STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045130	A. BUILDING: _____ B. WING _____	R 03/25/2024

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TERRABELLA OF HENDERSONVILLE	3851 HOWARD GAP ROAD HENDERSONVILLE, NC 28792

(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 has completed a follow-up survey on 03/20/24-03/22/24 and 03/25/24.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide adequate supervision for 2 of 2 sampled residents (#3 and #5) who had a history of falls with no additional safety interventions ordered or implemented to minimize future falls. The findings are: Review of the facility's undated policy and procedures for falls management revealed: -An initial assessment was conducted on admission to identify risk factors. -A fall assessment was completed semi-annually, with a change of condition, or when a resident had two or more falls in a 1-month period. -A post fall investigation was completed after each fall to determine possible causative factors and the effectiveness of safety measures implemented to minimize falls.	D 270		

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D 270	Continued From page 1 -All falls were reported to the resident's primary care provider (PCP) for review and any possible recommendations they may have. -Incident reports were completed for each fall and residents who fell were placed on "alert" charting for a 72-hour period after a fall. -Interventions were documented on the resident's individualized service plan as well as communicated to appropriate caregivers. -Potential fall interventions to consider implementing included physical therapy for gait/balance and strength training, nighttime toileting routine, caffeine and fluid limitation in the late evening, night lights, glow-in-the-dark decals for light switches, low beds, floor mats, scoop mattresses, engagement rounds on a planned schedule including offering appropriate things for residents such as a snack, a walk down the hall, an extra activity, incontinent care, accompanying to the toilet, playing music, assist with calling a family member. -Other interventions to consider included lift chair, raised toilet seat, seat cushions to raise height, non-slip pad under cushions, appropriate footwear, calcium and vitamin D supplements, relocate the resident closer to an active part of the facility, assistive devices, declutter, evaluate feet for injury, body/bed/chair alarms, proper clothing, maintain daily routine, and skid resistant strips in showers/tubs. 1. Review of Resident #3's current FL2 dated 04/10/23 revealed: -Diagnoses included anxiety, depression, bipolar disorder, seizure disorder, history of cerebral vascular accident, and Parkinson's disease. -She was semi-ambulatory with the use of a walker. -She was continent of bowel and bladder.	D 270		

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D 270	Continued From page 2 Review of Resident #3's Resident Register dated 05/11/22 revealed an admission date of 05/11/22. Review of Resident #3's Service Plan (currently used as an updated Care Plan) dated 12/06/23 revealed: -Orientation was documented as had occasional confusion and some difficulty recalling details. -Behaviors were documented as occasional anxiety and depression. -Resident #3 was continent of bowel and bladder and managed toileting self independently. -General mobility was documented as required 1-person assistance to push wheelchair because of physical limitations, required standby assistance with transfers, and Resident #3 was wheelchair bound but could stand and pivot for transfers. -Assistive devices were documented as manual wheelchair and a no scoop mattress was not needed. -Incidents were documented as Resident #3 had 1 fall within the past 3 months. -Third party provider service was documented as Resident #3 was a patient of a local hospice agency. -There was no documentation of any fall prevention interventions for Resident #3. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 02/14/24 revealed Resident #3 needed assistance from staff with wheelchair transfers. Review of Resident #3's LHPS review dated 08/17/23 revealed: -Resident #3 required assistance from 1 staff member with transfers. -Resident #3 used a wheelchair for mobility.	D 270		

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D 270	Continued From page 3 Interview with Resident #3 on 03/20/24 at 10:08am revealed: -She tried to get up by herself to go to the bathroom around 4:00am on 03/14/24, fell, and landed on her back on the floor. -Her roommate pressed the button on her call pendant, but staff never came to the room, so her roommate had to go looking for staff to assist her up from the floor. -She had experienced "multiple" falls during the past couple of months because she called staff for assistance, and it took them "hours" to respond if they "came at all". -Staff "never" checked on her. Review of Resident #3's 12/02/23 through 03/20/24 Incident and Accident (I&A) Reports revealed: -On 12/05/23 at 4:30pm, there was documentation Resident #3 had an unwitnessed fall in her room trying to get into her wheelchair and missed it hitting her head and sustaining 2 skin tears on the right leg and one on the left shoulder, hospice was notified, and interventions to prevent fall reoccurrence was documented as Resident #3 was reminded to push her call button for assistance. -On 12/11/23 at 6:25am, there was documentation Resident #3 was getting up from her wheelchair and had an unwitnessed fall trying to go to the bathroom and no injury noted with interventions to prevent fall reoccurrence was documented as call for assistance for transfers in the dark. -On 12/22/23 at 3:18am, Resident #3 had an unwitnessed fall in the bathroom, there was no documentation of injury or that hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged Resident #3 to call for assistance.	D 270		

