



Division of Health Service Regulation

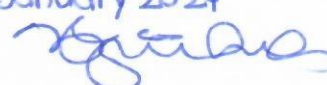
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 11/09/2023
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NAME OF PROVIDER OR SUPPLIER TERRABELLA NORTHRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NEWTON ROAD RALEIGH, NC 27609
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D 000	Initial Comments The Adult Care Licensure Section and Wake County Department of Social Services conducted an annual and follow up survey and complaint investigation on November 7-9, 2023.	D 000	<u>10A NCAC 13F .0902 (b) Health Care</u> ED or designee conducted investigation prior to start of state survey team arrival. Investigation included self-identified plan of correction. Completed: 12/6/2023	
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 A1 VIOLATION Based on observations, record reviews, and interviews the facility failed to ensure the routine and acute health care needs of 1 of 5 (#2) sampled residents as evidenced by failure to notify the resident's primary care provider, on call services or send the resident to the local emergency department (ED) for her right knee that was swollen and painful and a right leg and knee deformity. The findings are: Review of Resident #2's current FL2 dated 10/27/23 revealed: -Diagnoses included dementia, hypertension, and vitamin D deficiency. -The resident was non-ambulatory, constantly disoriented, and was incontinent of bladder and bowel. -The resident required total care for activities of daily living (ADLs). -The resident's level of care was Special Care Unit (SCU).	D 273	ED, RCC or designee conducted Inservice for MedTech's to re-educate MedTech's on the bin system for processing orders, reporting and follow up. Completed: 11/15/23 ED, RCC or designee conducted Inservice for Care Givers to re-educate on reporting, follow up and transfers. Completed: 11/16/23 ED, RCC or designee coordinated training for care givers to re-educate on transfers. Completed: 11/16/23 ED, RCC or designee will conduct weekly observations for health care referral follow up of .0902 that MedTech's are using the bin system and procedures . Completed 12/16/23 & Ongoing 	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Senior Executive Director (X6) DATE 12/12/23
STATE FORM Sherry Tabor 6899 7XHU11 If continuation sheet 1 of 29

Reviewed and acknowledged, 2 January 2024


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D 273	Continued From page 1	D 273		
	<p>Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 07/22/21.</p> <p>Review of Resident #2's care plan dated 10/17/23 revealed:</p> <ul style="list-style-type: none"> -The resident required one person assistance for transfers and required staff assistance with utilizing her wheelchair due to the resident's inability to self-propel her wheelchair. -The resident required extensive assistance with dressing, bathing, toileting, and grooming. <p>Review of a local emergency medical services (EMS) dispatch report dated 11/05/23 revealed:</p> <ul style="list-style-type: none"> -EMS was dispatched to the facility for Resident #2 on 11/05/23 at 4:33pm for a right knee injury. -When EMS arrived to the resident's room, the resident was found laying upside down on her bed, with her head at the bottom of the bed and her legs at the head of the bed. -The resident's right leg was bent at the knee, with clear deformity and swelling. -The resident's right leg was propped up with a pillow, the resident was awake but nonverbal. -Facility staff reported to EMS staff that during second shift, staff came into the resident's room and found her upside down on her bed with her right leg twisted, and staff was not aware of how her right leg became twisted. -Facility staff reported to EMS staff that the resident complained of right knee pain last night after dinner. -Facility staff reported that triage had referred the resident for mobile x-ray earlier in the day; but mobile x-ray had not arrived to complete the resident's x-rays. -Facility staff reported to EMS staff that there was no documentation as to how the resident's right leg was injured, the resident was non-ambulatory 			

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D 273	<p>Continued From page 2</p> <p>was dependent on staff for transfers and was unable to self-propel herself in her wheelchair.</p> <p>-Facility staff reported to EMS that Resident #2 was unable to walk independently or move herself independently in her wheelchair.</p> <p>-Facility staff reported to EMS that they did not have any notes or knowledge of the resident suffering from any falls, injuries, traumas, or illness recently.</p> <p>-The resident had an obvious deformity to the right knee with swelling, redness and tenderness and pain when her right leg was touched.</p> <p>-The resident was unable to voice complaints but did cry out in pain when transferred from her bed to the stretcher.</p> <p>-Due to the severity of the injury, the resident being non-ambulatory and non-verbal, and that facility staff were unable to explain how the injury occurred with no documentation of the injury or how it occurred, law enforcement was contacted due to suspicion of abuse.</p> <p>Review of a local ED summary for Resident #2 dated 11/05/23 revealed:</p> <p>-Resident #2 was seen in the local ED for knee pain, with an obvious right knee/leg deformity, the facility was unsure of what happened to the resident; facility staff told the EMS staff that they did not provide report to on or off coming shift.</p> <p>-Facility staff reported that the resident had an abnormally angled knee.</p> <p>-The resident's right thigh was swollen and tender to touch, the resident's right knee was swollen, and distal leg was angulated out laterally.</p> <p>-The resident was diagnosed with a closed fracture of the distal end of the right femur (A distal end fracture of the thighbone occurs above the knee joint), a urinary tract infection (UTI), dehydration, hypernatremia (hypernatremia means there is a high concentration of sodium in</p>	D 273		
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D 273	<p>Continued From page 3</p> <p>the blood which can cause dehydration), acute renal insufficiency, and fecal impaction. -On arrival the resident moaned in pain, but the resident was nonverbal.</p> <p>Review of an orthopedic surgical note for Resident #2 dated 11/07/23 revealed Resident #2 had surgery on 11/07/23 to repair her right distal femur fracture.</p> <p>Review of a communication note completed by a medication aide (MA) to the PCP dated 11/01/23 revealed Resident #2 had swelling and pain to her right knee.</p> <p>Review of Resident #2's electronic progress notes from the facility revealed: -On 11/04/23 at 11:20am Resident #2's leg was swollen, and it hurt the resident to be moved, would put Resident #2 on the doctor's list. -On 11/04/23 at 11:23am, Resident #2's leg was warm to touch. -On 11/05/23 at 9:17am Resident #2 had swelling to her thigh, knee, ankle and foot, the resident's leg was warm to touch, the MA had called the PCP on call services to report her findings, the on-call services ordered an x-ray of the resident's hip, knee, and ankle and ordered a doppler. -On 11/05/23 at 4:00pm a PCA reported to her that Resident #2 was unable to be transferred due to increased pain, she went to the resident's room and observed the resident in bed with pain to her right leg.</p> <p>Review of a communication note completed by a MA to the PCP dated 11/04/23 revealed Resident #2's knee was swollen and warm to touch.</p> <p>Review of a communication note completed by a MA to the PCP dated 11/05/23 revealed Resident</p>	D 273		

