Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063011	A. BUILDING: ______ B. WING ______	R **02/22/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	**820 S. MCNEILL STREET CARTHAGE, NC 28327**

(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 Moore County Department of Social Services conducted an annual and follow up survey and a complaint investigation on February 21, 2024, through February 22, 2024. The complaint investigation was initiated by the Moore County Department of Social Services on December 8, 2023.	D 000		
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: Based on interviews and record reviews, the facility failed to ensure prompt notification to the primary care provider and referral for emergency room evaluation for 1 of 5 sampled residents (#2) who was found with three schedule II opioid patches on his body when he was ordered to have one patch applied every three days and the old patch removed. The findings are: Review of Resident #2's current FL-2 dated 04/09/23 revealed: -Diagnoses included dementia with psychosis and chronic pain. -There was an order for fentanyl 62.5mcg/hour patch every three days; remove the old patch. (Fentanyl patches are a schedule II opioid used to treat severe pain, is a high risk for addiction and dependence, and can cause respiratory distress and death in high doses.) Review of Resident #2's primary care provider	D 273		

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(PCP) visit note dated 06/06/23 revealed:
-Resident #2 reported that sometimes, "I get so dizzy."
-Resident #2 reported becoming dizzy upon standing.
-There was an order to decrease the fentanyl patch to 25mcg/hour every 3 days.

Review of Resident #2's Physician's Orders dated 07/22/23 revealed an order for fentanyl 25mcg/hour patch every three days; remove the old patch.

Review of Resident #2's Occurrence Record dated 12/04/23 revealed:
-A MA documented Resident #2 was sent to the emergency room (ER) for observation.
-Resident #2's blood pressure was low; he was not acting like himself and was not responding normally.

Review of Resident #2's Occurrence Record dated 12/04/23 revealed:
-The Unit Care Coordinator (UCC) documented Resident #2 had three fentanyl 25mcg/hour patches on his body.
-She was notified on 12/03/23 by a MA about finding the three fentanyl patches on Resident #2.
-She instructed the MA to remove all the fentanyl patches, push plenty of fluid and to monitor Resident #2.
-She came to work on 12/04/23 and checked on Resident #2.
-She documented, "He was still very out of it."
-Resident #2's PCP was notified at 8:31am on 12/04/23 "of the situation."
-The PCP instructed her to administer naloxone to Resident #2 and to check his blood pressure.
-The PCP instructed the UCC to send Resident #2 to the ER for evaluation if the blood pressure

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was abnormal or low.
-Resident #2's blood pressure was 94/60 in his left arm and 84/50 in his right arm (normal range is between 90/60 and 120/80).
-Resident #2 was sent to the ER via emergency medical services (EMS).

Review of Resident #2's EMS record dated 12/04/23 revealed:
-EMS was called for Resident #2 for possible overdose and hypotension.
-Staff reported finding 3 fentanyl 25mcg/hour patches on Resident #2 and administering naloxone 4mg that morning (12/04/23).
-Staff reported the resident's blood pressure was 86/40.
-EMS documented a blood pressure result of 96/56.

Review of Resident #4's ER history of present illness note dated 12/04/23 revealed:
-Resident #2 presented to the ER with likely opioid overdose.
-Resident #2 was found lethargic that morning and staff administered naloxone after finding 3 fentanyl patches on him.
-It was unclear how Resident #2 got 3 fentanyl patches on him and it was likely the patches were not removed.

Review of Resident #2's ER discharge instructions dated 12/04/23 revealed:
-There were instructions on preventing overdoses which included the following:
-Get help right away if you think you or someone else may have taken too much of a substance.
-Get help right away if you or someone else has symptoms of accidental drug poisoning including behavior changes such as confusion, sleepiness, slowed breathing and seizures.

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-These symptoms might be an emergency, get help right away; call 911.
-Do not wait to see if the symptoms go away.

