STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023048	A. BUILDING: _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

(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 The Adult Care Licensure Section and the Cleveland County Department of Social Services conducted an annual survey and complaint investigations from 07/11/23 to 07/13/23. The complaint investigations were initiated by the Cleveland County Department of Social Services on 06/23/23.	D 000		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had a care plan completed within 30 days of admission. The findings are: Review of Resident #4's FL2 dated 04/19/23 revealed: -Diagnoses included type 2 diabetes, atrial fibrillation and hypertension. -The resident required assistance with dressing and bathing. -She was non-ambulatory and incontinent of bladder and bowel. -She had a wound on her coccyx (tailbone) that required daily dressing changes.	D 259		

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D 259	Continued From page 1 Review of Resident #4's Resident Register revealed an admission date of 04/21/23. Review of Resident #4's Care Plan dated 06/21/23 revealed: -The resident was non-ambulatory and used a wheelchair. -She required two staff members to assist with toileting, locomotion, bathing, dressing, personal hygiene and transfers. Interview with Resident #4 on 07/13/23 at 3:20pm revealed she required staff assistance with toileting, personal care and pushing her wheelchair. Interview with the Resident Care Coordinator (RCC) revealed: -She was responsible for completing resident care plans and getting them signed by the resident's Primary Care Provider (PCP) within 30 days of admission. -When residents were admitted to the facility, she placed them on a tracker to ensure documents were completed on time. -She was unsure why she had not completed Resident #4's care plan within 30 days of admission. Interview with the Administrator on 07/13/23 at 5:23pm revealed: -The RCC was responsible for completing resident care plans. -She was not aware Resident #4's care plan was not completed within 30 days of admission. -She expected the care plans of new residents to be completed within 30 days of admission.	D 259		

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D 270	Continued From page 2	D 270		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents resulting in a resident eloping from the facility's locked Special Care Unit (SCU) by accessing an enclosed outside courtyard through a sitting room door. The findings are: Review of Resident #1's current FL2 dated 6/12/23 revealed: -Diagnoses included restless agitation, vascular dementia, and hemiparesis (mild or partial weakness on one side of the body) from a cerebral infarction (stroke). -He was ambulatory. -He was constantly disoriented. -There was documentation he had wandering behaviors. -His level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register dated 06/13/23 revealed: -He was admitted to the facility on 06/13/23. -He did not require assistance with ambulation.	D 270		

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D 270	Continued From page 3 -He had significant memory loss. Review of Resident #1's Incident/Accident report dated 06/23/23 revealed: -Resident #1 was found on the sidewalk in the courtyard laying on his back. -The type of occurrence was elopement. -The location was documented as outside. -The description of unusual occurrence revealed "found resident". -Resident #1's family member was notified on 06/23/23 at 7:42am and the Primary Care Provider (PCP) was notified at 4:35pm. -Resident #1 was transported to the hospital via Emergency Medical Services (EMS). Review of the EMS encounter document dated 06/23/23 revealed: -Resident #1 had a history of dementia. -Resident #1 was left outside the facility the previous night and was found on the ground that morning (06/23/23). Review of the Emergency Department (ED) After Visit Summary dated 06/23/23 revealed: -Resident #1 was seen for fatigue. -Diagnosis of the encounter was contusion (bruise) of the buttock. Observation on 06/26/23 at 2:00pm revealed: -There were two doors in the sitting room that led to the C-hall SCU courtyard. -Beside each door there was a switch covered by a clear plastic cover that was able to be lifted easily. -The switches next to both doors were in the off position. Interview with Resident #1 on 06/23/23 at 3:15pm revealed he spent the night outside.	D 270		