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D 273	<p>Continued From page 4</p> <p>#2 had a broken right leg.</p> <p>Review of the PCP on call services progress note dated 11/05/23 revealed:</p> <ul style="list-style-type: none"> -The facility contacted call services for Resident #2 who had right knee pain. -The resident also had swelling of the right knee, edema of the resident's entire right leg, and bruising on the side of her knee. -The on-call services ordered mobile x-ray immediately for the resident's right knee, ankle, and hip due to pain and edema. -The on-call services also ordered a venous doppler of her right lower extremity. <p>Telephone interview with Resident #2's family member on 11/07/23 at 4:54pm revealed:</p> <ul style="list-style-type: none"> -He received a telephone call from the MA working with Resident #2 on 11/05/23 at 9:00pm. -The MA informed him that Resident #2 was sent to the hospital due to a possible fracture of her right leg. -He received a telephone call from the Administrator on 11/06/23 to let him know she was investigating the incident. -Resident #2 was dependent on staff for everything, the resident was not able to communicate her needs. -The resident was unable to self-propel herself in her wheelchair and staff propelled her in her wheelchair to activities and to the dining room for meals. -He was upset and concerned for his family member because the resident was unable to verbalize her needs, was unable to tell staff where she was hurting and was unable to tell staff what happened to her to cause the injury to her right leg. <p>Interview with a personal care aide (PCA) on</p>	D 273		

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D 273	<p>Continued From page 5</p> <p>11/08/23 at 2:40pm revealed: -She worked the first shift from 7:00am to 3:00pm on 11/01/23. -She propelled the resident in her wheelchair to the dining room for breakfast on 11/01/23. -Following breakfast she noticed the resident needed to be repositioned in her wheelchair. -When she attempted to assist the resident with repositioning her in the wheelchair, the resident flinched as if she was in pain. -Another PCA that was working with her on the SCU on 11/01/23 told her that the resident complained of pain in her right leg on 10/31/23. -She helped the resident transfer from her wheelchair to her bed. -She removed the resident's pants to provide incontinence care and noticed the resident's right knee was red and swollen on the top of her knee. -When she provided incontinence care the resident moaned like she was in pain. -She reported the change in condition to the medication aide (MA) on duty. -The MA on duty observed the resident's right leg and knee. -When she returned to work on 11/03/23 the resident's right knee was red and swollen on the top of her right knee, and the resident moaned like she was in pain.</p> <p>Interview with a second PCA on 11/08/23 at 2:48pm revealed: -She observed another PCA propel Resident #2 in her wheelchair without the leg lifts on her wheelchair out of the dining room on 10/31/23. -She heard the resident yell "owwww." -The PCA that propelled the resident out of the dining room came to ask her for assistance with putting the resident to bed. -She observed the PCA transfer the resident from her wheelchair to a seated position on the edge</p>	D 273		
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D 273	<p>Continued From page 6</p> <p>of the bed.</p> <p>-She provided assistance with transferring the resident to a position where the resident could lie down in her bed.</p> <p>-She placed her hand under the resident's knees to help get her legs onto the bed, the resident said "owww" and was unable to lift the resident, so she transferred the resident to her bed by herself.</p> <p>-The resident's PCA was going to provide incontinence care to the resident, but she advised the PCA to wait and to notify the MA on duty of the resident's complaint of pain and that the resident yelled "owww" when she propelled her in the wheelchair back to her room from the dining room.</p> <p>-She returned to work on 11/02/23 and another PCA was assigned to the resident.</p> <p>-She observed the resident with pants on and observed swelling to her right knee.</p> <p>Interview with a third PCA on 11/09/23 at 4:18pm revealed:</p> <p>-He worked second shift on the SCU but did not work with Resident #2, however he was familiar with the resident.</p> <p>-He observed the resident in her wheelchair at dinner on 11/02/23, 11/03/23, 11/04/23, and 11/05/23.</p> <p>-When he arrived for his shift at 3:00pm on 11/05/23 he observed the resident sleeping in her bed.</p> <p>-Shortly after 3:00pm, a PCA that worked with Resident #2 in her room came out of the resident's room and asked him for assistance with Resident #2.</p> <p>-When he entered the resident's room, he noticed the resident had her head at the foot of the bed, and her feet were at the head of the bed.</p> <p>-He noticed that the resident's right leg was</p>	D 273		
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D 273	<p>Continued From page 7</p> <p>turned "backwards as if it were twisted." -He told the PCA that was working with Resident #2 to wait so he could get the MA on duty. -He returned to the resident's room with a MA. -The PCA that was working with the resident reported that she entered the resident's room and found her on the bed turned around with her leg twisted. -The MA started to check to see if the resident was on hospice before calling 911, however he told the MA she was in excruciating pain and told the MA to call 911 immediately. -He observed Resident #2 in pain because she was moaning, and her facial expressions appeared that she was in pain. -When EMS arrived, the EMS staff asked the MA what happened to the resident's right leg. -The MA and PCA were unable to explain what happened to the resident's right leg.</p> <p>Interview with a fourth PCA on 11/09/23 at 6:08pm revealed: -She worked second shift on the SCU with Resident #2 on 11/05/23. -She did not receive an update from the PCA on the first shift about Resident #2. -She went in Resident #2's room to check on her at the beginning of her shift and observed the resident laying the wrong way in the bed. -The resident had her head at the foot portion of the bed, and her feet were at the headboard. -The resident was moaning and groaning, she could tell the resident was hurting and in pain. -She immediately found the MA on the SCU to report to her and the MA called EMS. -She was not sure what happened to Resident #2.</p> <p>Interview with a MA on 11/08/23 at 9:25am revealed:</p>	D 273	