Telephone interview with a MA on 02/22/24 at 4:26pm revealed:
-She saw that Resident #2 was not himself and was acting "funny" on 12/03/23 which was a Sunday.
-Resident #2 fell that day (12/03/23) and the day before (12/02/23).
-Resident #2 refused to go the ER and she notified the UCC.
-Later that day (12/03/23) she was changing Resident #2's shirt because it was wet, and she found the 3 fentanyl patches on him.
-He had one patch on each shoulder and one on his lower back towards his side.
-She removed the patches and called the UCC.
-The UCC told her to put the patches on a piece of paper and slide them under her office door.
-She documented everything on Resident #2's occurrence record which was kept in a binder at the front desk.
-She did not call Resident #2's PCP.
-She was nervous, afraid, and worried about Resident #2's wellbeing.
-The first thing on her mind at that time was calling the UCC.
-She thought she checked Resident #2's vital signs and documented the results on his occurrence record.
-She thought Resident #2's blood pressure result was abnormal; it was a little high or a little low.
-She could not remember exactly what the blood pressure was.
-She completed an incident/accident report and put it under the UCC's office door.

Upon request, Resident #2's care notes, incident

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D 273	Continued From page 4 and accident reports, and occurrence records dated 12/03/23 were not provided for review. Interview with the UCC on 02/22/24 at 2:51pm revealed: -On 12/02/23, she received a call from a MA that Resident #2 fell and was not injured. -She instructed the MA to notify the PCP and monitor Resident #2. -On 12/03/23, she received a second call from a MA that Resident #2 fell and injured his head and knee. -Resident #2 refused to go with EMS to the ER for evaluation. -She instructed the MA to check Resident #2 for any further injuries such as bruises and skin tears. -The MA lifted Resident #2's shirt and saw that he had 3 fentanyl patches on his body. -The MA told her Resident #2 appeared to be fine. -She instructed the MA to encourage Resident #2 to drink fluids, for staff to monitor the resident, and to send him to the ER if he was not okay. -Resident #2's PCP was not notified because he appeared okay. -She planned to notify the PCP on Monday 12/04/23 when she completed the medication error report. -It was the facility's policy to complete a medication error report and notify the PCP with all medication errors. -She did not know exactly what stopped the MA from contacting the PCP on 12/03/23. -On arrival to work on 12/04/23, she went to check on Resident #2. -The MA on duty said that Resident #2 was sleepy. -Resident #2 was not himself when she saw him; he was altered in his mental status and not	D 273		

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D 273	Continued From page 5 talking normally. -She called Resident #2's PCP. -The PCP told her to check Resident #2's blood pressure and if the result was low or abnormal, the PCP instructed her to administer naloxone and call EMS. -Resident #2's blood pressure was low, so she called EMS and administered naloxone to the resident. -An incident report should have been completed but one was not; there was only a medication error report. -Finding three fentanyl patches was a serious incident due to the severity of fentanyl. -Misuse of fentanyl was a risk for overdose. Second interview with the UCC on 02/22/24 at 5:59pm revealed she thought the occurrence record dated 12/02/23 was dated incorrectly and should have been dated 12/03/23. Telephone interview with Resident #2's PCP on 02/22/23 at 4:07pm revealed: -She did not remember the exact date the UCC called her about Resident #2 being lethargic. -She did not work on Sundays, so it was not 12/03/23. -The staff on duty should have called the on-call provider with her office that day (12/03/23) when they found the 3 fentanyl patches on Resident #2. -Staff on duty should have at least checked Resident #2's blood pressure when they found the patches on him. -Having 3 patches on his body put Resident #2 at risk for fentanyl overdose. -Symptoms of fentanyl overdose included lethargy, falls with severe injuries, decrease level of awareness, respiratory distress, and unresponsiveness. -Staff normally called her when there were	D 273		