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D 270	Continued From page 4 Interview with the Resident Care Director (RCD) on 06/23/23 at 2:00pm revealed: -Resident #1 went missing last night (06/22/23) and Department of Social Services (DSS) and Law Enforcement were not contacted. -It was estimated that Resident #1 went missing around 9:00pm on 06/22/23 until about 7:00am the next morning (06/23/23). -The third shift personal care aide (PCA) knew Resident #1 was not in his bed but did not report it to the Supervisor. -The third shift Supervisor went to the SCU to administer medications to Resident #1 on 06/23/23 at 6:00am and found the resident was not in his bed. -The third shift Supervisor documented on Resident #1's electronic medication administration record (eMAR) the resident was on a leave of absence (LOA). Interview with Resident #1's family member on 06/23/23 at 3:20pm revealed: -She was called by a first shift medication aide (MA) that morning (06/23/23) and was asked if Resident #1 was with her. -The MA informed her Resident #1 was not in his bed when he went to administer his medications. -When she and another family member arrived at the facility on 06/23/23, they were informed Resident #1 was found at approximately 8:00am. -The MA informed the family Resident #1 was found outside in the courtyard, laying on his back with his hands on his chest. Interview with first shift MA on 06/27/23 at 11:00am revealed: -He was the first shift MA on 06/23/23 in the C-hall SCU. -The third shift Supervisor from the previous night	D 270		

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reported to him Resident #1 was on LOA.
-The Supervisor reported to him she had looked for Resident #1 and assumed he was on LOA.
-The Supervisor requested he contact Resident #1's power-of-attorney (POA) and ask if the resident was out with the family.
-When he spoke with the family, they confirmed Resident #1 was not with them.
-He and the Supervisor looked in several rooms including Resident #1's room.
-He then unlocked the courtyard doors and noticed Resident #1 was outside.
-Resident #1 was lying on his back on the ground and was physically wet from the rain.
-There was mulch and dirt on Resident #1's clothes and his shoes were in a nearby flower bed.
-Two staff members assisted Resident #1 up off the ground.
-Resident #1 was physically shivering and cold.
-Resident #1 was able to stand to get into the wheelchair.
-Resident #1 had two scratches on his forehead and a bruise on his lower back.
-EMS was called and transported Resident #1 to the hospital.
-The courtyard doors on hall-C were unlocked for residents to go out as they wanted.

Interview with the SCU Coordinator on 06/27/23 at 2:16pm.
-She received a text from the first shift PCA on 06/23/23 asking if she knew anything about Resident #1 being out of the facility.
-She responded to the text at 7:28am indicating she did not know of Resident #1 being out of the facility and that he was there when she left the previous day (06/22/23) after 5:00pm.
-The PCA informed her the third shift staff did not know if Resident #1 went out with family or went

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to the emergency department (ED).
-The third shift PCAs were responsible to do rounds at 11:00pm
-The third shift PCAs noticed that Resident #1 was not in his room when the 11:00pm rounds were done.
-She called the facility and spoke with the MA when she was notified Resident #1 could not be located.
-She asked the MA if anyone had looked for Resident #1 and was informed no one had looked for the resident.
-She was informed by a PCA shortly after that Resident #1 had been found outside in the courtyard.
-She spoke with the MA who informed her Resident #1 was muddy but okay.

Interview with a MA on 06/27/23 at 12:45pm revealed:
-He was the MA on hall-C SCU on 06/22/23 on second shift.
-He administered medications to Resident #1 on 06/22/23 at 8:00pm.
-Resident #1 was very active during second shift on 06/22/23.
-He did rounds during his shift to ensure residents were dry, clean, and safe.
-He checked on Resident #1 on 06/22/23 between 9:00pm and 10:00pm and the resident was dry.
-He asked the on-coming third shift PCAs how their initial round went, and they reported to him they did not find any issues.

Interview with a third shift PCA on 06/27/23 at 2:00pm revealed:
-She worked on 06/22/23 from 11:00pm to 7:00am.
-The second shift PCA on 06/22/23 left without

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communicating to her about the shift.
-She began her rounds to check residents for being wet and being in their beds.
-She went into Resident #1's room and his bed was made.
-She assumed Resident #1 was gone from the facility because she did not get a report from the previous shift.
-She did a head count at the beginning of her shift and there were only 14 residents.
-When the third shift Supervisor went into Resident #1's room on 06/23/23 at 6:00am to administer medications, she informed her Resident #1 was not in the facility.
-She was informed by the Supervisor Resident #1 was marked in the computer as being in the facility.