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D 273	<p>Continued From page 8</p> <ul style="list-style-type: none"> -Resident #2 required total assistance with her ADLs. -The resident was non ambulatory, and staff had to propel the resident in her wheelchair. -The resident was not able to communicate her needs verbally but would make sounds. -The resident required one person assistance for transfers. -She worked first shift from 7:00am to 3:00pm on 11/01/23 on the SCU. -On 11/01/23 she observed a PCA propelling Resident #1 in her wheelchair without her leg rests and observed the resident's right foot dragging on the floor. -She directed the PCA to stop propelling the resident in the wheelchair and to get the resident's leg lifts for her wheelchair. -She assisted the PCA place the leg lifts onto the resident's wheelchair. -The resident groaned and moaned when they placed her legs in the leg lifts on the wheelchair. -She observed the resident's feet to check for any injury and only noticed a small scrape that had a scab on it on her right middle toe. -Near the end of her shift a PCA reported to her that Resident #2 had swelling in her right knee. -She observed the resident's right knee and observed slight swelling over the resident's right kneecap and the resident moaned when she touched the knee cap. -She wrote a communication note for the primary care provider (PCP) that the resident's right kneecap was swollen, and the resident had pain at her right knee. -She placed the communication note in the folder for the PCP to review when she visited residents on 11/02/23. -She should have called the PCP or the on-call services for the PCP to report the swelling to Resident #2's right kneecap and the resident's 	D 273		
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D 273	<p>Continued From page 9</p> <p>pain at her right kneecap.</p> <ul style="list-style-type: none"> -She was not sure why she did not call Resident #2's PCP or the on-call services for the PCP. -She worked on the SCU first shift on 11/05/23 from 7:00am to 3:00pm. -She observed Resident #2's right leg on 11/05/23. -The resident's right leg had swelling from the top of her right thigh to her right foot, and her right knee was warm to touch and swollen. -The resident had pants on while sitting in her wheelchair and she observed that the resident had noticeable swelling of her right leg and foot compared to her left leg. -She contacted the on-call services for the PCP and informed the triage team that the resident had swelling from her right foot to the top of her right hip, the resident complained of pain, and her right knee had redness, swelling, and was warm to touch. -The on-call services ordered a mobile x-ray to be provided for the resident immediately of the resident's right hip, right knee, and right ankle, and ordered a doppler. -The mobile x-ray provider had not arrived at the facility when her shift ended at 3:00pm on 11/05/23. -Prior to leaving her shift she provided a verbal update to the MA that came on duty for second shift. <p>Interview with a second MA on 11/09/23 at 5:08pm revealed:</p> <ul style="list-style-type: none"> -She worked second shift from 3:00pm to 11:00pm on 11/05/23. -A male PCA came to get her shortly after 3:00pm regarding concern for Resident #2. -She observed Resident #2 in her bed turned around, her head was at the foot of the bed, and her feet were at her headboard. 	D 273		
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D 273	<p>Continued From page 10</p> <ul style="list-style-type: none"> -The resident's right leg looked "horrible." -The resident's right leg from her mid-calf to her foot was twisted outward to the right. -The resident was moaning and groaning in pain when she arrived at the resident's room. -The MA that was on first shift on 11/05/23 provided her with an update that triage had ordered the resident mobile x-rays but they had still not arrived at the facility. -After she observed that Resident #2 was injured, she called 911 so the resident could be taken to the local ED. -When EMS arrived, she remembered the EMS staff looking at Resident #2 very concerned because no one could explain how the resident was in her bed backwards, and how her right leg and foot were twisted when the resident was unable to walk independently. -She called the resident's family member to inform them that the resident had been taken to a local ED for a possible fracture of her leg. -She called the Resident Care Coordinator (RCC) to inform her that the resident had been taken to a local ED for a possible fracture of her leg. <p>Attempted interview with the RCC on 11/09/23 at 2:00pm was unsuccessful.</p> <p>Interview with the Assistant Administrator on 11/09/23 at 9:43am revealed:</p> <ul style="list-style-type: none"> -The PCAs were expected to notify the MAs if a resident had a change in condition or a possible injury. -The MAs were expected to notify the resident's PCP or the on-call services for the PCP of a change in condition or possible injury. -The MAs were expected to document any resident concerns and notification of any concerns to the PCP or the on-call services for the PCP in the facility's electronic progress note. 	D 273		
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D 273	Continued From page 11 -The MAs were also expected to complete a shift report note that was provided to the Resident Care Coordinator (RCC). -Monday through Friday a management meeting was held in the morning which included the Administrator, Assistant Administrator, department heads, the RCC and the SCU Coordinator. -Staff reviewed and discussed if a resident had to go out to the hospital, if there were any changes in residents and if there were any concerns about residents in the management meetings. -The facility used a "BIN" system where MAs, the RCC or the SCU Coordinator completed a communication note for the PCP about any change in condition for a resident or concern about a resident. -The MAs or RCC placed a copy of the communication note in the PCP's folder; when the PCP visited the facility, she would review any communication notes or orders that had been placed in her folder. -The MAs or RCC were expected to notify the PCP by telephone of any concern or change in condition for a resident; if the PCP was not available, staff was expected to communicate to the triage staff that was on call for the PCP. -If there was an urgent situation after hours regarding a resident the MAs were expected to contact the RCC or the SCU Coordinator. -She received a telephone call from the RCC during the evening of 11/05/23 to inform her that Resident #2 was sent out to the local ED due to pain in her right leg, emergency management staff (EMS) staff reported that the resident's femur appeared to be fractured. -The RCC informed her that she left a message for the Administrator that evening as well. -The Assistant Administrator also left a message for the Administrator regarding the call she	D 273		
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NAME OF PROVIDER OR SUPPLIER TERRABELLA NORTHRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NEWTON ROAD RALEIGH, NC 27609
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D 273	<p>Continued From page 12</p> <p>received from the RCC.</p> <p>-The Administrator returned her call on 11/05/23 and informed her that she was taking care of the investigation of what occurred resulting in the resident needing to go to the local ED.</p> <p>Interview with the Administrator on 11/07/23 at 2:45pm revealed:</p> <p>-Resident #2 was sent to a local ED on 11/05/23 from what appeared to be two separate injuries.</p> <p>-A PCA reported that they observed another PCA on 10/31/23 propelling the resident in her wheelchair out of the dining room and the resident somehow had an injury to her knee when the staff propelled the resident in her wheelchair.</p> <p>-She discovered from staff interviewed that on 11/01/23 the resident's knee bothered her.</p> <p>-The PCA reported that the resident's knee bothered her to the MA and the MA put the resident on a list for the PCP to see when she came for her regular visits with residents on Thursday 11/02/23.</p> <p>-Facility staff called the PCP to notify the PCP that the resident had pain in her right knee on 11/04/23 but the PCP was unable to come back to the facility.</p> <p>-Facility staff sent the resident out to the local ED on 11/05/23.</p> <p>Interview with the Administrator on 11/09/23 at 10:30am revealed:</p> <p>-She had interviewed staff that worked during the week of 10/31/23 to 11/05/23 related to Resident #2 being sent to a local ED for a possible right leg fracture.</p> <p>-When she interviewed staff that worked with Resident #2 on 10/31/23, a PCA informed her that another PCA was propelling the resident in her wheelchair out of the dining room and the resident's right foot got caught under her</p>	D 273		
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D 273	<p>Continued From page 13</p> <p>wheelchair.</p> <ul style="list-style-type: none"> -The PCA reported the resident's foot getting caught under the wheelchair to the MA on duty. -She received a telephone call from the RCC and the Assistant Administrator on 11/05/23 that the resident had been sent out to the local ED due to pain in her right leg. -The MA on duty on 11/05/23 informed her that the local EMS staff informed her that the resident's femur could be broken. -All staff that she had interviewed reported that the resident did not have any signs of pain and did not complain of pain. -Based on interviews with staff the resident did yell "owwww," however staff did not observe the resident in pain on 10/31/23. -Based on staff interviews, a second PCA went to transfer the resident on 11/05/23 and the resident screamed out in pain. -The PCA that attempted to transfer the resident notified the MA on duty. -Resident #2 was not able to self-propel herself in the wheelchair and was dependent on staff to propel her in her wheelchair. -PCAs were expected to inform MAs if a resident had a change in condition, had pain, or a bruise. -The MAs documented any change in the resident's condition and notified the RCC or the SCU Coordinator and notified the PCP. -A MA left a communication note for the PCP in the PCP's folder related to the resident's right knee being swollen. -She was not aware that the MA documented on the communication note for the PCP that the resident was in pain. -The MA should have contacted the on-call services for the PCP instead of leaving only written documentation about the resident's right knee. -She expected the MAs to immediately contact a 	D 273		
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D 273	<p>Continued From page 14</p> <p>resident's PCP or the on-call services if a resident had a change in a condition or was in pain.</p> <p>Interview with Resident #2's PCP on 11/09/23 at 1:08pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was calm and cooperative during her visits with the resident. -She informed the RCC on 10/30/23 that she would not be back at the facility for visit the remainder of the week and for staff to use the on-call services if needed. -Staff should have notified on-call services on 10/31/23 because the resident yelled out in pain when she was being propelled in her wheelchair. -Anytime the MAs were aware of a change in a resident's condition they were expected to attempt to contact her and if she was unavailable the on-call services would provide orders as needed. -She saw communication notes that were placed in her folder at the facility on 11/06/23 when she returned to the facility. -Facility staff should have ensured appropriate follow up with the on-call services after the resident screamed out in pain when a PCA was propelling her in her wheelchair on 10/31/23. -There should not have been a delay in staff contacting the on-call services to have Resident #2 further assessed. <p>Interview with Resident #2's PCP on 11/13/23 at 2:25pm revealed:</p> <ul style="list-style-type: none"> -Facility staff should have followed up with her on call services on 10/31/23, and each day after to ensure the resident was seen for complaints of pain and swelling of her right leg. -Anytime a resident had redness, swelling or pain staff were expected to notify her immediately, if she was unavailable the on-call services would provide orders as needed. 	D 273		
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D 273	<p>Continued From page 15</p> <p>-She did not understand why MAs had not realized that the physician communication notes that had been left in her folder, had not been addressed; this should have prompted any MA working with Resident #2 to follow up with the on-call services.</p> <p>-If a MA had called the on-call services on 11/01/23, the on-call services could have attempted to reach her and she could have conducted a telehealth visit for Resident #2 and ordered x-rays.</p> <p>-Resident #2's pain level would have been difficult, even with each individual experiencing pain on different levels, with the distal end of her femur fractured and being non-verbal would have been difficult for the resident.</p> <p>-When staff transferred Resident #2 it would have been very difficult to not cause the resident further pain due to her fracture.</p> <p>-She expected staff to notify her anytime they had a concern about a resident so that she could complete an assessment and provide orders as needed.</p> <p>-The facility should have a system in place to follow up on what resident's still need, someone should have realized that she had not seen the physician communication notes in her file because she had not signed and dated them; that should have triggered staff to reach out to the on-call services to ensure Resident #2 was not in pain.</p> <p>The facility failed to meet the acute health care needs of a resident (#2) who had a diagnosis of dementia, was non-verbal, dependent on staff for ambulation, transfers, and activities of daily living, who experienced a right knee injury when staff was propelling her in her wheelchair from the dining room on 10/31/23, resulting in swelling, pain, and redness to her right knee. The resident</p>	D 273		
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D 273	<p>Continued From page 16</p> <p>continued with pain, swelling and redness to her knee and five days later staff noticed a deformity of her right leg and knee which resulted in the resident being sent to the hospital and diagnosed with a right femur fracture above the knee that required surgery. This failure resulted in serious physical injury and neglect of Resident #2 which constitutes a Type A1 Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/09/23.</p> <p>CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 9, 2023.</p>	D 273		
D 276	<p>10A NCAC 13F .0902(c)(3-4) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician orders were implemented for 2 of 5 sampled residents who had an order for compression stockings (#1 and #5).</p> <p>The findings are:</p> <p>1. Review Resident #1's current FL2 dated 04/17/2023 revealed:</p>	D 276	<p><u>10A NCAC 13F .0902 (c) (3-4) Health Care</u></p> <p>RCC, MCD, ED or designee will monitor weekly resident orders to ensure ongoing refusals are documented and communicated with PCP and hospice by Medtech.</p> <p>Completed: 12/22/23</p> <p>RCC, MCD, ED or designee will re-educate MedTech's of procedures for residents with ongoing refusals of orders to ensure PCP and Hospice are aware.</p> <p>Completed: 12/22/23</p> 	



