablets			
		08/19 at 10:07am leaving a			
	remaining count of ze				
	•				
		tation 10 alprazolam tablets			
	were received on 04/6	-			
		tation 60 alprazolam tablets			
	were received on 04/				
	-On 04/18/19 at 6:22p				
	administering one alp				
		om, staff documented			
	administering one alp				
	-There were no discre	•			
	documented 04/19/19	at 6:20am through			
	05/09/19 at 6:17am.				
	-On 05/09/19 at 6:17a	am there were 7 alprazolam			
	tablets remaining.				
	Observation of medic	ations on hand for Resident			
	#4 on 05/10/19 at 11:	21am revealed:			
	-There was a bubble	pack with a pharmacy label			
		44's name and instructions			
	for alprazolam 0.25m				
		indicated 60 tablets were			
	The phantiacy label	maisated of tableto well	1		

remaining.

dispensed on 04/09/19 and there were 5 tablets

STATE FORM 6899 ZE7D11 If continuation sheet 188 of 267

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				B. WING		
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL HOUSE			64 EAST			
		COLUMB	IIA, NC 27925			
(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 392	Continued From page	e 188	D 392			
	revealed: -She could not recall since March 2019She came back to the a "bunch" of alprazolation of 5/15/19 at 9:40pt -Regarding Resident 04/02/19, medication facility at 2:00amThe 3rd shift MA had delivered on the elect administration record -MAs were responsib when the number of the sheat never borrowneresident for another she had never borrowneresident for another supposed to getIf a resident did not gresident would come medication. Interview with a second state of the controlled Substate of the c	with a medication aide (MA) m revealed: #4's alprazolam on s were delivered to the It to enter the amount cronic medication . Ile for reordering medication ablets was down to seven. wed a controlled drug from her resident. medication was given, then iven. It medications they were get the medication, the and ask about the Ind MA on 05/16/19 at Ive balance documented on ance Report for Resident did not know how the drug record would record a s) try to put negative zero it				

Division of Health Service Regulation

-The MAs counted the number of tablets and

STATE FORM E899 ZE7D11 If continuation sheet 189 of 267

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			1			
		Hal089002	B. WING		05/17/2019	
		11000002			03/11/2013	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
TYPPELL	HOUSE	950 HWY	64 EAST			
TYRRELL	HOUSE	COLUME	BIA, NC 27925			
(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	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE	
				DETIGIENCY)		
D 392	Continued From page	e 189	D 392			
	entered the amount a	•				
	•	m would either take the				
	number or not.	and the communication of the Lands				
		see the remaining balance				
	when entering the co					
	-On 04/18/19, she ma					
	• .	plam twice but only gave it				
	once.					
	error and she would h	outer system would show				
	-The count was not a					
		he Care Manager (CM).				
	· ·	she did not know where the				
	note would be.	she did flot know where the				
	note would be.					
	Second interview with	n a MA on 05/17/19 at				
	3:25pm revealed:	14 107 (011 007 177 13 41				
	•	he order information for				
	controlled drugs.					
	-The dose and freque	ency came up on the				
		en the MA administered or				
	counted the medication					
	The CM was not avai	lable for interview on				
	05/16/19 and 05/17/1	9.				
	Interview with the Adr	ministrator on 05/17/19 at				
	3:44pm revealed:					
	-She did not know wh	nat happened on 04/02/19				
	with documenting neg					
	deliveries of 1 or 2 ta	•				
		vere system issues from				
	•	king off" on administering				
	alprazolam.					
		Resident #4's 03/01/19				
		orm, March, April and May				
		ntrolled substance records,				
	and interview with the					
	pharmacy's Pharmac	ist, there was insufficient	1			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 190 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	Hal089002	B. WING		05/17/2019	
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	950 HWY 6	PRESS, CITY, STA 4 EAST A, NC 27925	TE, ZIP CODE		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 392 Continued From page 190 documentation to accurat for alprazolam 0.25mg. The included no Controlled Sta 03/01/19 through 03/24/1 between the eMAR and the Record with documentation 04/02/19 and 04/07/19, to administered within one to other on 04/06/19 and 04 subsequent discrepancy it tablets were dispensed from contracted pharmacy with having been administered. Refer to interview with a moderate of the contracted pharmacy with having been administered. Refer to interview with the Director (RCD) on 05/17/1/1/19 at 11:21am. Refer to telephone interview from the facility's contract 05/15/19 at 2:00pm. Refer to interview with the 05/17/19 at 3:44pm. Interview with a medication 05/10/19 at 11:21am reversible. -MAs counted controlled deach shift. -One MA counted and a sonumber onto the computer of the number entered was would have to recount. -On the third count the syany further attempts and call the Care Manager (Contract Manager (Contract Manager) called the Care Manager (Contract Manager)	tely reconcile the record The discrepancies ubstance Record for 19, discrepancies the Controlled Substance ion of three tablets on wo tablets were to three minutes of each 4/18/19 with no in the count and 142 rom the facility's h documentation of 135 d. medication aide (MA) on e Regional Clinical /19 at 4:00pm. riew with the Pharmacist sted pharmacy on on aide (MA) on ealed: drugs at the change of second MA entered the er system. as wrong, then the MAs yetem would not allow the MA would have to CM) or the Administrator.	D 392			

Division of Health Service Regulation

Administrator after the second attempt to resolve

STATE FORM E899 ZE7D11 If continuation sheet 191 of 267

Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3	3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _			COMPLETED
		Hal089002	B. WING			05/17/2019
NAME OF D		etdeet vi	DDEEC CITY CTA	TE ZID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	II E, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
		COLUMB	IA, NC 27925			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT		(X5) COMPLETE
TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO	THE APPROPRIATE	
				DEFICIENC	CY)	
D 392	Continued From page	191	D 392			
	. •					
	the problem.					
	Interview with the Red	gional Clinical Director				
	(RCD) on 05/17/19 at					
	. ,	ched electronic medication				
	administration record					
	03/25/19.					
		t was the only report for				
		ds she was able to retrieve				
	for Resident #4 for da	•				
		Inventory Report" was the				
		the Controlled Substance				
	changed.	tronic record system was				
	crianged.					
	Interview with the Adr	ministrator on 05/17/19 at				
	3:44pm revealed:					
	-Medications were de	livered on the 3rd shift.				
	-The MAs were respo					
	•	eceipt and immediately				
		n the computer system.				
		econd MA to sign off on the				
	received amount ente					
	computer system.	CM would sign off on the				
	' '	e system issues, the MA				
	had to call her or the					
		e able to remotely see the				
	whole computer syste	<u> </u>				
	-Two MAs were respon	onsible for counting				
	controlled drugs ever					
		controlled drugs, the				
		ne amount into the computer				
	and both MAs sign of					
		nts were monitored daily by				
	•	eview of online tracking				
	reports.					
	The facility failed to h	ave an accurate accounting				

Division of Health Service Regulation

of the receipt, administration and disposition of

STATE FORM E899 ZE7D11 If continuation sheet 192 of 267

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE	
TYRRELL	HOUSE		Y 64 EAST BIA, NC 27925		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
D 392	controlled substances Oxycontin and alpraz #4's record. The facili accurate accounting of allowed for an unmor potential drug diversion errors which was deto and welfare of reside constitutes a Type B The facility provided a accordance with G.S. this violation. THE CORRECTION	s including Oxycodone, olam available in Resident ity's failure to assure an of controlled substances intored opportunities for on and risk of medication rimental to the health, safety ints in the facility and	D 392		
D 438	Registry 10A NCAC 13F .1205 Registry The facility shall comsupporting Rules 10A .0102. This Rule is not met TYPE A2 VIOLATION Based on observation reviews, the facility far Personnel Registry (Finvestigation requirements)	ns, interviews and record illed to complete Health Care	D 438		

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 193 of 267

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
			IA, NC 27925			
(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 438	Continued From page	e 193	D 438			
	injuries of unknown o	rigin.				
	The findings are:					
	02/05/19 revealed dia dysfunction, dementia	a, hypertension, lower stipation, hyperlipidemia,				
	Review of Resident #11's Resident Register revealed the resident was admitted to the facility 09/3016 and discharged 02/15/19 for a change in the level of care to a skilled nursing facility.					
	-Resident #11 was for her bed.	or Resident #11 revealed: und sitting on the floor by uising to her left forehead,				
	(PCA) on 05/16/19 at -It was about 5:00am walked by Resident # Resident #11 on the f -The Care Manager (asked her what happe week later (02/12/19)	on 02/05/19 when she of 02/05/				
	9:35pm with the MA v	interview on 05/16/19 at who completed the incident ated 02/05/19 at 6:10am				
	Review of an acciden	t/injury report dated				

Division of Health Service Regulation

02/05/19 at 10:15pm for Resident #11 revealed:

STATE FORM E899 ZE7D11 If continuation sheet 194 of 267

	of Health Service Regu				I	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LAN	51 CONNECTION	DENTI IOATION NOMBER.	A. BUILDING: _		JOINI LETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
NAME OF T	NOVIDER OR OUT FIER	950 HWY	, ,	11 L, ZII OOBL		
TYRRELL	HOUSE		IA, NC 27925			
			IA, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(*	
PREFIX TAG	•	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 438	Continued From page	104	D 438			
D 430	Continued From page	: 194	D 430			
	-Resident #11's knees	s were swollen.				
	-Resident #11 was se	ent to the emergency room				
	(ER) and admitted to	the hospital.				
		vith a PCA on 05/16/19 at				
	11:00pm revealed:					
	-	5/19, Resident #11 was sent				
	to the ER.					
		oaning in pain when she				
	swollen.	t night and her legs were				
		uises under her eye, on her				
	arm and her legs.	dises under her eye, on her				
	•	sident #11 the evening				
		/19), and the resident did				
	not have any bruises.	-				
	,,					
	Review of Resident #	4's February 2019 Activities				
	of Daily Living (ADL)	Log revealed Staff C, PCA				
	documented providing	g ADL assistance for the				
	resident on 02/04/19	from 3:00pm until 11:00pm.				
		interview with Staff C on				
	05/16/19 at 9:43pm w	as unsuccessful.				
	Daview of Decident #	4415 becauted records dated				
	02/05/19 through 02/	11's hospital records dated				
	•	ted to the ER with extensive				
	bruising over her bod					
	healing.	, tanodo otagos or				
		d white photos of bruises to				
		front left arm, left shoulder,				
	• •	to clavicle, left forehead				
	and bilateral shins da	-				
	-Resident #11 was dia	agnosed with a urinary tract				
	infection, acute kidne	y injury and anemia with				
	guaiac positive stools					
	-There was documen	tation the hospital Case				

Division of Health Service Regulation

Manager was working with Adult Protective Services (APS) for a safe discharge plan; the

STATE FORM E899 ZE7D11 If continuation sheet 195 of 267

DIVISION	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
		Hal089002	B. WING		05/17/2019
NAME OF D	20//DED OD 01/DD1/ED	OTDEET A	DDE00 0ITV 0T4	TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STA	ITE, ZIP CODE	
TYRRELL	HOUSE	950 HWY	64 EAST		
IIIXIXLLL	HOUSE	COLUME	SIA, NC 27925		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (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	IATE DATE
				DEFICIENCY)	
D 400	0 " 15	405	D 400		
D 438	Continued From page	9 195	D 438		
	facility was not a safe	discharge plan			
	radinty was not a said	disoriarge plan.			
	Tolophono intonviow v	vith the hospital Nurse			
		05/16/19 at 4:04pm revealed:			
	,	•			
		ultiple bruises in different			
	stages of healing.				
		uises just above the left			
	-	left cheek, left shoulder, left			
	upper arm and scatte	red on her lower			
	extremities.				
	-Resident #11 also ha	ad scattered skin tears on			
	her lower extremities.				
	-The bruises on Resid	dent #11's left arm, shoulder,			
		e a deep dark purple color.			
		esident #11's left eye was			
	black and blue.	Sident # 11 3 left eye was			
		rore on Desident #444 less			
		ere on Resident #11's legs,			
		e the resident's eye and the			
		ruises were "in between			
	(being the newest and				
		ty were unable to tell the			
	Case Manager at the	hospital where the bruises			
	came from.				
	-The staff did not know	w the bruise that went from			
	Resident #11's left ell	oow to her shoulder was			
	even there.				
	-The bruise on Reside	ent #11's forehead could			
	have been from a fall				
		dent #11's chest, arm and			
		ear to come from a fall.			
	onodiadi dia not appe	a. to dome from a fall.			
	Telephone interview v	with the hospital Casa			
	•	<u>-</u> '			
		at 4:49pm revealed she did			
		who she spoke to at the			
	racility, the date or de	tails of the conversation.			
		vith Resident #11's family			
	member on 05/15/19	at 7:25pm revealed:			
	-Resident #11 was se	ent to the hospital for bruises			

Division of Health Service Regulation

on her arms and chest.

STATE FORM E899 ZE7D11 If continuation sheet 196 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			71. 201221110.			
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
		COLUMBI	A, NC 27925			
(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	(X5) COMPLETE DATE
D 438	Continued From page	e 196	D 438			
D 430	-After Resident #11 wan investigation was can a camployee hit Resider -She did not remember done the investigation happenedAn investigation was had bruises found what were not consisted. Interviews with three 9:40pm and 05/17/19 -The staff had "heard" "beat up" or handled causing the bruises or chestThe staff did not known caused the bruises to chestResident #11's bruised came from a fall. Interview with the Dep (DSS) representative revealed: -She and her Superviof the hospital with the Administrator several -There were discrepa	vas hospitalized on 02/05/19, done. and it was determined a new on #11. er the details of who had on and what exactly had a done because Resident #11 then she went to the hospital ent with a fall. staff between 05/15/19 at	D 436			
	•	mer Administrator said about ent #11.				
	on 05/17/19 at 11:56a	with the APS representative am revealed: uises on Resident #11 while				

Division of Health Service Regulation

she was hospitalized 02/05/19 - 02/15/19.

STATE FORM E899 ZE7D11 If continuation sheet 197 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL HOUSE 950 HWY 6		64 EAST				
THREEL	TIOOOL	COLUMB	IA, NC 27925			
(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	(X5) COMPLETE DATE
D 438	Continued From page	: 197	D 438			
D 438	-Resident #11 had a I from her hairline to he bruise on her left chee that looked like a fist i both shins with one bredThere was concern to bruises Resident #11 -Staff reported not know Resident #11. Interview with the Reg (RCD) on 05/16/19 at -Resident #11's injurice abuseResident #11 fell and -The Administrator reg in the hospital said Resident #11 had been she had just started training the week of 0 -The hospital staff did Resident #11 had been she had "gathered" to abuse because the her facility updates when she had not complet Health Care Personner Resident #11She had not conduct cause of Resident #11She did not know any being done and the sident with one of the staff did not know any being done and the sident #15.	arge purple bruise that went er eyelid; a blue/purple st just below the collar bone imprint; and large bruises on eing purple and the other that a fall did not match the had. owing what happened to gional Clinical Director 10:19am revealed: es were not the result of a sustained the bruises. ported to her that someone esident #11 was abused. The Administrator on revealed: as the Administrator in 2/04/19. The anot specifically say en abused. There was a suspicion of ospital stopped giving the staff called the hospital. ed an initial report for the el Registry (HCPR) for ed an investigation into the 1's bruises. Aptring about an investigation	D 438			
		d a report from the hospital. ected Resident #11's injuries				

were the result of physical abuse.