An additional interview via telephone with the third shift PCA on 07/13/23 at 3:53pm revealed staff were to report any residents on LOA to the on-coming staff during shift change.

Interview with a third shift MA Supervisor on 06/27/23 at 2:45pm revealed:
-She worked third shift beginning 06/22/23 at 11:00pm.
-She was responsible to administer medications on C-hall and D-hall.
-She went to C-hall SCU on 06/23/23 at 6:00am to administer medications.
-She went to administer medications to Resident #1, but he was not in his room.
-She asked the two PCAs working the hall where Resident #1 was, and both reported he had not been there all night.
-She did not know Resident #1 was missing until she went to give him his medications.
-The doors to the courtyard were locked on 06/22/23 at 9:00pm until after 7:00am the next

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D 270	Continued From page 8 morning (06/23/23). Interview with the SCU Coordinator on 7/11/23 at 12:51pm revealed: -All staff were responsible to lay eyes on the residents on their hall. -All staff in the building were responsible to do room checks. -Room checks were not documented. -If a resident was not in the building, it should be established at the beginning of the shift. -If residents were in the courtyard a staff member should always be with them. Interview with a first shift PCA on C-hall SCU on 07/11/23 at 10:25am revealed: -MAs and Supervisors were to know when a resident was signed out of the facility. -Doors were always locked and if residents wanted to go out, staff had to go with them. A second interview with the first shift PCA on C-hall SCU on 07/13/23 at 9:20am revealed: -If she was not looking at the courtyard doors, she would not know if a resident went out the door. -A staff member should be in the day room to supervise the residents. -There were no alarms on the courtyard doors on C-hall SCU. -When the courtyard doors opened, it sent an alert to pagers carried by the assisted living (AL) staff. -She worked at the facility for about 1.5 years, and she could remember maybe one or two times staff from the AL side came back to C-hall SCU and stated the doors had been opened. Interview with a MA on 07/11/23 at 10:17am revealed the C-hall courtyard doors were	D 270		

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sometimes unlocked so residents could come and go as they pleased.

Interview with SCU Coordinator on 07/12/23 at 12:27pm revealed:
-Staff were responsible to always supervise residents.
-Resident head counts were to be done every shift at the beginning of the shift.
-Every two hours staff were to complete toileting rounds on every resident.
-If a resident could not be found, the staff member was to notify the Supervisor.
-The Supervisor was responsible to contact the Administrator.

Interview with a second shift PCA on 07/12/23 at 5:00pm revealed:
-She did not do resident head counts prior to the incident with Resident #1.
-The only way staff knew a resident was on LOA was if the SCU Coordinator or the previous shift staff told them.
-She saw Resident #1 on 06/22/23 at 8:30pm when the MA gave him his medication.
-On 06/22/23 between 9:30pm and 10:00pm she and the MA did the last round of the shift.
-She communicated to the MA that all residents were in their rooms, including Resident #1.
-When the third shift PCAs came in, she and the MA communicated to them that all residents were in their rooms.
-The courtyard doors were left opened until after supper on 06/22/23 and she locked the doors that evening.
-Staff did not check the courtyard of C-hall SCU the night of 06/22/23.
-The sensors on the courtyard doors of C-hall SCU were broken.
-The doors were fixed after DSS came on