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D 270	Continued From page 4 -On 01/12/24 at 8:00am, Resident #3 had an unwitnessed fall in her room, no injury occurred, hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged resident to call for assistance with transfers. -On 01/12/24 at 9:15am, Resident #3 had an unwitnessed fall in her room, there was no documentation of an injury or that hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged resident to call for assistance with all transfers. -On 01/29/24 at 1:00am, Resident #3 had an unwitnessed fall in her room, no injury was seen, there was no documentation hospice was notified, and interventions to prevent fall reoccurrence was documented as wheelchair would be moved away from the bed at night and encouraged Resident #3 to call for assistance. -On 02/03/24 at 5:30am, Resident #3 had an unwitnessed fall in the bathroom, no injury was seen, there was no documentation hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged resident to call for assistance when needing to go to the bathroom. -On 02/13/24 at 12:10pm, Resident #3 had an unwitnessed fall in her room, no injuries were found, hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged to call for assistance. -On 02/14/24 at 7:10am, Resident #3 had an unwitnessed fall in her room, no injuries were found, there was no documentation hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged to call for assistance and locking the wheels on the wheelchair. -On 02/17/24 at 4:30am, Resident #3 had an unwitnessed fall in her room, injuries were	D 270		

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abrasions to Resident #3's right shoulder and right flank back area with no documentation of first aide provided and complaints of back pain, hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged to call for assistance.
-On 02/28/24 at 6:15pm, Resident #3 had an unwitnessed fall in her bathroom, no injuries were seen, and interventions to prevent fall reoccurrence was documented as encouraged to call for assistance with transfers when needed.
-On 03/03/24 at 6:30pm, Resident #3 had an unwitnessed fall in her bathroom, there were no visible skin issues, hospice was notified, and interventions to prevent fall reoccurrence was documented as encouraged to call for assistance.
-There was no I&A Report dated 03/14/24 around 4:00am for Resident #3.

Review of Resident #3's chart notes revealed:
-On 12/04/23 at 6:34am, there was documentation Resident #3 had no complaints from the fall earlier and bruising was noted to the right flank area.
-On 12/05/23 at 4:34pm, there was documentation Resident #3 fell at 4:30pm.
-On 12/22/23 at 3:51pm, there was documentation Resident #3 had a bruise on her right lower forearm from a fall.
-On 01/30/24 at 7:32am, there was documentation Resident #3 fell last night and an incident report was filled out.
-On 02/08/24 at 9:19am, there was documentation that recent falls continued, and staff would continue to monitor and address symptoms for comfort or discomfort.
-On 02/14/24 at 2:48pm, there was documentation Resident #3 fell at 7:10am with no known injuries.
-On 03/14/24 at 10:07am, there was

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documentation the facility staff discussed in the daily staff meeting that Resident #3 continued to fall without injury by attempting to get up without assistance.
-There were no interventions documented to prevent further falls in the chart notes.

Interview with Resident #3's family member on 03/20/24 at 3:38pm revealed:
-Resident #3 fell often but she did not know how often since she was not Resident #3's HCPOA.
-Resident #3 told her she would call for staff's assistance and staff would not come or take a long time to respond.
-She visited about a week ago and Resident #3 had to go to the bathroom, so she pressed the call button, waited 45 minutes, and when staff never came to the room, she had to go and find staff.
-Resident #3's hospice registered nurse (RN) notified Resident #3's HCPOA on 03/14/24 that Resident #3 fell.
-Staff not responding to Resident #3's call bell for assistance contributed to Resident #3 falling so she expressed her concerns to the Executive Director (ED) and the ED said that he checked the staffs' response times daily and all call bells were answered in 15 minutes or less.

Telephone interview with Resident #3's HCPOA on 03/21/24 at 3:29pm revealed:
-Resident #3 experienced an increase in falls over the last 6 months.
-The ED told her Resident #3 fell most of the time getting into the wheelchair because the wheelchair was not locked, and also she tried getting up by herself.
-Resident #3 told her she pushed the call button light for assistance at night but staff would not come to assist her and so she would try to get up

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on her own to go to the bathroom.
-Resident #3's roommate would have to go and find staff to assist Resident #3 because staff would not come to the room, or it would take at least 45 minutes to 1 hour to respond.
-Staff took at least 45 minutes to an hour to respond when she pressed the call bell for assistance.
-She tested it several times when she visited Resident #3 at the facility.
-Staff were always sitting around in a group talking and looking at their cell phones instead of checking on the residents when she visited.
-She reported her concerns to the ED, and was told he would investigate it.
-She was not informed by staff of any interventions being done to prevent further falls for Resident #3.

Telephone interview with Resident #3's hospice registered nurse (RN) on 03/20/24 at 3:58pm revealed:
-Since October 2023, Resident #3 had experienced a general decline in health with increased weakness and multiple falls and was not supposed to get up without the assistance from the facility staff.
-Resident #3's family member reported to her that the facility staff took at least 45 minutes to respond to Resident #3's request for assistance.
-Resident #3's roommate told her on multiple occasions that she had called for help for Resident #3, staff did not answer the call, and the roommate had to go find staff to help.
-She was visiting Resident #3 once when the resident started vomiting.
-She pressed the call button light but saw the MA in the hallway and she asked the MA to come in to assist her with getting the resident cleaned up.
-The personal care aide (PCA) came to the room

