STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments	D 000		

D 000 Initial Comments

The Adult Care Licensure Section and the Tyrrell County Department of Social Services conducted an annual, follow-up and complaint investigation on 08/31/22 and 09/01/22. The complaint investigation was initiated by the Tyrrell County Department of Social Services on 08/09/22.

D 273 10A NCAC 13F .0902(b) Health Care

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on interviews and record reviews, the facility failed to ensure provider notification and follow-up for 2 of 5 sampled residents (#1, #4) related to a resident experiencing worsening of a pressure wound that was not reported to the primary care provider (PCP) (#1) and a resident that was on blood thinning medications that was sent to the local emergency department for evaluation due to blood in his urine and failing to notify the PCP of his return (#4).

The findings are:

1. Review of Resident #1's current FL-2 dated 04/27/22 revealed:
-Diagnoses included diabetic/borderline, hypertension, obesity, frequent urinary tract infections.
-The resident was constantly disoriented and incontinent of bowel and bladder.

Review of Resident #1's Resident Register

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ____ B. WING ____	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 1	D 273		

revealed she had an admission date of 05/11/22.

Review of Resident #1's admission skin assessment dated 05/11/22 revealed:
-The observation was made by a medication aide (MA).
-There was bruising seen on Resident #1's middle buttocks area and right forearm.
-There was no discoloration, redness, pressure sore, or rash seen.

Review of Resident #1's shower skin assessments revealed:
-On 05/12/22, all skin assessment observations were marked as "no" except flaking seen to "both feet".
-On 05/13/22, all skin assessment observations were marked as "no" except bruising seen to "middle of buttocks".
-On 05/14/22, all skin assessment observations were marked as "no" except pressure sore seen "between her butt cheeks".
-On 05/15/22, all skin assessment observations were marked as "no" except pressure sore seen "between her butt cheeks."
-On 05/16/22, all skin assessment observations were marked as "no" except redness seen and pressure sore seen "between her butt cheeks".
-Skin assessment observations continued to be completed for Resident #1 with each bath through 07/05/22 and were marked as "no" except for pressure sore seen "between her butt cheeks".

Review of Resident #1's PCP visit note dated 05/17/22 revealed:
-Resident #1 stated that she had pain to her buttock area.
-Resident #1 had a stage II pressure wound to an unspecified buttock. (Pressure wounds are caused by constant pressure on an area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273		D 273		

Continued From page 2

Pressure wounds are staged from I-IV. A stage I pressure wound has redness present with no broken skin. A stage II pressure wound is a shallow open ulcer with a pink wound bed. A stage III pressure wound is full thickness tissue loss that exposes fat, but bone, tendon, or muscle are not exposed. A stage IV pressure wound is full thickness tissue loss with exposed bone, tendon, or muscle.)
-There were orders for zinc oxide 20% apply to buttock after each brief change (Zinc oxide is used to treat or prevent minor skin irritations).
-There was an order for home health for wound management of stage II wound on buttock.

Telephone interview with Resident #1's PCP on 09/01/22 at 1:41pm revealed:
-Resident #1 had a small stage II pressure wound on her right buttock and her intergluteal fold(Intergluteal fold is the area between the buttocks).
-The first time she noticed Resident #1's wound on 05/17/22 she ordered home health for her.

Review of a printout of an email sent to a home health agency by the Resident Care Coordinator (RCC) revealed:
-The email was sent on 05/19/22 for home health to evaluate Resident #1.
-The email stated face notes, order, and face sheet were attached.

Review of Resident #1's record revealed there were no home health notes for evaluation or treatment of Resident #1's wound.

Review of Resident #1's Care Plan dated 05/20/22 revealed:
-Resident #1 had a decubitus and her skin care needs were listed as "zinc on buttock area" (A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 3	D 273		

decubitus is the same as a pressure wound).
-There was no staging of the decubitus listed on Resident #1's Care Plan.

Review of Resident #1's PCP visit note dated 06/07/22 revealed:
-Resident #1 had a small stage II pressure wound on her right buttock and a small stage II pressure wound to her intergluteal fold.
-Facility staff reported that home health was no longer coming to the facility for stage II wound management.
-There was an order for an Allevyn patch to be placed on right buttock every 3 days and as needed (Allevyn patch is a foam dressing used to treat pressure wounds).