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D 273	Continued From page 6 medications errors. -Notifying her of medication errors was important so she could give instructions on what to do. Interview with the Administrator in Charge (AIC) on 02/22/24 at 5:24pm revealed: -The UCC told staff to check Resident #2 after his falls which was how the fentanyl patches were found. -The UCC told staff to keep Resident #2 hydrated and to monitor him on 12/03/23. -The UCC came into work on 12/04/23 and found Resident #2 lethargic when she checked on him. -The UCC completed the medication error report on 12/04/23 because the MA on duty on 12/03/23 had never completed a medication error report before. -Part of the policy and procedure for medication errors was contacting the PCP. -Staff were trained on medication administration, medication errors and what to do. -The MA should have called the PCP and documented the contact on the resident's occurrence record when the 3 fentanyl patches were found on Resident #2. Attempted telephone interview on 02/22/24 at 4:25pm with the second medication aide (MA), was unsuccessful.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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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:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#8) observed during the medication pass including errors with an inhaler for chronic obstructive pulmonary disease and nasal sprays for sinusitis; and for 1 of 3 sampled residents (#2) including errors with a schedule II opioid medication for complex pain conditions.

The findings are:

Review of the facility's Pharmaceutical Policy and Procedure Manual dated 02/20/18 revealed the facility shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: orders by a licensed prescribing practitioner which are maintained in the resident's record; and the facility's policy and procedures.

1. Review of Resident #2's current FL-2 dated 04/09/23 revealed:
-Diagnoses included dementia with psychosis and chronic pain.
-There was an order for fentanyl 62.5mcg/hour patch every three days; remove the old patch. (Fentanyl patches are a potent synthetic opioid (schedule II controlled substance) used to treat severe pain, is a high risk for addiction and dependence, and can cause respiratory distress and death in high doses.)
-There was an order for naloxone 4mg nasal

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spray one spray as needed for overdose; call 911 when a dose was administered. (Naloxone nasal spray is an opiate antagonist used to reverse the life-threatening effects of known or suspected opiate overdose.)

Review of Resident #2's primary care provider (PCP) visit note dated 06/06/23 revealed:
-Resident #2 reported that sometimes, "I get so dizzy."
-Resident #2 reported becoming dizzy upon standing.
-There was an order to decrease the fentanyl patch to 25mcg/hour every 3 days.

Review of Resident #2's Physician's Orders dated 07/22/23 revealed:
-There was an order for fentanyl 25mcg/hour patch every three days; remove the old patch.
-There was an order for naloxone 4mg nasal spray one spray as needed for overdose; call 911 when a dose was administered.

Review of Resident #2's November 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for fentanyl 25mcg/hour patch every three days; remove the old patch scheduled at 7:00pm with space to document the site where the patch was placed on Resident #2's body.
-There was documentation a fentanyl patch was placed on Resident #2 every three days as follows: 11/03/23 on the left upper back, 11/06/23 on the left upper back, 11/09/23 on the right upper back, 11/12/23 on the left upper arm, 11/15/23 on the left upper back, 11/18/23 on the right upper back, 11/21/23 on the left upper back, 11/24/23 on the left upper back, 11/27/23 on the left upper arm, and 11/30/23 on the left upper

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back.

Review of Resident #2's December 2023 eMAR revealed:
-There was an entry for fentanyl 25mcg/hour patch every three days; remove the old patch scheduled at 7:00pm with space to document the site where the patch was placed on Resident #2's body.
-There was documentation Resident #2 refused the fentanyl patch on 12/03/23.
-There was an entry for naloxone 4mg nasal spray one spray as needed for overdose; call 911 when a dose was administered.
-There was no documentation naloxone 4mg was administered in December 2023 for Resident #2.

Review of Resident #2's Occurrence Record dated 12/02/23 revealed:
-A medication aide (MA) documented that Resident #2 had an unsupervised fall.
-Resident #2 told the MA he hit his head and could not stand on his knee.
-Emergency medical services (EMS) was called at 12:15pm and Resident #2 refused to go with EMS to the emergency room (ER) at 12:40pm.

Review of Resident #2's Occurrence Record dated 12/04/23 revealed:
-A MA documented Resident #2 was sent to the ER for observation.
-Resident #2's blood pressure was low; he was not acting like himself and was not responding normally.