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D 270	Continued From page 8 about 45 minutes later to answer the call, but she had already asked the MA to help her. Interview with a PCA on 03/21/24 at 8:02am revealed: -Resident #3 was a hospice patient and needed assistance from staff with transfers and toileting. -Resident #3 fell a "couple" of times trying to "do things on her own". -She just "kept an eye out" on Resident #3 to try to prevent falls. -She rounded on all the residents on the hallway she was assigned to every 2 hours. -The Resident Care Coordinator (RCC) and MAs instructed her to do rounds and check on Resident #3 every couple of hours, but no other instructions were given to prevent falls. -Resident #3 was "good" about using the call button to call for assistance. -She did not document when she rounded on the residents, but she thought the MAs documented rounds somewhere. Interview with a MA on 03/21/24 at 8:11am revealed: -Resident #3 fell "quite a bit". -She did not know if Resident #3's falls were contributed to being weak or if staff just did not respond to Resident #3 calling for assistance. -Resident #3 along with several other residents had previously complained to her that staff took a long time to respond to calls for assistance and she reported the complaints to the RCC. -The PCAs were supposed to round on the residents every 2 hours. -Management did not instruct her to do anything for Resident #3 to prevent Resident #3 from falling in the future. Telephone interview with the third shift MA	D 270		

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supervisor on 03/21/24 at 8:45am revealed:
-Resident #3 became weaker over the past month.
-Resident #3 fell "all the time" because she did not call for assistance and tried to get up on her own.
-The last time Resident #3 fell was on 03/14/24 around 4:00am and Resident #3's roommate came outside the room and yelled for help.
-She forgot to fill out an incident report for Resident #3's fall on 03/14/24 around 4:00am.
-The only intervention to prevent Resident #3 from falling was encouraging her to call staff for assistance.
-Management had not instructed her to do anything else for Resident #3 to prevent future falls.
-She had not contacted Resident #3's PCP or hospice provider to see if there were any additional orders needed to prevent future falls.
-The residents' call bell system did not alert staff when the residents called for assistance and staff only knew residents needed assistance when staff walked to the computer screen to see who called.
-Resident rounds were completed by PCAs and not documented anywhere.

A second telephone interview with the third shift MA supervisor on 03/21/24 at 2:30pm revealed resident falls at night could be related to staff sleeping, including herself, and not completing rounds or seeing when a resident called out for assistance.

Interview with a second shift PCA on 03/21/24 at 4:33pm revealed:
-Resident #3 had fallen a couple of times in the bathroom during her shift in the past few months.
-She told Resident #3 to call for assistance to

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prevent falls.
-She made rounds every 2 hours on the residents or when a call showed up on the computer screen.
-She did not know when a resident called out for assistance if she was in other rooms and could not see the computer screen.
-She was not instructed by other staff or management to do anything else to prevent Resident #3 from falling.

Telephone interview with a former third shift PCA on 03/22/24 at 3:17pm revealed:
-She went to the ED several times and reported staff working third shift including the third shift MA supervisor for sleeping during the work shift and the ED told her he would address it.
-Staff continued to sleep on third shift and that was part of the reason she quit.
-She thought there were too many residents who fell at night, and it was directly related to the third shift staff sleeping.
-Rounding on the residents at night was not being done because staff were sleeping.
-The third shift MA supervisor told her she could also sleep at night as long as one person in the building stayed awake.
-She "dozed off" once during a shift because she had a migraine.
-She knew she was not supposed to sleep during her shift.
-Room trays were served in to-go containers.
-She saw two staff members on second shift one night taking resident's to-go containers when they left at 11:00pm.
-She asked the staff about the resident's food trays and they said that the trays were extras.
-Some of the residents complained that night that they were hungry because they were not served a room tray for dinner.

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D 270	Continued From page 11 Interview with the Resident Care Coordinator (RCC) on 03/22/24 at 8:45am revealed: -She was not aware of Resident #3 complaining of long response times or staff not responding to requests for assistance. -Resident #3 fell because she would try to get up on her own and not call staff for assistance. -She did not know there were any issues with residents' calls not being answered. -Staff encouraged Resident #3 to call for assistance when getting up and rounded on the residents every couple of hours. -She did not know of any other interventions ordered to prevent Resident #3 from future falls. Interview with the ED on 03/25/24 at 9:17am revealed: -The facility's policy for fall management included periodically rounding on residents but staff tried to complete rounds every 2-3 hours. -Staff were expected to respond to residents' calls for assistance. -Staff were not allowed to sleep while on duty. -Staff were supposed to check the computer screen when walking by the computer to see if any residents were calling out for assistance. -Rounds were not documented but he knew when they were last completed because he asked staff when they last saw the resident after a fall occurred. -He did not know of any other interventions implemented or ordered to prevent Resident #3 from future falls. 2. Review of Resident #5's current FL2 dated 01/31/24 revealed: -Diagnoses included dementia, history of seizures and stroke. -The recommended level of care was Special	D 270		

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D 270	Continued From page 12 Care Unit (SCU). Review of Resident #5's Service Plan (currently used as an updated Care Plan) dated 03/17/24 revealed: -Orientation was documented as requiring regular prompting due to confusion and disorientation. -Behaviors were documented as agitated, anxious and combative and fluctuates emotionally. -Resident #5 needed maximum physical assistance with transfers to walker or wheelchair. -Resident #5 required staff to escort or push wheelchair because of physical limitations. -There was documentation Resident #5 had experienced more than 1 fall since his 01/31/24 admission. -There was no documenting of any fall interventions to minimize or prevent falls on Resident #5's care plan. Review of Resident #5's Licensed Health Professional Support (LHPS) dated 02/14/24 revealed Resident #5 needed assistance with transfers from staff with sit to stand to with walker or wheelchair. Review of Resident #5's incident report dated 02/15/24 at 3:45pm revealed: -Resident #5 slid out of his chair and was "heard" by staff who responded and found Resident #5 on the floor. -Resident #5 was checked for injury and returned to recliner. -Interventions to prevent fall reoccurrence was documented as Resident #5 would continue to be monitored and positioned in his chair. Review of the chart notes for Resident #5 dated 02/15/24 at 6:42pm revealed Resident #5 was	D 270		

