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
	HAL049035	A. BUILDING: _____ B. WING _____	01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 conducted an annual survey on 01/17/24 through 01/18/24.	D 000	In reference to rule area 10A NCAC 13F .0703(a): DHW and/or designee will audit all medical charts for TB compliance. TB testing will be completed on all residents that are not found to be in compliant.	03/06/24
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure 1 of 7 sampled residents (#7) was tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #7's current FL2 dated 10/08/23 revealed diagnoses included anemia, heart failure and hyperthyroidism. Review of Resident #1's Resident Register revealed an admission date of 05/10/21. Review of Resident #7's record on 01/18/24 revealed:	D 234	DHW, SLC, BOM, ED and/or designee will be re-educated on TB requirements in effort to increase compliance during the admission process. Ongoingly, the DHW and/or designee will review move in paperwork prior to physical admission date to ensure TB documentation is included.	03/06/24

Reviewed and Acknowledged by MH on 02/26/2024

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D 234	Continued From page 1 -There was a TB test record consent form with no documented TB test #1 and #2 were administered. -The was a note on the TB test record consent dated 04/27/21 with documentation Resident #7's family member would take Resident #7 to get the TB tests completed and send the results to the facility. Interview with Resident #7 on 01/18/24 at 2:00pm revealed: -She had lived at the facility for almost 2 years. -She lived in the Independent Living section of the facility prior to the Assisted Living. -She could not remember if a TB skin test was placed upon admission to the facility. Interview with the Health and Wellness Director (HWD) on 01/14/24 at 2:38pm revealed: -The Sales department was responsible for getting all of the resident's paperwork together before admission and gave it to her and she was responsible for making sure the step #1 TB test was completed before admission. -There was no process to audit resident records for completion of the TB tests. -She thought all the residents received their TB tests. Interview with the Administrator on 01/14/24 at 3:27pm revealed: -The Sales staff were responsible for giving the TB information to the Assistant HWD and the HWD for verification prior to the resident's admission. -The first step TB was to be completed prior to a resident being admitted to the facility. -The Assistant HWD and HWD were responsible for monthly audits on 7-10 random resident to check for completion of things such as the TB	D 234		

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D 234	Continued From page 2 tests. -She was not aware Resident #7 did not have the required TB test prior to admission to the facility.	D 234		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Home And 10A NCAC 13F .0704 Resident Contract, Information On Home And Resident Register (b) The administrator or administrator-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the facility and revise the information on the form as needed. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed within 72 hours of admission to the facility for 3 of 7 sampled residents (#1, #2, and #5). The findings are: 1. Review of Resident #1's current FL2 dated 11/22/23 revealed diagnoses included dementia, hypertension, and chronic kidney disease.	D 248	In reference to rule area 10A NCAC 13F .0703(b): DHW and/or designee will perform a complete chart audit to determine if other Resident Registers on file have incomplete signature(s). DHW, SLC, BOM, ED and/or designee will be re-educated on signature requirements to maintain Resident Register compliance. Ongoingly, the ED, BOM and/or designee will sign Resident Register upon admission. DHW, ADHW, and/or designee will complete a chart audit of new admissions within 48-hours of move in date to ensure Resident Register is signed appropriately.	03/06/24 03/06/24

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D 248	Continued From page 3 Review of Resident #1's record revealed she was admitted on 08/21/23. Review of Resident #1's Resident Register revealed: -There was no documentation of the date of admission. -The resident had signed the Resident Register but did not provide the date signed. -It had not been signed and dated by the Administrator or designee. Refer to the interview with the Health and Wellness Director (HWD) on 01/18/24 at 2:35pm. Refer to the interview with the Administrator on 01/18/24 at 3:30pm. 2. Review of Resident #2's current FL2 dated 09/12/23 revealed diagnoses included hypertension, chronic kidney disease, congestive heart failure and hypothyroidism. Review of Resident #2's record revealed she was admitted on 11/22/21. Review of Resident #2's Resident Register revealed: -There was no documentation of the date of admission. -There were no dates identifying when it was signed by the resident and a facility staff member. Refer to the interview with the HWD on 01/18/24 at 2:35pm. Refer to the interview with the Administrator on 01/18/24 at 3:30pm.	D 248		

