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FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL080030 | A. BUILDING: ______<br>B. WING ______ | 01/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TERRABELLA SALISBURY | 1915 MOORESVILLE ROAD<br>SALISBURY, NC 28147 |

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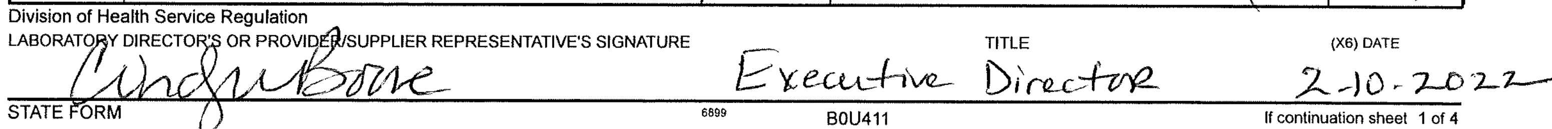
| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a annual survey from January 26 2022 through January 27, 2022 | D 000 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to ensure follow up with health care providers for 1 of 5 sampled residents (#5) related to an anti-coagulant medication and scheduled International Normalized Ratio (INR) lab work.<br><br>The findings are:<br><br>Review of Resident #5's current and admission FL2 dated 06/04/21 revealed:<br>-Diagnoses included dementia and history of aortic valve replacement.<br>-There was an order for warfarin 2.5mg (a blood-thinning medication) every evening.<br><br>Review of Resident #5's physician's order dated 12/27/21 revealed there was an order to collect an INR (lab work that measures the time it takes for blood to clot) for Resident #5 on 01/06/22.<br><br>Review of Resident #5's INR lab work collected 01/06/22 revealed Resident #5's INR was 1.51 (normal reference range was 2.0-3.0 for patients taking warfarin therapy).<br><br>Review of Resident #5's physician's order dated | D 273 | Director of Health & Wellness (DHW) / Designee will educate medication aides and Resident Care Coordinator (RCC) on the importance of communicating any missed doses of critical medication such as Coumadin immediately to MD for further orders. DHW/Designee will review scheduled lab orders prior to the day of testing to ensure each resident has the appropriate test, date and lab requisition form completed. (Continued) | 1-27-2022 and ongoing |

Division of Health Service Regulation



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 2-10-2022

STATE FORM 6899 B0U411 If continuation sheet 1 of 4

Reviewed and acknowledged 02/14/22 Catherine Prater

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| D 273 | Continued From page 1 <br><br> 01/07/22 revealed there was an order to increase warfarin dose to 5mg daily for three days, then resume 2.5mg daily after that, and recheck INR on 01/20/22. <br><br> Review of Resident #5's January 2022 electronic medication administration record (eMAR) revealed: <br> -There was an entry for warfarin 2.5mg, take one tablet daily at 8:00pm. <br> -There was documentation warfarin 2.5mg was administered daily from 01/01/22 through 01/25/22. <br> -There was an entry for warfarin 2.5mg, take one tablet daily with scheduled dose (total 5mg) for 3 days starting 01/07/22. <br> -There was documentation the additional 2.5mg tablet was administered on 01/08/22 and 01/09/22, and documentation that Resident #5 refused her medication on 01/07/22. <br> -The warfarin dose total Resident #5 should have received for the week of 01/06/22 through 01/12/22 was 25mg, but there was documentation she had only received 20mg. <br><br> Review of INR lab work collected 01/27/22 revealed Resident #5's INR was 1.53. <br><br> Telephone interview with a representative at Resident #5's primary care provider's (PCP) office revealed: <br> -They were responsible for managing Resident #5's warfarin dose based on her INR levels. <br> -Resident #5 had been prescribed warfarin due to her history of valve replacement. <br> -Resident #5's goal range for her INR was 2.0-3.0. <br> -They had not been notified by the facility that Resident #5 did not have her INR lab work collected on 01/20/22 as ordered. | D 273 | DHW/Designee will follow up the day of scheduled lab visit for completion. If lab test was not completed, the MD will be notified promptly by DHW/Designee. Executive Director/Designee will monitor for compliance weekly for 4 weeks - then monthly thereafter. | |

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| D 273 | Continued From page 2<br>-They had not been notified by the facility that on 01/07/22 Resident #5 had refused her medication, so instead of taking the 5mg warfarin dose as ordered, she didn't take any warfarin that evening.<br>-The facility had not called to ask if the PCP would want them to give that extra 2.5mg tablet on 01/10/22 since she refused it on 01/07/22.<br>-Typically, if a resident was overdue for an INR result, they would contact the facility for follow up after a couple of days. They completed their INR audits on Fridays so they would have noticed the missed lab the following day (01/28/22) and contacted the facility at that time.<br>-It was the PCP's expectation that the facility would collect INR labs for Resident #5 on the day they were ordered, and the facility would contact them if they were unable to collect a lab.<br>-It was the PCP's expectation that the facility would contact them for any missed, extra, or deviated doses of warfarin from what was ordered.<br>-Missed doses of warfarin could cause INR levels to decrease, which would place the resident at risk for blood clots and could cause a pulmonary embolism, deep vein thrombosis, or stroke.<br><br>Interview with the Director of Health and Wellness (DHW) on 01/27/22 at 10:25am revealed:<br>-The INR lab that was ordered to be collected for Resident #5 on 01/20/22 had not been completed, and she had been unaware of it until today (01/27/22).<br>-She had been told by lab staff that morning Resident #5's order had not been on their blood draw log for Thursday 01/20/22, so that was why they had not collected the lab.<br>-The Resident Care Coordinator (RCC) was responsible for preparing the list of lab orders due to be collected by lab on Thursdays when they | D 273 | | |

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| D 273 | Continued From page 3<br>were at the facility; she did not know how or why Resident #5's INR lab was missed.<br>-The RCC was unavailable so she was unable to ask her about the missed lab.<br>-The medication aide (MA) who had worked the evening on 01/07/22 when Resident #5 refused her medications no longer worked at the facility.<br><br>Interview with the Executive Director (ED) on 01/27/22 at 2:45pm revealed:<br>-Lab staff came to the facility to collect specimens every Thursday.<br>-It was the responsibility of the RCC or the DHW to prepare the lab orders for Thursday and give them to lab staff, then to follow up and make sure all labs had been collected as ordered.<br>-She was unaware Resident #5's INR lab ordered for 01/20/22 had been missed.<br>-If lab had attempted to collect Resident #5's INR but she had refused, they would have documented that on the lab record, but they had not.<br>-It was the facility's protocol if a resident refused their medications more than 3 days in a row, the MA would be responsible for notifying the PCP. They did not have exceptions for earlier notification for high risk medications such as warfarin.<br>-The RCC completed monthly eMAR audits, but would not have notified the MD or DHW unless there were three or more refusals.<br><br>Based on observation and record review, it was determined that Resident #5 was not interviewable. | D 273 | | |