Telephone interview with Resident #1's PCP on 09/01/22 at 1:41pm revealed when she came out to visit Resident #1 on 06/07/22, she was told by facility staff that home health no longer came out to the facility to treat stage II pressure wounds, so she ordered a foam dressing for Resident #1.

Telephone interview with the home health supervisor on 09/01/22 at 10:18am revealed:
-There was no record of ever receiving a home health referral for Resident #1.
-The home health agency did not go out and evaluate residents for stage II wounds.
-If they were notified that the wound progressed beyond a stage II the home health agency would go out and evaluate the resident.
-There was nothing in the home health records showing there was a home health referral for Resident #1 and she did not recall receiving a referral but the agency could have received a referral that did not get entered into the system because the resident did not meet the criteria to be seen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 273	Continued From page 4	D 273		

Review of Resident #1's PCP visit note dated 06/14/22 revealed:
-Resident #1 stated she was having pain to her buttocks.
-In one area of the note it was noted that Resident #1 had stage II pressure wound to her left buttock and intergluteal fold and in another area, it was noted Resident #1 had stage II pressure wound to her right buttock and intergluteal fold.
-There was an order for Tegaderm on silicone foam border 2 X 2 apply to stage II wound on left buttock and stage II wound on intergluteal cleft daily and as needed (Tegaderm is a dressing used to treat pressure wounds).

Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:
-There was no entry for Allevyn patch.
-There was no entry for Tegaderm dressing.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for Tegaderm bandage apply to stage two wound on left buttock and stage two wound of intergluteal fold daily and as needed.
-The Tegaderm bandage was documented as administered 07/01/22-07/03/22.
-The Tegaderm bandage was documented as resident unavailable 07/04/22-07/08/22.
-It was documented that the resident was in the hospital 07/09/22-07/30/22.

Telephone interview with a pharmacist at Resident #1's pharmacy on 09/01/22 at 2:55pm revealed:
-There was no order in their system for Allevyn dressings for Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 5	D 273		

-There was a handwritten prescription dated 06/14/22 for Tegaderm dressings for Resident #1.
-They received the prescription for Resident #1's Tegaderm on 06/28/22.
-They did not have the Tegaderm in stock at the pharmacy and had to order them.
-Anything that had to be ordered usually came in the next day and, if so Resident #1's Tegaderm would have been available to pick up either 06/29/22 or 06/30/22.
-Resident #1's Tegaderm dressings were picked up from the pharmacy on 07/01/22.

Review of Resident #1's progress notes from 05/11/22-07/05/22 revealed:
-There was no documentation that Resident #1's PCP had been notified of any skin breakdown or worsening of skin breakdown.
-There was no documentation that Resident #1's PCP had been notified of any change in condition for Resident #1.

Review of Resident #1's PCP visit noted dated 07/05/22 revealed:
-The PCP did not observe Resident #1's wounds on her buttocks.
-Resident #1 was slouched down in her chair with dry skin around her lips and she appeared lethargic.
-She had facility staff send Resident #1 to the emergency department (ED) for evaluation and possible dehydration.

Telephone interview with Resident #1's PCP on 09/01/22 at 1:41pm revealed:
-She saw Resident #1 for a routine visit on 07/05/22.
-When she visited Resident #1 at the facility on 07/05/22 she did not assess her pressure wounds because the resident was up in a chair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 6	D 273		

-Resident #1 was not feeling well on 07/05/22 and she thought she was dehydrated because her lips were dry, so she sent her to the ED for evaluation.

Review of Resident #1's hospital progress note dated 07/05/22 revealed:
-The progress note was completed by a Registered Nurse (RN) when Resident #1 was admitted to her hospital room.
-Resident #1 had a stage III pressure injury noted to her sacrum measuring 4.25 centimeters (cm) by 4.0 cms (The sacrum is a bony structure at the bottom of the lumbar vertebrae, just above the coccyx or tail bone).

Review of Resident #1's hospital progress note dated 07/07/22 revealed:
-There was a picture of Resident #1's pressure wound.
-Resident #1's sacrum had an area of skin breakdown with brown and black tissue present as well as an area with yellow tissue present at the center and a black border around it.
-There was dark skin discoloration between the two areas.
-The area of skin breakdown was bordered by reddened skin and beefy red tissue.

Review of Resident #1's hospital surgical consult dated 07/07/22 revealed:
-Resident #1 was admitted to the hospital with necrotic tissue in her sacral area (Necrotic tissue is dead skin tissue that is either black or dark brown in color).
-Resident #1 had a stage IV pressure wound with no gross infection in the area.