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D 276	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Diagnoses included unspecified dementia, myasthenia, hypertension, acute non-rheumatic, carditis, and paroxysmal atrial fibrillation. -The recommended level of care was documented as a special care unit (SCU). <p>Review of Resident #1 physician's order dated 06/08/23 revealed an order for knee high compression stockings to be placed each morning and removed in the evening.</p> <p>Review of Resident #1's Licensed Health Professional Support (LHPS) dated 09/06/23 revealed the facility to follow up on recommendations, including compression hose.</p> <p>Observation of Resident #1 on 11/07/23 at 10:16 am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was sitting in a chair in her room with her legs down and feet on the floor. -The compression hose was lying on a white cart across the room. -There was a white sign on the wall in Resident #1's room with instructions for staff to apply compression hose on Resident #1's legs in the morning. <p>Interview with Resident #1 family member on 11/07/23 at 10:16 am revealed:</p> <ul style="list-style-type: none"> -The family came every day to visit the resident. -Resident #1 wore compression hose. -It took two months to get them in. Once the resident got them, it was like "pulling teeth" to get staff to put them on her. -On 11/07/23, around 9:30 am, the family found the compression hose lying on the white cart. -The Resident complained about pain, and she could not walk until the compression hose was on. -The Resident did not complain of knee pain 	D 276		
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D 276	<p>Continued From page 18</p> <p>when the compression hose was on her legs.</p> <p>Second observation of Resident #1 on 11/08/23 at 11:28 am revealed:</p> <ul style="list-style-type: none"> -The resident was sitting in a chair with her legs down and feet on the floor. -The Resident's compression hose was lying on a white cart across the room. <p>Interview with Resident #1's family member on 11/08/23 at 11:28 am revealed:</p> <ul style="list-style-type: none"> -On 11/08/23 around 10:30 am, the family found the compression hose lying on the white cart. -When the family realized the stockings were not being placed on the Resident, the family made a sign and placed it on the wall, asking staff to place stockings on the resident in the morning and remove stockings in the evening. -When the family asked the staff to put on the stockings, it was hard to get them on because she had walked to breakfast, and her legs were already swollen. She was in so much pain that she couldn't get them on. -The family tried to put them on, but after she walked to breakfast, her legs were swollen and in pain. -Breakfast was served around 8:00 am every morning. <p>Interview with a personal care aide (PCA) on 11/08/23 at 11:55 am revealed:</p> <ul style="list-style-type: none"> -The PCA worked with Resident #1; her shift began at 7:00 am. Resident #1 was already up and ready for breakfast, and the PCA walked her down to breakfast. -This is the PCA's second time hearing that Resident #1 wore a compression hose. <p>Interview with a Medication Aide (MA) on 11/08/23 at 12:02 pm revealed:</p>	D 276		
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D 276	<p>Continued From page 19</p> <ul style="list-style-type: none"> -The MA was responsible for putting on Resident #1's compression hose. -The compression hose was placed on the resident between the hours of 7:00 am to 7:45 am. -Today the resident refused to put stockings on. -When given medication, the MA asked to put the stockings on, and the resident refused. The MA returned 5 to 10 minutes later and asked again about the hose, and the resident refused, stating her legs hurt. -The resident may refuse three days in a row; the next day, she may wear them, and then the next day, she may refuse. -When the MA applied the compression hose, she would see the resident later in the day in the hallway with them off. -The MA did not see the hose's location once they were off. -The protocol was that the MA notified the Residential Care Coordinator (RCC) about the refusal, and the RCC notified the doctor for a follow-up visit. <p>Interview with a second MA on 11/09/23 at 9:55 am revealed:</p> <ul style="list-style-type: none"> -The MA was responsible for putting on the resident's compression hose during the medication pass. -She never had a problem with refusal. The resident would put on the compression hose without issues. -Last week, she worked on Resident #1's hall and noticed that the compression hoses were not on during the evening. -The MA did not know if the resident was taking them off. -When the compression stockings were not on her legs, the MA noticed them once on her walker and once on the counter. 	D 276		
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D 276	Continued From page 20 -The resident did not want them on. -The resident has not had shortness of breath, and the MA has not noticed if the stockings on or off made a difference in breathing. -The protocol is that when the patient refuses, the MA documents in the 24-hour book and follows up with the RCC that the resident refused. The RCC states that the resident has the right to refuse. -The MA does not know how long the refusal has been going on -The MA states that a refusal of an order was documented in the Quick Mar and the 24-hour shift report book. Interview with Resident's #1 Primary Care Provider (PCP) on 11/09/23 at 1:08 pm revealed: -The order for the compression hose was to treat edema. -Been an ongoing issue for her. She was referred to a specialty clinic and placed on Lasix (to treat fluid retention). -The first pair of stockings that were ordered on 05/04/23, the resident refused because they were too tight. -Getting Resident #1 to wear them has been a long battle. -The PCP's concern was that if the resident did not wear the compression hose as ordered, the resident would continue to have fluid build-up in her lower extremities. - The PCP was concerned about the edema build-up and comfortability; for this reason, the resident may have issues with getting into her shoes. Interview with the facility Administrator on 11/09/23 at 4:05 pm revealed: -She was notified of Resident #1's refusal to put stockings on but did not know the resident	D 276	