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D 270	Continued From page 13 screaming for staff not to touch him when he was found on floor beside his recliner. Review of Resident #5's incident report dated 02/15/24 at 11:00pm revealed: -Resident #5 was found on the floor in his room by staff. -The table and lamp were turned over onto the floor. -Resident #5 was checked for injury and returned to recliner. -Interventions to prevent fall reoccurrence was documented as monitor for care needs and provide assistance with transfers. Review of the chart notes for Resident #5 dated 02/16/24 at 6:22pm revealed: -There was no mention of a fall. -Resident #5 had stitches in left shin/leg with wound area being wrapped and secured with bandages done by the hospital. Review of Resident #5's incident report dated 02/19/24 at 9:00am revealed: -Resident #5 was being assisted back to his room after breakfast and personal care aide (PCA) stated he lost his balance and he lowered Resident #5 to the floor. -Resident #5 was taken to the local emergency department (ED) a preexisting compression fracture was noted. -Interventions to prevent fall reoccurrence was documented as provide assistance with transfers whenever possible. Review of Resident #5's incident report dated 02/29/24 at 8:15pm revealed: -Resident #5 found on floor beside his recliner. -Resident #5 checked for injury and returned to recliner.	D 270		

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-Interventions to prevent fall reoccurrence was documented as encourage Resident #5 to wait for assistance before transferring and to offer toileting throughout the day.

Review of Resident #5's incident report dated 03/05/24 at 11:00am revealed:
-Resident #5 was calling out and was found to have fallen out of his recliner.
-EMS was called and Resident #5 was sent to the local ED for evaluation.
-Interventions to prevent fall reoccurrence was documented as removed cushion in recliner.

Review of Resident #5's incident report dated 03/06/24 at 10:00am revealed:
-Resident #5 was found on the floor
-Resident #5 was checked for injury and three staff assisted him to his wheelchair
-Interventions to prevent fall reoccurrence was documented as whenever possible will have Resident #5 in public areas.

Review of Resident #3's physician's orders from 01/31/24 through 03/21/24 revealed there were no orders for interventions for fall prevention.

Interview with a PCA on 03/21/24 at 3:22pm revealed:
-Resident #5 had more than 4 falls since he was admitted..
-Resident #5 had fallen and hurt his leg requiring stitches.
-He had not been told to do anything to prevent Resident #5 from falling.
-Resident #5 would try to get up on his own.

Interview with the Maintenance Director on 03/21/24 at 12:27pm revealed:
-The only way for staff to be alerted to residents

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who required assistance was for the staff to look at the computer screen on A hall or hear it ringing.
-The computer had a soft belling ringing if a resident needed assistance.
-The screen would tell who needed assistance and how long they had been waiting.
-The computer would alert staff if the battery was low in the residents pendant.
-If the battery in the pendant was not changed and it died their was no way for staff to know the pendant had died.
-He checked the computer every morning for low battery alerts and it was the responsibility of staff to alert him if the low battery alert came up after he had checked it in the morning in order to prevent the battery from completely dying.

Interview with a medication aide (MA) on 03/20/24 at 9:10am revealed:
-Resident #5 had experienced multiple falls since his admission on 01/31/24.
-There was documentation in the facility computer Resident #5 had fallen on 02/15/24, went to the local ED with a skin tear on the left leg that required stitches.
-Resident#5 had a fall on 02/29/24 was sent to the local ED and had a skin tear on his right elbow.
-On 02/19/24 Resident #5 fell backwards coming out of the dining room and he was complaining of back pain and he was sent out to the hospital.
-If Resident #5 fell they were call the physician to see he was to go to the local ED.
-She was not aware of any interventions for Resident #5 related to his falls.

Telephone interview with a MA on 03/21/24 at 8:26am revealed:
-Resident #5 slept in his recliner.
-Resident #5 used to be able to use his walker

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but he really required a wheelchair now.
-If Resident #5 needed to go to the bathroom or got agitated he would attempt to get up from his recliner.
-She recalled Resident #5 falling and having to go to the local ED and have stitches in his leg.
-She had not been instructed by management or anyone else to do anything to prevent Resident #5 from falling.

Interview with a MA on 03/22/24 at 9:40am revealed:
-Resident #5 would become agitated if he stayed in his recliner to long.
-Resident #5 would then try to get up and out of his recliner.
-She had not received any instructions for interventions for Resident #5.

Interview with the Resident Care Coordinator (RCC) on 03/22/24 at 8:45am revealed:
-Resident #5 fell because he would try to get up on his own and not call staff for assistance.
-Staff encouraged Resident #5 to call for assistance when getting up and rounded on the residents every couple of hours but he would forget.
-She did not know of any other interventions ordered to prevent Resident #5 from future falls.

Interview with a hospice aide on 03/22/24 at 1:10pm revealed:
-She would assist hospice residents with their baths or showers.
-Frequently (at least 1 time a week) when she was giving a shower she would need assistance getting a resident out of the shower.
-She would pull the cord in the shower for assistance in the morning and after 10-15 minutes she would have to leave the resident, go

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and get the MA to assit getting the hospice resident out of the shower.