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D 248	Continued From page 4 3. Review of Resident #5's current FL2 dated 11/10/23 revealed: - Diagnoses included dementia, diabetes mellitus, coronary artery disease, and hypertension. -The Resident was admitted to the facility on 02/22/23. Review of Resident #5's Resident Register revealed: -There was no documentation of the date of admission. -The family member had signed the Resident Register on 02/02/23. -The Resident Register had not been signed and dated by the Administrator or designee. Refer to the interview with the HWD on 01/18/24 at 2:35pm. Refer to the interview with the Administrator on 01/18/24 at 3:30pm. Interview with the HWD on 01/18/24 at 2:35pm revealed: -The Administrator and Sales Representative were responsible for completing the Resident Register. -She was not sure of any audits being completed but she was not sure. Interview with the Administrator on 01/18/24 at 3:30pm revealed: -The Resident Registers were to be signed by the responsible party and the Administrator. -The facility was changing the process of auditing the charts. -The Resident Registers were to be audited by the Assistant HWD. -The Resident's responsible party and her were supposed to sign the Resident Register.	D 248		

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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 7 sampled residents (#2) had a care plan completed annually. The findings are: Review of Resident #2's current FL2 dated 09/12/23 revealed: -Diagnoses included hypertension, chronic kidney disease, congestive heart failure and hypothyroidism. -The resident was admitted to the facility on 11/22/21. Review of Resident #2's care plan dated 12/23/21 revealed: -The resident was independent with mobility, dressing, grooming, and toileting. -The resident required stand-by assistance for bathing. -The care plan was not signed by the assessor and Resident #2's Primary Care Provider (PCP). Interview with the Health and Wellness Director (HWD) on 01/18/24 at 2:39pm revealed: -She and the Assistant HWD were responsible for	D 259	In reference to rule area 10A NCAC 13F .0802(d): DHW and/or designee will perform an audit of all current care plans to ensure signature requirements are met by/before 03/06/24 and ongoingly on a monthly basis. DHW, ADHW, and/or designee will sign all care plans at time of assessment completion.	03/06/24 03/06/24

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D 259	Continued From page 6 completing resident care plans annually. -The was no audit in place to ensure resident care plans were completed annually. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -The HWD and the Assistant HWD were responsible for ensuring resident care plans were completed annually. -The facility utilized a tracking system that flagged when care plans were due. -She believed a current care plan had been completed but was unsure why it was not in the resident's record.	D 259		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 7 sampled residents had an accurate care plan that were signed by the assessor upon completion (#4 and #7). 1. Review of Resident #4's current FL2 date 10/18/23 revealed: -Diagnoses included Alzheimer's hyperlipidemia, depression and hypothyroidism. -Resident #4 was admitted to the Assisted Living on 11-24-21. -Resident #4 was constantly disoriented. Review of Resident #4's Care Plan dated 12/21/23 revealed: -Resident #4 was independent with eating,	D 262	In reference to rule area 10A NCAC 13F .0802(d): DHW and/or designee will perform an audit of all current care plans to ensure signature requirements are met by/before 03/06/24 and ongoingly on a monthly basis. DHW, ADHW, and/or designee will sign all care plans at time of assessment completion.	03/06/24 03/06/24

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D 262	Continued From page 7	D 262		

ambulating and transfers.
-Resident #4 required moderate physical assistance with bathing, dressing, grooming and toileting.
-The care plan was not signed by the assessor.

Refer to the interview with the Health and Wellness Director (HWD) on 01/08/24 at 2:38pm.

Refer to the interview with the Administrator on 01/18/24 at 3:27pm.

2. Review of Resident #2's current FL2 dated 09/12/23 revealed:
-Diagnoses included hypertension, chronic kidney disease, and congestive heart failure (condition in which the heart cannot pump blood as well as it should).
-Resident #2 was admitted to the facility on 11/22/21.

Review of Resident #2's Care Plan dated 12/23/21 revealed:
-Resident #2 was independent with eating, grooming, and mobility.
-The care plan was not signed by the assessor.

Refer to the interview with the HWD on 01/08/24 at 2:38pm.

Refer to the interview with the Administrator on 01/18/24 at 3:27pm.