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D 276	<p>Continued From page 21</p> <p>continued to refuse.</p> <ul style="list-style-type: none"> -The policy for refusal was to notify the doctor to decide the next step, no matter the order. -The MA were taught to notify the resident's PCP or Hospice (if applicable). -The protocol was that the MA documented the resident refusal on the MAR and in the 24-hour book. -The 24-hour book was reviewed daily by the Memory Care Director or the Executive Director. -If a resident did not wear the compression hose regularly as ordered, it could cause health problems, leg swelling, and discomfort. -Audit charts were added on a rotating basis each week; a certain number was pulled each week. <p>-Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.</p> <p>2. Review of Resident #5's current FL-2 dated 09/07/22 revealed diagnoses included adult failure to thrive, muscle weakness, anxiety, hypertension, dementia, hyperlipidemia, and constipation.</p> <p>Review of Resident #5's physician's orders dated 05/29/23 revealed an order to provide medium, regular, beige T.E.D. (thrombo-embolitic deterrent) hose every morning and remove every evening. (T.E.D. hose are used to prevent blood clot formation in the legs.)</p> <p>Review of Resident #5's current care plan dated 09/13/22 revealed there was no documentation for the application of T.E.D. hose.</p> <p>Review of Resident #5's current licensed health professional support (LHPS) assessment and evaluation dated 09/14/23 revealed:</p>	D 276	