Interview with a MA on 03/22/24 at 10:20am revealed:
-The current call system was not effective in that staff have to walk to A-hallway (in the middle of the building) to look at the computer screen to see who needs assistance.
-Residents, family members and outside agencies have asked her to leave the medication pass in order to assist the residents as they rang the pendant and no one comes.
-Her medication pass is interrupted at least 1-2 times daily with residents needing assistance because no one has answered their call lights.
-She has assisted residents who were soiled when she went into the room to give them their medications because no one came to assist them.
-Some residents do not get taken to the dining room when they are ready because staff do not answer the call light as they are in the dining room and do not know the resident has pushed their pendant for assistance.
-She had discussed her concerns with the RCC during the first week of March 2024 and the Executive Director and was told the facility had used walkie-talkies and pagers in the past but staff lost them and the facility had replaced them multiple times.
-She had been told by staff their were night shift staff who were sleeping while on duty but it had been approved by the night shift MA.

Interview with the Special Care Coordinator (SCC) on 03/25/24 at 9:28am revealed:
-Staff are expected to check on Resident #5 every two hours.
-Staff are not expected to be off the floor at the

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same time so that there is someone on the floor if a resident needs assistance.
-Resident #5 tries to get up on his own at times when he is agitated or needs to go to the bathroom.
-The staff should know who tries to get up on their own and should keep a closer eye on them.
-She had not told staff any other interventions ordered to prevent Resident #5 from future falls.

Interview with the Executive Director on 03/21/24 at 5:10pm revealed:
-Staff were to make rounds checking on the residents every 2-3 hours.
-Interventions could be footwear, checking to ensure a clear path so the resident didn't fall.
-Staff did not document rounds.
-He would ask staff the last time they checked on the resident when there was an accident/incident.
-The family member for Resident #5 had removed the cushion for his recliner and he was not aware of any other falls so there would be no need for other interventions.
-He was not aware Resident #5 had fallen once since the cushion had been removed.
-He was not aware of any other interventions for Resident #5.

Attempted telephone interview with family member on 03/22/24 at 4:10pm was unsuccessful.

Based on observation, interviews, and record review it was determined Resident #5 was not interviewable.

_____

The facility failed to provide supervision for two residents who had a history of multiple falls, including Resident #3 who had 12 documented falls since 12/05/23 resulting in hitting her head,

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D 270	Continued From page 19 bruises, abrasions to her right shoulder and right flank back area and back pain and Resident #5 who resided on the SCU and had 6 documented falls since 01/30/24, resulting in 2 transfers to the emergency department for sutures to his left leg and complaints of back pain. This failure placed residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/22/24. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED April 24, 2024.	D 270		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the rights of all residents were maintained including being treated with dignity and respect when responding to residents who called for assistance from staff. The findings are: Review of the facility's policy on Resident Bill of Rights dated 09/2022 revealed: -Residents were to be treated with respect, consideration, and dignity.	D 338		

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D 338	Continued From page 20 -Residents were to receive care and services that were adequate, appropriate, and in compliance with relevant federal and state laws, rules, and regulations. -Residents were to be free from mental and physical abuse, neglect, and exploitation. Interview with a resident on 03/20/24 at 9:19am revealed: -The facility provided a call button for him to wear around his neck to use when he needed assistance from staff. -It always took staff a couple of hours to respond when he called for assistance. -He fell twice in the past month, and it took staff a couple of hours each time to come after he pressed his button for assistance to get up off the floor. -He had never received a quick response from staff when he fell, and an injury occurred. Interview with a second resident on 03/20/24 at 9:36am revealed: -When she called for assistance, it normally took staff up to 5 hours to respond. -She needed assistance from staff with transferring into her wheelchair and activities of daily living (ADL's). -She fell recently and hit her head trying to go to the bathroom by herself because she called for assistance and staff never responded to her call. Interview with a third resident on 03/20/24 at 9:48am revealed: -She was independent with all her ADL's. -The facility staff took a "long" time to answer calls. -She heard another resident yelling for help about a week ago around 7:00pm and the resident told her she called for staff to help her to get into bed	D 338		

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and staff never responded.
-She found a second shift medication aide (MA) and told her the other resident needed help and the MA said, "that's not my job".
-The MAs would not help residents at all unless they were "laying on the floor bleeding".

Interview with a fourth resident on 03/20/24 at 10:00am revealed:
-She only called staff to help her roommate when her roommate needed assistance.
-Sometimes staff would not come to the room when she called and after about an hour she would go and look for staff to assist her roommate.

Interview with a fifth resident on 03/20/24 at 10:08am revealed:
-She fell off her bed onto her back about a week ago and could not get up by herself.
-Her roommate called for assistance from staff and staff never came to the room.
-Her roommate had to go and look for staff.
-She fell several times in the last couple of months.