Interview with the HWD on 01/08/24 at 2:38pm revealed:
-She and the Assistant HWD were responsible for completing and signing the care plan.
-She did not realize the care plan did not print her name automatically.
-There was no process in place to ensure care

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D 262	Continued From page 8 plans were signed by the assessor. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -The assessor was to sign the care plan. -The assessor would be the Assistant HWD and the HWD. -The Assistant HWD/HWD was responsible for completing and signing the care plan as the assessor. -Care plans were supposed to be completed during the initial assessment for new residents and then annually or with significant changes in condition.	D 262		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 5 of 7 sampled residents had an accurate care plan that was signed by a provider within 15 days of the residents' being assessed (#1, #2, #4, #5 and #7). The findings are:	D 263	In reference to rule area 10A NCAC 13F .0802(e): DHW, ADHW, and/or designee will audit all current resident care plans to ensure each are signed by physician. DHW, ADHW, and/or designee will ongoingly ensure that all care plans are signed by physician. In the event that the physician has not provided timely signature, as of 03/06/24 forward, proof of the community's efforts to obtain physician signature will be included with any updated care plan.	03/06/24

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D 263	Continued From page 9 1. Review of Resident #7's current FL2 dated 10/08/23 revealed: -Diagnoses included anemia, heart failure and hyperthyroidism. -Resident #7 was admitted to the Assisted Living on 5/10/21. -The was no orientation documented. Review of Resident #7's Resident Register revealed an admission date of 05/10/21. Review of Resident #7's Care Plan dated 11/29/23 revealed: -Resident #7 was independent with eating, toileting, ambulating, bathing, dressing, grooming and transfers. -The care plan was not signed by the physician. Interview with the Health and Wellness Director (HWD) on 01/18/24 at 2:38pm revealed she was not aware Resident #7's care plan was not signed by the physician. Interview with the Administrator on 01/18/24 at 3:27pm revealed she was not aware Resident #7's care plan was not signed by the physician. Refer to interview with the HWD on 01/18/24 at 2:38pm. Refer to interview with the Administrator on 01/18/24 at 3:27pm. 2. Review of Resident #1's current FL2 dated 11/22/23 revealed: -Diagnoses included dementia, hypertension, and chronic kidney disease. -Resident #1 was admitted to the facility on 08/21/23.	D 263		

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D 263	Continued From page 10 Review of Resident #1's Resident Register revealed no admission date. Review of Resident #1's Care Plan dated 08/15/23 revealed: -Resident #1 was independent with eating and toileting. -Resident #1 required minimal assist with dressing, and grooming. -Resident #1 required reminders to use her walker while ambulating. -The care plan was not signed by the physician. Refer to interview with the HWD on 01/18/24 at 2:38pm. Refer to interview with the Administrator on 01/18/24 at 3:27pm. 3. Review of Resident #2's current FL2 dated 09/12/23 revealed: -Diagnoses included hypertension, chronic kidney disease, and congestive heart failure (condition in which the heart cannot pump blood as well as it should). -Resident #2 was admitted to the facility on 11/22/21. Review of Resident #2's Resident Register revealed no admission date. Review of Resident #2's Care Plan dated 12/23/21 revealed: -Resident #2 was independent with eating, toileting, dressing, grooming, and mobility. -The care plan was not signed by the physician. Refer to interview with the HWD on 01/18/24 at 2:38pm.	D 263		

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D 263	Continued From page 11 Refer to interview with the Administrator on 01/18/24 at 3:27pm. 4. Review of Resident #4's current FL2 date 10/18/23 revealed: -Diagnoses included Alzheimer's hyperlipidemia, depression and hypothyroidism. -Resident #4 was admitted to the Assisted Living on 11-24-2021. - Resident #4 was constantly disoriented. Review of Resident #4's Care Plan dated 11/29/23 revealed: -Resident #4 was independent with eating, toileting, ambulating, bathing, dressing, grooming and transfers. -The care plan was not signed by the physician. Interview with the HWD on 01/18/2024 at 2:38pm revealed she was not aware Resident #4's care plan was not signed by the physician. Interview with the Administrator on 01/18/24 at 3:27pm revealed she was not aware Resident #4's care plan was not signed by the physician. Refer to interview with the HWD on 01/18/24 at 2:38pm. Refer to interview with the Administrator on 01/18/24 at 3:27pm. 5. Review of Resident #5's current FL2 dated 11/10/23 revealed: -Diagnoses included dementia, diabetes mellitus, coronary artery disease and hypertension. -Resident #5 was intermittently disoriented. -His recommended level of care was Assisted Living.	D 263		