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D 270	Continued From page 10 06/23/23. Interview with the SCU Coordinator on 7/12/23 at 4:34pm revealed: -Staff were to give a shift report at the beginning of each shift. -The C-hall SCU sitting room doors were left unlocked during the day if staff were monitoring the residents. -When a resident was on LOA, she typed a note stating the resident was LOA and posted it on the bulletin board behind the nurse's station. A second interview with the SCU Coordinator on 07/13/23 at 9:05am revealed: -She would not know if a resident went into the C-hall courtyard unless she saw the resident go out or if AL staff reported it to her, as they were the staff that carried the pagers. -There was no auditory alarm if the C-hall SCU courtyard doors were opened. Interview with a MA on C-hall SCU on 07/13/23 at 9:55am revealed: -She would not know if the courtyard doors were opened unless she saw it or staff from the AL came and told her. -She would have to physically see the resident go outside to know the resident went out. Interview with the SCU Coordinator on 07/13/23 at 2:03pm revealed: -Resident room checks were to be done every two hours, but they were not documented. -The MA was responsible for ensuring the door to the courtyard was locked. -The MA was to walk around the courtyard to make sure no residents were outside before locking the doors. -The courtyard doors should not be opened on	D 270		

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D 270	Continued From page 11 third shift at all. Interview with second shift PCA on 07/13/23 at 3:23pm revealed: -Residents were checked on every two hours but the checks were not documented. -PCAs and MAs were responsible for doing the two-hour checks. -All staff were responsible for ensuring the courtyard doors were locked. -The keys for the courtyard doors hung on a hook behind the nurse's station. -It was possible a resident could get the keys. -She was told by the SCU Coordinator that Resident #1 wandered. -Resident #1 was having to be constantly redirected because of his wandering. -Resident # 1 could not stay seated at the supper table due to getting up to wander. -The previous shift was to tell oncoming staff if a resident was on LOA. -If the previous shift did not communicate a resident was LOA, the oncoming staff would not know. Interview with the Administrator on 07/11/23 at 3:13pm revealed: -The facility did not have cameras or video surveillance. Interview with the Administrator on 07/13/23 at 5:23pm revealed: -She was notified Resident #1 was missing on 06/23/23. -By the time she called the nurse at the facility, Resident #1 had been found. -Resident #1 got out into the courtyard without staff noticing. -The doors to the C-hall courtyard were to be locked daily at 7:00pm.	D 270		

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D 270	Continued From page 12 -Residents were not to be out in the courtyard without a staff or family member present. -She was notified that evening by the RCD that DSS was in the building. -She instructed the RCD not to lie; the facility was at fault and needed to 'own it'. _____ The facility failed to ensure Resident #1, with a history of dementia and wandering behavior, was supervised. The lack of supervision resulted in Resident #1 eloping from the facility's locked C-hall Special Care Unit by accessing an outside courtyard through a sitting room. Resident #1 was outside in the elements the night of 06/22/23 until the morning of 06/23/23 when he was found lying on the ground, physically wet from the rain, mulch and dirt on his clothes and physically shivering and cold. The facility's failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on and 06/27/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 12, 2023.	D 270		
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.	D 276		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 5 sampled residents who had orders for a medication to lower cholesterol and two medications for pain (Resident #1).

The findings are:

Review of Resident #1's FL2 dated 06/12/23 revealed diagnoses included hyperlipidemia (high levels of fat/cholesterol in the blood) and hemiparesis (mild or partial weakness on one side of the body) from a cerebral infarction (stroke).

Review of the resident register for Resident #1 revealed an admission date of 06/13/23.

a. Review of Resident #1's FL2 dated 06/12/23 revealed there was an order for Crestor 20mg, one tablet daily.

Review of Resident #1's June 2023 electronic medication administration record (eMAR) revealed there was no entry for Crestor (a medication to lower cholesterol levels) 20mg, one tablet daily.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am.

Refer to the interview with the Resident Care Director (RCD) on 07/12/23 at 4:03pm and 5:48pm.

Refer to the interview with the Special Care Unit (SCU) Coordinator on 07/13/23 at 4:47pm.