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 198 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/201	19
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/11/20	
		950 HWY				
TYRRELL	HOUSE		A, NC 27925			
(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 COM	(X5) MPLETE DATE
D 438	Continued From page	: 198	D 438			
	"beat up" by a staff.	e were allegations of abuse.				
	05/16/19 at 10:44am -She was the Adminis	revealed: trator at the time Resident				
		5/19). ent and accident reports nt #11 on 02/05/19; one for				
	the fall and a second	for her knees being swollen. ial report for the HCPR for				
	injury of unknown orig					
	hospital that there we -No staff was terminar	re suspicions of abuse. ted because of Resident				
		uises on her head, chest ling off the bed and hitting				
	-She knew this becau reported that was what					
	-The 3rd shift staff regunwitnessed.					
	 -The 3rd shift staff reported Resident #11 was found tangled in her blanket on the floor. -There was no report of any physical abuse toward Resident #11 from staff. 					
		ns, interviews and record nined Resident #11 was not				
	Refer to interview with 05/17/19 at 3:44pm.	n the Administrator on				
	2. Review of Residen 01/22/19 revealed dia	t #8's current FL-2 dated ignoses included				

Division of Health Service Regulation

Alzheimer's dementia, osteoarthritis, Lewy body

dementia, vitamin B12 deficiency,

STATE FORM E899 ZE7D11 If continuation sheet 199 of 267

	of Health Service Regu				ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019)
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STAT	E ZIP CODE		
NAIVIE OF PI	NOVIDEN ON SUFFLIER		, ,	L, ZII 000L		
TYRRELL	HOUSE		Y 64 EAST BIA, NC 27925			
			DIA, NC 2/925			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(5) PLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
D 438	Continued From page	- 199	D 438			
		flux disease and peripheral				
	edema.					
	Intorvious with a conc	erned citizen on 05/10/19 at				
	1:00pm revealed:	erned chizen on 05/10/19 at				
		ge bruises on her arms in the				
		w how she got the bruises.				
		member visited on 05/05/19				
	and found the resider	nt crying and difficult to				
	console.					
	·	noticed bruises on both of				
	Resident #8's hands.					
	-A staff had reported					
	Resident #8 had slap					
	had never been "ugly	ave episodes of crying but				
	· ·	#8 on 05/06/19 and had				
	seen the bruises on t					
		because the bruises looked				
		abbed Resident #8 by her				
	wrists.					
	-	Care Manager (CM) about				
	the bruises on 05/06/	19.				
	Di	and Demonstrates				
		are Personnel Registry				
	Resident #8 revealed	al Report dated 05/10/19 for				
		ns of abuse which occurred				
	_	ity became aware of on				
	05/10/19 at 7:30am.	,				
		esident #8's clothes off at				
	the front desk when a	another staff told Staff C to				
	stop.					
		at #8 to her room by the				
	resident's hands "rou					
	-Staff C yelled loudly					
	-Resident #8 had bru					
	i -Kesident #x nad a h	ruise on her right hand on	1 1			

Division of Health Service Regulation

"yesterday (05/09/19)".

STATE FORM E899 ZE7D11 If continuation sheet 200 of 267

Division of	of Health Service Regu	ilation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		Hal089002	B. WING		05/1	17/2019
					1 00/1	172010
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
		COLUMB	A, NC 27925	T.		
(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 APPROPE		COMPLETE DATE
iAG		,	IAG	DEFICIENCY)		
D 400	0 " 15		D 400			
D 438	Continued From page	e 200	D 438			
	Review of a Body Eva	aluation & Observation sheet				
	dated 05/10/19 at 7:0	4am for Resident #8				
	revealed the CM doci	umented the resident had				
	medium/large dark sp	oots on both hands.				
	The CM was not avai					
	05/16/19 and 05/17/1	9.				
	Tolophono intonviowe	with Resident #8's family				
		at 11:36am and 8:24pm				
	revealed:	at 11.30am and 0.24pm				
), he found two large bruises,				
	•	lent #8's hands in the same				
		been squeezed down on				
	her hands.	. soon squoseed down on				
	-He had taken picture	es of the bruises on				
	05/05/19.					
	-He talked with the st					
		bruises and did not get a call				
	back until Friday (05/					
	•	staff on 05/10/19 at 10:30am				
		one knew what happened.				
	him on 05/10/19.	ber which staff had called				
		had been another incident				
		aff had found a bump and a				
	bruise on Resident #8					
	-He got a call from the	e Regional Clinical Director				
	(RCD) on 05/10/19.	-				
	-The RCD said the br	ruises were different on				
	05/10/19 from the bru	uises noted on 05/05/19, and				
	the employee who wa	as responsible was" let go".				
	_	ry of what happened on				
	05/05/19.					
	-He had spoken with					
		ruises on Resident #8's				
	hands on 05/05/19 ar					
		ported having to follow a 5				
		re terminating the staff.				
	- I his was not the first	t time Resident #8 had]

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 201 of 267

DIVISION	i Health Service Regu		1		1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
			B. WING			
		Hal089002	D. WING		05/17	//2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY				
TYRRELL	HOUSE		A, NC 27925			
			A, NC 2/925			
(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
IAG		,	IAG	DEFICIENCY)		
			+			
D 438	Continued From page	e 201	D 438			
	bruises: he had chalk	ed the others up to falls.				
		ncerned that incidents with				
	staff being abusive ha					
	stall being abusive ha	ва паррепеа ветоге.				
	Review of photos reco	eived from Resident #8's				
		stamped 05/05/19 at 6:52pm				
	revealed:	stamped 03/03/19 at 0.32pm				
		lar sized oval shaped purple				
		B's right hand below the wrist				
	and next to the thumb	•				
		sized round purple bruise				
		hand below the wrist and				
	next to the thumb are	a.				
	Observations of Bosis	dent #8 on 05/10/19 at				
		uent #6 on 05/10/19 at				
	1:40pm revealed:	lan alma di accali ale anno di accompla				
		lar sized oval shaped purple				
		t's right hand below the wrist				
	and next to the thumb					
	-	area of purple at the center				
	of the bruise.					
		egularly shaped purple and				
		dent's left hand below the				
		to just under the second				
	finger.					
	Intensions with the DO	D on 05/15/10 at 2:225m				
		D on 05/15/19 at 3:23pm				
	revealed:	abor whather staff reserved				
		nber whether staff reported				
		ent #8's hands or if she had				
	seen the bruises first.					
	-After seeing the bruis					
		d found out there was an				
	•	shift for 2nd into 3rd shift				
		9 witnessed by two staff.				
		t #8 to the bathroom and				
	the resident returned	with marks on her hands.				
	-She did not know ab	out bruises or other				
	incidents earlier in the	e week (05/05/19).				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 202 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6			
0/0/15	SHIMMADV ST.	ATEMENT OF DEFICIENCIES	A, NC 27925	PROVIDER'S PLAN OF CORRECTION	d over
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 438	Continued From page 202		D 438		
	dated 05/15/19 for Re-The RCD spoke with member (date not doe -The family member weeks ago and the remean to her; the family CResident #8 was vermember visited; the faseen the resident like -Resident #8 was agi around her and had serviced -The RCD questioned deny the allegations.	Resident #8's family cumented). visited Resident #8 several esident reported a staff was ly member described Staff y agitated the day the family amily member had never that before. tated when Staff C was lapped Staff C in the past. known to hit anyone before. If Staff C and Staff C did not rent Administrator on			
	hands on Monday or 05/07/19)No one had reported Staff C treated Reside-There was no concereport prior to 05/10/1 Based on observation reviews, it was determined to interview with 05/17/19 at 3:44pm. 3. Review of Resident	ident #8 on 05/05/19. ise on one of Resident #8's Tuesday (05/06/19 or any concerns about how ent #8 before 05/09/19. rn to submit an initial HCPR			
		on and decubitus ulcer.			

Division of Health Service Regulation

Observation on 05/07/19 at 12:57pm revealed:

STATE FORM E899 ZE7D11 If continuation sheet 203 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL HOUSE 950 HWY 6					
	T		IA, NC 27925		
(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 438	Continued From page	e 203	D 438		
	from near the wrist to -The bruise was red,	large bruise on his right arm the mid-forearm area. irregularly shaped and ches wide by six inches in			
	05/07/19 at 12:59pm -She had noticed the arm, but she was not -She was "pretty sure (MAs) knew about the knew about the bruise	bruise on Resident #12's sure when. " the medication aides bruise because all the staff be. Imented in the shower book			
	revealed: -The bruise on Reside popped up," she did refromShe reported the bruic (CM), Administrator a Professional Support (RN)She could not rement	ent #12's right forearm "just not know where it came lise to the Care Manager and Licensed Health (LHPS) Registered Nurse liber the date she found and but she had written a note			
	03/17/19 through 05/0 not available for revieus Second interview with 12:42pm revealed: -She documented the right forearm the day -She must have been	n the MA on 05/14/19 at bruise on Resident #12's			

Division of Health Service Regulation

than care notes.

STATE FORM E899 ZE7D11 If continuation sheet 204 of 267

DIVISION	n nealth Service Regu	iation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			1		
		11-100000	B. WING		05/47/0040
		Hal089002			05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TVDDELL	HOUSE	950 HWY	64 EAST		
TYRRELL	HOUSE	COLUMBI	A, NC 27925		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE DATE
				DEI IOIENOT)	
D 438	Continued From page	204	D 438		
	Review of a shower a	ssessment sheets dated			
		9 for Resident #12 revealed			
		resident had a bruise on his			
	right forearm.				
	Review of an incident	report dated 05/09/19 at			
	Review of an incident report dated 05/09/19 at 7:33pm revealed: -Resident #12 had bruising on his lower right arm.				
		nentation of how Resident			
	#12 bruised his lower				
	-The report was comp	neted on 05/09/19 at			
	7:35pm by the CM.				
	Telephone interview v	vith Resident #12's primary			
		on 05/15/19 at 3:28pm			
	revealed:	511 00/ 10/ 10 at 0.20pm			
		nt #12 on three occasions			
	for bruises; the reside				
	-He had seen Reside	nt #12 on 04/30/19,			
	05/07/19 and 05/14/1	9.			
	-He did not know any	thing about an investigation			
	into the cause of the l	oruise on Resident #12's			
	right forearm.				
	-On 05/14/19, the bru	ised area had a small			
	laceration at the center	er and looked as if an			
	infection had started.				
	-He started Resident	#12 on an antibiotic.			
	Interview with the CM	on 05/09/19 at 5:35pm			
	revealed:				
	-She had seen the "re	ed spots" on Resident #12's			
	arms after a staff had	reported the "bruise" on			
	05/07/19.				
	-She let the PCP know	w on 05/07/19 when the			
	PCP was at the facilit	у.			
		w what caused the bruise			
	on Resident #12's rigi				
		ral staff about the bruise; the			

Division of Health Service Regulation

staff did not know where the bruise came from.

STATE FORM E899 ZE7D11 If continuation sheet 205 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPLI	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
			A, NC 27925			
(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	(X5) COMPLETE DATE
D 438	Continued From page	≥ 205	D 438			
	did not where the bruine reported it to the MA. -The MA reported to hadministrator. -She reported all bruine Administrator so a Herman Registry (HCPR) reported Administrator. -She had not reported #12's right forearm to she did not know if a to the Administrator a been done. Interview with the Administrator a been done. Interview with the Administrator a been done. Interview with the Administrator a been done. PCP had seen the bruine she had not sent a Herman PCP had seen Reside was from aging.	ses of unknown origin to the ealth Care Personnel ort could be done by the d the bruise on Resident the Administrator. a MA had reported the bruise and if a HCPR report had ministrator on 05/09/19 at uise on Resident #12's right week (05/07/19). HCPR report because the ent #12 and said the bruising ms, interviews and record				
	interviewable.	nined Resident #12 was not				
	Refer to interview with 05/17/19 at 3:44pm.	h the Administrator on				
	3:44pm revealed: -Staff were expected instances of verbal or Manager (CM) and/or -Staff would be writter -If there were any sus	and knew to report any physical abuse to the Care r Administrator. n up for not reporting. spicions of abuse, neglect or nt it was reported to the				

Division of Health Service Regulation

-She was responsible for completing reports to

STATE FORM E899 ZE7D11 If continuation sheet 206 of 267

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		11-1080002	B. WING		05/47/0040
		Hal089002	3:		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
		950 HWY	64 EAST		
TYRRELL	HOUSE		BIA, NC 27925		
			<u> </u>		
(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 APPROPR	
				DEFICIENCY)	
D 100			5.400		
D 438	Continued From page	e 206	D 438		
	the HCPR.				
	The facility failed to co	omplete an initial report			
	-	stigate and complete an			
	investigation report w				
	-	th bruises of unknown origin			
	•	d accusations of physical			
		The facility's failure placed			
	residents at substantial risk of serious injury and				
abuse because of delayed or a					
	and investigating which constitutes a Type A2 Violation.				
	The facility provided a	a plan of protection in			
	• •	. 131D-34 on 05/16/19 for			
	this violation.				
	THE CORRECTION I	DATE FOR THE TYPE A2			
		NOT EXCEED JUNE 16,			
	2019.				
D 405	40 A NO A O 40 E 40 0	2/-)	D 405		
D 403	10A NCAC 13F . 1308	B(a) Special Care Unit Staff	D 465		
	40 A NO A O 40 E 40 0	0.00			
		Special Care Unit Staff			
		sent in the unit at all times in			
	sufficient number to n				
		me shall there be less than			
	· · · · · · · · · · · · · · · · · · ·	meets the orientation and			
	training requirements				
		nt residents on first and			
		our of staff time for each			
	•	nd one staff person for up to			
		shift and .8 hours of staff			
	time for each addition	iai resident.			
	This Dula is not mot	as avidanced by:			
	This Rule is not met TYPE A2 VIOLATION				
	III LAZ VIOLATION	•	- 1		

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 207 of 267

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SURVI			
		Hal089002	B. WING		05	5/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
TYRRELL	HOUSE		/ 64 EAST BIA, NC 27925			
	SLIMMARY ST	FATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	OPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 465	Continued From page	e 207	D 465			
	reviews, the facility fa enough staff present attentive to meet the	ns, interviews and record ailed to assure there was on the special care unit and personal care, supervision ds of the residents for 14 of				
	The findings are:	view of a resident census report dated 19/19 (Friday) revealed the facility's in-house usus on the special care unit (SCU) was 24 idents, which required at least 24 hours of staff				
	04/19/19 (Friday) rev census on the specia					
	04/19/19 (Friday) rev	time detail report dated realed there were 17.08 staff st shift, leaving the shift short s.				
		revealed the facility's the SCU was 24 residents, st 24 hours of staff duty on				
	04/20/19 (Sunday) re -There were 14.52 st shift, leaving the shift -There were 13.02 st	time detail report dated evealed: taff hours provided on first t short staffed by 9.08 hours. taff hours provided on the shift short staffed by				
	census on the SCU v	census report dated evealed the facility's in-house was 23 residents, which I hours of staff duty on third				

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 208 of 267

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY 6	64 EAST		
		COLUMBIA	A, NC 27925		
(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 465	Continued From page	e 208	D 465		
	04/21/19 (Sunday) re	time detail report dated vealed there were 13.52 on third shift, leaving the shift hours.			
	Review of a resident census report dated 04/22/19 (Monday and a Holiday) revealed the facility's in-house census on the SCU was 23 residents, which required at least 18.4 hours of staff duty on third shift. Review of the punch time detail report dated 04/22/19 (Monday and a Holiday) revealed there were 21.78 staff hours provided on third shift, leaving the shift short staffed by 1.22 hours.				
	census was 24 reside	evealed the SCU's in-house ents, which required at least on first shift and at least			
	04/27/19 (Saturday) r -There were 21 staff I leaving the shift short -There was one medi the facility for first shir assigned to the SCU.	nours provided on first shift, staffed by 3 hours. cation aide (MA) on duty for ft; all of the MA's hours were			
	aideThere were two cook 6:31pmThere were 22 staff I shift, leaving the shift -There was one MA ir until 10:47pm; all of the assigned to the SCU.				