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D 263	Continued From page 12 -He was admitted to the facility on 02/22/23. Review of Resident #5's Resident Register revealed the admission date was blank. Review of Resident #5's care plan dated 03/15/23 revealed: -He had occasional confusion and some difficulty recalling details. -He required minimal physical assistance with dressing and grooming. -He required reminders on using assistive devices when walking and using protective garment for bathroom assistance. -He was independent for eating. -Resident #5's care plan was signed and dated by a family member and the Assistant HWD. -The care plan was not signed by the physician. Refer to interview with the HWD on 01/18/24 at 2:38pm. Refer to interview with the Administrator on 01/18/24 at 3:27pm. _____ Interview with the HWD on 01/08/24 at 2:38pm revealed: -She and the Assistant HWD were responsible for faxing the new care plan to the physician for a signature after it was completed. -There was no process in place to ensure care plans were signed by the physician. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -The Assistant HWD/HWD were responsible for completing the care plan and obtaining the physician's signature. -Care plans were supposed to be completed during the initial assessment for new residents	D 263		

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D 263	Continued From page 13 and then annually or with significant changes in condition. -Once the care plan was completed at the initial assessment, the document should be faxed or emailed to their physician within 15 days for review and to be signed.	D 263		
D 278	10A NCAC 13F .0903(a) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (a) An adult care home shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage);	D 278	In reference to rule area 10A NCAC 13F .0903(a): DHW, ADHW, and/or designee will perform a complete chart audit to confirm that residents that utilize oxygen have an LHPS on file that includes oxygen management. DHW, ADHW, and/or designee will audit charts of those residents with oxygen orders quarterly to ensure proper completion of LHPS.	03/06/24

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D 278	Continued From page 14 (10) care for pressure ulcers up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections, excluding anticoagulants such as heparin. (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph(a)(14) of this Rule); (21) the monitoring of continuous positive air pressure devices (CPAP and BiPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or	D 278		

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D 278	Continued From page 15 non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) assessment was completed on 1 of 7 sampled residents (Resident #7) for identify new a task for oxygen. The findings are: Review of Resident #7's FL2 dated 10/08/23 revealed diagnoses included anemia, heart failure and hyperthyroidism. Observation of Resident #7's room on 01/17/24 at 4:00pm revealed: -There was an oxygen concentrator which supplied oxygen at 4 liters via nasal cannula to Resident #7. -There were 2 portable oxygen tanks and 2 portable oxygen concentrators. Telephone interview with a representative from Resident #7's Pulmonologist office on 01/18/24 at 12:13pm revealed: -On 08/11/23, Resident #7's oxygen saturation on room air walking 5 feet was 81% (normal was >90%). -On 08/11/23, Resident #7's oxygen saturation on 4L via nasal canula was 98%. -There was an order dated 08/11/23 for oxygen at	D 278		

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D 278	Continued From page 16 4L via nasal canula continuously. Review of Resident #7's LHPS evaluation dated 08/24/23 revealed there were no task documented. Interview with th Health and Wellness Director (HWD) on 01/18/24 at 2:38pm revealed: -Resident #7 was considered self-administration for her oxygen. -There was no LHPS task for self-administration of oxygen. -There was no assessment of Resident #7's capability for self-administration of oxygen. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -There was a facility nurse consultant used to completed LHPS on all residents. -The HWD was to review all tasks. -Resident #7 was to have a task for oxygen administration documented on the LHPS.	D 278		
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: Based on record reviews, and interviews, the facility failed to administer medications as	D 358	In reference to rule area 10A NCAC 13F .1004(a): DHW, ADHW, and/or designee will re-educate all Medication Aides on the importance of processing new orders and monitoring timely refills. DHW, ADHW, and/or designee will audit medication carts weekly, at minimum, to ensure medications are ordered and received timely. DHW, ADHW, and/or designee will review missed medication report on a daily basis and provide follow up to any concerns.	03/06/24