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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 14 Refer to the interview with the Administrator on 07/13/23 at 5:23pm. b. Review of Resident #1's FL2 dated 06/12/23 revealed there was an order for meloxicam (a medication to relieve pain) 7.5mg, one tablet daily. Review of Resident #1's June 2023 eMAR revealed there was no entry for meloxicam 7.5mg, one tablet daily. Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am. Refer to the interview with the RCD on 07/12/23 at 4:03pm and 5:48pm. Refer to the interview with the SCU Coordinator on 07/13/23 at 4:47pm. Refer to the interview with the Administrator on 07/13/23 at 5:23pm. c. Review of Resident #1's FL2 dated 06/12/23 revealed there was an order for aspirin (a medication to relieve pain) 81mg, one tablet daily. Review of Resident #1's June 2023 eMAR revealed there was no entry for aspirin 81mg, one tablet daily. Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am. Refer to the interview with the RCD on 07/12/23 at 4:03pm and 5:48pm.	D 276		

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D 276	Continued From page 15 Refer to the interview with the SCU Coordinator on 07/13/23 at 4:47pm. Refer to the interview with the Administrator on 07/13/23 at 5:23pm. _____ Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am revealed: -Resident #1's medications were sent to the facility on 06/15/23. -The pharmacy did not send Resident #1's Crestor, meloxicam, and aspirin because they were listed on his allergy list or flagged in the system. -The pharmacy called and left a message at the facility and faxed the facility on 06/15/23 for clarification of Resident #1's medications in order for them to dispense them. Interview with the RCD on 07/12/23 at 4:03pm and 5:48pm revealed: -When a resident was admitted to the facility, the FL2 was faxed to the pharmacy. -The pharmacy was responsible for putting medication orders on the residents' eMARs. -Resident #1 brought medications with him when he was admitted to the facility. -Resident #1's medications were reviewed with the FL2 and then placed on the medication cart. -She was unsure if she or the RCC reviewed Resident #1's medications with the FL2. -The RCC was responsible for verifying the resident's eMAR medication orders were accurate after the pharmacy entered them. Interview with the SCU Coordinator on 07/13/23 at 4:47pm revealed: -The RCD or the Resident Care Coordinator	D 276		

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D 276	Continued From page 16 (RCC) were responsible to ensure medications were on the residents' eMARs. -She was not aware three of Resident #1's medications were not on his eMAR and were not administered. -If a resident was admitted with medications, the medication labels were compared with the order on the FL2. -If the medication label matched the order, the medications were placed on the medication cart. -Medications were not administered to residents unless they appeared on their eMAR. Interview with the Administrator on 07/13/23 at 5:23pm revealed: -The RCD was responsible for clarification of orders and ensuring medications were placed on the eMAR by the pharmacy. -The RCC was responsible for performing cart audits monthly. -Cart audits included comparing the medications on the cart with the medication order. -She was not aware Resident #1 did not receive medications as ordered.	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 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:	D 358		

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Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered for 2 of 6 sampled residents (#4 and #6) related to a medication to decrease blood clotting time (#6), a medication to lower blood sugar levels and a medication to treat fungal infections (#4).

The findings are:

1. Review of Resident #6's FL2 dated 06/07/23 revealed diagnoses included chronic atrial fibrillation (irregular heartbeat), ventricular tachycardia (abnormal heartbeat) and chronic congestive heart failure (inefficient pumping of the blood).

Review of Resident #6's Primary Care Provider's (PCP) order dated 06/28/23 revealed:
-There was an order for Coumadin 3mg, on Monday, Wednesday, Friday, and Sunday beginning 06/28/23.
-There was an order for Coumadin 2mg, on Tuesday, Thursday, and Saturday.
-There was an order to recheck the resident's PT/INR (a blood test to check how quickly the blood clots) on Monday, 07/03/23.

Review of Resident #6's PCP order dated 07/03/23 revealed:
-An order for Coumadin 3mg, daily.
-An order to recheck the resident's PT/INR on 07/07/23.