Review of Resident #2's second Occurrence Record dated 12/04/23 revealed:
-The Unit Care Coordinator (UCC) documented Resident #2 had three fentanyl 25mcg/hour patches on his body.

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D 358	Continued From page 10 -She was notified on 12/03/23 by a medication aide (MA) about finding the three fentanyl patches on Resident #2. -She instructed the MA to remove all the fentanyl patches, push plenty of fluid and to monitor Resident #2. -She came to work on 12/04/23 and checked on Resident #2. -She documented, "He was still very out of it." -Resident #2's PCP was notified at 8:31am on 12/04/23 "of the situation." -The PCP instructed her to administer naloxone to Resident #2 and to check his blood pressure. -The PCP instructed the UCC to send Resident #2 to the ER for evaluation if the blood pressure was abnormal or low. -Resident #2's blood pressure was 94/60 in his left arm and 84/50 in his right arm (normal range is between 90/60 and 120/80). -Resident #2 was sent to the ER via EMS. Review of Resident #2's EMS record dated 12/04/23 revealed: -EMS was called for Resident #2 for possible overdose and hypotension. -Staff reported finding 3 fentanyl 25mcg/hour patches on Resident #2 and administering naloxone 4mg that morning (12/04/23). -Staff reported the resident's blood pressure was 86/40. -EMS documented a blood pressure result of 96/56. Review of Resident #4's ER history of present illness note dated 12/04/23 revealed: -Resident #2 presented to the ER with likely opioid overdose. -Resident #2 was found lethargic that morning and staff administered naloxone after finding 3 fentanyl patches on him.	D 358		

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-It was unclear how Resident #2 got 3 fentanyl patches on him and it was likely the patches were not removed.
-Resident #2 was seen recently for a closed head injury and had continued bruising to the right side of his head.

Review of Resident #2's medication error reports dated 12/04/23 revealed:
-There were two medication reports for Resident #2; one for each of two MAs.
-There was documentation that each MA failed to remove the old fentanyl 25mcg/hour patch at the time a new patch was applied to the resident's skin.
-The MAs did not follow the order documented on the eMAR or the facility's medication policy.

Telephone interview with a MA on 02/22/24 at 4:26pm revealed:
-She saw that Resident #2 was not himself and was acting "funny" on 12/03/23 which was a Sunday.
-Resident #2 fell that day (12/03/23) and the day before (12/02/23).
-Resident #2 refused to go the ER and she notified the UCC.
-Later that day (12/03/23) she was changing Resident #2's shirt because it was wet, and she found the 3 fentanyl patches on him.
-He had one patch on each shoulder and one on his lower back towards his side.
-MAs were supposed to date and initial each patch placed and all 3 had dates and initials.
-She did not remember the dates on the patches, but they were all recent dates.
-She removed the patches and called the UCC.
-The UCC told her to put the patches on a piece of paper and slide them under her office door.
-She documented everything on Resident #2's

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occurrence record which was kept in a binder at the front desk.
-She thought she checked Resident #2's vital signs and documented the results on his occurrence record.
-She thought Resident #2's blood pressure result was abnormal; it was a little high or a little low.
-She could not remember exactly what his blood pressure was.
-She completed an incident/accident report and put it under the UCC's office door.

Upon request, Resident #2's care notes, incident and accident reports, and occurrence records dated 12/03/23 were not provided for review.

Interview with the UCC on 02/22/24 at 2:51pm revealed:
-On 12/02/23, she received a call from a MA that Resident #2 fell and was not injured.
-She instructed the MA to notify the PCP and monitor Resident #2.
-On 12/03/23, she received a second call from a MA that Resident #2 fell and injured his head and knee.
-Resident #2 refused to go with EMS to the ER for evaluation.
-She instructed the MA to check Resident #2 for any further injuries such as bruises and skin tears.
-The MA lifted Resident #2's shirt and saw that he had 3 fentanyl patches on his body.
-She (UCC) did not see the patches on Resident #2.
-The MA told her Resident #2 appeared to be fine.
-She instructed the MA to encourage Resident #2 to drink fluids, for staff to monitor the resident, and to send him to the ER if he was not okay.
-She instructed the MA to remove all the fentanyl