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D 276	<p>Continued From page 22</p> <p>-Applying T.E.D. hose was listed as a LHPS task for Resident #5.</p> <p>-There was documentation included in the assessment narrative that there was an order for T.E.D. hose to be applied in the morning and removed at bedtime.</p> <p>-"See personnel file" was documented for staff competency validation for applying T.E.D. hose.</p> <p>Review of Resident #5's service plan dated 10/14/23 revealed:</p> <p>-Resident #5 required minimal assistance with dressing.</p> <p>-"Yes" was marked next to resident does not wear T.E.D. hose and manages independently.</p> <p>-"No" was marked next to resident needs assistance with T.E.D. hose.</p> <p>Review of Resident #5's September, October and November 2023 electronic medication administration records (eMARs) revealed:</p> <p>-There was an entry for anti-embolic hose apply every morning and remove at bedtime scheduled at 8:00am and 8:00pm.</p> <p>-There was documentation that the anti-embolic hose were applied every morning and removed daily at bedtime 09/11/23 through 11/07/23.</p> <p>-There was no documentation Resident #5 declined to wear the anti-embolic hose.</p> <p>Review of Resident #5's electronic progress notes revealed:</p> <p>-There were 3 entries for the requested review period (09/01/23 through 11/07/23).</p> <p>-The 3 entries were dated 10/23/23 and 10/25/23 (2).</p> <p>-There was no documentation of Resident #5 not wearing or declining to wear T.E.D. hose.</p> <p>Review of Resident #5's primary care provider</p>	D 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/09/2023
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NAME OF PROVIDER OR SUPPLIER TERRABELLA NORTHRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 NEWTON ROAD RALEIGH, NC 27609
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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
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D 276	<p>Continued From page 23</p> <p>(PCP) visit note dated 10/05/23 revealed: -Resident #5 was seen for routine follow up and there were no concerns reported from staff. -Active medical problems included abnormal gait, muscle weakness, dementia, and peripheral vascular disease. -Resident #5 was forgetful, had poor strength and was dependent on a walker. -Resident #5 received hospice services for weight loss and adult failure to thrive.</p> <p>Review of Resident #5's physician visit note dated 11/08/23 revealed: -The resident was seen for evaluation and management for physician supervision to ensure safety. -Resident #5 had venous insufficiency due to peripheral vascular disease and was to continue with T.E.D. hose and a diuretic medication. -Resident #5 did not have any edema or shortness of breath at the time of the visit.</p> <p>Observation of Resident #5 on 11/08/23 at 11:56am revealed: -She was walking to the dining room with her walker. -She was wearing ankle pants, slip on running shoes and white socks that came to her ankle bone. -She was not wearing T.E.D. hose.</p> <p>Interview with the medication aide (MA) on 11/09/23 at 11:56am revealed: -Resident #5 probably took her T.E.D. hose off because she (the MA) had put the hose on that morning (11/09/23). -She frequently put the T.E.D. hose on Resident #5 only for the resident to remove the hose. -Resident #5 would take off the T.E.D. hose, fold them neatly and place them under clothing in her</p>	D 276		
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D 276	<p>Continued From page 24</p> <p>dresser drawer.</p> <p>-She told Resident #5's PCP several times prior to 11/09/23.</p> <p>-Resident #5's hospice nurse (HN) had reminded her (MA) about the resident wearing her T.E.D. hose.</p> <p>Telephone interviews with the Clinical Manager for Resident #5's hospice provider on 11/09/23 at 12:58pm and 2:02pm revealed:</p> <p>-He was not aware of any issues with Resident #5 wearing T.E.D. hose.</p> <p>-There was no documentation that staff reporting the resident declined to wear her T.E.D. hose in the hospice visit notes.</p> <p>-The primary nurse was not aware of any problems with Resident #5 wearing her T.E.D. hose.</p> <p>Interview with Resident #5's PCP on 11/09/23 at 1:19pm revealed:</p> <p>-She was told today (11/09/23) for the first time that Resident #5 was not wearing her T.E.D. hose and hiding them.</p> <p>-Staff should have notified her that Resident #5 had a pattern of declining to wear her T.E.D. hose so she could re-evaluate the order.</p> <p>Interview with the Administrator on 11/09/23 at 4:05pm revealed:</p> <p>-MAs were responsible to notify the resident's PCP and hospice for treatment refusals such as T.E.D. hose.</p> <p>-MAs were responsible for documenting notification of the PCP and hospice.</p> <p>-It a resident declined to wear T.E.D. hose as ordered, the MAs were responsible for documenting refusals on the eMAR.</p> <p>Based on observations, interviews, and record</p>	D 276		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092207	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 11/09/2023
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D 276	Continued From page 25 reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with the Resident Care Coordinator (RCC) on 11/09/23 at 2:00pm was unsuccessful.	D 276		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the medication aide observed 1 resident (#6) take her medications before documenting the medication was administered as evidenced by 3 capsules of Resident #6's antidepressant medication being found in another resident's room. The findings are: Review of Resident #6's current FL-2 dated 07/25/23 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, and anxiety. -There was an order for venlafaxine 75mg 3 capsules daily. (Venlafaxine is used to treat depression and anxiety.)	D 366	<u>10A NCAC 13F .1004 (i) Medication Administration</u> RCC, MCD, ED or designee will re-educate MedTech's of procedure to follow to ensure the 6 rights of medication administration are followed with no pre-pouring or charting. Completed: 12/22/23 RCC, MCD, ED or designee will randomly observe medication administration pass for follow up to the 6 rights of medication administration are being followed by Medtech. Completed: 12/22/23 	