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D 358	Continued From page 17 ordered to 2 of 7 sampled residents (#1 and #2) related to a medication to treat dementia (#1) and a medication to treat elevated cholesterol levels (#2). The findings are: Review of the facility's Medication Administration Policy and Procedure dated 08/27/20 revealed: -The purpose of the resident's medication agreement was to ensure residents received medications in accordance with the physician's orders. -Medications were to be ordered in a timely manner by the facility. 1. Review of Resident #1's current FL2 dated 11/22/23 revealed: -Diagnoses included dementia. -There was an order for memantine (a medication to treat dementia) 10mg, one tablet twice daily. Interview with Resident #1's family member on 01/17/24 during initial tour at 10:10am revealed he was concerned because Resident #1 had dementia and had missed five straight doses of the medication to treat her memory loss. Review of Resident #1's December 2023 electronic Medication Administration Record (eMAR) revealed: -There was an entry for memantine 10mg, one tablet twice daily at 8:00am and 8:00pm. -The entry was circled, indicating not administered on 12/30/23 at 8:00pm and on 12/31/23 at 8:00am and 8:00pm. -The documented reasons the medication was not administered was the medication was unavailable.	D 358		

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D 358	Continued From page 18 Review of Resident #1's January 2024 eMAR revealed: -There was an entry for memantine 10mg twice daily at 8:00am and 8:00pm. -The entry was circled, indicating not administered on 01/01/24 at 8:00am and 8:00pm. -The documented reasons the medication was not administered was the medication was unavailable. Telephone interview with a representative from the facility's contracted pharmacy on 01/18/24 at 10:10am revealed: -Resident #1's memantine order was from her FL2 and therefore there were no refills. -Memantine 10mg, 60 tablets were dispensed to the facility on 11/24/23 and 56 tablets were dispensed on 12/28/23. -Resident #1 could experience increased forgetfulness, hallucinations, or act out more if she did not receive her memantine as ordered. Interview with a Medication Aide (MA) on 01/18/24 at 1:38pm revealed: -The MAs were responsible to order resident medications from the pharmacy when there were five or six doses left to administer. -If a medication was not available to administer, the MAs were to inform the MA Supervisor. -She was aware Resident #1 was out of her memantine but only because she heard it during shift report. -She was not involved in the refill process for Resident #1's memantine because the resident's medications were on another MA's medication cart. Interview with the MA Supervisor on 01/18/24 at 1:51pm revealed: -She called the facility's contracted pharmacy	D 358		

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D 358	Continued From page 19	D 358		

regarding Resident #1's memantine not being available.
-She was unsure when she contacted the pharmacy.
-She thought the pharmacy needed to get authorization for it to be refilled.

Interview with the Health and Wellness Director (HWD) on 01/18/24 at 2:39pm revealed:
-The MAs were responsible to contact the pharmacy when medications needed refilled.
-Resident eMARs were audited for missed medication doses during the morning meeting, Monday through Friday.
-It was her responsibility to investigate when there were two to three continually missed doses of a medication.
-She was aware Resident #1 had missed doses of memantine.
-She thought the pharmacy needed either a prior authorization or new script.

Refer to the interview with the Administrator on 01/18/24 at 3:27pm.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 01/18/24 at 3:50pm was unsuccessful.

Based on observations, interviews and record review, it was determined that Resident #1 was not interviewable.

2. Review of Resident #2's current FL2 dated 09/12/23 revealed:
-Diagnoses included hypertension and congestive heart failure.
-There was an order for pravastatin (a medication to lower cholesterol levels in the blood) 10mg, one tablet daily.

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D 358	Continued From page 20 Review of Resident #2's December 2023 eMAR revealed: -There was an entry for pravastatin 10mg, one tablet daily at 8:00pm. -The entry was circled, indicating not administered, from 12/05/23 to 12/17/23 and from 12/19/23 to 12/26/23. -The documented reasons the medication was not administered was the medication was unavailable. Telephone interview with a representative from the facility's contracted pharmacy on 01/18/24 at 10:10am revealed: -Resident #2 had an order for pravastatin 10mg, one tablet daily. -Resident #2's medications were cycle filled every 28 days. -There was a disruption in Resident #2's pravastatin order in November 2023 because the pharmacy needed a new order for refills to be continued. -When refills were needed for a medication, the pharmacy sent an email to the HWD and the Assistant HWD at the facility. -Pravastatin 10mg, 28 tablets were dispensed for Resident #2 on 10/24/23, 7 tablets were dispensed on 11/21/23, 9 tablets were dispensed on 12/24/23 and 28 tablets were dispensed on 12/29/23. -If Resident #2 did not receive pravastatin 10mg as ordered her cholesterol could rise and there was a chance a clot could form which could cause a pulmonary embolism (a blood clot in the lungs) or a deep vein thrombosis (DVT) (a blood clot in a deep vein, usually in the legs). Interview with a MA on 01/18/24 at 1:38pm revealed:	D 358		