Interview with a sixth resident on 03/21/24 at 11:41am revealed:
-Staff often yelled down the hallway or across the dining room and dismissed residents' needs.
-He heard a resident ask for hot chocolate in the dining room and was taken coffee and when the resident said I wanted hot chocolate a PCA said "I brought you coffee and that's what you are going to drink".
-He was not served dessert a couple of weeks ago and when he asked for some a PCA said they ran out and he was not offered anything else.
-He asked the PCA to get the kitchen manager

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and the PCA told him it was not her job to find the kitchen manager.
-Sometimes the facility served small portions of food and would not offer anything additional if he asked for more.
-He had observed the night shift staff sitting around, using their cell phones, and sleeping when they were supposed to be working.
-He saw a third shift MA sleeping in the RCC's office one night about 2-3 weeks ago when she was supposed to be working.
-Many of the facility's staff have "attitudes".
-He called out for a cup of ice when he was first admitted about a month ago and the day shift PCA told him no he could not have a cup of ice and shut his door.
-He called out about 3 weeks ago and asked for something to drink and the third shift PCA told him no.
-The third shift PCA did bring him an apple juice to drink after she said no, but then she told him to not press his call button anymore because he called too much, and it was not a toy.
-He reported the third shift PCA to the ED.

Interview with seventh resident on 03/22/24 at 9:10am revealed:
-He experiences long wait times for help when he needs to go to the bathroom.
-He wouldl ring his pendent and had to wait between 30 minutes and a hour.
-During meal times it would be a longer wait because all the staff were in the dining room assisting residents and their was no one on the floor to help the residents in their rooms.
-He would have accidents on himself because he could not take himself to the bathroom and it was "humiliating".
-Sometimes staff were just slow to come and just "resentful" they had to come help him.

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D 338	Continued From page 23 Interview with a eighth resident on 03/22/24 at 10:00am revealed: -He only called for assistance from staff when he falls. -He fell a couple of months ago in his bathroom and broke his right leg. -He had issues with staff not coming to his room when he called at night. -He pressed the call button and staff did not pay it any attention because they would not come to his room. -He informed the ED that staff were not coming to his room when he called for assistance. -The ED told him staff were supposed to make rounds and check on him every couple of hours, but staff did not check on him at all during the day and he did not know if staff checked on him at night because he was sleeping. Interview with a ninth resident on 03/22/24 at 11:15am revealed: -She was frustrated and angry with the way staff spoke to her at the facility. -She had just left the dining room as she wanted to know what was for lunch and asked a staff member who told her she did not have time to deal with that she was busy and walked off. -The same staff member had walked off when she was attempting to talk with her on 03/21/24. -She stated staff frequently were very rude when asked to assist in some way. -"Its hell living here." -She felt the worst thing about living at the facility was the staff's "nasty attitude". -She had spoken to the ED weeks ago and nothing was done about her concerns about the way staff talked to the residents. -Some residents were afraid to say something as they were afraid of retaliation or being asked to	D 338		

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D 338	Continued From page 24 leave the facility. Second interview with a third shift MA supervisor on 03/21/24 at 2:30pm revealed: -She told the third shift facility staff they were allowed to take "naps" and sleep while at work as long as 1 person stayed awake. -She has slept during shifts because "expletive, sometimes I'm sick". -She knew she was not supposed to sleep or allow other staff to sleep while working. Interview with another second shift PCA on 03/21/24 at 5:03pm revealed: -The third shift MA supervisor told her it was okay to sleep while working as long as one person stayed awake. -She never slept while working because she normally left at 11:00pm and slept at home. Interview with the ED on 03/25/24 at 9:17am revealed: -One resident told him that a staff member said it was not their job when the resident asked the staff member for assistance, but the resident had a diagnosis of bipolar disorder and could not give any details such as who the staff member was. -He asked other residents if staff refused to help, and he did not get any "feedback" regarding the issue. -He expected staff to assist residents with any reasonable request.	D 338		
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,	D 358		

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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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 1 sampled resident (Resident #1) related to a medication used to prevent blood clots.

The findings are:

Review of Resident #1's current FL2 dated 08/30/23 revealed diagnoses including heart failure, hypertension, and chronic kidney disease.

Review of Resident #1's Care Plan dated 03/07/24 revealed the resident was legally blind.

Review of Resident #1's physician's order dated 09/12/23 revealed Eliquis (used to prevent blood clots) 5mg 1 tablet twice daily.

Review of a subsequent physician's order dated 03/18/24 revealed discontinue Eliquis 5mg 1 tablet twice daily.

Review of Resident #1's March 2024 eMAR revealed:
-There was an entry for Eliquis 5mg 1 tablet twice a day scheduled at 8:00am and 8:00pm.
-The Eliquis was documented as administered from 03/01/24 to 03/21/24 at 8:00am.

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TERRABELLA OF HENDERSONVILLE	3851 HOWARD GAP ROAD HENDERSONVILLE, NC 28792

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D 358	Continued From page 26 Observation of Resident #1's medications on hand on 03/20/24 at 3:15pm revealed: -There was one pack of Eliquis 5mg tablets with a dispense date of and start date of 03/12/24. -There were 11 of an original supply of 28 Eliquis 5mg tablets available for administration. Interview with Resident #1 on 03/21/24 at 11:20am revealed: -He was taking an anticoagulant, but his Cardiologist did not want him to continue it. -His Cardiologist had discontinued the anticoagulant at his last visit (03/18/24). -He was not supposed to be taking any anticoagulant "now." Review of Resident #1's Cardiologist visit note dated 03/18/24 revealed: -Resident #1 diagnoses included macular degeneration (an eye disease affecting the central part of the retina (the macula) resulting in distortion or loss of central vision), nonischemic cardiomyopathy (any cause of abnormal heart function other than those caused by blocked arteries or heart attack), chronic systolic heart failure (the heart is weak and the left ventricle cannot contract normally when the heart beats), and a biventricular ICD (a small battery operated implanted device that helps keep your heart pumping normally). -The appointment was arranged to discuss anticoagulation (reduces the risk of blood clots). -Resident #1 had a recent fall where he hit his head. -Resident #1 had a history of other falls in the past. -The falls were mechanical events due to the resident's blindness. -After discussing the risks of anticoagulation with the resident and a family member, they decided	D 358		

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to discontinue anticoagulation given the risk of injury and bleeding with falls.