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D 366	<p>Continued From page 26</p> <p>Review of Resident #6's October and November 2023 electronic administration records (eMARs) revealed:</p> <ul style="list-style-type: none"> -There was an entry for venlafaxine 75mg 3 capsules daily scheduled for 8:00am. -There was documentation that venlafaxine 75mg 3 capsules was administered daily from 10/01/23 through 11/08/23. <p>Observation during the morning medication pass on 11/08/23 at 8:35am revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) was in another resident's room administering medications to the resident. -There were 3 pink capsules inside a plastic medication cup which was inside a plastic drinking cup on the hall shelf inside the other resident's room. <p>Observation of Resident #6's medications on hand on 11/08/23 at 8:47am revealed:</p> <ul style="list-style-type: none"> -There was a bubble pack of venlafaxine 75mg ER (extended release) with a pharmacy label which included instructions for 3 capsules daily. -The pharmacy label indicated 84 capsules were dispensed on 10/13/23 and there were 3 capsules remaining in the bubble pack. -There were handwritten date entries next to 7 individual bubbles which documented the first dose was removed on 10/13. -The last date entry was 10/30 next to bubble 11. <p>Interview with the MA on 11/08/23 at 8:35am revealed:</p> <ul style="list-style-type: none"> -The 3 pink capsules in the medication cup were medications that did not belong to the resident whose room the capsules were found in. -The 3 pink capsules belonged to Resident #6; she was the only resident on the transitional unit 	D 366		
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NAME OF PROVIDER OR SUPPLIER TERRABELLA NORTHRIDGE		STREET ADDRESS, CITY, STATE, ZIP CODE 600 NEWTON ROAD RALEIGH, NC 27609		
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D 366	<p>Continued From page 27</p> <p>that took that medication.</p> <ul style="list-style-type: none"> -She did not know how Resident #6's medications got into another resident's room. -She had already administered Resident #6's morning medications for 11/08/23. -Resident #6 was in the front common area when she administered the resident her medications. <p>Interview with Resident #6 on 11/08/23 at 9:21am revealed she could not remember if she took her medications that morning (11/08/23) and did not remember what her medications looked like.</p> <p>Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/09/23 at 5:02pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy had an order for venlafaxine 75mg 3 capsules daily dated 08/07/23 for Resident #6. -The pharmacy dispensed 84 capsules which was a 28-day supply on 10/06/23 and 11/03/23. <p>Interview with Resident #6's primary care provider (PCP) on 11/09/23 at 1:19pm revealed:</p> <ul style="list-style-type: none"> -Medications should not be left out for anyone to have access to medications that were not prescribed for them. -Staff should ensure medications were administered as ordered to the resident the medications were ordered for. <p>Interview with the Assistant Executive Director (ED) on 11/09/23 at 9:43am revealed medications should not be found sitting around in any resident room because MAs were responsible for observing residents take their medications before moving on to the next resident.</p> <p>Interview with the Administrator on 11/09/23 at 10:28am revealed:</p>	D 366		