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patches, stick the patches on a piece of paper, and put the paper with the patches under her door.
-MAs were responsible for dating and initialing each patch placed on a resident.
-Two of the patches had the MAs initials and the third patch did not.
-All 3 patches had dates on them; she did not remember the dates that were written on the patches.
-The patches had not been on Resident #2 for weeks or months; all the dates were within the same couple of weeks.
-She identified the MAs who placed the patches by the dates.
-Resident #2 ended up with 3 patches on his body because the MAs did not follow the instructions in the documented order to remove the old patch.
-The MA held the fentanyl patch on 12/03/23 due to finding 3 patches on Resident #2 that same day.
-On arrival to work on 12/04/23, she checked on Resident #2.
-The MA on duty said that Resident #2 was sleepy.
-Resident #2 was not himself when she saw him; he was altered in his mental status and not talking normally.
-She called Resident #2's PCP.
-The PCP told her to check Resident #2's blood pressure and if the result was low or abnormal, the PCP instructed her to administer naloxone and call EMS.
-Resident #2's blood pressure was low, so she called EMS and administered naloxone to the resident.
-An incident report should have been completed but one was not; there was only a medication error report.

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-Finding three fentanyl patches was a serious incident due to the severity of fentanyl.
-Errors with fentanyl were a risk for overdose.

Telephone interview with Resident #2's PCP on 02/22/23 at 4:07pm revealed:
-She did not remember the exact date the UCC called her about Resident #2 being lethargic.
-She did not work on Sundays, so it was not 12/03/23.
-The staff on duty should have called the on-call provider with her office that day (12/03/23) when they found the 3 fentanyl patches on Resident #2.
-Staff on duty should have at least checked Resident #2's blood pressure when they found the patches on him.
-She could not remember if she gave a verbal order to hold the fentanyl patch when she spoke to the UCC.
-Having 3 patches on his body put Resident #2 at risk for fentanyl overdose.
-Symptoms of fentanyl overdose included lethargy, falls with severe injuries, decreased level of awareness, respiratory distress, and unresponsiveness.

Second interview with the UCC on 02/22/24 at 5:59pm revealed:
-There was no order to hold Resident #2's fentanyl patch on 12/03/23.
-The MA held the fentanyl patch on 12/03/23 due to finding the 3 patches on Resident #2.
-She thought the occurrence record dated 12/02/23 was dated incorrectly and should have been dated 12/03/23.

Interview with the Administrator on 02/22/24 at 2:05pm revealed:
-MAs were expected to administer medications according to the orders and instructions on the

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eMAR.
-Resident #2 was found with three fentanyl patches because staff did not follow the orders and instructions on his eMAR.
-MAs knew to sign and date the new fentanyl patch and remove the old patch.

Interview with the Administrator in Charge (AIC) on 02/22/24 at 5:24pm revealed:
-The UCC told staff to check Resident #2 after his falls which was how the fentanyl patches were found.
-The UCC told staff to keep Resident #2 hydrated and to monitor him on 12/03/23.
-The UCC came into work on 12/04/23 and found Resident #2 lethargic when she checked on him.
-The UCC completed the medication error report on 12/04/23 because the MA on duty on 12/03/23 had never completed a medication error report before.
-Part of the policy and procedure for medication errors was contacting the PCP.
-The staff on duty were focused on taking care of Resident #2 and making sure he was okay.
-Staff were trained on medication administration, medication errors and what to do.
-MAs were expected to administer medications according to the order entered on the eMAR.
-The old fentanyl patch should have been removed by the MA at the time a new patch was put on.

Attempted telephone interview on 02/22/24 at 4:25pm with the second medication aide (MA), was unsuccessful.

2. The medication error rate was 10% as evidenced by 3 errors out of 28 opportunities during the morning medication pass on 02/22/24.