Review of Resident #6's July 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Coumadin 2mg, one tablet daily.
-The entry was documented as administered on

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D 358	Continued From page 18 Sunday, 07/02/23 at 5:00pm. -There was an entry for Coumadin 2mg, one tablet daily. -The entry was documented as administered on Monday, 07/03/23 at 5:00pm. Interview with a medication aide (MA) on 07/13/23 at 10:00am revealed: -New medications were indicated on the resident's eMARs. -He administered Resident #6's Coumadin according to the order on the eMAR. -He did not see the PCP's orders for medication changes. -He was not aware he made an error when administering Coumadin to Resident #6's on 07/03/23. -He did no know if resident eMARs were audited for accuracy. Interview with Resident #6's PCP on 07/12/23 at 5:38pm revealed she was not aware of the Coumadin errors. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am revealed: -The pharmacy received the PCP's order dated 06/28/23 that day (06/28/23) and Coumadin 2mg, 30 tablets and Coumadin 3mg, 30 tablets were dispensed on 06/28/23. -The pharmacy received the PCP's order dated 07/03/23 that day and Coumadin 3mg, 14 tablets were dispensed on 07/03/23. -If Resident #6 received too much Coumadin she would be at risk for increased bleeding. -If Resident #6 received too little Coumadin, her PT/INR would not be in therapeutic range and would not treat her condition properly.	D 358		

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D 358	Continued From page 19 Interview with the Administrator on 07/12/23 at 4:45pm revealed she was not aware of the Coumadin medication errors for Resident #6. Refer to the interview with the Administrator on 07/12/23 at 4:45pm. 2. Review of Resident #4's current FL2 dated 04/19/23 revealed: -Diagnoses included Type 2 diabetes. -There was an order to check the resident's fingerstick blood sugar (FSBS) three times daily before meals. -There was an order for novolog (a rapid acting insulin used to lower elevated blood sugar levels) inject per sliding scale three times daily before meals: FSBS: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = give 10 units and call the Primary Care Provider (PCP). a. Review of Resident #4's PCP orders dated 05/31/23 and 06/21/23 revealed an order for novolog insulin inject four times daily before meals and at bedtime per sliding scale: FSBS: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = give 10, 401-450 = 12 units, 451-500 = 15 units, 501-550 = 20 units, greater than 551 give 22 units and call the PCP. Review of Resident #4's May 2023 electronic medication administration record (eMAR) revealed: -There was an entry dated 04/27/23 for novolog insulin inject per sliding scale four times daily to be administered at 7:30am, 11:30am, 4:30pm and 8:00pm.: FSBS: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = give 10, 401-450 = 12 units, 451-500 =	D 358		

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15 units, 501-550 = 20 units, greater than 551 give 22 units and call the PCP.
-On 05/03/23 at 8:00pm, the resident's FSBS was 310 and she received 10 units of insulin when the order stated she should have received 8 units.
-On 05/09/23 at 8:00pm, the resident's FSBS was 271 and she received 4 units when the order stated she should have received 6 units.
-On 05/23/23 at 8:00pm, the resident's FSBS was 314 and she received 14 units when the order stated she should have received 8 units.

Review of Resident #4's June 2023 eMAR revealed:
-There was an entry dated 05/24/23 for novolog insulin inject per sliding scale four times daily to be administered at 7:30am, 11:30am, 4:30pm and 8:00pm: FSBS: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = give 10, 401-450 = 12 units, 451-500 = 15 units, 501-550 = 20 units, greater than 551 give 22 units and call the PCP.
-On 06/05/23 at 11:30am, the resident's FSBS was 291 and she received 4 units of insulin when the order stated she should have received 6 units.

Interview with a medication aide (MA) on 07/13/23 at 10:00am revealed:
-Resident #4's FSBS was checked prior to administering the sliding scale insulin.
-When the FSBS results were entered into the eMAR system, the sliding scale became highlighted.
-He reviewed the sliding scale to determine the amount of insulin to be given.
-He was not aware he had made two errors administering insulin to Resident #4.

Interview with the Resident Care Director (RCD)

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on 07/12/23 at 4:03pm revealed:
-She was not aware of the sliding scale insulin errors for Resident #4.
-One of the MAs who made the insulin errors was re-trained recently because of medication administration issues.
-The Resident Care Coordinator (RCC) was responsible for medication cart audits and sliding scale audits.