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 209 of 267

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPL	EIED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
	Г		A, NC 27925			
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 465	Continued From page	209	D 465			
	meal break at 10:00p	m and punched in after the a total of two consecutive				
	worked 04/27/19 seconds - She normally "ran bate of SCU and the assisted of the were short of states - Short staffing for 1st two PCAs on the SCU and one MA for the bate of the second one MA for the bate of the SCU while medications on the Alarment of the Fermi she would got and send one of the Fermi she would got and send one of the Fermi she would got and send one of the Fermi she would got and send one of the Fermi she would got and send one of the Fermi she would got and send one of the Fermi she would got and send one of the Fermi she would got the she would got the paperwork" and contact the she would got the s	ack and forth" between the d living (AL) side. gement in the facility when aff on weekends. and 2nd shift meant having J, one PCA on the AL side uilding. be three staff on the SCU, send the PCA from the AL she worked alone passing L side. the SCU to pass medications PCAs to the AL side. the proper care and there was not enough time. onsible for completing "all of overing meal breaks. the was responsible for 50				
	census was 24 reside	vealed the SCU's in-house ents, which required at least on first shift and at least				
	04/28/19 (Sunday) re-There were 16.25 stashift, leaving the shift-There was one MA ir-There was no punch aide.	time detail report dated vealed: aff hours provided on first short staffed by 7.75 hours. In the facility for first shift. Itime detail for a dietary				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 210 of 267

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 210 6:15pmThere were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hoursThere was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCUOne PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm for a total of 1.5 consecutive hours.	STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S COMPLE	
TYRRELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CA(4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 210 6:15pmThere were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hoursThere was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCUOne PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm			Hal089002	B. WING		05/1	7/2019
TYRRELL HOUSE COLUMBIA, NC 27925 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 210 6:15pm. -There were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hours. -There was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCU. -One PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 210 6:15pm. -There were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hours. -There was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCU. -One PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm	TYRRELL	HOUSE					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 465 Continued From page 210 6:15pm. -There were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hours. -There was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCU. -One PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm		OLUMBARY OT		<u> </u>		. 1	
6:15pmThere were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hoursThere was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCUOne PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
-There were 15 staff hours provided on second shift, leaving the shift short staffed by 9 hoursThere was one MA in the facility from 4:30pm until 11:00pm; all of the MA's hours were assigned to the SCUOne PCA punched out for a meal break at 6:22pm and punched in after the break at 7:57pm	D 465	Continued From page	210	D 465			
Interview with a PCA on 05/07/19 at 1:29pm revealed: -Staff were able to take naps during their shift, just not in the buildingStaff had to take a nap in their car on their lunch breakIf the shift was short of staff, then staff could not go out to their car and take a nap on their lunch breakThe facility was 24-hour care, staff could not sleep while on duty because a resident might get up an fall. Interview with the Administrator on 05/08/19 at 2:15pm revealed: -Staff were allowed to take a two-hour break if they worked 12 or more hours, their was enough staff to cover the break and the break was not during times such as the medication passWhether or not staff could take a two-hour break was determined and scheduled by the Care Manager (CM). Review of a resident census report dated 05/03/19 (Friday) revealed the facility's in-house census on the SCU was 23 residents, which required at least 23 hours of staff duty on first and		6:15pmThere were 15 staff is shift, leaving the shiftThere was one MA ir until 11:00pm; all of the assigned to the SCUOne PCA punched of 6:22pm and punched for a total of 1.5 consoluterview with a PCA revealed: -Staff were able to take just not in the building Staff had to take a nabreakIf the shift was short go out to their car and breakThe facility was 24-h sleep while on duty be up an fall. Interview with the Adr 2:15pm revealed: -Staff were allowed to they worked 12 or mostaff to cover the breaduring times such as -Whether or not staff was determined and shanager (CM). Review of a resident of 05/03/19 (Friday) revecensus on the SCU were consus on the SCU were staff to CU we consus on the SCU were supported to the staff to CU we consus on the SCU were supported to the staff to CU we consus on the SCU were supported to the staff to CU we consus on the SCU were supported to the staff to CU we consus on the SCU were supported to the staff to CU we consus on the SCU were supported to the staff to CU we consus on the SCU were supported to the staff to CU were supported to the supported to the staff to CU were supported to the sta	nours provided on second short staffed by 9 hours. In the facility from 4:30pm ine MA's hours were ut for a meal break at in after the break at 7:57pm inecutive hours. on 05/07/19 at 1:29pm in their car on their lunch in their car on their lunch in their car on their lunch in the data and on their lunch in the cause a resident might get in the break was not the medication pass. In the could reak at two-hour break in the medication pass. In the could recover the medication pass. In the could recover the medication pass. In the could recover the medication pass. In the medication pass in the medication pass in the medication pass in the medication pass. In the medication pass in th				

Division of Health Service Regulation

Review of the punch time detail report dated

STATE FORM E899 ZE7D11 If continuation sheet 211 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	B. WING		05/17/2019
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	
TYRRELL HOUSE		64 EAST IA, NC 27925		
PREFIX (EACH DEFIC	LY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
shift, leaving the -There were 22.9 second shift, leav 1.08 hours. Review of a resid 05/04/19 reveale was 23 residents hours of staff dut Review of the pu 05/04/19 reveale -There were 8 ho provided on third staffed by 10 hou -There was one for third shift Review of a resid 05/05/19 reveale was 23 residents hours of staff dut hours of staff dut hours of staff dut hours of staff dut Review of the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale -There were16 ho provided on third staffed by 1 hour -There was one for the pu 05/05/19 reveale	revealed: 5 staff hours provided on first shift short staffed by 1.35 hours. 2 staff hours provided on ing the shift short staffed by ent census report dated d the facility's in-house census which required at least 18.44 on third shift. Inch time detail report dated d: urs 29 minutes of staff hours shift, leaving the shift short rs. PCA on duty for the facility SCU ent census report dated d the facility's in-house census which required at least 23 on second shift and 18.44 on third shift. Inch time detail report dated d: purs 28 minutes of staff hours shift, leaving the shift short	D 465		

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 212 of 267

STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		Halaganaa	B. WING		05/	47/2040
NAME OF D		Hal089002			05/	17/2019
NAME OF P	ROVIDER OR SUPPLIER		ODRESS, CITY, STA ' 64 EAST	TE, ZIP CODE		
TYRRELL	HOUSE		BIA, NC 27925			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 465	reminded the residen	ident up into her chair and	D 465			
	[Refer to Tag 271, 10A NCAC 13F .0901(c) Supervision]					
	dated 05/05/19 and M medication administrative revealed: -The resident fell on 0 new left side pain at 6 3rd shift on 05/05/19) -The resident's prima notified of the resider in the previous 24 ho -On 05/08/19 the resir	ation record (eMAR) 05/05/19 and complained of 0:08am on 05/06/19 (end of 0. ry care provider was not nt's new pain following a fall				
	4:10am revealed: -There were two PCA 3rd shift on 05/06/19There was one MA v -The MA worked on b for 3rd shift on 05/06/ -There were 22 reside -The facility had some shifts because they be especially for 3rd shift -Shift times were 7:00 3:00pm to 11:00pm for to 7:00am for third shift	vorking in the building. both the SCU and the AL side (19. ents in the SCU. e issues with short staffed ould not keep staff (t. Dam to 3:00pm for first shift, or second shift and 11:00pm				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 213 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
TYRRELL	HOUSE	950 HWY	64 EAST			
ITRRELL	HOUSE	COLUMBI	A, NC 27925			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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	(X5) COMPLETE DATE
D 465	with her back towards in the chair. -The chair was covered PCA had a sweatshirt. -The PCA stood from blanket and placed the in the seat of the chair. -The PCAs eyes were startled and disheveled. -A second PCA was seed desk. Interview with the PCA revealed: -She was not sleeping. -The blanket was on the urinated on the chairs.	n revealed: a chair in the common area the hallway and her feet up ed with a blanket and the over her shoulders. the chair, rolled up the e sweatshirt and the blanket r. e red and she appeared ed. eated at the SCU front A on 05/07/19 at 5:32am g at 4:18am on 05/07/19. he chair because residents ecause she was tired at nile working because o up" visits at night.	D 465			
	in the common area a -She had worked with	at the other PCA was doing it 4:18am on 05/07/19. the other PCA one other				
	duty third shift on 05/0 -She tried to check or the SCU every two ho -She checked to make rounds and completin -How often she was a residents on the SCU	at 5:43am with the MA on 06/19 revealed: If the staff and residents in ours. It is sure staff were doing g daily tasks.				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 214 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	950 HWY 6	PRESS, CITY, STA 4 EAST A, NC 27925	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	(X5) COMPLETE DATE
D 465	Continued From page	214	D 465			
	MA on duty third shift -What was going on it sometimes a resident need her attention, m delivered from the ph be short staffedThere were usually m she would spend "mo sideDaily tasks were task responsible to sign of -The tasks were activ making sure residents toileting, bathing, dree assisting with ambula -She did not know wh doing at 4:18am on 0 -She had worked with had any problemsThird shift on the pas and 04/27/19), the face because two PCAs w Confidential interview revealed: -She stopped working there was not enough residentsStaff worked 13 to 14 row with no lunch bree sideStaff were overwhelf -There was resident p getting doneThere was not enoug who needed increase	would fall, someone might edications might be armacy and the shift might more PCAs on the SCU, so st" of her time on the AL as the PCAs were f on the computer. ities of daily living such as swere clean and dry, ssing, changing the bed and tion. at the PCA on the SCU was 5/07/19. In the PCA before and never st two weekends (04/20/19 cility had been short staffed ere a no call/no show. with a former staff at the facility because a staff to take care of the thours a day for days in a ak on both the SCU and AL				

Division of Health Service Regulation

other residents.

STATE FORM E899 ZE7D11 If continuation sheet 215 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 03/11	772013
TYRRELL	HOUSE	950 HWY (COLUMBI	64 EAST A, NC 27925			
(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	(X5) COMPLETE DATE
D 465	Continued From page	215	D 465			
	5:05pm revealed: -She had enough start day to complete incre residents with increases. She was not aware of for the SCU, one PCA medication aide coverside. [Refer to Tag 269, 10. Personal Care] Interview with the Car 05/07/19 at 7:41am resumed to 105/07/19 at 7:41am resumed to 105/07/19 at 7:41am resumed to 105/07/19. Interview with the Add 105/07/19. Interview with the Add 10:55pm revealed: -One of the PCAs whom the SCU 05/06/19The second PCA that 4:18am on 05/07/19; -The facility had chan hour shifts since 05/1The staff were a tear doneStaff were not working hour shifts.	evealed: to her on 05/07/19 before her shift; the PCA said she ident to the Administrator on ministrator on 05/15/19 at o was working on 3rd shift quit. It was seen in the chair at out her two week notice in. ged all staff schedules to 12				
	revealed: -Laundry was being fi	inished from what the 1st ne washer and dryer before				

Division of Health Service Regulation

the end of their shift.

STATE FORM E899 ZE7D11 If continuation sheet 216 of 267

Division of Health Service Regulation

DIVISION	n nealth Service Regu	iation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		Hal089002	B. WING	·····	05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		950 HWY			
TYRRELL HOUSE					
		COLUMBI	A, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	
IAG			IAG	DEFICIENCY)	
D 465	Continued From page	216	D 465		
	The DCAs on the Al	side folded the laundry and			
		-			
	she was pulling it awa	ay for the SCU residents.			
	lasta muia vuu vuitla tlaa. Aalm	ministrator on 05/47/40 of			
		ministrator on 05/17/19 at			
	3:44pm revealed:				
		ry and housekeeping staff;			
	PCAs only assisted w	-			
		rated in housekeeping			
	•	ekeepers were able to do			
	-	not responsible for doing the			
	laundry.				
	-	onsible for doing facility and			
	residents' laundry.				
	-She was responsible	for making the staff			
	schedule.				
	-She used the "regula				
	determine staff need	•			
		I make calls to staff to cover			
	short shifts.				
	_	o find staff to work, then the			
		or ED covered the shift.			
		onths" since she worked on			
	the floor to cover a sh				
	-When she or the CM	worked on the floor			
	providing direct care,	they "clocked in" on the time			
	clock.				
	-"Clocking in" meant \	_			
	-She provided oversig	ght and monitoring of staff			
	while working on the f	floor.			
	The CM was not avail				
	05/16/19 and 05/17/1	9.			
		ssure enough staff were			
	present on the specia	l care unit for 14 of 27			
	sampled shifts. The fa	acility's failure resulted in a			
	lack of personal care	•			
		d dressing, supervision with			
		residents wandering away			

Division of Health Service Regulation

from the facility and into the main kitchen, and a

STATE FORM E899 ZE7D11 If continuation sheet 217 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	PRESS, CITY, STA	TE, ZIP CODE	1 00	
TYRRELL	HOUSE	950 HWY 6 COLUMBIA	4 EAST A, NC 27925			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 465	Continued From page 217		D 465			
	failure to report symptoms of serious injury following a fall. This failure placed residents at substantial risk of serious neglect and physical harm which constitutes a Type A2 Violation.					
	The facility provided a accordance with G.S. this violation.	a plan of protection in . 131D-34 on 05/10/19 for				
		DATE FOR THE TYPE A2 NOT EXCEED JUNE 16,				
D911	G.S. 131D-21(1) Dec	laration of Residents' Rights	D911			
	 G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. 					
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	interviews, the facility were treated with resp and right to privacy as doors and window blincontinence and batt #3, #6, #15); speaking residents (#4, #14); a	ns, record reviews, and refailed to assure residents pect, dignity, consideration, is related to staff leaving inds open while providing thing care to residents (#2, g and being disrespectful to find failed to provide an efacility for a resident whose th bedbugs (#9).				
	The findings are:					
	1. Review of Resider	nt #2's current FL-2 dated				1

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 218 of 267

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE COMPI	
		Hal089002	B. WING	B. WING		17/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	03/	1772019
		950 HWY		,		
TYRRELL	HOUSE	COLUMB	IA, NC 27925			
(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
D911	blood pressure, Vitan pre-renal disease. -The resident was co-the resident was se-the resident require dressing, and feeding. -The resident was income. Review of Resident # care plan dated 02/12 -The resident was and-the resident was and-the resident was tot grooming, and toileting. -The resident required dressing, transferring. Observation of Resides: -The personal care and resident's room and toward the personal care and resident #2 was lying and she was lying on the resident did not co-the PCA did not closs.	Alzheimer's disease, high nin D deficiency, and unstantly disoriented. mi-ambulatory. disoriented assistance with bathing, disoriented of bladder and continent of bladder and continent of bladder and continent assessment and continence of bladder abulatory with a wheelchair. Continence of bladder ally dependent for bathing, and dimited assistance with and ambulation. The continence of bladder and continence of bladder and continence of bladder and limited assistance with and ambulation. The continence of bladder and continence of bladder and ambulation.	D911	DEFICIEN	CY)	
	bedroom. -The PCA did not close the window blinds in the resident's room leaving the resident visible from the front parking lot of the facility. -The PCA removed the resident's pajama bottoms. -At 5:18am, a male resident walked by Resident #2's room in the hallway and looked in the room.					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 219 of 267

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	ED
			B. WING			
		Hal089002	B. WING	· · · · · · · · · · · · · · · · · · ·	05/17/	2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY 6	SA FAST			
TYRRELL HOUSE		A, NC 27925				
			H, NC 27925			
(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	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
IAG	REGOLATORI ORE	100 IBENTIL TING IN GRAMMATION,	TAG	DEFICIENCY)		
			+			
D911	Continued From page	e 219	D911			
	Desident #2 was lyin	a on the had wearing on				
		g on the bed wearing an				
		cks, and a t-shirt when the				
	male resident looked					
		erson walked by the room				
	•	pen and the resident was not				
	fully clothed.					
	-The PCA assisted the	e resident to the shower in				
	the resident's private					
		the resident in the bathroom				
	and gave her a showe	er without out ever closing				
	the door to the bathro	oom or the resident's room				
	for privacy.					
	-At 5:28am, the PCA	got the resident out of the				
	shower and assisted	the resident with walking				
		out clothing or a towel to				
	cover the resident.	3				
	-The resident was stil	I wet on some areas of her				
	skin and was not drie					
		e resident in sitting on the				
	bed and the resident	<u> </u>				
	clothing.					
		vay to the resident's closet to				
		leaving the resident naked				
		oor and window blinds still				
	open.	oor and window billias still				
	•	the resident and finished				
	drying her with a was					
		d to the resident's bathroom				
		the resident's room, leaving				
	the resident naked on					
	-The door and window blinds were still openA car pulled in the parking lot and drove by the					
	resident's window.					
		walked back in the room,				
		and came back to the				
	resident to apply deod					
	-At 5:31am, the PCA	put on the resident's socks,				
	an incontinence brief,	jogging pants, shoes, and				
	then a bra.					