Review of Resident #1's hospital discharge summary revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 7	D 273		

-Resident #1 was sent to the ED by facility staff to be evaluated for altered mental status.
-Upon arrival to the ED Resident #1 stated she had felt unwell for several weeks.
-Resident #1 reported having pain "all over".
-Resident #1 was admitted to the hospital on 07/05/22 with sepsis due to a urinary tract infection (Sepsis is an illness caused by the body's response to an infection).
-Resident #1 was noted to have a sacral wound on admission.
-During the course of her hospital stay Resident #1 was seen by a wound provider who debrided the sacral wound (Debridement is removal of unhealthy tissue to a wound).
-Resident #1 had a poor prognosis for her wound to heal, and her family requested no further surgical procedures be performed on the wound.
-Resident #1 would be admitted to rehabilitation for wound care with a possible referral to hospice if her conditioned deteriorated further.
-Resident #1 was discharged to a skilled nursing facility (SNF) on 07/22/22.

Telephone interview with Resident #1's family member on 08/31/22 at 10:41am revealed:
-When Resident #1 was admitted to the facility on 05/11/22, she did not have any wounds or skin breakdown, but she did have a rash on her buttocks.
-He was never informed by the facility that Resident #1 had developed a wound on her buttocks.
-On 07/05/22, facility staff informed him that they thought Resident #1 was dehydrated and they were sending her to the ED.
-The PCP at the hospital informed him that Resident #1 was septic due to a bladder infection.
-The PCP from the hospital also informed him that Resident #1 had a stage III wound with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 8	D 273		

exposed bone on her bottom.
-Resident #1 was discharged from the hospital on 07/22/22 and admitted to a SNF.
-Resident #1 passed away at the SNF on 07/30/22.

Interview with a personal care aide (PCA) on 09/01/22 at 4:15pm revealed:
-Skin observations were done on residents with each bath and documented on the skin assessment sheet.
-When doing a skin observation, a PCA would look for cuts, dry skin, bruises, bed sores, or skin tears and document if any were seen.
-MAs looked at the skin assessment sheets once they were completed by the PCA.
-Sometimes skin breakdown was verbally reported to a MA and it was the MA's responsibility to report the skin breakdown to someone else.
-Resident #1 had a rash and redness on her bottom but did not have any broken skin.

Interview with a MA on 09/01/22 at 2:25pm revealed:
-Routine skin observations should be done on every resident with each bath.
-PCAs usually did the skin observations on residents unless a MA helped with the resident's bath then the MA would do the skin observation.
-If any changes were noticed on a resident's skin observation it was reported to the lead MA or the RCC.
-If changes to a skin observation were noticed on a resident it was not documented anywhere that it was reported to the lead MA or RCC.
-She observed Resident #1's skin when she was admitted to the facility and documented that she had bruising on her buttocks.
-Resident #1 developed redness to her buttocks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 9	D 273		

but did not have any broken skin.
-She did not recall if she reported the redness on Resident #1's buttocks to the lead MA, RCC, or PCP.
-Resident #1's PCP prescribed "fake skin" to apply to her buttocks to prevent the area on her buttocks from worsening.
-She last worked with Resident #1 on 07/03/22 and at that time Resident #1 only had redness on her buttocks.
-If a PCP was contacted about Resident #1's skin breakdown or a change in a her condition it should be documented in her progress notes.

Interview with the lead MA on 09/01/22 at 4:31pm revealed:
-Skin observations should be completed on each resident with each bath.
-The skin assessment form was completed by either a PCA or MA and was then reviewed by the RCC.
-If the skin assessment form noted that there were any issues the RCC would go look at the resident's skin herself.
-Resident #1 had a sore on her backside that was pink and flesh-colored.
-The sore was not open and was not draining.
-Resident #1 reported pain when hitting the sore while wiping after using the restroom and he thought she was sent to the ED either that night or the next day.
-There was an incident where Resident #1 experienced pain while wiping and it happened approximately one week prior to her being sent to the ED on 07/05/22.
-He was unsure if the pain was reported to Resident #1's PCP or not.
-The last time he observed Resident #1's buttocks was about 4 days before she was admitted to the hospital on 07/05/22 and at that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10 time her wound was larger but still pink and the skin was intact. -There was no documentation of his observation of Resident #1's buttocks on that day. -Home health was ordered for wound care for Resident #1 but he was told by the RCC that home health did not come out and evaluate Resident #1 because her wound was a stage I. -If Resident #1's wound progressed and became pinker he expected to be notified so he or the RCC could observe the area. -If Resident #1's PCP was contacted about any skin breakdown or change in condition it should be documented in her progress note. Interview with the RCC on 09/01/22 at 5:15pm revealed: -All residents should receive a skin observation with each bath. -Any skin problems were documented on the skin assessment form by either a PCA or MA. -She tried to look at the skin assessment forms daily but, if not daily at least 3 times per week. -Sometimes the lead MA looked at the skin assessment forms as well. -Once skin breakdown was identified on a resident, she or the lead MA would observe the skin breakdown. -When she observed the skin breakdown if there was not anything she could do for the resident she would notify the PCP. -MAs were expected to continue to monitor any skin breakdown and report to her or the lead MA if a resident's skin condition worsened. -MAs did not receive any formal training on skin or wound assessment. -At first, Resident #1 had redness to her buttock area but then it developed into a stage II pressure wound. -The PCP was who classified the wound as a	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11	D 273		