Interview with the Resident Care Coordinator (RCC) on 03/21/24 at 12:30pm revealed:
-She did not know Resident #1's Cardiologist wrote an order on 03/18/24 to discontinue Eliquis 5mg.
-The transport staff had left employment and failed to communicate the new order to her before leaving.
-It was her responsibility to fax discontinued medication orders to the pharmacy, remove the discontinued medication from the medication cart, and to ensure the resident's eMAR was updated.

Interview with the Administrator on 03/21/24 at 3:07pm revealed:
-The RCC was responsible to ensure medication discontinuation orders were followed up.
-The transport staff had failed to give Resident #1's orders to the RCC when they returned from the resident's cardiology office visit on 03/18/24.

Telephone interview with Resident #1's family member on 03/22/24 at 10:04am revealed:
-Resident #1's Cardiologist had discontinued the Eliquis on 03/18/24, because Resident #1 was at a high risk of additional falls.
-The risk of injury and bleeding while on anticoagulation therapy was higher than the risk of Resident #1 developing a blood clot due to not having anticoagulation.

Telephone interview with Resident #1's Cardiologist's Registered Nurse (RN) on 03/22/24 at 11:03am revealed Resident #1's Eliquis was discontinued because of Resident #1's risk of bleeding with falls.

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D 358	Continued From page 28 The facility failed to discontinue Resident #1's Eliquis on 03/18/24 as ordered continuing to administer the medication through 03/21/24 increasing Resident #1's risk of bleeding while being at an increased risk of falls. This failure was detrimental to Resident #1's health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/22/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 9, 2024.	D 358		
D 359	10A NCAC 13F .1004 (b) Medication Administration 10A NCAC 13F .1004 Medication Administration (b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure Staff B, personal care aide (PCA), was qualified to administer medications to residents. The findings are:	D 359		

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D 359	Continued From page 29 Review of the facility's undated policy and procedures for medication administration revealed: -Appropriately trained staff would administer medications/treatments following the specific state regulations and guidelines of right resident, right medication/treatment, right dose, right time, right route, right documentation, and right to refuse. -Documentation will be completed at the time of administration. -Medications will be administered to one resident at a time. -Each resident would be observed taking the medication. -Documentation of the administration would be completed immediately. 1. Review of Resident #6's current FL2 dated 07/04/23 revealed diagnoses included mood disorder, anxiety, chronic pain, fibromyalgia, hyperlipidemia, and hyperthyroidism. Interview with Resident #6 on 03/20/24 at 9:48am revealed: -Sometimes there was only one medication aide (MA) working in the building at night for the assisted living (AL) unit and special care unit (SCU). -She was concerned there was not enough qualified staff to administer medications at night. -The night shift MA supervisor usually worked 12-hour shifts and arrived for her shift around 7:00pm. -She saw the night shift MA supervisor was preparing multiple residents' medications at night by lining the cups on top of the medication cart and then handing the medication cups to a PCA, to administer to the residents. -A PCA last administered her evening	D 359		

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medications on 03/19/24 but had administered her medications many other times.

Review of Resident #6's 03/01/24-03/20/24 electronic medication administration record (eMAR) revealed:
-The night shift MA supervisor documented she administered 7 medications at 9:00pm on 03/19/24.
-There was no documentation Staff B administered medications at 9:00pm on 03/19/24.

Telephone interview with the night shift MA supervisor on 03/21/24 at 8:45am revealed:
-She worked 12-hour shifts from 7:00pm to 7:00am.
-She was the only MA on duty at night for the entire building.
-She gave a PCA Resident #6's scheduled 9:00pm medications along with 2 other residents' medications to administer on 03/19/24.
-She always prepared the residents' medications and on several occasions a PCA administered them to the residents.
-She asked a PCA to help administer some of the residents' medications to keep the medications from being late and she knew she was "cutting corners" by asking a PCA to help.
-Staff B had not been trained to be a MA.

Interview with Staff B, PCA, on 03/21/24 at 4:33pm revealed:
-She was hired about 6 months ago as a PCA.
-She was not trained to be a MA.
-The night shift MA supervisor was always "running late" with administering medications so she helped administer the medications to residents.
-The night shift MA supervisor always prepared the medications, and she gave them to

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approximately 5 residents including Resident #6.
-She did not know she was supposed to be trained in order to administer the medications to residents.
-The night shift MA supervisor was the only MA that asked her to help administer medications.

Refer to the interview with Interview with the Resident Care Coordinator (RCC) on 03/21/24 at 9:40am.

Refer to the interview with the Executive Director (ED) on 03/25/24 at 9:17am.

2. Interview with a resident on 03/21/24 at 11:13am revealed:
-He saw the night shift medication aide (MA) supervisor prepare his scheduled night medications and she gave them to a PCA to administer to him on several occasions.
-The PCA told him she was administering his medications to "expedite things".
-He thought the medications administered to him were correct, but he was unsure what the pills looked like and only knew the number of pills he was supposed to receive.