Division of Health Service Regulation

-The incontinence brief and the jogging pants

STATE FORM E899 ZE7D11 If continuation sheet 220 of 267

DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D WING		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	NOVIDER OR OUT FIER			, 2.11 3332	
TYRRELL	HOUSE		64 EAST		
		COLUME	IA, NC 27925		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JAIL DAIL
				,	
D911	Continued From page	e 220	D911		
		the resident's knees as the			
	resident was still sittir				
		e male resident walked up to			
		aved at the PCA, and told			
	the PCA "hey".				
	-The PCA spoke back	k to the male resident and			
		esident #2 with dressing.			
	-The PCA did not try to cover Resident #2 or				
	close the door to prevent the male resident from				
	seeing Resident #2 e	xposed.			
	-The PCA assisted th	e resident in standing to pull			
	up incontinence briefs	s and pants and the same			
	male resident came b	pack to the door and spoke			
	to the PCA again.	·			
		essing the resident, assisted			
		neelchair, and left the room			
	at 5:46am.	,			
	Interview with the PC	A on 05/07/19 at 6:50am			
	revealed:				
	-She usually closed the	he residents' doors when			
	she provided persona				
		lose the door that morning			
		was providing care to			
	Resident #2.	mae promaining canonic			
		ring weekend because they			
	were short staffed an				
		Resident #2' blinds were			
	open as well.	Tredicent #2 billide were			
	open de wen.				
	Based on observation	ns interviews and record			
	Based on observations, interviews, and record reviews, it was determined Resident #2 was not				
	interviewable.	THIS I CONGOTT IF WAS NOT			
	into viewabie.				
	Confidential interview	with staff revealed:			
		red PCAs leave residents'			
		viding personal care to			
	residents.	المراجع المراجع والمراجع والمراجع والمراجع المراجع			
	- ine staπ nad observ	ed it "sometimes" but could			

Division of Health Service Regulation

not specify how often.

STATE FORM E899 ZE7D11 If continuation sheet 221 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		2019
NAME OF P	ROVIDER OR SUPPLIER	950 HWY	DRESS, CITY, STA 64 EAST A, NC 27925	TE, ZIP CODE	,	
(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	(X5) COMPLETE DATE
D911	1 Continued From page 221		D911			
	rooms and bathrooms "extra sense of privace -Staff should also close careShe was not aware sor window blinds where residents. 2. Review of Resider 07/13/18 revealed: -Diagnoses included chronic anxiety, hype-The resident was interpresent of the resident was selected.	evealed: to close doors to residents's when providing care for an cy". se window blinds if providing staff were not closing doors on providing care to at #6's current FL-2 dated dementia, hypertension, rlipidemia, and glaucoma. ermittently disoriented. mi-ambulatory. was functionally limited. d assistance with bathing, l.				
	care plan dated 12/27 -The resident was am -The resident was conbowelThe resident required bathing, grooming, dr -The resident required	nbulatory with a wheelchair. Intinent of bladder and It extensive assistance with It essing, and toileting. It il				
	eating, transferring, and ambulation. Observation of Resident #6 on 05/07/19 from 5:52am - 6:24am on the assisted living (AL) side of the facility revealed: -The personal care aide (PCA) entered the resident's room and turned on the lights.					

Division of Health Service Regulation

-Resident #6 was lying in bed, wearing pajamas,

STATE FORM E899 ZE7D11 If continuation sheet 222 of 267

DIVISION	i rieaitii Service Regu				1		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		Hal089002	B. WING		05/47/2040		
		паноэни2			05/17/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
TYRRELL	HOUSE	950 HWY	64 EAST				
IIKKELL	HOUSE	COLUMB	IA, NC 27925				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)		
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPL	ETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	·	
			1	DEFICIENCY)			
D911	Continued From page	e 222	D911				
	and had an incontine	nce pad underneath her.					
		e resident to the wheelchair					
	and pushed her to the	e suite bathroom.					
	•	and the bathroom were left					
	open.						
	•	the resident in the bathroom					
	with the door open.						
	-There was a very str	ong odor of urine.					
	-	ed out into the hall and					
	announced she need						
		taff (did not provide personal					
		nded a bottle of body wash					
	to the PCA while the						
		pen, leaving the unclothed					
	resident visible.	pen, leaving the unclothed					
		ting naked on the toilet and					
	the PCA bathed the re	esident with body wash,					
		th while the resident was					
	sitting on the toilet.						
		e resident with dressing and					
	transferring back to the						
	-The PCA pushed the						
	bedroom and left the	room at 6:24am.					
	Interview with the PC	A on 05/07/19 at 6:50am					
	revealed:						
	-She usually closed the	he residents' doors when					
	she provided persona	al care.					
	-She "just forgot" to c	lose the door that morning					
	(05/07/19) when she						
	Resident #6.	-					
	-It had been a long, ti	ring weekend because they					
	were short staffed and	-					
	Interview with Reside	nt #6 on 05/10/19 at					
	11:25am revealed:	,, 5 511 557 157 15 41					
		th bathing and dressing.					
		ot the door closed when they					
		e was not sure because she					
	provided date but Sile	was not suit because sile	1				

Division of Health Service Regulation

was blind and could only see shadows.

STATE FORM E899 ZE7D11 If continuation sheet 223 of 267

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			D WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
			IA, NC 27925			
(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	(X5) COMPLETE DATE
D911	Continued From page	223	D911			
	-She wanted the door	closed for privacy.				
	doors open while pro- residents.	red PCAs leave residents' viding personal care to red it "sometimes" but could				
	rooms and bathrooms "extra sense of privace -Staff should also clost care.	evealed: I to close doors to residents' s when providing care for an cy". se window blinds if providing				
	07/18/18 revealed: -Diagnoses included hypertension, chronic hyperlipidemia, chronic bilateral knees, lumbadegenerative joint dis-The resident was am	c renal insufficiency, nic back pain, arthritis ar spondylosis, and sease. nbulatory with a walker. d assistance with bathing				
	and care plan dated (-The resident was am device (type not specified as occupied and bowel.	nbulatory with an aide or				

Division of Health Service Regulation

bathing, grooming, and dressing.

STATE FORM E899 ZE7D11 If continuation sheet 224 of 267

STATEMENT OF CERCICIONS NAME OF PROVIDER OR SUPPLIER NAME OF PROVIDER OR SUPPLIER SHARED AND EAST TOLUMBIA, NC 27255 NAME OF PROVIDER OR SUPPLIER SHARED AND EAST TOLUMBIA, NC 27255 NAME OF PROVIDER OR SUPPLIER SHARED AND EAST COLUMBIA, NC 27255 NAME OF PROVIDER OR SUPPLIER SHARED AND EAST SHARED AND EAST SHARED AND EAST PROVIDER OR SUPPLIER SHARED AND EAST PROVIDER OR SUPPL	Division of	of Health Service Regu	ilation				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PRETIX P	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 950 HWY 64 EAST COLUMBIA, NC 27935 CALUMBIA, NC 27935 TAG PREFIX (PACH DEPOISEORY MUST BE PRECIDED BY PULL PREFIX TAG 10 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (PACH DEPOISEORY MUST BE PRECIDED BY PULL PREFIX TAG 10 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 11 PREFIX TAG 12 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 13 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 14 PREFIX TAG 15 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 16 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 16 PREFIX TAG 17 PREFIX TAG 17 PREFIX TAG 18 PROVIDERS PLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 18 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 18 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 18 PROVIDER SPLAN OF CORRECTION MUST BE PRECIDED BY PULL PREFIX TAG 18 PREFIX TAG 19 PROVIDER SPLAN OF CORRECTION MUST BE PROVIDER SPLAN OF CORRECTION MUST BE PLAN OF	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 950 HWY 46 EAST COLUMBIA, NC 27825 MAI, ID PREVIOUS SUPPLIED ON THE PROVIDER'S PLAN OF CORRECTION PROVIDER'S PL							
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TYRRELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST LAS PERCEDED BY PLILL FACE OF TAG. PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST LAS PERCEDED BY PLILL FACE OF TAG. PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHI OULD BE CONFIDENCY OF ILS DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHI OULD BE CONFIDENCE TO THE APPROPRIATE DEFICIENCY) DIFFERENCE TO THE APPROPRIATE DEFICIENCY			Hal089002	B. WING		05/1	7/2019
TYRRELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST LAS PERCEDED BY PLILL FACE OF TAG. PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST LAS PERCEDED BY PLILL FACE OF TAG. PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHI OULD BE CONFIDENCY OF ILS DEFICIENCY) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHI OULD BE CONFIDENCE TO THE APPROPRIATE DEFICIENCY) DIFFERENCE TO THE APPROPRIATE DEFICIENCY	NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS CITY STA	TE ZIP CODE		
COLUMBIA, NC 27925 PROVIDERS NAME OF REPORTED AND STATE OF CORRECTION (CASCIDERS NAME OF CORRECTION (CASCIDERS NAME OF CORRECTION) (CASCIDERS NAME OF CASCIDERS NAME OF CASCID					, 2 0002		
CANTID SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLANOF CORRECTION (SCAND REFORED BY PILL REQUIATORY OR LSC IDENTIFYNO INFORMATION) PREFX TAG PROVIDERS PLANOF CORRECTION ACTION SHOULD BE CROSS-KEPERENCED TO THE APPROPRIATE DATE	TYRRELL	HOUSE					
PRETIX TAG TAG CROSS-REFERENCE TO THE APPROPRIATE D911 Continued From page 224 -The resident required limited assistance with toileting and transferringThe resident required supervision with ambulation. Observation of Resident #15 on 05/07/19 at 4.41 am on the assisted living (AL) side of the facility revealed: -The personal care aide (PCA) entered the resident #15 wing in bed with the right clothes onThe PCA provided standby assistance to the resident with transfer from bed to wheelchairThe PCA powled the resident from her room to the shared suite bathroomThe PCA possible the resident from the room to were left open and visible from the hallwayThe PCA assisted the resident with transfer from wheelchair to the toiletThe PCA assisted the resident with standing so the PCA could wash the resident with standing so the PCA could wash the resident with standing so the PCA assisted the resident to ne continence briefs and clothingBoth doors remained open during the entire time the PCA was providing care to the residentThe PCA assisted the resident back to her bedroom, made the resident back to her bedroom, made the resident shot, and then left the room. Interview with the PCA on 05/07/19 at 6:50 am revealed: -She usually closed the residents' doors when she provided personal careShe "just forgot" to close the door that morning			COLUMB	IA, NC 2/925			T
D911 Continued From page 224 -The resident required limited assistance with toileting and transferringThe resident required supervision with ambulation. Observation of Resident #15 on 05/07/19 at 4.41am on the assisted living (AL) side of the facility revealed: -The personal care aide (PCA) entered the resident's noom and turned on the lightsResident #15 was lying in bed with her night clothes onThe PCA provided standby assistance to the resident with transfer from bed to wheelchairThe PCA possible the resident from her room to the shared suite bathroomThe door to the suite and the door the bathroom were left open and visible from the hallwayThe PCA assisted the resident from the toiletThe PCA assisted the resident's clothing and bathed the resident with water, soap, and a washcloth while the resident with standing so the PCA could wash the resident from the toilet without clothes onThe PCA assisted the resident sprivate area and helped the resident put on clean incontinence briefs and clothingBoth doors remained open during the entire time the PCA was providing care to the residentThe PCA assisted the resident back to her bedroom, made the resident back to her bedroom, made the resident back to her bedroom, made the resident's bed, and then left the room. Interview with the PCA on 05/07/19 at 6:50am revealed: -She usually closed the residents' doors when she provided personal careShe "just forgot" to close the door that morning							
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Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 225 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/11/2010
		950 HWY 6		· - , · · · · · · · · · · · · · · · · · ·	
TYRRELL	HOUSE	COLUMBIA	A, NC 27925		
(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
D911	Continued From page	225	D911		
	Resident #15It had been a long, tiring weekend because they were short staffed and she forgot it.				
	1:10pm and 05/13/19 -She needed assistar got a sink bath every showersShe could not recall	ent #15 on 05/07/19 at at 11:28am revealed: nce with bathing; she usually day since she did not take if staff closed the door when her, but she would like for or.			
	Confidential interview with staff revealed: -The staff had observed PCAs leave residents' doors open while providing personal care to residentsThe staff had observed it "sometimes" but could not specify how often.				
	rooms and bathrooms "extra sense of privace -Staff should also clost care.	evealed: to close doors to residents' s when providing care for an ey". se window blinds if providing			
	02/07/19 revealed: -Diagnoses included infection and inflamm acquired absence of lhypertension, atheros	t #3's current FL-2 dated type 2 diabetes mellitus, atory reaction to left hip, left upper limb above elbow, sclerotic heart disease, bry of healed traumatic			

Division of Health Service Regulation

-The resident was semi-ambulatory.

STATE FORM E899 ZE7D11 If continuation sheet 226 of 267

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			B. WING			
		Hal089002	B. WING		05/17/2019	9
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TO THE OT T	NOVIDEN ON OUT FIEN					
TYRRELL	HOUSE		64 EAST			
		COLUME	BIA, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	,	X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		PLETE ATE
TAG REGULATORY OR		LOC IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	MATE 5	
				, , , , , , , , , , , , , , , , , , ,		
D911	Continued From page	e 226	D911			
	-The resident was inc	continent of bowel and				
	bladder.					
		d assistance with bathing				
	and dressing.					
	Review of Resident #	3's current assessment and				
	care plan dated 02/08	3/19 revealed:				
	-The resident was am	bulatory with a wheelchair.				
	-The resident had lim	ited range of motion in				
	upper extremities.					
	-The resident was dai	ily incontinence of bladder				
	and bowel.	,				
	-The resident was full	y dependent with bathing,				
	dressing, and groomi					
		d limited assistance with				
	transferring and ambi					
	and amore	diation.				
	Interview with the ner	sonal care aide (PCA) on				
	05/07/19 at 6:50am re					
		ne residents' doors when				
	she provided persona					
		lose the doors that morning				
		provided care to three				
	residents prior to 6:50	•				
	•	ring weekend because they				
	were short staffed and	d she lorgot it.				
	Observation of Doold	ent #3 on 05/07/19 at				
		ed living (AL) side of the				
	facility revealed:					
		red the resident's room and				
	turned on the lights.					
		ng in bed with incontinence				
	brief only.					
		m and told the resident she				
	was going to get him					
	-The PCA left the roo	m at 7:22am to get some				
	gloves and came bac	k to the room.				