Interview with the RCC on 07/13/23 at 4:35pm revealed:
-The MAs were trained on insulin administration by the pharmacy or by the RCD upon hire.
-She did not audit Resident #4's eMAR for insulin errors.
-She was not aware there were times Resident #4's insulin was administered incorrectly.

Interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am revealed:
-If Resident #4 was given too much insulin her blood sugar could drop below normal.
-If Resident #4 was given too little insulin she could have elevated blood sugar levels and if it continued to be elevated, she could suffer long-term damage to her eyes and feet.

Refer to the interview with the Administrator on 07/12/23 at 4:45pm.

b. Review of Resident #4's PCP order dated 06/19/23 revealed an order for fluconazole (a medication to treat fungal infections) 150mg, one tablet once, may repeat dose in three days if redness continued.

Review of Resident #4's June eMAR revealed:
-There was an entry dated 06/19/23 for

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fluconazole 150mg, one tablet daily.
-The entry was documented as administered at 8:00am on 06/20/23 and 06/21/23.
-There was a second entry dated 06/19/23 for fluconazole 150mg may repeat in 3 days if redness continued.
-The entry was not documented as administered.

Interview with the RCC on 07/13/23 at 4:35pm revealed:
-She was not aware Resident #4's fluconazole was not administered as ordered.
-She thought a MA had discussed it with the RCD, but she was not sure.

Interview with a Pharmacist with the facility's contracted pharmacy on 07/13/23 at 11:04am revealed:
-Fluconazole 150mg, two tablets were dispensed to the facility on 06/19/23 for Resident #4.
-She believed the fluconazole order was placed in the eMAR system incorrectly by pharmacy staff.
-The fluconazole was placed in the system to administer daily and should not have been.

Refer to the interview with the Administrator on 07/12/23 at 4:45pm.

_____

Interview with the Administrator on 07/12/23 at 4:45pm revealed:
-The RCC was responsible for ensuring the orders on the eMAR were accurate.
-The RCD was responsible to be the second review for all medication orders.
-The RCD was responsible for completing medication cart audits monthly.
-The RCD was responsible for clarification of any medication orders.
-She expected medications to be administered as ordered.

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D 461	10A NCAC 13F .1304 Special Care Unit Building Requirements 10A NCAC 13F .1304 Special Care Unit Building Requirements In addition to meeting all applicable building codes and licensure regulations for adult care homes, the special care unit shall meet the following building requirements: (1) Plans for new or renovated construction or conversion of existing building areas shall be submitted to the Construction Section of the Division of Facility Services for review and approval. (2) If the special care unit is a portion of a facility, it shall be separated from the rest of the building by closed doors. (3) Unit exit doors may be locked only if the locking devices meet the requirements outlined in the N.C. State Building Code for special locking devices. (4) Where exit doors are not locked, a system of security monitoring shall be provided. (5) The unit shall be located so that other residents, staff and visitors do not have to routinely pass through the unit to reach other areas of the building. (6) At a minimum the following service and storage areas shall be provided within the special care unit: staff work area, nourishment station for the preparation and provision of snacks, lockable space for medication storage, and storage area for the residents' records. (7) Living and dining space shall be provided within the unit at a total rate of 30 square feet per resident and may be used as an activity area. (8) Direct access from the facility to a secured outside area shall be provided. (9) A toilet and hand lavatory shall be provided	D 461		

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within the unit for every five residents.
(10) A tub and shower for bathing of residents shall be provided within the unit.
(11) Use of potentially distracting mechanical noises such as loud ice machines, window air conditioners, intercoms and alarm systems shall be minimized or avoided.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors accessible to residents to the enclosed courtyard were equipped with a security monitoring system that activated for the safety of all residents in the C-Hall Special Care Unit (SCU) which included one resident (Resident #1) who entered the courtyard without staff knowledge and stayed in the elements, including rain, overnight.