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D 358	Continued From page 21 -The MAs were responsible to order resident medications from the pharmacy when there were five or six doses left to administer. -If a medication was not available to administer, the MAs were to inform the MA Supervisor. -She was unsure if she was aware Resident #2 did not receive her pravastatin 10mg because it was not given on her shift. Interview with the MA Supervisor on 01/18/24 at 1:51pm revealed: -She was not aware Resident #2 had missed 21 doses of her pravastatin 10mg. -Cart audits of medications available for administration were completed by the MAs twice a day, usually on first and third shifts. -There was a form completed when cart audits were completed and included documentation of missed medications in the past 30 days. -The completed form was placed in a file folder and reviewed by the HWD or the Assistant HWD. Interview with the HWD on 01/18/24 at 2:39pm revealed: -The MAs were responsible to contact the pharmacy when medications needed refilled. -Resident eMARs were audited for missed medication doses during the morning meeting, Monday through Friday. -It was her responsibility to investigate when there were two to three continually missed doses of a medication. -The facility switched from multi-dose packaging to a 28 day cycle with medications packaged in bubble packs around the time Resident #2 missed her pravastatin 10mg medication. -She believed the change in packaging was the cause of the pharmacy not delivering Resident #2's pravastatin 10mg.	D 358		

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D 358	Continued From page 22 Refer to the interview with the Administrator on 01/18/24 at 3:27pm. Attempted telephone interview with Resident #2's PCP on 01/18/24 at 3:50pm was unsuccessful. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -The MAs or MA Supervisors were responsible to reorder medications from the pharmacy when needed. -The HWD and Assistant HWD ran a report each day to audit the residents' eMARs for missed medications. -She was aware there were some medication issues, but she was unsure of the specifics. -She expected medications to be administered as ordered by the PCP.	D 358		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375	In reference to rule area 10A NCAC 13F .1005(a): DHW, ED, and/or designee will provide a quarterly notification to families and/or residents to serve as a reminder to alert the DHW/ADHW of any changes to their current medication regimen and/or treatment plan. This includes prescribed and/or over the counter medications and/or supplements.	

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D 375	Continued From page 23 This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure 2 of 7 sampled resident (#7 and #2) had a physician's order to self-administer medications related to oxygen (#7) and a medication to treat pain and fevers (#2). The findings are: Review of the facility's policy Resident Self-Administration of Medications dated 08/27/20 revealed: -A self-administration of medications assessment was required upon admission, quarterly or per state guidelines. -The Health and Wellness Director (HWD) was responsible for completing the self-administration assessments. -The HWD was responsible for documentation in the resident's electronic Medication Administration Record (eMAR) for all residents who self-administer medications and to be updated as orders were received for additions, changes, discontinuations etc. -The HWD was responsible for documenting on the resident's care plan the resident's ability to self-administer his/her medications. -If the facility staff suspects a resident was not able to properly administer their medication, then the HWD was to be notified. -The HWD was responsible for a repeat assessment of their ability to continue to "self-administer" medications and the resident's physician was to be notified of the results. -If the resident was unable to safely self-medicate, the staff would notify the resident's physician and an order would be obtained from the physician for the staff to administer medications to the resident going forward.	D 375	Details such as how many liters of oxygen and the provider of the oxygen supply/materials will be added to the resident(s) Electronic Medical Record (eMAR). The wellness staff will verify O2 compliance per shift by recording signature. Quarterly, the DHW, ADHW, and/or designee will assess each resident on O2 to ensure safety of O2 management. Monthly visual safety checks will be completed by DHW, ADHW, and/or designee to ensure medication storage compliance.	03/06/24