-The PCA sat the resident up in bed.

-The door to the resident's room and the suite

STATE FORM 6899 ZE7D11 If continuation sheet 227 of 267

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	950 HWY 6	ORESS, CITY, STA 64 EAST A, NC 27925	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	(X5) COMPLETE DATE
D911	up to his knees, and hardeness the bed while she well washcloth to wipe his the resident was only his knees and slipper the doors still open are staff and residents whallway. The PCA then washed him up, pulled up his to the wheelchair. Interview with the sand 7:43am revealed: She "forgot" to close providing care that me she had no other extendoor. She should have closs care but he was not she thought staff clos care but he was not she thought the door providing care. Confidential interview The staff had observed doors open while provinces in the staff had observed doors open while provinces in the staff had observed doors open while provinces in the staff had observed or some staff had observed had the some staff had observed h	ble from the hallway. resident's socks, his pants his slippers. dent sitting on the side of hit to his bathroom to get a face. y wearing socks, pants to while sitting on his bed with hid visible from the hallway. Vere passing by in the ed the resident's face, stood pants, and transferred him The PCA on 05/07/19 at Resident #3's door while forning (05/07/19). Tolanation for not closing the sed the door. Int #3 on 05/10/19 at Hed the door when providing ure. The headed to be closed when with staff revealed: The headed to be closed when with staff revealed: The headed to be could the door when but could the manager (CM) on	D911			

Division of Health Service Regulation

-Staff were supposed to close doors to residents'

STATE FORM E899 ZE7D11 If continuation sheet 228 of 267

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			B. WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		A, NC 27925			
			1			T
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D044	0 " 1 =					
D911	Continued From page	228	D911			
	rooms and bathrooms	s when providing care for an				
	"extra sense of privac					
		se window blinds if providing				
	care.	g				
	-She was not aware s	staff were not closing doors				
	or window blinds whe					
	residents.	, ,				
	5. Review of Residen	t #14's current FL-2 dated				
	02/26/19 revealed dia	agnoses included Huntington				
		at causes the nerve cells in				
	•	wn causing uncontrolled				
	movements).	5				
	,					
	Observation of on 05/	/16/19 at 11:28 am revealed:				
	-Resident #14 was sit	tting in a wheelchair on the				
	Assisted Living (AL) h	_				
	-Resident #14 had un	controllable movements to				
	her head, arms, trunk	x, and legs.				
	-There was a persona	al care aide (PCA) standing				
	behind Resident #14	that leaned forward close to				
	Resident #14's right e	ear.				
	-The PCA told Reside	ent #14, "Stop. Be still. I				
	don't know what I'm g	joing to do with you".				
	-Resident #14 continu	ued to have uncontrollable				
	movements to her he	ad, arms, trunk, and legs				
	that were at a slower	speed.				
	Interview with the PC	A on 05/16/19 at 11:45 am				
	revealed:					
		not control her movements.				
	-Resident #14 could of	control the speed of her				
	movements.					
		nxious" movements that				
	were "fast when staff	could not move fast				
	enough".					
	-She told Resident #1	14 to "Stop. Be still. I don't				
	know what I'm going t	to do with you" to get her to "				

Division of Health Service Regulation

of the wheelchair".

...calm down and be still so she wouldn't fall out

STATE FORM E899 ZE7D11 If continuation sheet 229 of 267

(X3) DATE SURVEY COMPLETED	
5/17/2019	
(X5) COMPLETE DATE	

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 230 of 267

DIVISION	of Health Service Regu	lation			1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		Hal080002	B. WING		05/47/2040	
		Hal089002			05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		IA, NC 27925			
			17, 110 27020			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION	(
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
IAG			IAG	DEFICIENCY)		
D911	Continued From page	e 230	D911			
	use her left arm."					
		assistance with bathing,				
		p her incontinence brief.				
	-She did not know of	any staff being demeaning				
	or rude to Resident #-	4 about helping.				
	Interview with Reside	nt #4 on 05/08/19 at 3:28pm				
	revealed:					
	-She had been gone	from the facility from				
	September 2018 thro					
		from a life threatening low				
	_	caused her to have a				
	metabolic brain injury					
		rself clean but was not				
	always able to manag					
		raise and use her left arm,				
		n her legs and her balance				
	was off.					
		e to transfer herself and				
	used a wheelchair for					
	_	a hard time getting up from				
	the recliner.					
	-She would have to ro	ock back and forth to get				
	enough momentum to	raise up from sitting.				
	-Some days she need	ded help with bathing,				
	dressing, getting out	of the chair and cleaning				
	after toileting.	-				
	_	o have to ask for assistance.				
		her and called her lazy				
	behind her back.					
		d her a wad of toilet paper				
		rd you can do it yourself,"	1			
	and then walked awa	- ·				
		ppened two or three weeks				
	ago and she reported	the stail to the				
	Administrator.					
		in for work last weekend	1			
	(05/04/19 and 05/05/ ⁻	19) and was supposedly	1			

Division of Health Service Regulation

night (05/07/19).

fired, but the staff was at work on 3rd shift last

STATE FORM E899 ZE7D11 If continuation sheet 231 of 267

	n rieaitii Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	=1ED
				_		
			D. MING	D. WING		
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TVAINE OF T	NOVIDEN ON OUT FIEN		, ,	(I, Zii GGBE		
TYRRELL	HOUSE	950 HWY				
		COLUMB	A, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
D911	Continued From page	231	D911			
	Continued From page	201				
	-She could not remen	nber the staff's name.				
	-She had gotten to the	e point where she did not				
	want to ask for assista					
		fection to her groin, rectum				
	-	e she was not able to clean				
	well enough by herse					
		imary care provider (PCP)				
	, ,	and he prescribed a cream				
	because her bottom v	vas "raw".				
	-Her bottom only start	ted feeling better yesterday				
	(05/07/19).					
	,					
	Observation of Reside	ent #4 on 05/08/19 at				
	4:10pm revealed:					
	•	back and forth in her recliner				
		being able to push up and				
	stand.					
	 -Resident #4's left arr range of motion. 	n was weak and had limited				
	•	able to use her left arm to				
	assist with getting out					
		veral small shuffling steps to				
	turn and transfer into	.				
		able to use her left arm to				
	•	ng down in the wheelchair.				
		I down into the wheelchair				
	on her bottom.					
	Interview with a perso	onal care aide (PCA) on				
	05/10/19 at 11:43am					
		always needed help; she				
	was at the facility in 2					
	-	.o to attu ulu tiol fleed				
	assistance.					
		ight," the resident needed				
	•	g her bottom after she had a				
	bowel movement.					
	-Resident #4 also nee	eded help in the shower				
		d feet and help getting her				
	bottoms pulled up wh					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 232 of 267

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		H-1080002	B. WING		05/47/2040	
		Hal089002			05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		950 HWY	64 EAST			
TYRRELL	HOUSE		SIA, NC 27925			
			<u> </u>			
(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 APPROPR		
				DEFICIENCY)		
D044	0 " 1 =		5044			
D911	Continued From page	e 232	D911			
	Interview with a secon	nd MA on 05/10/19 at				
	11:52am revealed:					
		tween constipation and				
		medications and laxatives.				
	-	assistance with cleaning				
	after toileting.	assistance with cleaning				
	•	able to reach her bottom				
	and wipe herself well.					
		perienced diarrhea recently				
	_	ere (bottom)" from not				
	getting cleaned well.	16				
		sk for assistance when she				
		ped Resident #4 herself				
	when she was working	_				
		her that some staff had told				
	the resident that prov	-				
	_	g was not on her care plan				
	and did not help her.					
		e staff because Resident #4				
	did not name the staf	f.				
		with Resident #4's PCP on				
	05/15/19 at 9:55am re					
	-He did not see the ex	xcoriation (raw) and/or				
	erythema (red) on Re					
	-Resident #4 did not v	want him to see the area for				
	privacy.					
	-He prescribed an oir	ntment to treat the area				
	empirically because F	Resident #4 reported having				
	diarrhea and rectal bu					
		ny issue with staff not				
	assisting Resident #4	with cleaning after toileting.				
	Interview with the Adr	ministrator on 05/09/19 at				
	4:45pm revealed:					
	-She did not know Re	esident #4 had felt so				
	humiliated and develo	oped a rash due to not				
	wanting to ask for hel	- ' - '				
		to provide care according to				

Division of Health Service Regulation

the residents' needs.

STATE FORM E899 ZE7D11 If continuation sheet 233 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		Hal089002	B. WING		05/17/2	019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
	QUILLEN OT		A, NC 27925	220//2520 2144 05 00225070		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE C	(X5) COMPLETE DATE
D911	Continued From page	233	D911			
	01/23/19 revealed diadementia, chronic atridiabetes mellitus, hypanxiety, gout, hyperter Review of a charting 3:36pm for Resident adocumented the resident refused to went home with a famous Telephone interview of member on 05/09/19 resident #9 left the fraction of the bed bugs in her room recliner. Resident #9 had bed her neck and arms. The facility was suppfor Resident #9. The room the facility #9 had a toilet that was did not flush. The headboard on the The family member of the supplementary is together." This was the 3rd time since October 2018. The family members	perlipidemia, depression with ension and hypothyroidism. Inote dated 05/05/19 at #9 revealed staff lent's room had bed bugs; o go to another room and nily member. With Resident #9's family at 9:58am revealed: facility on 05/05/19 and was family member because of at the facility. All over Resident #9's I bug bites on the back of posed to have another room offered to move Resident as running continuously and				
	while away from the f Interview with Reside member on 05/09/19 -He had picked up Re on 05/05/19.	nt #9's second family				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 234 of 267

DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		
		Hal089002	B. WING	·····	05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		950 HWY	64 FAST		
TYRRELL	HOUSE		A, NC 27925		
			A, NO 27925	T	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAG			IAG	DEFICIENCY)	
D911	Continued From page	234	D911		
	When he arrived at the	he facility, he had seen a			
	bed bug crawling on F				
		t #9's neck was "ate up"			
	•	nd there were bite marks "all			
	up and down her arm				
	-	per had to shower Resident			
	#9 before the residen				
	-He had brought new	clothing for Resident #9 to			
	wear.				
	Interview with a medic	cation aide (MA) on			
	05/14/19 at 9:10am re	evealed:			
	-Resident #9 came ou	ut to the front desk on the			
	special care unit (SCI	J) and said she was itching			
	overnight on 05/04/19				
	~	bugs on Resident #9's arm			
	which she removed.	3			
		ed the resident's room and			
	there were bed bugs				
	•	40 bed bugs on the sheet,			
		he seams of the pillow.			
		d linens from Resident #9's			
	bed and put them in t				
		9 out of her room for the			
	remainder of that shift				
		r. r shift (7:00am-3:00pm) on			
	-				
	05/05/19 cleaned Res	Sident #8 S Cidthing.			
	Interview with the Car	re Manager (CM) on			
	05/08/19 at 3:17pm re				
		her over the last weekend			
		ugs were found in Resident			
	,	ugs were round in Resident			
	#9's room.				
		nber which staff reported			
	finding the bed bugs.				
	-	aging bed bugs in the			
		report to her and she			
	reported to the Admin				
	-The Administrator wo	ould then put a work order in			

Division of Health Service Regulation

the computer and maintenance would come out

STATE FORM E899 ZE7D11 If continuation sheet 235 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
					05/17/2019	\dashv
NAME OF P	ROVIDER OR SUPPLIER	950 HWY	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE		IA, NC 27925			
OUT THE PLANE OF T		ID	PROVIDER'S PLAN OF CORRECT	ON (X5)	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE COMPLET	Έ
D911	Continued From page	e 235	D911			
	bugs as of 05/08/19 bugs as of 05/08/19 bugs as of 05/08/19 bugs at a waiting for the pest of resident #9 was start until the room had be Observations of Residuat 4:44am revealed: -The mattress was ture and leaned against the bed. -There were no linear and leaned against the bed. -There were personal blanket on the recline storage bins and clott drawers. -None of the clothing, were sealed in plasticular and fine of the chair that reservisions.	and not been treated for bed because the facility was portrol company. It is possible to the facility was portrol company. It is possible to the facility was portrol company. It is possible to the folds and the facility with a family member en treated for bed bugs. I dent #9's room on 05/07/19 I dent #9's room on 05/07/19 I med up on the box spring the wall at the head of the so on the mattress. I items in the room such as a ser, throw pillows, plastice in the closet and the blanket or throw pillows to bags. I white particles in the folds in the bed bug eggs. I will up on and around the folds in the folds in the bed bug eggs. I will up on and around the folds in the				
	Observations of Resident #9's room on 05/09/19 from 12:35pm until 12:45pm revealed: -There were small black specks resembling bed bug excrement around the call bell, electrical outlet, a picture hanger on the wall above the bed and around a small hole in the wall in the corner above the headboard. -There were two small pale bed bugs next to the picture hanger and four small pale bed bugs on the headboard. -There was a live bed bug where the wall meets the ceiling above the window. Interview with the Administrator on 05/09/19 at 12:47pm revealed:					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 236 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		7/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 00/11	72010
TYRRELL	HOUSE	950 HWY (COLUMBI	64 EAST A, NC 27925			
(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
D911	process and time fran-When staff found bethe staff sent photos of cell phone. -She sent the bed but staff and he sent the pest control compand heat treat the root-she did not know who company would be at Interview with the Adr 4:50pm revealed: -She had offered a robeginning of the week-Resident #9's family because the room waresident had. -Resident #9 was in a the rooms were separating of the week-resident and family roommate was not agaround the SCU. -Resident #9's family the resident with the froom on the SCU was Observation on 05/07/belongings remaining	nt at the facility was "a nes were different." d bugs in a resident's room, of the bed bugs to her via g photos to her maintenance photos to his supervisor and rany. Inpany would then come out om. Iden the pest control the facility. Ininistrator on 05/09/19 at Ininistrator on 05/09	D911	DELIGITIENCI)		
	Interview with the Adr	ministrator on 05/15/19 at				

Division of Health Service Regulation

2:55pm revealed:

STATE FORM E899 ZE7D11 If continuation sheet 237 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•	
		950 HWY (•		
TYRRELL	HOUSE		A, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	COMPLETE DATE
D911	Continued From page	e 237	D911			
D911	-The facility had starter room out on 05/12/19 -Resident #9's room had storage unit. The family member were recliner and any other reclin	ed clearing Resident #9's and been cleared out. g was placed in plastic en outside and placed by the was going to pick up g. said to throw away the r furniture belonging to ard and bed frame were yed with rubbing alcohol. sealed off and was awaiting pest control company. ersonal furniture were 9. eturn to the facility following ment of the resident's room. The corporate office at the oc (05/13/19) to have the pest the out and treat for bed apany would not be available eek 05/17/19). The family member of the the week (05/13/19) related as, interviews and record mined Resident #9 was not reat at least 7 residents with	D911			
	Resident #15 resultin	g in residents who were used to other residents and				