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D 358	Continued From page 16 Review of Resident #8's current FL-2 dated 07/05/23 revealed diagnoses included chronic obstructive pulmonary disease (COPD) and allergic rhinitis. a. Review of Resident #8's Physician's Orders dated 01/09/24 revealed an order for Trelegy Ellipta 100/62.5/25mg one puff daily. (Trelegy Ellipta is used to treat symptoms of COPD.) Review of Resident #8's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Trelegy Ellipta 100/62.5/25mg one puff daily at 8:00am. -There was documentation that Trelegy Ellipta was administered at 8:00am on 02/22/24. Observation during the morning medication pass on 02/22/24 from 7:39am until 8:15am revealed: -At 7:39am, the medication aide (MA) began removing Resident #8's 8:00am medications from the medication cart drawer. -The MA removed cassettes containing oral medications, an insulin pen, glucometer, nasal sprays, eyedrops, a nebulizer treatment and the Trelegy Ellipta inhaler; she compared each medication to the resident's eMAR. -The MA returned all of Resident #8's 8:00am medications to the medication cart drawer, locked the cart, and went to the medication room for insulin pen needles. -The MA returned to the medication cart and pulled all Resident #8's 8:00am medications from the medication cart drawer except the Trelegy Ellipta inhaler. -At 7:59am, the MA administered all the oral medications to Resident #8 in the resident's room. -The MA checked Resident #8's blood sugar	D 358		

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level, administered insulin, nasal sprays, eye drops and initiated the nebulizer treatment at 8:07am.
-The MA documented medications administered on the eMAR at the medication cart outside of Resident #8's room.
-The MA instructed a personal care aide (PCA) at 8:13am, to assist Resident #8 to the dining room for breakfast after completion of her nebulizer treatment.
-The PCA was assisting Resident #8 to the dining room at 8:15am.
-The MA did not administer the Trelegy Ellipta inhaler to Resident #8.

Interview with the MA on 02/22/24 at 8:08am revealed she had administered all of Resident #8's 8:00am medications and there were no additional medications to be administered.

Second interview with the MA on 02/22/24 at 2:24pm revealed:
-She remembered taking the Trelegy Ellipta inhaler out the first time she pulled Resident #8's medications out.
-She remembered putting the Trelegy Ellipta inhaler back in the cart to go and get the insulin pen needles.
-She did not remember pulling the Trelegy Ellipta inhaler out when she returned to the cart.
-She did not remember administering the Trelegy Ellipta inhaler to Resident #8 that morning (02/22/24).
-She remembered that she did not administer the Trelegy Ellipta inhaler to Resident #8 when she returned to the medication room.
-She went back and administered the Trelegy Ellipta inhaler to Resident #8 between 9:00am and 10:00am.

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Interview with Resident #8 on 02/22/24 at 2:39am revealed:
-She took one inhaler every morning.
-She did not remember getting her inhaler that morning (02/22/24).
-She used the inhaler to help reduce shortness of breath.
-She was always short of breath and the inhaler helped some.
-She could not tell if she was experiencing any increased shortness of breath because she had a terrible headache.

Interview with the Unit Care Coordinator (UCC) on 02/22/24 revealed:
-Resident #8 had days of increased complaints of physical discomforts like headaches.
-Resident #8 was forgetful, but otherwise cognitively appropriate.
-It was possible that Resident #8 did not receive her Trelegy Ellipta inhaler.

Telephone interview with Resident #8's primary care provider (PCP) on 02/22/24 at 4:07pm revealed:
-Resident #8 was prescribed Trelegy Ellipta to treat (COPD).
-Not receiving the Trelegy Ellipta inhaler could cause increased cough and shortness of breath.

b. Review of Resident #8's Physician's Orders dated 01/09/24 revealed an order for an acapella flutter device with instructions to blow into the device 10 times twice daily. (The acapella flutter device is used to remove mucous from the airways.)