stage II.
-The development of the wound was not reported to the PCP by facility staff, but the PCP observed it on her own when she saw Resident #1 on a routine visit to the facility.
-The PCP ordered home health to treat Resident #1's wound.
-Home health told the RCC they would not come out to the facility for stage II wounds.
-There was no documentation of the conversation with home health staff.
-Resident #1's PCP was not made aware that home health was not coming out to treat her wound until the PCP made a routine visit to the facility.
-There was no documentation that Resident #1's PCP had been made aware that home health was not going to assess or treat Resident #1's wound.
-Resident #1's PCP also ordered Tegaderm for her wound.
-Any PCP notification for Resident #1 should be documented in the resident's progress notes.

Telephone interview with the Administrator on 09/01/22 at 5:49pm revealed
-If a resident was admitted to the facility with skin breakdown it should be documented on the original skin assessment form.
-A skin observation was expected to be done on every resident with each bath.
-The RCC should look at skin observations daily for any changes and it should be documented that she looked at the skin assessment forms.
-The RCC was expected to look at resident's wounds and document if they were getting better or getting worse.
-If a resident's wound was getting worse, she expected the RCC to report it to the PCP and document that it had been reported.
-If the PCP was contacted about a resident it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12	D 273		

should be documented in the progress notes.

Telephone interview with Resident #1's PCP on 09/01/22 at 1:41pm revealed:
-She was not aware that Resident #1's pressure wound was a stage III- IV when she was admitted to the hospital in July 2022.
-She did not receive any contact from facility staff that Resident #1's wounds had worsened.
-She expected facility staff to notify her if Resident #1's developed a wound or if her wounds worsened.
-Pressure wounds could progress quickly, and she was concerned that facility staff did not notify her of any worsening wounds on Resident #1.
-If she had been notified by facility staff that Resident #1's wounds had worsened she would have made another referral to home health to evaluate and treat her wounds.

2.Review of Resident #4's current FL-2 dated 01/19/22 revealed:
-Diagnoses included hypertension, anemia and spinal stenosis.
-There was a physician's order for aspirin 81mg to be administered daily. (Aspirin is used to decrease the risk of stroke by thinning the blood.)

Review of Resident #4's current Licensed Health Professional Support dated 03/23/22 revealed he required assistance with emptying of the urinary catheter bag and cleaning around the urinary catheter.

Review of Resident #4's physician's order dated 08/19/22 revealed there was an order for Eliquis 2.5mg to be administered twice daily. (Eliquis is a medication used prevent blood clotting.)

Review of the official website for Eliquis,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 13	D 273		

professional warnings information revealed:
-Eliquis increased the risk of bleeding and can cause serious, potentially fatal, bleeding.
-There was an increased risk of bleeding when used with other antiplatelet agents including aspirin.

Review of Resident #4's after visit summary from the local emergency department dated 08/31/22 revealed he was seen for blood in the urine.

Telephone interview with Resident #4's primary care provider (PCP) on 09/01/22 at 3:32pm revealed:
-She was aware Resident #4 was sent to the local hospital emergency room for evaluation on 08/31/22 for blood in his urine.
-She was not aware Resident #4 had returned to the facility after being evaluated and she had not received any discharge papers from the emergency room visit.
-She was concerned the facility had not notified her of Resident #4's return because the Eliquis would need to be stopped because the medication increased the risk of bleeding.
-She expected the facility to notify her immediately upon return.