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 238 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD 950 HWY 6	RESS, CITY, STA 4 FAST	TE, ZIP CODE	
TYRRELL	HOUSE		A, NC 27925		
(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
D911	Continued From page	238	D911		
	health, safety, and we constitutes a Type B				
	The facility provided a accordance with G.S. 05/10/19.	a plan of protection in 131D-34 on 05/09/19 and			
	CORRECTION DATE VIOLATION SHALL N	FOR THE TYPE B NOT EXCEED JULY 1, 2019.			
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912		
	G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.				
	reviews, the facility fa received care and ser appropriate and in co- federal and state laws related to medication	as evidenced by: ns, interviews and record iled to ensure residents rvices which were adequate, mpliance with relevant s and rules and regulations administration, controlled ekeeping and furnishings.			
	The findings are:				
	reviews, the facility fa	ions, interviews and record iled to maintain an azards in the special care			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 239 of 267 ZE7D11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		Hal089002	B. WING		0;	5/17/2019
NAME OF PROVID	DER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	ZIP CODE		
TYRRELL HOU	JSE	***************************************	64 EAST BIA, NC 27925			
(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 ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
uni bed day that [Re Ho Vio Vio 2. If rev me the observance incomplete in the control of the con	d bug infestation to the served during the bors with a vitamin of for 3 of 10 sampled to treat low pot do to treat low pot do treat low pot do to treat low pot do to treat low pot do treat low pot do to treat low pot do to treat low pot do to treat low pot do low pot	Resident #9's room having a hat was left untreated for 7 vindow in resident room 209 d for more than 6 weeks. A NCAC 13F .0306(a)(5) Furnishings (Type B attions, interviews, and record ailed to administer red and in accordance with r 2 of 11 residents (#18, #19) medication passes including D supplement (#18, #19); alder residents (#3, #2, #4) a diuretic (#3), medications assium, treat and prevent and prevent stomach ulcers on to treat chronic obstructive and asthma (#4) [Refer to Tag .1004(a) Medication	D912			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 240 of 267

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
		Hal089002	B. WING		05/17/2	019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TVDD=::	HOUSE	950 HWY 6	4 EAST			
TYRRELL	HOUSE	COLUMBIA	A, NC 27925			
(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 C	(X5) COMPLETE DATE
D912	Continued From page	240	D912			
	#3, #6, #15); speaking residents (#4, #14); a acceptable bed at the room was infested with	g and being disrespectful to nd failed to provide an facility for a resident whose th bedbugs (#9) [Refer to (1) Residents' Rights (Type				
D914	D914 G.S. 131D-21(4) Declaration of Residents' Rights		D914			
	G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.					
	This Rule is not met a	_				
	reviews, the facility fa (#8 and #11) were fre evidenced by bruises hands following incide and Staff C where Sta roughly; and bruises i	ons, interviews and record iled to assure 2 residents e of physical abuse as occurring on Resident #8's ents between Resident #8 aff C handled Resident #8 nconsistent with fall found ospital for Resident #11.				
	The findings are:					
	02/05/19 revealed: -Diagnoses included of hypertension, lower e constipation, hyperlip depressionResident #11 was co	idemia, anemia and				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 241 of 267

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		Hal089002	B. WING		05/	17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
			IA, NC 27925			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D914	Continued From page	e 241	D914			
	revealed the resident 09/3016 and discharg the level of care.	11's Resident Register was admitted to the facility ged 02/15/19 for a change in				
	Review of a charting note for Resident #11 dated 02/05/19 at 9:00am revealed: -The Care Manager (CM) documented Resident #11 was found sitting on the floor by her bed with bruising over her left eye and the front of her left shoulder. -Resident #11's primary care provider (PCP) was					
	resident every 15 mir	nstructions to monitor the nutes for changes. Resident #11 on 02/05/19.				
	Review of an accident/injury report dated 02/05/19 at 6:10am for Resident #11 revealed: -Resident #11 was found sitting on the floor by her bedResident #11 had bruising to her left forehead,					
	sent to the emergence	ne, and the resident was not y room (ER). ident #11's primary care				
	(PCA) on 05/16/19 at -She was working 3rd assisted living (AL) si -She was late getting	d shift on 02/05/19 on the de. to work that night.				
	midnight; the resident	Resident #11 just after t was sleeping. lity for her lunch break. getting residents up for the				
	-It was about 5:00am Resident #11's room.					

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 242 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY				
	OLUMBA DV OT		A, NC 27925			
(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	(X5) COMPLETE DATE
D914	Continued From page 242		D914			
D914	-She found Resident foot of her bedResident #11's bed wheelchair was at the wallShe left Resident #1' went to the medicatio -The MA got Resident end of her bedShe did not assist wi from the floorShe was off work for returned other staff wup" Resident #11She did not see any while she was sitting -The CM and the Adm happened to Resident (02/12/19)She did not see any roughly or physically and resident #11 did not wheelchair and needed. Attempted telephone 9:35pm with the MA wand accident report did was unsuccessful. Review of a charting to 02/05/19 at 7:00pm re-The CM documented her PCP and diagnos forehead, fall from slip left shoulder pain.	#11 on the floor near the was near the window and her foot of the bed toward the I sitting on the floor and n aide (MA). I #11 up and sat her on the th getting Resident #11 up a day or two and when she ere saying someone "beat bruises on Resident #11 on the floor. Ininistrator asked her what It #11 a week later one handle Resident #11 abuse her. Italk, she was in a ed help to get up. iinterview on 05/16/19 at who completed the incident ated 02/05/19 at 6:10am note for Resident #11 dated evealed: I Resident #11 was seen by ed with contusion of the left oping, trip or stumble and	D914			
	-The PCP ordered a r	nobile x-ray of Resident d scheduled a follow up visit				

Division of Health Service Regulation

Telephone interview with Resident #11's PCP on

STATE FORM E899 ZE7D11 If continuation sheet 243 of 267

Division of	<u>of Health Service Regu</u>	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF D		OTDEET AS	DDESS CITY STA	TE ZIR CODE		
NAME OF PR	ROVIDER OR SUPPLIER		DRESS, CITY, STA	IE, ZIP GODE		
TYRRELL	HOUSE	950 HWY				
			IA, NC 27925			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D914	Continued From page	e 243	D914			
	05/15/19 at 3:28pm re					
	02/05/19 and had left	d Resident #11 had fell on				
	hematoma on her left					
		ent #11 on 02/05/19; the				
		that went from her shoulder				
	to halfway down her a					
	-	x-ray of Resident #11's left				
	shoulder.					
		cheduled for a follow up visit				
	in 2 weeks.					
	-	thing suspicious at that				
	time."					
	Deview of a charting	note for Resident #11 dated				
		revealed staff documented				
		nt to the hospital for swollen				
	knees.					
	1					
	Review of a second a	accident/injury report dated				
		for Resident #11 revealed:				
	-Resident #11's knees					
		ent to the ER and admitted to				
	the hospital.					
	Telephone interview v	with a second PCA on				
	05/16/19 at 11:00pm					
	-The night Resident #					
		orking on the special care				
	unit (SCÚ) and did no					
	-The next evening sh					
	Resident #11 was ser	nt to the emergency room				
	(ER).					
		oaning in pain when she				
	-	at night and her legs were				
	swollen.					
		uises under her eye, on her				
	arm and her legs.	05/10 said Decident #11 fells				
	-Stall working on 02/0	05/19 said Resident #11 fell;	·			

she did not remember which staff.

STATE FORM 6899 ZE7D11 If continuation sheet 244 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	950 HWY 6	PRESS, CITY, STA 4 EAST A, NC 27925	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	(X5) COMPLETE DATE
D914	known Resident #11 -The bruises on Resident with Resident with Resident with Resident #11; she did that nightResident #11; she did that nightResident #11 was not by herself and neede ambulation. Review of Resident #Activities of Daily Livi C documented provideresident on 02/04/19 Attempted telephone 05/16/19 at 9:43pm with resident #11 present bruising over her bod healingThere were black and Resident #11's upper left chest from breast and bilateral shins darkesident #11 was did infection, acute kidnet with resident w	icility for a year and had not to fall. Ident #11 looked as if r. Isident #11 the night before lent did not have any It could have done that to it not know who was working It difficult, she did not walk it staff to help with It is February 2019 Ing (ADL) Log revealed Staff ling ADL assistance for the from 3:00pm until 11:00pm. Interview with Staff C on vas unsuccessful. It is hospital records dated 15/19 revealed: It it to the ER with extensive y in various stages of it white photos of bruises to front left arm, left shoulder, to clavicle, left forehead ted 02/05/19. It is agnosed with a urinary tract y injury and anemia. It is to the plant it is agnosed with Adult Protective safe discharge plan; the	D914			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 245 of 267

DIVISION	n nealth Service Regu	ilation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			P WING			
		Hal089002	B. WING		05/	17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE. ZIP CODE		
		950 HWY (·		
TYRRELL	HOUSE		A, NC 27925			
		COLUMBI	A, NC 2/925	1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE
IAG	REGOLATORI ORT	EGO IDENTIF TING IN ONWATION	TAG	DEFICIENCY		
						+
D914	Continued From page	e 245	D914			
	-Resident #11 had mu	ultiple bruises in different				
	stages of healing.	antiple braices in amerent				
	•	uises just above the left				
		, left cheek, left shoulder, left				
	upper arm and scatte					
	extremities.	ied on her lower				
		ad scattered skin tears on				
	her lower extremities.					
		dent #11's left arm, shoulder,				
		e a deep dark purple color.				
		esident #11's left eye was				
	black and blue.					
		vere on Resident #11's legs,				
		s above the resident's eye				
		chest bruises were "in				
	between".					
		ty were unable to tell the				
	Case Manager at the	hospital where the bruises				
	came from.					
	-The staff did not know	w the bruise that went from				
	Resident #11's left elb	bow to her shoulder was				
	even there.					
	-The bruise on Reside	ent #11's forehead could				
	have been from a fall.					
	-The bruises on Resid	dent #11's chest, arm and				
	shoulder did not appe	ear to come from a fall.				
		itially combative, however				
		in the hospital, the calmer				
	she became.					
	Telephone interview v	with the hospital Case				
	· · · · · · · · · · · · · · · · · · ·	at 4:49pm revealed she did				
	_	who she spoke to at the				
	facility or the date.	and the opone to at the				
	radility of the date.					
	Telephone interview	with Resident #11's family				
	member on 05/15/19	-				
	-Resident #11 was a	umcuit person with				
	dementia.		1	1		1

Division of Health Service Regulation

-Resident #11 was combative and would hit

STATE FORM E899 ZE7D11 If continuation sheet 246 of 267

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE	
			R WING		
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE		64 EAST		
COLUMBIA			IA, NC 27925		
(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
D914	Continued From page	e 246	D914		
	peopleResident #11 was se 02/05/19 for bruises of -After Resident #11 was not an investigation was had bruises found what that were not consisted. She did not remembed done the investigation happenedThe APS was involved employee that hit Resident #11 has ame sideSomeone said the bruished resident #11 has ame sideStaff kept saying it was investigatedNo one ever came at about what happened about what happened resident #11 was in walked. Confidential interview revealed: -The concerned citized months ago and had "God awful bruising or -Resident #11 had bruished bruished in the resident #11 had bruished in th	ent to the hospital on on her arms and chest. vas hospitalized on 02/05/19, done. done because Resident #11 len she went to the hospital ent with a fall. er the details of who had an and what exactly had ed, and it was a new sident #11. with a resident revealed: of Resident #11's face was ruise was from a fall. and more bruising on the ras from falls. told residents it was being round asking any questions a to Resident #11. with a concerned citizen en was at the facility a few seen Resident #11 with	D914		
	Telephone interview v	vith a third PCA on 05/16/19			

Division of Health Service Regulation

at 9:29pm revealed:

STATE FORM E899 ZE7D11 If continuation sheet 247 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	05/17/2019	
		950 HWY		,		
TYRRELL	HOUSE	COLUMBI	A, NC 27925			
(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	
D914	Continued From page	e 247	D914			
	before she went to th -Resident #11 did not 02/04/19. -She had heard from Resident #11 went to bruises. -She did not know wh #11.	thave any bruises on her on other staff in February 2019 the hospital and had nat happened to Resident				
	Interviews with three staff between 05/15/19 at 9:40pm and 05/17/19 at 3:15pm revealed: -The staff had heard from other staff that a staff "beat up" or handled Resident #11 roughly causing the bruises on the resident's arm and chestResident #11's bruises did not look like they came from a fall.					
	(DSS) representative revealed: -She and her Supervi of the hospital with th former Administrator: -There were discrepa hospital said about th	ncies between what the e bruises and what the and former Administrator				
	Telephone interview with the APS representative on 05/17/19 at 11:56am revealed: -She had seen the bruises on Resident #11 while she was hospitalized 02/05/19 - 02/15/19Resident #11 had a large purple bruise that went from her hairline to her eyelid; a blue/purple bruise on her left chest just below the collar bone that looked like a fist imprint; and large bruises on both shins with one being purple and the other					

red.