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D 366	Continued From page 28 -MAs were responsible to pull the medication from the medication cart, verify order against the eMAR, administer the medication, observe the resident take the medication and then document the medication administration. -The Health and Wellness Director (HWD), Resident Care Coordinator (RCC) and Memory Care Coordinator (MCC) were responsible for observing random medication passes. -There was a pharmacy quality assurance audit done within the last 60 days which included observing MAs administer medications. Attempted telephone interview with the Resident Care Coordinator (RCC) on 11/09/23 at 2:00pm was unsuccessful.	D 366		
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Washington, Bynithia T

From: SHERRY TABOR <stabor@terrabellanorthridge.com>
Sent: Tuesday, January 2, 2024 11:52 AM
To: Washington, Bynithia T
Subject: [External] Corrections for POC - TerraBella Northridge
Attachments: SKM_C750i24010212490.pdf

CAUTION: External email. Do not click links or open attachments unless verified. Report suspicious emails with the Report Message button located on your Outlook menu bar on the Home tab.

Bynithia

Please see attached corrections for the POC for Terrabella Northridge. Let me know if you have any questions.

Sherry Tabor
Senior Executive Director
TerraBella Northridge
Stabor@terrabellanorthridge.com
421 Van Thomas Drive
Raleigh NC 27615
919-848-4906



From: escan@astongardens.com <escan@astongardens.com>
Sent: Tuesday, January 2, 2024 12:50 PM
To: SHERRY TABOR <stabor@terrabellanorthridge.com>
Subject: Message from KM_C750i