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D 375	Continued From page 24 -If there was a medication in the resident's room that was not on the resident's eMAR, then the physician was to be notified for clarification on the continued usage of that medication. 1. Review of Resident #7's current FL2 dated 10/08/23 revealed: -Diagnoses included anemia, heart failure and hyperthyroidism. -There was no order for oxygen documented. Review of Resident #7's Resident Register revealed an admission date of 05/10/21. Review of Resident #3's Care Plan dated 11/29/23 revealed: -Resident #7 was independent with eating, toileting, ambulating, bathing, dressing, grooming and transfers. -Resident #7 was not independent with self-administration of medications. -Resident #7 required staff to assist/administer medications up to 3 times per day or more than 4 medications per medication pass. -The care plan was not signed by the physician. Review of Resident #7's Self-Administration of Medication Assessment Tool dated 06/08/23 revealed: -The Assistant HWD completed the self-administration assessment. -Resident #7 refused the physical assessment which included; if Resident #7 could see the medication label, open the container, poured or administer the medication properly, or if Resident #7 could operate the lock/key of the medication box. -Resident #7 was unsure about what the medication was used for, what side effects to watch out for, the time the medication was to be	D 375		

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D 375	Continued From page 25 administered, and how much to take. -Resident #7 refused to remove the correct amount of the medication from the container. -Resident #7 was unsure how to track the medication administration times for an as needed medication (PRN). -Resident #7 was documented as unable to safely administer her own medications on 06/08/23. Review of Resident #7's November and December 2023, and January 2024 electronic Medication Administration Record (eMAR) revealed 11/01/23 to 01/17/24, there was no entry for oxygen. Interview with a medication aide (MA) on 01/18/24 at 10:45am revealed: -She administered and documented medications for Resident #7 but not oxygen. -She was aware Resident #7 used oxygen but did not know how much or if Resident #7 was to always wear oxygen. -She was instructed by the HWD, Resident #7 handled her own oxygen such as ordering any supplies, oxygen tanks and Resident #7 was also responsible for setting the oxygen tank and concentrator regulators as ordered by the physician. -About two months ago, she was informed in shift report Resident #7 oxygen saturations dropped and Emergency Medical Services (EMS) was called. -The EMS found that Resident #7's oxygen tubing had holes in the tubing possibly caused by Resident #7's cats. -EMS changed Resident #7's oxygen tubing and Resident #7 oxygen saturation came back up to normal. -She was aware oxygen could be listed on the	D 375		

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D 375	Continued From page 26 eMAR with the other medications but Resident #7 did not have oxygen listed on the eMAR. Interview with the HWD on 01/18/24 at 11:00am revealed: -She was aware Resident #7 used oxygen continuously and used oxygen concentrators in Resident #7's room. -Resident #7 was responsible for self-administration of oxygen. -On 06/08/23, the Assistant HWD completed a Self-Administration Assessment and resident #7 was not capable of administering her medications. -Resident #7's physician was notified, and Resident #7 medications were entered into the eMAR system for administration by the staff. -There was no order for oxygen in Resident #7's record and she did not call the physician or ask Resident #7 about who ordered the oxygen. -Since there was no order for the oxygen, Resident #7 was not assessed during the self-administration assessment for the oxygen and therefore remained as self-administration. -Oxygen was considered a medication and per the 06/08/23 self-administration assessment which Resident #7 failed to pass, and the oxygen should have been administered/monitored by the staff. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -A self-administration assessment was completed on all residents upon admission and every 6 months for the residents who were considered self-administration. -During the re-assessments or when a resident was identified as unable to safely administer their medications, if the resident failed the self-administration assessment, then the	D 375		

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	HAL049035	A. BUILDING: _____ B. WING _____	01/18/2024

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D 375	Continued From page 27	D 375		

physician was notified, and an order was obtained for the staff to administer all medications.
-Since Resident #7 failed the self-administration assessment on 06/08/23, then the staff should have administered/monitored Resident #7's oxygen.
-The staff did not document anything regarding oxygen, and she did not know oxygen was considered a medication and required monitoring and the very least.

2. Review of Resident #2's current FL2 dated 09/12/23 revealed:
-Diagnoses included hypertension, chronic kidney disease, and congestive heart failure (condition in which the heart cannot pump blood as well as it should).
-Resident #2 was admitted to the facility on 11/22/21.
-There was no order for acetaminophen 500mg.

Review of Resident #2's Resident Register revealed no admission date.

Review of Resident #2's record on 01/17/24 revealed there was no signed physician order for acetaminophen 500mg.

Observation of Resident #2's room on 01/17/24 at 9:50am revealed:
-There was a bottle of acetaminophen 500mg on the table next to Resident #2's chair.
-The bottle was not labeled with resident identifiers.