Review of Resident #8's February 2024 electronic medication administration record (eMAR) revealed:

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D 358	Continued From page 19 -There was an entry for an acapella flutter device with instructions to blow into the device 10 times twice daily at 8:00am and 8:00pm. -There was documentation that the acapella device was administered at 8:00am on 02/22/24. Observation during the morning medication pass on 02/22/24 at 7:57am revealed: -The medication aide (MA) handed Resident #8 the acapella flutter device and instructed the resident to breath in and blow into the device twice. -Resident #8 blew into the acapella flutter device twice and handed the device back to the MA. Interview with the MA on 02/22/24 at 2:24pm revealed: -She did not realize Resident #8 was supposed to blow into the acapella flutter device 10 times. -She must have read the instructions on the eMAR wrong. c. Review of Resident #8's Physician's Orders dated 01/09/24 revealed an order for fluticasone 50mcg one spray in each nostril daily. (Fluticasone is used to treat allergy symptoms.) Review of Resident #8's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone 50mcg one spray in each nostril daily at 8:00am. -There was documentation that fluticasone was administered at 8:00am on 02/22/24. Observation during the morning medication pass on 02/22/24 at 8:02am revealed: -The medication aide (MA) administered two sprays of fluticasone 50mcg in each of Resident #8's nostrils.	D 358		

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-The pharmacy label on Resident #8's fluticasone indicated the spray was dispensed from the pharmacy on 02/01/24 and had instructions to administer one spray in each nostril daily.

Interview with the MA on 02/22/24 at 2:24pm revealed:
-Resident #8's order for fluticasone must have changed and she did not realize it.
-Resident #8 used to receive 2 sprays of fluticasone every morning.

d. Review of Resident #8's Physician's Orders dated 01/09/24 revealed an order for saline nasal spray two sprays in each nostril twice daily. (Saline nasal spray is used to treat allergy symptoms.)

Review of Resident #8's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for saline nasal spray two sprays in each nostril twice daily at 8:00am and 8:00pm.
-There was documentation that saline nasal spray was administered at 8:00am on 02/22/24.

Observation during the morning medication pass on 02/22/24 at 8:06am revealed:
-The medication aide (MA) administered one spray of saline nasal spray in each of Resident #8's nostrils.
-The pharmacy label on Resident #8's saline nasal spray indicated the spray was dispensed from the pharmacy on 01/22/24 and had instructions to administer two sprays in each nostril twice daily.

Interview with the MA on 02/22/24 at 2:24pm revealed she forgot that Resident #8 was

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supposed to receive two sprays of saline nasal spray.

Interview with the Unit Care Coordinator (UCC) on 02/22/24 at 2:51pm revealed:
-MAs were expected to administer medications according to the order entered on the eMAR.
-The MAs normally administered medications accurately.

Telephone interview with Resident #8's primary care provider (PCP) on 02/22/24 at 4:07pm revealed:
-The nasal sprays were prescribed to treat Resident #8's allergy symptoms.
-It was not a major concern that the incorrect number of sprays were administered.

Interview with the Administrator in Charge (AIC) on 02/22/24 at 5:24pm revealed:
-Staff were trained on medication administration.
-MAs were expected to administer medications according to the order entered on the eMAR.

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The facility failed to administer fentanyl, a potent schedule II opioid medication for complex pain conditions, as ordered by the primary care provider to Resident #2 by neglecting to remove the old patch prior to applying the new patch every three days resulting in three patches being found on Resident #2's body after two falls, Resident #2 experiencing opioid overdose symptoms including altered mental status, slurred speech, and a low blood pressure result of 86/40 (normal range is between 90/60 and 120/80). The facility's failure resulted in substantial risk of serious harm and death of Resident #2 and constitutes a Type A2 Violation.

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The facility provided a plan of protection in

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accordance with G.S. 131D-34 on 02/22/24 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 23, 2024.

D 451

10A NCAC 13F .1212(a) Reporting of Accidents and Incidents

10A NCAC 13F .1212 Reporting of Accidents and Incidents
(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the county Department of Social Services (DSS) of accidents or incidents resulting in injuries for 3 of 5 sampled residents (#2, #3, #4)

The findings are:

Review of the facility's accident and incident report policy revealed:
-The facility completed an incident report.
-The facility reported appropriately to (DSS, Administrator, Physician, responsible party, etc.).