Interview with the Resident Care Coordinator (RCC) on 09/01/22 at 5:15pm revealed:
-Staff reported seeing blood in Resident #4's catheter bag in the morning of 08/31/22 and he was sent to the local emergency department for evaluation.
-The PCP was made aware of the blood in the urine and that he was being sent out for evaluation but she did not notify the PCP that Resident #4 had returned to the facility.
-It was the RCC's responsibility to notify the PCP when a resident returned from the hospital and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 14	D 273		

ensure the discharge paperwork is sent to the PCP.

Interview with the Administrator on 09/01/22 at 5:45 revealed:
-She expected the RCC to notify the PCP when a resident returned from the hospital because the PCP might need to make medication or treatment changes.
-Notification to the PCP would ensure needed changes to medications or treatments would be implemented as soon as possible.

____

The facility failed to ensure provider notification and follow-up for 2 of 5 residents in which Resident #1 was admitted to the facility without any skin breakdown and developed a stage II pressure wound that was not reported to the primary care provider (PCP) which worsened to a stage III-IV pressure wound that was also not reported to the PCP. The resident was admitted to the hospital and discharged to a higher level of care. Resident #4 returned to the facility after evaluation for blood in his urine and continued to be administered 2 medications known to increase the risk of bleeding. The facility's failure to provide notification and follow-up as ordered resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation.

____

The facility provided a plan of correction in accordance with G.S. 131D-34 on 08/31/22 for this violation.

CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 1, 2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 15	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 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. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure orders were implemented for 1 of 5 sampled residents (#1) including a delay in implementing a dressing change. The findings are: Review of Resident #1's current FL-2 dated 04/27/22 revealed diagnoses included diabetic/borderline, hypertension (HTN), obesity, frequent urinary tract infections (UTI) (Hypertension is high blood pressure). Review of Resident #1's primary care provider (PCP) visit note dated 06/07/22 revealed: -Resident #1 had a small stage II pressure wound on her right buttock and a small stage II pressure wound to her intergluteal fold (Intergluteal fold is the area between the buttocks. A stage II pressure wound is a shallow open ulcer with a pink wound bed). -There was an order for an Allevyn patch to be placed on right buttock every 3 days and as needed (Allevyn patch is a foam dressing used to treat pressure wounds). Review of Resident #1's record revealed there	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 276	Continued From page 16	D 276		

was a copy of a paper prescription dated 06/14/22 for 3m Tegaderm silicone foam border 2 X 2, apply to stage II wound of left buttock and stage II wound of intergluteal cleft daily and as needed (Tegaderm is a dressing used to treat pressure wounds).

Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:
-There was no entry for Allevyn patch.
-There was no entry for Tegaderm dressing.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for Tegaderm bandage apply to stage two wound on left buttock and stage two wound of intergluteal fold daily and as needed.
-The Tegaderm bandage was documented as administered 07/01/22-07/03/22.
-The Tegaderm bandage was documented as resident unavailable 07/04/22-07/08/22.
-It was documented that the resident was in the hospital 07/09/22-07/30/22.

Review of Resident #1's progress notes from 06/14/22-07/05/22 revealed there was no documentation that Resident #1 was receiving dressing changes.

Telephone interview with Resident #1's family member on 08/31/22 at 10:41am revealed he was never informed by the facility that Resident #1 had developed a wound on her buttocks.

Interview with a personal care aide (PCA) on 08/31/22 at 1:05pm revealed Resident #1 had a wound on her right buttock but she did not recall the resident ever having a dressing on the area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 17 Interview with a medication aide (MA) on 09/01/22 at 2:25pm revealed: -Resident #1's PCP prescribed "fake skin" to apply to her buttocks to prevent the area on her buttocks from worsening. -Resident #1 was receiving Tegaderm dressing changes in June 2022 but it was not recorded on the eMAR. -Documentation of dressing changes were documented on the eMAR and there was nowhere else they would be documented. Interview with the lead MA on 09/01/22 at 4:31pm revealed: -Medication and treatment orders were usually faxed to the pharmacy when they were received from the PCP. -Resident #1 did not use the facility's contacted pharmacy and used a local pharmacy instead. -Sometimes the local pharmacy did not supply things to the facility on time. -If Resident #1's pharmacy did not have what she needed, or it was going to take a long time to get what was ordered they could use the facility's contracted pharmacy to get what was needed for Resident #1. -He did not know why Resident #1 did not receive the Allevyn dressing but it might have been because her insurance would not pay for it. -He took Resident #1's paper prescription for Tegaderm dressings to Resident #1's pharmacy on 06/14/22. -He was told by someone at the pharmacy that the dressings were expensive. -He talked to Resident #1's family member and the family member did not want to pay for the dressings. -He did not document the communication with the pharmacy and Resident #1's family member anywhere.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	**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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 18	D 276		

-He left a copy of Resident #1's paper prescription at the pharmacy on 06/14/22 and brought the original paper prescription back to the facility.