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 248 of 267

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			_			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY (64 EAST			
		COLUMBI	A, NC 27925			
(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	(X5) COMPLETE DATE
D914	Continued From page	248	D914			
D914	-There was concern to bruises Resident #11 -She initiated her investaff reported they do to Resident #11. Interview with the Reg (RCD) on 05/16/19 at 1-The Administrator regin the hospital said Regident #11 fell and were worsened by gradient #11 fell and were worsened by gradient #10:19am -She had just started training the week of 0-The hospital staff did Resident #11 had been she had gathered the abuse because the head gathered the facility updates when she had not conduct cause of Resident #1 -She did not know and being done and the sense had not received she had never suspendent were the result of physical provides the sense were the result of physical provides the suspendent with the sense had never suspendent were suspendent with the sense had never suspendent with the sense had not received she had never suspendent with the sense had never suspendent with the sense had not received she had never suspendent with the sense had not received she had never suspendent with the sense had not received she had never suspendent with the sense had not received she had never suspendent with the sense had not received she had never suspendent with the sense had not received she	hat a fall did not match the had. estigation on 02/13/19. id not know what happened gional Clinical Director t 10:19am revealed: ported to her that someone esident #11 was abused. es were not the result of d sustained bruises which avity. rent Administrator on revealed: as the Administrator in 12/04/19. I not specifically say en abused. ere was a suspicion of ospital stopped giving the staff called the hospital. ted an investigation into the 1's bruises. ything about an investigation taff being terminated. e extent of Resident #11's d a report from the hospital. ected Resident #11's injuries	D914			
	"beat up" by a staff.	e were allegations of abuse.				
	Interview with the form 05/16/19 at 10:44am					

Division of Health Service Regulation

-She was the Administrator at the time Resident

STATE FORM E899 ZE7D11 If continuation sheet 249 of 267

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY (64 EAST A, NC 27925			
0/0/15	STIMMADA ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	M OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D914	Continued From page	e 249	D914			
	#11 was injured (02/0 -There were two incide completed for Reside the fall and a second -She was never notifichospital that there we -No staff was termina #11's injuriesResident #11 had broand shoulder from fall the night standShe knew this because reported that was whather and shoulder from fall the night standThe 3rd shift staff regunwitnessedThe 3rd shift staff regunwitnessedThe 3rd shift staff regunwitnessedThe 3rd shift staff regunwitnessedThe 3rd shift staff regunwitnessed.	lent and accident reports int #11 on 02/05/19; one for for her knees being swollen. ed by anyone from the ire suspicions of abuse. ited because of Resident uises on her head, chest ling off the bed and hitting ise the 1st shift staff at happened. corted the fall was boarded Resident #11 was blanket on the floor. of any physical abuse from staff.				
	Interview with the current Administrator on 05/17/19 at 3:44pm revealed: -When she saw Resident #11 on 02/05/19, it looked like Resident #11 fellNo one reported suspecting physical abuseAPS came to the facility but she was not the Administrator then.					
		ns, interviews and record nined Resident #11 was not				
	Refer to interview with the Administrator on 05/17/19 at 3:44pm.					
	01/22/19 revealed: -Diagnoses included a osteoarthritis, levy bo	t #8's current FL-2 dated Alzheimer's dementia, dy dementia, vitamin B12 ophageal reflux disease and				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 250 of 267

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		Hal089002	B. WING		05/4	7/2019
		1181003002			1 03/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
TVDDELL	HOUSE	950 HWY	64 EAST			
TYRRELL			IA, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D914	Continued From page	250	D914			
		2 200				
	peripheral edema.					
		tation Resident #8 was				
	constantly confused,	ambulatory and wandered.				
	Interview with a conc	erned citizen on 05/10/19 at				
	1:00pm revealed:	cifica diazen dir do/ 10/ 10 at				
		ge bruises on her arms in the				
	_	w how she got the bruises.				
		member visited on 05/05/19				
		nt crying and difficult to				
	console.	nt orymig and amount to				
		noticed bruises on both of				
	Resident #8's hands.					
	-A staff had reported	to the family member				
		ped a staff on 05/05/19.				
	-	ave episodes of crying but				
	had never been "ugly					
	-She visited Resident	t #8 on 05/06/19 and had				
	seen the bruises on t	he resident's hands.				
	-She was concerned	because the bruises looked				
	as if some had grabb	ed Resident #8 by her				
	wrists.					
	-She spoke with the 0	Care Manager (CM) about				
	the bruises on 05/06/	19.				
		5				
	•	with Resident #8's family				
		at 11:36am and 8:24pm				
	revealed:) h = h = d f = d f l =				
), he had found two large				
	· ·	of Resident #8's hands in				
	down on her hands.	numbs had been squeezed				
	-He had taken picture	os of the bruisse on				
	05/05/19.	es of the bruises off				
	-The bruises on Resi	dent #8's hands were purple;				
		appened that day or the day				
	before (05/04//19 or 0					
	,	dent #8 was "hysterical and				

inconsolable."

-He talked with the staff working that day

STATE FORM 6899 ZE7D11 If continuation sheet 251 of 267

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZID CODE		
NAME OF F	ROVIDER OR SUFFLIER		, ,	TE, ZIF GODE		
TYRRELL	HOUSE		64 EAST			
		COLUME	SIA, NC 27925			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D914	Continued From page	e 251	D914			
	(05/05/19) and did no	t get a call back until Friday				
	(05/10/19).					
	-There was a staff wo	orking on 05/05/19 that said				
	Resident #8 was in a	bad mood and had slapped				
	her (staff).					
		er slapped anyone, to the				
	family's knowledge.					
	, ,	g on 05/05/19 said she was				
		nt #8 slapped the staff				
	•	did not like the staff that				
	was slapped.	ard free mile and oldin trial				
	-Something must hav	e hannened to make				
	Resident #8 slap the					
	•	at the staffs' names were but				
	he was able to descri					
		staff on 05/10/19 at 10:30am				
		one knew what happened.				
	· ·	ber which staff had called				
	him on 05/10/19.	ber writeri stati flad called				
		nad been another incident				
		aff had found a bump and a				
	bruise on Resident #8					
		e Regional Clinical Director				
	(RCD) on 05/10/19.					
		ruises were different on				
		ises noted on 05/05/19, and				
		as responsible was let go.				
	_	ry of what happened on				
	05/05/19.					
	-He had spoken with					
		ruises on Resident #8's				
	hands on 05/05/19 ar					
		ported having to follow a 5				
		e terminating the staff.				
	-The Administrator ki	new about the bruises on				
	05/05/19 and did not	do anything until 05/10/19.				
	-This was not the first	t time Resident #8 had				
	bruises; he had chalk	ed the others up to falls.				

-He was now very concerned that incidents with staff being abusive had happened before.

STATE FORM 6899 If continuation sheet 252 of 267 ZE7D11

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
			R WING	B. WING		
		Hal089002	D. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST IA, NC 27925			
040.45	CHMMADV CT.		1	DDOVIDEDIS DI ANI OF CODDECTIO	N	2/5
(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	(X5) COMPLETE DATE
D914	4 Continued From page 252		D914			
	family member date servealed: -There was a half doll bruise on Resident #8 and next to the thumbThere was a quarter on Resident #8's left Inext to the thumb are Observations of Resident 1:40pm revealed: -There was a half doll bruise on the resident and next to the thumbThere was a lighter a of the bruiseThere was a large irred bruise on the resident wrist from the thumb finger. Review of charting no 05/14/19 for Resident documentation related status for Resident #8 05/07/19. Review of a Body Evadated 05/08/19 at 7:0 revealed staff docume bruise on her right hall there with the RC revealed:	sized round purple bruise hand below the wrist and a. dent #8 on 05/10/19 at ar sized oval shaped purple it's right hand below the wrist of area. area of purple at the center degularly shaped purple and dent's left hand below the to just under the second of the bruises or change in 8 on 05/01/19 through aluation & Observation sheet 4am for Resident #8 ented the resident had a nd. D on 05/15/19 at 3:23pm				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 253 of 267

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	Hal089002	B. WING		05/17/2019
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-
TYRRELL HOUSE	950 HWY	64 EAST		
THREELHOOL	COLUMBI	A, NC 27925		
PREFIX (EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D914 Continued From page	253	D914		
checked with staff and incident at change of (11:00pm) on 05/09/1 -There were two staff standing at the special deskResident #8 had bee movementStaff C began pulling at the front deskThe two staff told Stara resident at the front -Staff C took Resident the resident returned -She did not know abouncidents earlier in the Telephone interview was care provider (PCP) or revealed: -He could not say for contacted him regard handsHe had been receiving calls and text message since 05/08/19He had last seen Reseident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 was still her hair was not particularly staff had reported Resident #8 staff had reported Residen	d found out there was an shift for 2nd into 3rd shift 9. who witnessed Resident #8 al care unit (SCU) front in incontinent of a bowel Resident #8's pants down aff C she could not do that to desk. It #8 to the bathroom and with marks on her hands. Out bruises or other week (05/05/19). with Resident #8's primary on 05/15/19 at 3:28pm sure whether or not staff fing bruises on Resident #8's ing an increased amount of les from staff and the CM sident #8's on 05/04/19. In dressed in her pajamas; cularly clean. It is sident #8 had been the assistance, was a staff. In all care aide (PCA) on evealed: It on 05/05/19. In member did not talk to her	D914		

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 254 of 267

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF D		etpeet AD	DECC CITY OTA	TE ZID CODE	<u>-</u>	
NAIVIE OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ile, ZIP CODE		
TYRRELL	HOUSE	950 HWY	A, NC 27925			
	OLIMANA DV. OT		1	DDOUIDEDIO DI AN OF CODDECTION		
(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	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D914	Continued From page	e 254	D914			
	incontinence careStaff C was not "rough" with Resident #8.					
	-Staff C would get lou	-				
	Resident #8.	id when she talked to				
	Resident #8Staff C was only like that with Resident #8.					
		hing to anyone about Staff				
	C.	S ,				
	-She just "took over" in helping Resident #8.					
	Observations of Resid	dent #8 on 05/16/19 at				
		e were no bruises on her				
		on her hands were fading to				
	purple and yellow.					
	Review of a Health C	are Personnel Registry				
	(HCPR) 5 Day/Invest					
	05/15/19 for Resident					
	-Staff C was accused	of taking Resident #8's				
	clothes off at the from	t desk area on the SCU.				
		t #8 to her room "roughly"				
	-	led loudly at the resident.				
		ises on both hands on				
	05/10/19; there was a 05/09/10.	a bruise on the right hand on				
	-The RCD spoke with	Resident #8's family				
	member (date not do					
		visited Resident #8 several				
		esident reported a staff was				
	mean to her; the fami	ily member described Staff				
	C.					
		o very agitated the day the				
	•	d; the family member had				
	never seen the reside				ĺ	
	9	tated when Staff C was slapped Staff C in the past.			ĺ	
		known to hit anyone before.			ĺ	
		d Staff C and Staff C did not				
	deny the allegations.				ĺ	
	actif and anoguations.					

Review of a PCA's hand-written witness

STATE FORM 6899 ZE7D11 If continuation sheet 255 of 267

DIVISION C	of Health Service Regu	lation				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
			_			
			D WING			
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
	(01)BEI(01(00) 1 EIE(
TYRRELL	HOUSE	950 HWY (
		COLUMBI	A, NC 27925			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	CIATE	DATE
				22.13.213.7		<u> </u>
D914	Continued From page	e 255	D914			ı
						ı
ļ	statement for Resider				ļ	1
ļ	On 05/09/19 at 11:00	Opm, Staff C stopped at the			ļ	ı
	front desk area in the	SCU and started taking off				ı
	Resident #8's pants.					ı .
	-Staff C was going to	provide incontinence care at				ı
		se she did not want to take				ı .
	Resident #8 to her ro	om.				ı
		aff C to take Resident #8 to				ı
	her room.	iii o to tako resident o to				ı .
		the front desk yelling at				ı
	Resident #8 in the res					ı
		check on Resident #8.				ı
	-Aliutilei Stail Wellt to	Check on Resident #6.				ı
	T-lambama intervious	with a third DOA on OF/15/10				ı
		with a third PCA on 05/15/19				ı
	at 9:28pm revealed:					ı
		the incident between Staff C				ı
		ne front desk on the SCU.				ı
		er what day the incident				ı
		esident #8 and Staff C; it was				ı
	either the beginning of	of the week 05/013/19) or the				ı
	end of last week (05/2	10/19).				ı
	-Staff C was taking R	esident #8 to get changed				ı
	and took the resident					ı
	-She did not see Resi					ı
		bruises on Resident #8's				ı
	hands before.					ı
		se on Resident #8's waist;				ı
	she could not remem	•				ı
		le and the size of a quarter.				ı
		mber the date she saw the				ı
	bruise on Resident #8					ı
						I
	-Staff C spoke roughl					I
		C yell at Resident #8, "Stop				I
	it. Don't be doing that					I
		Staff C more than once.				1
	-Resident #8 never hi	it anyone before or anyone				I
	else.					I
	-Resident #8 was nor	rmally sweet and not violent.			ľ	1

Division of Health Service Regulation

Review of a second PCA's hand-written witness

STATE FORM E899 ZE7D11 If continuation sheet 256 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING	B. WING		05/17/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 03/11	72013	
TYRRELL	HOUSE	950 HWY COLUMBI	64 EAST A, NC 27925				
(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	(X5) COMPLETE DATE	
D914	SCU trying to "strip" F-Staff C was going to the front desk because Resident #8 to her ror-She told Staff C to ta-Staff C was yelling a went to check on the Staff C was being ror stayed in the room to hurt Resident #8. Attempted telephone witnessing staff on 05 unsuccessful. Review of a Body Evadated 05/10/19 at 7:0 revealed the CM door medium/large dark sp. The CM was not avait 05/16/19 and 05/17/1 Review of a corrective dated 05/10/19 revealed until an investigation of the composition of the comp	was at the front desk on the Resident #8. provide incontinence care at the she did not want to take form. It Resident #8 to her room. It Resident #8 "so loud" she resident. It with Resident #8 so she make sure Staff C did not want to take on the sure Staff C did not was on both hands. It was sure Staff C did not was sure staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands. It was sure Staff C did not was on both hands.	D914				
	Based on observation	ns, interviews and record					

Division of Health Service Regulation

reviews, it was determined Resident #8 was not

STATE FORM E899 ZE7D11 If continuation sheet 257 of 267

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		Hal089002	B. WING		05/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
TYRRELL	HOUSE		7 64 EAST BIA, NC 27925		
240.15	QUIMMADV QT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	ON OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
D914	D914 Continued From page 257		D914		
	interviewable. Refer to interview with the Administrator on 05/17/19 at 3:44pm.				
	3:44pm revealed: -Staff were expected instances of verbal or -Staff were expected Approach" which was resident resisting or a three timesThe fourth time staff The facility failed to p Resident #11 from portion facility's failure results Resident #11 including resembling a fist which risk of abuse and ser constitutes a Type A2 The facility provided a	to do the "Three Time is to walk away from a agitated and try again later were to get someone else. Trotect Resident #8 and obtential physical abuse. The ed in multiple bruises on ag a bruise to the chest ch demonstrates substantial ious physical harm and			
	this violation. THE CORRECTION VIOLATION SHALL N 2019. II. Based on observat reviews, the facility fa for the personal care residents (#1, #2, #4, were unable to attention.	DATE FOR THE TYPE A2 NOT EXCEED JUNE 16, tions, interviews and record ailed to provide assistance needs 7 of 8 sampled #5, #6, #8 and #15) who to themselves including fileting, bathing and dressing A NCAC 13F .0901(a)			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 258 of 267