The findings are:

Review of Resident #1's FL2 dated 06/12/23 revealed:
-Diagnoses included restless agitation, vascular dementia, and speech defects from a cerebral infarction (stroke).
-He was ambulatory.
-He was constantly disoriented.
-There was documentation he had wandering behaviors.
-His level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register dated 06/13/23 revealed:
-He was admitted to the facility on 06/13/23.
-He did not require assistance with ambulation.

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D 461	Continued From page 25 -He had significant memory loss. Review of Resident #1's Incident/Accident report dated 06/23/23 revealed: -Resident #1 was found on the sidewalk in the courtyard laying on his back. -The type of occurrence was elopement. -The location was documented as outside. Review of the emergency medical services (EMS) encounter document dated 06/23/23 revealed: -Resident #1 had a history of dementia. -Resident #1 was left outside the facility the previous night and was found on the ground that morning (06/23/23). Observation on 06/26/23 at 2:00pm revealed: -There were two doors in the sitting room that led to the C-hall courtyard. -Beside each door there was a switch, resembling a light switch, covered by a clear plastic cover that was able to be lifted easily. -The switches next to both doors were in the off position. -There was no auditory alarm that sounded when the doors were opened. Interview with Resident #1 on 06/23/23 at 3:15pm revealed he spent the previous night outside. Interview with a medication aide (MA) on 06/27/23 at 11:00am revealed: -He was the first shift MA on 6/23/23 in the C-hall SCU. -The third shift Supervisor reported to him on 06/23/23 around 7:00am that she had looked for Resident #1 and assumed he was on LOA because she could not find him. -He found Resident #1 lying on his back in the courtyard, physically wet from the rain.	D 461		

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D 461	Continued From page 26 Interview with a first shift PCA on C-hall SCU on 07/11/23 at 10:25am revealed doors were always locked and if residents wanted to go out, staff had to go with them. Interview with a first shift PCA on C-hall SCU on 07/13/23 at 9:20am revealed: -If she was not looking at the courtyard doors, she would not know if a resident went out the door. -There were no alarms on the courtyard doors on the C-hall SCU. -When the courtyard doors opened, it sent an alert to pagers carried by the assisted living (AL) staff. -She worked at the facility for about 1.5 years, and she could remember maybe one or two times staff from the AL came back to C-hall SCU and stated the doors had been opened. Interview with the SCU Coordinator on 07/12/23 at 4:34pm revealed the C-hall SCU sitting room doors were left unlocked during the day if staff were monitoring the residents. Interview with the SCU Coordinator on 07/13/23 at 9:05am revealed: -She would not know if a resident went into the C-hall courtyard unless she saw the resident go out or if AL staff reported it to her, as they were the staff that carried the pagers. -There was no auditory alarm when the C-hall SCU courtyard doors were opened. Interview with a MA on C-hall SCU on 07/13/23 at 9:55am revealed: -Unless she saw it, she would not know if the courtyard door were opened unless the staff from the AL came and told her.	D 461		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL023048	A. BUILDING: _____ B. WING _____	C 07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SHELBY	1550 CHARLES ROAD SHELBY, NC 28152

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D 461	Continued From page 27 -She would have to physically see the resident go outside to know the resident went out. Interview with the Administrator on 07/13/23 at 3:05pm revealed: -There was a notification system on the C-Hall courtyard door. -If the notification system was activated for the C-hall courtyard doors, when the doors were opened it sent a signal to pagers that staff on the AL carried. -The notification system was activated and deactivated by the switches under the plastic covers next to each courtyard door. -Staff and residents could lift the cover to the switch. -Prior to the incident with Resident #1 on 06/22/23 to 06/23/23, C-hall SCU staff did not carry pagers because it was a locked unit. -The clear plastic covers over the switches were placed to discourage residents from flipping the switch. -When Resident #1 was found in the C-hall courtyard the morning of 06/23/23, the switch under the plastic cover was in the off position. Attempted telephone interview with Resident #1's Primary Care Provider on 07/13/23 at 8:58am was unsuccessful.	D 461		