Interview with Resident #2 on 01/17/24 at 3:25pm revealed:
-The bottle of acetaminophen 500mg belonged to her.
-She usually kept it in a cupboard but had

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D 375	Continued From page 28 forgotten to put it away. -She took the medication occasionally when she needed it for pain. -She could not recall when she last took it. Review of Resident #2's Care Plan dated 12/23/21 revealed: -Resident #2 was independent with eating, toileting, ambulating, dressing, grooming and transfers. -Resident #2 required stand by assist with bathing. -There was no information regarding self-administration of medications for Resident #2. -The care plan was not signed by the physician. Review of Resident #2's November 2023, December 2023, and January 2024 eMARs revealed no entry for acetaminophen 500mg. Interview with the HWD on 01/17/24 at 3:46pm revealed: -Residents required a self-administration assessment and a physician order to keep medications in their rooms. -Resident #2 did not have a self-administration assessment. -Resident #2 did not have an order for acetaminophen or to keep any medications in her room. -Sometimes family members brought in over-the-counter medications for a resident and did not notify facility staff. Interview with the Administrator on 01/18/24 at 3:27pm revealed: -Residents required a self-administration assessment and a physician order to keep medications in their rooms.	D 375		

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D 375	Continued From page 29 -She was not aware Resident #2 had a bottle of acetaminophen in her room. -The staff were trained to take medications found in resident's rooms who did not self-administer medications.	D 375		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#6) residing in the Special Care Unit (SCU) had a diagnosis for appropriate placement. The findings are:	D 463	In reference to rule area 10A NCAC 13F .1306: DHW, ADHW, MCD, and/or designee will perform a chart audit of all Memory Care residents to ensure accuracy of SCU Disclosure and FL2 requirements. DHW, SLC, BOM, ED, MCD and/or designee will be re-educated on FL2 and SCU Disclosure requirements during the admission process. Immediately, ED, DHW, and/or designee will review all upcoming move ins/internal transfers to ensure SCU Disclosure and FL2 documentation is included prior to the physical move.	03/06/24 03/06/24

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D 463	Continued From page 30 Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 120 residents with a SCU capacity of 20. Review of the facility's census on 01/17/24 revealed there were 17 residents in the SCU. Review of Resident #6's current FL-2 dated 01/03/23 revealed: -Diagnoses included transient ischemic attack (TIA) and unsteady gait. -There was no diagnosis for appropriate placement. -She was ambulatory. -She was oriented. -The current level of care was domiciliary (rest home). Review of Resident #6's care plan dated 10/24/23 revealed: -The resident required regular prompting due to confusion and disorientation. -The resident required moderate physical assistance with dressing, grooming, bathing, and staff assistance in managing bowel and bladder care. -She required staff to push her wheelchair due to a physical limitation and needed standby assistance with transfers. Review of Resident #6's record on 01/18/24 revealed: -She had a SCU disclosure, pre-screening, and resident profile. -She did not have a diagnosis appropriate for SCU placement. -She did not have a current FL-2.	D 463		

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D 463	Continued From page 31 Interview with resident #6's son on 01/18/24 at 12:15pm revealed: -She was more forgetful and getting more urinary tract infections and the family and facility felt the SCU was better for her. -She was placed in the SCU in October 2024. Telephone interview with the facility contractual pharmacy for the facility on 01/18/24 at 1:25pm revealed: -The Pharmacy had not sent any medications to the facility as of 11/30/23. -There was no diagnoses of dementia or Alzheimer's Disease on her record at the Pharmacy. Attempted telephone interview with Resident #6's primary care physician (PCP) on 01/18/24 at 1:30pm was unsuccessful. Interview with the Health and Wellness Director (HWD) on 01/18/24 at 2:35pm revealed: -The HWD and the assistant HWD were responsible for resident FL2's. -The PCP signs off on the FL2's and sometimes fills them out. -The FL2 was done with a diagnosis of dementia but was not found. -She was not aware of the FL2, and an appropriate diagnosis was not on the chart. -There was no audit put in place to ensure the residents had an up to date FL2 with appropriate diagnosis for admission to the SCU. Interview with the Administrator on 01/18/24 at 3:30pm revealed: -She was not aware Resident #6 did not have an updated FL2 and a diagnosis appropriate for SCU placement. -The Administrator was now taking on internal	D 463		

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D 463	Continued From page 32 transfers within the facility. -She was supervising chart audits which were done randomly on a quarterly rotating basis. -She was sure no one was in the SCU without a diagnosis appropriate for placement.	D 463		