Interview with the Resident Care Coordinator (RCC) on 09/01/22 at 5:15pm revealed:
-She did not know why Resident #1 did not receive Allevyn dressing changes, but she thought the Allevyn dressings were too expensive.
-Resident #1's PCP ordered Tegaderm dressings for her wound.
-She thought the Tegaderm dressings were expensive as well and that is why there was a delay in Resident #1 receiving the Tegaderm dressings.
-The facility was using dressings they already had at the facility to change Resident #1's dressing in June 2022.
-There was no documentation that Resident #1 was receiving dressing changes in June 2022.
-She was responsible for entering medications and treatments on the eMAR for Resident #1.
-Resident #1's dressing changes should have been documented on the eMAR.

Telephone interview with the Administrator on 09/01/22 at 5:49pm revealed:
-She expected medication or treatments orders to be implemented on a resident within 24 hours of receiving the order from the PCP.
-She expected all dressing changes to be documented on the eMAR.
-She did not know why there was a delay in Resident #1 receiving the dressing changes.

Telephone interview with a pharmacist at Resident #1's pharmacy on 09/01/22 at 2:55pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 276	Continued From page 19 -There was no order in their system for Allevyn dressings for Resident #1. -There was a handwritten prescription dated 06/14/22 for Tegaderm dressings for Resident #1. -They received the prescription for Resident #1's Tegaderm on 06/28/22. -They did not have the Tegaderm in stock at the pharmacy and had to order them. -Anything that had to be ordered usually came in the next day and, if so Resident #1's Tegaderm would have been available to pick up either 06/29/22 or 06/30/22. -Resident #1's Tegaderm dressings were picked up from the pharmacy on 07/01/22. Interview with Resident #1's PCP on 09/01/22 at 1:41pm revealed: -She ordered foam dressings for Resident #1's pressure wounds. -She was told by facility staff that Resident #1's family member did not initially want to use the dressings because of cost. -Resident #1 was receiving dressing changes to her wounds before 07/01/22 because facility staff were borrowing dressings from another resident. Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20	D 358		

which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 1 of 5 sampled resident (#4) related to a heart medication prescribed with a loading dose to be administered for 4 days then to be followed by scheduled maintenance dose thereafter.

The findings are:

Review of Resident #4's current FL-2 dated 01/19/22 revealed diagnoses included hypertension, anemia and spinal stenosis.

Review of Resident #4's progress note dated 08/06/22 at 11:25pm revealed he complained of chest pain and was sent to the local emergency department for evaluation,

Review of Resident #4's progress notes dated 08/15/22 at 12:31pm revealed he was expected to return from the hospital with new cardiac medications.

Review of Resident #4's progress note dated 08/15/22 at 6:10pm revealed he returned to the facility from the hospital.

Review of Resident #4's physician's order dated 08/19/22 revealed Amiodarone 200mg, 2 tablets was to be administered each day for four days. (Amiodarone is a medication used to treat heart rhythm problems.)