1. Review of Resident #4's current FL-2 dated 04/10/23 revealed diagnoses included dementia.

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Review of Resident #4's hospital summary discharge dated 11/13/23 revealed:
-She was transported to the emergency room (ER) due to a fall with back pain.
-Diagnoses were multiple contusions, low back pain, a fall, debility, and dementia.
-The imaging test completed was an X-ray of the lumbar spine.

Review of Resident #4's progress note dated 11/13/23 revealed:
-She had an observed fall in the lobby and hit her head on the floor at approximately 8:30pm.
-She left by Emergency Medical Services at approximately 9:05pm.
-She returned from the ER at approximately 11:35pm.

Interview with the Unit Care Coordinator (UCC) on 02/22/24 at 4:10pm revealed:
-She was unaware that the accident and incident report had not been completed for the incident on 11/13/23.
-She looked in the accident and incident book where the facility keeps all reports and could not find an 11/13/23 report.

Interview with the Administrator on 02/22/24 at 4:30pm revealed she was unaware that the 11/13/23 accident and incident report had not been completed.

Interview with the county DSS Adult Home Specialist on 02/22/24 at 4:51pm revealed she had not received an accident and incident report for Resident #4 dated 11/13/23.

Attempted telephone interview with Resident #4's new legal guardian on 02/22/24 at 11:09am was unsuccessful.

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Refer to the interview with the UCC on 02/22/24 at 4:10pm.

Refer to the interview with the Administrator on 02/22/24 at 4:30pm.

2. Review of Resident #3's current FL-2 dated 10/06/23 revealed diagnoses of unspecified dementia depression, chronic obstructive pulmonary disease, depression, urinary incontinence, bilateral primary osteoarthritis of hip radiculopathy, and lumbar region low back pain.

Review of Resident #3's hospital summary discharge dated 02/03/24 revealed:
-She was transported to the emergency room (ER) due to a fall with a head injury.
-The imaging test completed was a CT head without contrast.

Refer to the interview with the UCC on 02/22/24 at 4:10pm.

Refer to the interview with the Administrator on 02/22/24 at 4:30pm.

3. Review of Resident #2's current FL-2 dated 04/09/23 revealed diagnoses included dementia with psychosis, coronary artery disease, glaucoma, hypertension, chronic pain, mood disorder, gout, and anxiety.

Review of Resident #2's emergency room (ER) history of present illness note dated 11/24/23 revealed:
-Resident #2 presented to the ER after an unwitnessed fall and was evaluated for a head injury and a fall.
-Resident #2 had an abrasion and contusion to

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his right forehead.
-Resident #2 complained of a mild right sided headache and neck pain.

Interview with the Administrator on 02/22/24 at 5:24pm revealed she could not find an incident/accident report dated 11/24/23 for Resident #2.

Interview with the county DSS Adult Home Specialist on 02/22/24 at 4:49pm revealed she had not received an incident/accident report dated 11/24/23 for Resident #2 from the facility.

Refer to the interview with the Unit Care Coordinator (UCC) on 02/22/24 at 4:10pm.

Refer to the interview with the Administrator on 02/22/24 at 4:30pm.

____

Interview with the Unit Care Coordinator (UCC) on 02/22/24 at 4:10pm revealed:
-The medication aide (MA) was responsible for completing the accident and incident report and then notified the UCC.
-The process was to keep all accident and incident reports for one year, then, after that one year, purge files and place them in a file in her office.

Interview with the Administrator on 02/22/24 at 4:30pm revealed:
-The medication aide (MA) was responsible for completing the accident and incident report, and then the UCC received the report to address any questions or concerns.
-The Administrator in charge reviewed the report and signed off.
-The process was to place the accident and

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063011	A. BUILDING: ______ B. WING ______	R 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TARA PLANTATION OF CARTHAGE	**820 S. MCNEILL STREET** **CARTHAGE, NC 28327**

(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 451	Continued From page 26 incident report in the book immediately after completion.	D 451		