Division of Health Service Regulation

MANE OF PROVIDER OR SUPPLIER SIDENT ADDRESS, CITY, STATE, ZIP CODE SUPPLIED SUBMENOVER STATEMENT OF DEPOSITIONS (PA) ID PRETTY 1AG SUBMENOVER STATEMENT OF DEPOSITIONS OF THE PROCESSOR OF THE PRETTY OF THE PROCESSOR OF THE PRETTY OF THE PROCESSOR OF THE PRETTY OF		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (CAS) ID PRETRY TAG COLUMBIA, NC 27925 D914 Continued From page 258 III. Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 3 of 11 sampled residents (#1, #14, #16) including two residents who wandered out of the special care unit unsupervised into a service hail and kitchen (#1, #16) and a resident with 29 falls in 6 months resulting in injuries and visits to the emergency room (#14) [Refer to Tag 270 10A NCAC 13F. 120F 410]; report a resident heart rate of 38 to the physician (#6); obtain a pressure release cushion for a resident's wheelchair and a referral to podative, (#2), #10); report a resident heart rate of 38 to the physician (#6); obtain a pressure release cushion for a resident's wheelchair and a referral to podative, (#3); obtain a stool culture as ordered due to diarrhea and to follow up with the PCP for a recheck visit after a fall and unsteady gait (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident record ordered testing (#4) [Refer to Tag 273 10A NCAC 13F .0.900(b) Personal Care ordered due to diarrhea and to follow up with the PCP for a recheck visit after a fall and unsteady gait (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident recorded ordered testing (#4) [Refer to Tag 273 10A NCAC 13F .0.9002(b) Health Care (Type A1 Violation)]. V. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5 day requirements for 3 of 3 sampled residents (#6, #11 and #12) sustaining physical abuse and injuries of unknown origin [Refer to Tag 438 10A NCAC 13F .100F	ANDIEAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		LILD
TYRRELL HOUSE SUMMARY STATEMENT OF DEPICIENCIES 10 PREPRIX PREPRIX			Hal089002	B. WING		05/1	7/2019
COLUMBIA, NC 27925 DAMMARY STATEMENT OF DEPICIENCIES DEPICIENCY AND INC. 27925 PROVIDER'S PLAN OF CORRECTION AND INC. 27925 DATE OF CROSS REFERENCE OF THAT APPROPRIATE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PRESTRET PLANCE CORRECTION PRESTREMENT OF DEFICIENCES PRESTREMENT CORRECTION PRESTREMENT CORRECTION PRESTREMENT CORRECTION CACH CORRECTION CAC	TYRRELL	HOUSE					
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D914 Continued From page 258 III. Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 3 of 11 sampled residents (#1, #14, #16) including two residents who wandered out of the special care unit unsupervised into a service hall and kitchen (#1, #16) and a resident with 29 falls in 6 months resulting in injuries and visits to the emergency room (#14) [Refer to Tag 270 10A NCAC 13F. 0901 (b) Personal Care and Supervision (Type A1 Violation)]. IV. Based on observations, interviews, and record reviews the facility failed to assure referral and follow up for routine and acute health care needs for 6 of 10 sampled residents (#3, #3, #4, #6, #10, and #17) as evidenced by failing to obtain routine and weekly lab work (#2, #10), report a resident heart rate of 38 to the physician (#6); obtain a pressure release cushion for a resident's wheelchair and a referral to podiatry (#3); obtain a stool culture as ordered due to diarnhea and to follow up with the PCP for a recheck visit after a fall and unsteady gait (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident received ordered testing (#4) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. V. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5 day requirements for 3 of 3 sampled residents (#8, #11 and #12) sustaining physical abuse and injuries of unknown origin [Refer to Tag 438 10A NCAC 13F -104] to the physician (#1) and #12) sustaining physical abuse and injuries of unknown origin [Refer to Tag 438 10A NCAC 14F -1205] the latter of Tag 273 10A NCAC 14F -1205 Health Care Personnel Registry				A, NC 2/925			
III. Based on interviews, observations, and record reviews, the facility failed to assure supervision was provided to 3 of 11 sampled residents (#1, #14, #16) including two residents who wandered out of the special care unit unsupervised into a service hall and kitchen (#1, #16) and a resident with 29 fails in 6 months resulting in injuries and visits to the emergency room (#14) [Refer to Tag 270 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A1 Violation)]. IV. Based on observations, interviews, and record reviews the facility failed to assure referral and follow up for routine and acute health care needs for 6 of 10 sampled residents (#2, #3, #4, #6, #10, and #17) as evidenced by failing to obtain routine and weekly lab work (#2, #10); report a resident heart rate of 38 to the physician (#6); obtain a pressure release cushion for a resident's wheelchair and a referral to podiatry (#3); obtain a stool culture as ordered due to diarrhea and to follow up with the PCP for a recheck visit after a fall and unsteady gail (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident received ordered testing (#4) [Refer to Tag 273 10A NCAC 13F. 0.9902(b) Health Care (Type A1 Violation)]. V. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5 day requirements for 3 of 3 sampled residents (#8, #11 and #12) sustaining physical abuse and injuries of unknown origin [Refer to Tag 438 10A NCAC 13F. 1205 Health Care Personnel Registry [Vision or the content of the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
reviews, the facility falled to assure supervision was provided to 3 of 11 sampled residents (#1, #14, #16) including two residents who wandered out of the special care unit unsupervised into a service hall and kitchen (#1, #16) and a resident with 29 falls in 6 months resulting in injuries and visits to the emergency room (#14) [Refer to Tag 270 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A1 Violation)]. IV. Based on observations, interviews, and record reviews the facility falled to assure referral and follow up for routine and acute health care needs for 6 of 10 sampled residents (#2, #3, #4, #6, #10, and #17) as evidenced by failing to obtain routine and weekly lab work (#2, #10); report a resident heart rate of 38 to the physician (#6); obtain a pressure release cushion for a resident's wheelchair and a referral to podiatry (#3); obtain a stool culture as ordered due to diarrhea and to follow up with the PCP for a recheck visit after a fall and unsteady gait (#2); report a fall with injury and emergency department visit to the physician (#17); and assure a resident received ordered testing (#4) [Refer to Tag 273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. V. Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5 day requirements for 3 of 3 sampled residents (#8, #11 and #12) sustaining physical abuse and injuries of unknown origin (Refer to Tag 438 10A NCAC 13F .1205 Health Care Personnel Registry	D914	Continued From page 258		D914			
VI. Based on observations, interviews and record		reviews, the facility farwas provided to 3 of #14, #16) including to out of the special card service hall and kitchewith 29 falls in 6 monvisits to the emergence 270 10A NCAC 13F. Supervision (Type A1 IV. Based on observareviews the facility fair follow up for routine at for 6 of 10 sampled re #10, and #17) as evic routine and weekly laresident heart rate of obtain a pressure relewheelchair and a refestool culture as order follow up with the PC fall and unsteady gait and emergency depa (#17); and assure a retesting (#4) [Refer to .0902(b) Health Care V. Based on observative reviews, the facility faresonnel Registry (Finvestigation requirem 5 day requirements for (#8, #11 and #12) sus injuries of unknown on NCAC 13F. 1205 Hear (Type A2 Violation)].	alled to assure supervision 11 sampled residents (#1, wo residents who wandered the unit unsupervised into a ten (#1, #16) and a resident this resulting in injuries and the cyroom (#14) [Refer to Tag 0901(b) Personal Care and Violation)]. Attions, interviews, and record led to assure referral and and acute health care needs the sidents (#2, #3, #4, #6, thenced by failing to obtain to work (#2, #10); report a 38 to the physician (#6); the sase cushion for a resident's the resident received ordered and to diarrhea and to the for a recheck visit after a the (#2); report a fall with injury trement visit to the physician the esident received ordered and the transition of the properties and the transition of the properties tions, interviews and record tilled to complete Health Care the HCPR) reporting and the transition of the transition of the physical abuse and trigin [Refer to Tag 438 10A alth Care Personnel Registry				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 259 of 267

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII ELTED
		Hal089002	B. WING		05/17/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
TYRRELL	HOUSE	950 HWY (64 EAST		
		COLUMBI	A, NC 27925		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D914	Continued From page	e 259	D914		
	enough staff present attentive to meet the and health care need 27 sampled shifts [Re	on the special care unit and personal care, supervision s of the residents for 14 of efer to Tag 465 10A NCAC Care Unit Staffing (Type A2			
	VII. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for supervision, health care, personal care and other staffing, personal care, health care personnel registry reporting, special care unit staffing, residents' rights, medication administration, controlled substances, housekeeping and furnishings, hot water requirements, training on cardio-pulmonary resuscitation, and nutrition and food service [Refer to Tag 980 G.S.131D-25 Implementation (Type A1 Violation)].				
D980	G.S. § 131D-25 Impl		D980		
	G.S. 131D-25 Implem	nentation			
	this Article shall rest v facility. Each facility	elementing the provisions of with the administrator of the shall provide appropriate element the declaration of ded in G.S. 131D-21.			
	This Rule is not met TYPE A1 VIOLATION				
		ns, interviews, and record rator failed to assure the			

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 260 of 267

Division of Health Service Regulation

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
IIKKELL	HOUSE	COLUMBI	A, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D980	Continued From page 260		D980			
	management, operatifacility were implement maintained for supervious care and other staffing personnel registry registaffing, residents' rigadministration, control housekeeping and fur requirements, training resuscitation, and nut. The findings are: Confidential interview revealed: -The quality of care and down to the floor. -There had been four facility.	ons, and policies of the nted and rules were vision, health care, personal g, personal care, health care porting, special care unit hts, medication olled substances, rnishings, hot water g on cardio-pulmonary crition and food service.				
	"the lady that owned a residents and resident Confidential interview -If resident complaine Administrator would "-The resident already residents and if they a complained about the even worse.	ats did not like it. Is with a resident revealed: and about anything the punish" the resident. If elt some staff mistreated				
	-The staff were not se memory care residen	ensitive to the needs of ts. ts like animals not people.				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 261 of 267

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		Hal089002	B. WING	B. WING		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY	64 EAST			
TTRRELL	HOUSE	COLUMB	IA, NC 27925			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D980	Continued From page	261	D980			
	5:15am revealed: -She was the interim was still on her probations -She started as the Ad 2019 and the probation -She got her Administ 2019She worked at the faftrom 9:00am until 5:00-She shared Manager with the Care Manager (AD), Transportation so Dietary Manager (DM -A Manager on Duty of the Nours every Saturathe Facility every or -The Regional Director at the facility every minimum still be still be seen as the facility every minimum still be seen as the facility every minimum still be seen as the facility every minimum still be seen as the seen as the seen as the facility every minimum still be seen as the	dministrator in February conary period was 180 days. crator's certificate in April cility Monday through Friday 0pm every week. r on Duty responsibilities er (CM), Activity Director staff, lead Supervisor and l). was present in the facility for orday and Sunday. Il Director (RCD) was usually ne to two weeks. or of Operations (RDO) was onth. ol Registered Nurse (RN)				
	3:44pm revealed: -She did interviews won pay dayShe pulled up perform on the computer and with the CMShe was just learning and PCP order to assistance with toiletina time on all shiftsOne week she would evening shift, the nex night shift and on the through at 6:00am or	compliance with providing ng and bathing four hours at I monitor four hours on the t week four hours on the weekends, she did a walk				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 262 of 267

Division of Health Service Regulation

Division (of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		Hal089002	B. WING		05/1	7/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TVAIVIL OF T	TOVIDER OR OUT FEEL	950 HWY	, ,	(I, Zii GODE		
TYRRELL	HOUSE		IA, NC 27925			
	OUR MARK OT					
(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	(X5) COMPLETE DATE
D980	Continued From page 262		D980			
	while working on the floorShe usually came in at random times on all three shifts; if staff were found sleeping they were terminated on the spotShe monitored staff providing assistance by sitting on the special care unit (SCU) for 20 minutes checking incontinent residentsThe last time she monitored for incontinence					
	care was one week a	go.				
	1. Based on observations, interviews and record reviews, the facility failed to maintain an environment free of hazards in the special care unit as evidenced by Resident #9's room having a bed bug infestation that was left untreated for 7 days and a broken window in resident room 209 that was not repaired for more than 6 weeks [Refer to Tag 079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].					
	reviews, the facility fatemperatures were m 116-degrees Fahrenh water temperatures lo	cions, interviews and record illed to assure hot water aintained between 100 - neit (F) as evidenced by hot ower than 100°F from five care unit (SCU) [Refer to 3F .0311(d) Other				
	facility failed to assure was on the premises completed within the cardio-pulmonary res choking management in April 2019 and May	last 24 months a course on				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 263 of 267

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		Hal089002	B. WING		05/17/2019	
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY COLUMB	64 EAST IA, NC 27925			
(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 APPROVIDEFICIENCY)	D BE COMPLETE	E
D980	reviews, the facility farmet the minimum requested for 9 days sampled in resulting in inadequat supervision and personal facility failed to responsion and procedures and in accordance with policy and procedures sampled (#1) who fell 271 10A NCAC 13F. (Supervision]. 6. Based on observative reviews the facility failing lemented for 2 of #6) for a daily posturated blood pressure and hoto Tag 276 10A NCAC 7. Based on observative reviews, the facility failed to were served as sampled (#2) with an meats diet who cough while eating food that ordered [Refer to Tag .0904(e)(4) Nutrition at 8. Based on observative reviews, the facility failed with eating two observative facility failed facility fai	ions, interviews, and record iled to assure aide hours uirements on 15 of 27 shifts April 2019 and May 2019 e staff to meet the onal care needs of residents NCAC 13F .0604(e) ther Staffing]. Inviews and interviews, the need to incidents immediately the the facility's established in the facility [Refer to Tag 10901(c) Personal Care and 10 sampled residents (#4, all vital signs (#4); and daily eart rate checks (#6) [Refer 10 13F .0902(c) Health Care]. It ions, interviews and record iled to assure therapeutic ordered for 1 of 4 residents order for a regular chopped need during a lunch meal was not chopped as 310 10A NCAC 13F and Food Service]. It ions, interviews and record iled to provide assistance wed meals in a manner that #21's dignity and respect by the resident during each meal a NCAC 13F .0904(f)(2)	D980			

Division of Health Service Regulation

STATE FORM 5899 ZE7D11 If continuation sheet 264 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		Hal089002	B. WING		05/17/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TYRRELL	HOUSE	950 HWY 6				
	OUR WARD COT		A, NC 27925			
(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	(X5) COMPLETE DATE
D980	Continued From page	Continued From page 264				
	reviews, the facility farmedications as ordered the facility's policy for observed during the rerrors with a vitamin I and for 3 of 10 samplincluding errors with a used to treat low pota acid reflux, and treat a (#2), and a medicatio pulmonary disease ar 358 10A NCAC 13F. Administration (Type	ed and in accordance with 2 of 11 residents (#18, #19) medication passes including D supplement (#18, #19); ed residents (#3, #2, #4) a diuretic (#3), medications assium, treat and prevent and prevent stomach ulcers in to treat chronic obstructive and asthma (#4) [Refer to Tag 1004(a) Medication B Violation)].				
	record reviews, the farmedication administrator 2 of 5 residents satinaccurate documents supplement (#2), an it obstructive pulmonary inhaler for shortness [Refer to Tag 367 104 Medication Administrations]	y disease (#4), and an of breath and wheezing (#4) A NCAC 13F .1004(j)				
	reviews, the facility fareadily retrievable recreatily retrievable recreation controlled substances Oxycontin and alpraz for accurate reconciliaresidents (#4) [Refer .1008(a) Controlled S Violation)].	iled to assure there was a cord documenting the n and disposition of sincluding Oxycodone, colam in the resident's record ation for 1 of 6 sampled to Tag 392 10A NCAC 13F				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 265 of 267

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		Hal089002	B. WING		05/1	7/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD 950 HWY 6- COLUMBIA	RESS, CITY, STATE, ZIP CODE 4 EAST			
(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	(X5) COMPLETE DATE
D980	and right to privacy as doors and window blin incontinence and bath #3, #6, #15); speaking residents (#4, #14); a acceptable bed at the room was infested with Tag 911 G.S.131D-21 B Violation)]. 13. Based on observative reviews, the facility faction (#8 and #11) were freevidenced by bruises hands following incide and Staff C where Staroughly; and bruises in on admission to the hole [Refer to Tag 914 G.S. Rights (Type A2 Violations)]. The Administrator, who overall operations of the responsibility for the infection governing personal care and oth health care personne care unit staffing, residentially administration, control housekeeping and fur Administrator's failure regulations resulted in physical harm which of Violation.	pect, dignity, consideration, is related to staff leaving ands open while providing thing care to residents (#2, g and being disrespectful to an a facility for a resident whose the bedbugs (#9) [Refer to II(1) Residents' Rights (Type III(1) Residents' Rights, Redication III(1) Residents' Rights, Redication Rights (Type III(1) Residents' Rights, Redication Rights (Type III(1) Rights (Type III(1) Rights) Residents' Rights, Redication Rights (Type III(1) Rights) Rights (Ty	D980			
	The facility provided a accordance with G.S. this violation.	a plan of protection in . 131D-34 on 05/16/19 for				

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 266 of 267

Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED									
Hal089002 B. WING	05/17/2019									
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
TYRRELL HOUSE 950 HWY 64 EAST COLUMBIA, NC 27925										
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTUAL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO DEFICIENCY	TION SHOULD BE COMPLETE THE APPROPRIATE DATE									
D980 Continued From page 266 THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16, 2019.										

Division of Health Service Regulation

STATE FORM E899 ZE7D11 If continuation sheet 267 of 267