Review of Resident #4's second physician's order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 21 dated 08/19/22 revealed Amiodarone 200mg 1 tablet was to be administered each day beginning 08/20/22. Review of Resident #4's electronic medication administration record (eMAR) for August 2022 revealed: -There was a computerized entry for Amiodarone 200mg, 2 tablets to be administered daily for 4 days. -There was documentation that Amiodarone 200mg, 2 tablets was administered daily from 08/20/22 through 08/23/22. -There was no computerized entry for Amiodarone 200mg, 1 tablet to be administered daily. Interview with Resident #4 on 09/01/22 at 8:48am revealed: -He had been sent to the hospital a few weeks ago for chest pain. -He was currently in no pain and did not know what was done while he was in the hospital. -He did not know if he was prescribed new medications after his hospital stay. Interview with the medication aide (MA) on 09/01/22 at 2:25pm revealed Resident #4 was administered Amiodarone for 4 days in August but was not currently receiving the medications. Interview with a second MA on 09/01/22 at 2:25pm revealed the Resident Care Coordinator or the pharmacy entered medications onto the eMAR. Telephone interview with Resident #4's pharmacist on 09/01/22 at 10:03am revealed: -Amiodarone was prescribed to ensure Resident #4's heart was beating correctly.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 358	Continued From page 22 -She received an order on 08/19/22 for Resident #4 to receive Amiodarone 200mg, 2 tabs to be administered daily for four days. -She also received an order for Amiodarone 200mg 1 tablet to be administered each day beginning on 08/20/22 but was meant to start once the four days was completed. -Both of Resident #4's orders were sent from a cardiology provider. -Eight tablets of Amiodarone 200mg was dispensed on 08/19/22 for the prescription written for Amiodarone 200mg, 2 tablets to be administered daily for four days. -There had been no other Amiodarone dispensed for Resident #4. -She had not been contacted by the facility for medication to be administered but 5 tablets had been "short filled" to be sent to the facility that day so that it lined up with routine monthly prescription fill. Telephone interview with Resident #4's primary care provider (PCP) on 09/01/22 at 3:32pm revealed: -Resident #4 had been sent to the local hospital for complaints of chest pain in the past but she could not remember how long he stayed or the result of the evaluation. -Amiodarone was prescribed for 4 days as a loading does to get his heart back into rhythm then scheduled at a lower dose to maintain the rhythm. -Amiodarone was a dangerous but effective medication but Resident #4's heart rhythm could revert back, causing cardiac issues, if he did not receive the Amiodarone as prescribed. -She was not aware Resident #4 was not receiving Amiodarone 200mg 1 tablet daily as prescribed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23 Interview with the Resident Care Coordinator (RCC) on 09/01/22 at 5:45pm revealed: -Resident #4 was sent to the local hospital emergency department a couple of weeks ago for evaluation when he complained of chest pain. -She had not contacted the pharmacy for amiodarone 200mg, 1 tablet to be administered daily to Resident #4 because she was not aware of the order. -It was her responsiblity to ensure medications were entered on the eMAR correctly. Interview with the Administrator on 09/01/22 at 5:45pm revealed: -She expected medications to be administered as prescribed. -She was not aware of the order for Resident #4 to recieve amiodarone 200mg 1 tablet daily.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 367	Continued From page 24	D 367		

(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 5 residents sampled (#1, #2) including duplicate documentation for medications (#1) and failing to document the administration of a standing order (#2).

The findings are:

1.Review of Resident #1's current FL-2 dated 04/27/22 revealed:
-Diagnoses included diabetic/borderline, hypertension (HTN), obesity, frequent urinary tract infections (UTI) (Hypertension is high blood pressure).
-There was an order for Ditropan XL 5mg daily (Ditropan XL is used to treat overactive bladder).

Review of Resident #1's physician order sheet dated 06/21/22 revealed:
-There was an order for Ditropan XL 5mg daily.
-There was an order for oxybutynin chloride extended release (ER) 5mg every day (Oxybutynin chloride ER and Ditropan XL are the same medications).

Review of Resident #1's June electronic medication administration record (eMAR) revealed:
-There was an entry for oxybutynin chloride ER 5mg every day.
-Oxybutynin chloride ER 5mg was documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 367	Continued From page 25 as administered every day except 06/02/22, 06/03/22, 06/07/22, 06/08/22, 06/09/22, 06/11/22-06/14/22, and 06/21/22-06/27/22 where it was documented as duplicate. -There was an entry for Ditropan XL 5mg daily. -Ditropan XL was documented every day except 06/10/22 and 06/15/22 where it was documented as refused. -Both oxybutynin chloride ER 5mg and Ditropan XL 5mg were documented as administered on 06/01/22, 06/04/22, 06/05/22, 06/06/22, 06/16/22, 06/17/22, 06/19/22, 06/20/22, 06/28/22, 06/29/22, and 06/30/22. Review of Resident #1's July 2022 eMAR revealed: -There was an entry for oxybutynin chloride ER 5mg every day. -Oxybutynin chloride ER 5mg was documented as administered 07/03/22-07/05/22. -Oxybutynin chloride ER 5mg was documented as duplicate on 07/01/22 and refused on 07/02/22. -It was documented that Resident #1 was in the hospital 07/06/22-07/30/22. -There was an entry for Ditropan XL 5mg daily. -Ditropan XL was administered every day except 07/01/22 where it was documented as duplicate and 07/02/22 where it was documented as refused. -Both oxybutynin chloride ER 5mg and Ditropan XL 5mg were documented as administered 07/03/22-07/05/22. -It was documented that Resident #1 was in the hospital 07/06/22-07/30/22. Interview with a medication aide (MA) on 09/01/22 at 2:25pm revealed: -The Resident Care Coordinator (RCC) or a pharmacist entered medications on the eMAR.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL089002	A. BUILDING: ______ B. WING ______	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYRRELL HOUSE	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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 26	D 367		

-Resident #1 only had one bottle of Ditropan XL on the medication cart so she would not have received two doses of the medication.
-Either the oxybutynin chloride or the Ditropan should have been documented as duplicate on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 09/01/22 at 5:15pm revealed:
-She was responsible for entering Resident #1's medications on the eMAR.
-Oxybutynin chloride and Ditropan should not both be entered on the eMAR because they are the same medication.
-MAs should have been marking one of the medications as duplicate.

Telephone interview with a pharmacist at Resident #1's pharmacy on 09/01/22 at 2:55pm revealed:
-There was an order for Ditropan XL 5mg daily.
-Ditropan XL 5mg and oxybutynin chloride ER 5mg were the same medication.
-Only one bottle of Ditropan XL containing 30 tablets was dispensed to Resident #1 once a month.

Based on observations, interviews, and record reviews, it was determined Resident #5 was not interviewable.

Refer to telephone interview with the Administrator on 09/01/22 at 5:49pm.

2.Review of Resident #2's current FL-2 dated 04/26/22 revealed:
-Diagnoses included advanced dementia, arthritis and seizure disorder.
-There was documentation her level of care was special care unit.

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D 367	Continued From page 27	D 367		

Continued From page 27

-She was constantly disoriented.

Review of Resident #2's physician's standing orders dated 04/26/22 revealed there was an order for triple antibiotic ointment to be applied daily, after cleansing with normal saline, and a Band-Aid as needed for skin tears.

Observation of Resident #2 on 08/31/22 at 8:46am revealed:
-She had a gauze bandage on her right forearm.
-The bandage was dated 08/08/22 or 08/28/22. (The ink was smearing making date difficult to read.)
-Resident #2 could not say why she had a bandage on her arm.

Interview with the medication aide (MA) on 08/31/22 at 10:53am revealed:
-Resident #2 had a skin tear on her right arm.
-The dressing was dated for 08/28/22 when she last changed the dressing.
-She did not remember when or how Resident #2 got the skin tear.

Review of Resident #2's electronic medication administration record (eMAR) for August 2022 revealed:
-There was a computerized entry for triple antibiotic ointment to be administered as needed for minor skin tears or abrasions after cleansing the area with normal saline, apply ointment and cover with a Band-Aid or gauze and tape and change daily.
-There was no documentation of administration from 08/01/22 through 08/31/22.

Second interview with the MA on 09/01/22 revealed:
-Medications ordered as needed should be

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D 367	Continued From page 28	D 367		

documented on the eMAR when they are administered.
-She thought the standing order was for the dressing to be changed and ointment applied every other day.
-She did not always document that she administered the antibiotic on the eMAR.

Telephone interview with Resident #2's primary care provider on 09/01/22 at 3:32pm revealed she was not concerned about over administration of the antibiotic ointment but all medications prescribed as needed should be documented when administered.

Interview with the lead MA on 09/01/22 revealed medications prescribed as needed should be documented on the eMAR when they were administered.

Interview with the Resident Care Coordinator (RCC) on 09/01/22 at 5:15pm revealed she expected all medications to be documented each time they were administered.

Refer to interview with the Administrator on 09/01/22 at 5:49pm.

Telephone interview with the Administrator on 09/01/22 at 5:49pm revealed she expected eMARs to be accurate because inaccurate information on eMARS could cause detriment to a resident.

D912 G.S. 131D-21(2) Declaration of Residents' Rights — D912

G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:

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D912	Continued From page 29 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Health Care. The findings are: Based on interviews and record reviews, the facility failed to ensure provider notification and follow-up for 2 of 5 sampled residents (#1, #4) related to a resident experiencing worsening of a pressure wound that was not reported to the primary care provider (PCP) (#1) and a resident that was on blood thinning medications that was sent to the local emergency department for evaluation due to blood in his urine and failing to notify the PCP of his return (#4). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].	D912		