Telephone interview with the night shift MA supervisor on 03/21/24 at 8:45am revealed:
-She worked 12-hour shifts from 7:00pm to 7:00am.
-She was the only MA on duty at night.
-She gave a PCA some of the residents' scheduled 9:00pm medications to administer on 03/19/24.
-She always prepared the residents' medications and on multiple occasions a PCA administered them to the residents.
-She asked a PCA to help administer some of the residents' medications to keep the medications

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from being administered late and she knew she was "cutting corners" by asking the PCA to help.
-Staff B had not been trained to work as an MA.

Interview with Staff B, PCA, on 03/21/24 at 4:33pm revealed:
-She was hired about 6 months ago as a PCA.
-She was not trained to be a MA.
-The night shift MA supervisor was always "running late" with administering medications so she helped administer the medications to residents.
-The night shift MA supervisor always prepared the medications, and she gave them to approximately 5 residents.
-She did not know she was supposed to be trained in order to administer the medications to residents.
-The night shift MA supervisor was the only MA that asked her to help administer medications.

Refer to the interview with the Resident Care Coordinator (RCC) on 03/21/24 at 9:40am.

Refer to the interview with the Executive Director (ED) on 03/25/24 at 9:17am.

_____

Interview with the Resident Care Coordinator (RCC) on 03/21/24 at 9:40am revealed:
-Staff B was hired to work as a PCA and was not trained to be a MA.
-Only MAs could administer medications to residents.
-The MAs knew they were not supposed to give medications to the PCAs or other unqualified staff to administer to the residents.
-She did not know the night shift MA supervisor gave residents' medications to Staff B to administer.

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D 359	Continued From page 33 Interview with the Executive Director (ED) on 03/25/24 at 9:17am revealed: -Only MAs were trained to administer medications to residents. -He was not aware of any PCAs administering medications to residents. -He did not know the third shift MA supervisor prepared medications and gave them to a second shift PCA to administer to the residents. -The MAs were supposed to prepare residents' medications, administer the medications, and immediately document the administration on the eMAR. -The MAs knew they were not supposed to give medications to the PCAs or other unqualified staff to administer. -He expected the MAs to follow the facility's policies and procedures for medication administration.	D 359		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to notify the Health Care Personnel Registry (HCPR) of an injury of unknown origin for 1 of 1 sampled resident's (#4) within 24 hours of knowledge of the injury. The findings are: Review of Resident #4's current FL2 dated	D 438		

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D 438	Continued From page 34 01/17/24 revealed: -Diagnoses included Alzheimer's Dementia, bilateral hearing loss, peripheral vascular disease, and chronic stage III kidney disease. -The recommended level of care was Special Care Unit (SCU). Observation of Resident #4 on 03/20/24 at 9:10am revealed: -Resident #4 was sitting in a chair in the living room of the SCU. -Resident #4 had her right hand bandaged and her fingers were dark and discolored. Review of Resident #4's incident report dated 03/16/24 7:00pm revealed: -Resident #4 was noted to have difficulty walking and bruising and swelling to the right hand. -There were no known falls or other incidents. -Resident #4 was encouraged by staff to rest. -Staff obtained an order from Resident #4's primary care provider (PCP) for Tylenol (a medication used for pain relief) and for a mobile x-ray of the right hand. -Resident #4's condition worsened overnight, and bruises were noted to the resident's right thigh and right knee during a telemedicine visit with the PCP on the morning of 03/17/24. -Resident #4 was sent to a local hospital emergency department (ED) for evaluation on the morning of 03/17/24. -Resident #4 was diagnosed with a fracture to the right-hand 3rd metacarpal bone (the third bone of the middle finger). -Resident #4 returned from the ED with a soft splint applied to the injured finger and right hand and pain management was provided. Interview with the Special Care Coordinator (SCC) on 03/21/24 at 8:51am revealed:	D 438		

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D 438	Continued From page 35 -She was not working on 03/16/24 when it was discovered Resident #4 had some bruising and swelling on her right hand. -"Last month" she reported to Palliative Care, Resident #4's recent changes including the resident's gait having become unstable and the resident requiring queuing at meals. Interview with a Personal Care Aide (PCA) on 03/21/24 at 11:17am revealed: -She worked on day shift on 03/16/24 in the special care unit. -After lunch (around 12:30pm), she noticed Resident #4 was the last one to get up from the dining room table. -She went to assist Resident #4 and noticed the resident's legs were very weak and she was having difficulty in walking. -She notified the medication aide (MA) on duty about the changes she observed in Resident #4. -She then assisted Resident #4 to her room and assisted the resident to lie down in her bed to rest. -She did not notice any bruising or swelling to Resident #4's right hand when she assisted the resident to bed. Telephone interview with a MA on 03/21/24 at 2:49pm revealed: -On 03/16/24 around 12:30pm, a PCA told her Resident #4 was having trouble walking. -The PCA assisted Resident #4 to bed to rest. -On 03/16/24 at 6:40pm, a second PCA asked her had she seen Resident #4's hand. -She looked at Resident #4's hand and it was "slightly" bruised and a "little" swollen. -No one had reported the bruising or swelling on Resident #4's right hand to her until 6:40pm on 03/16/24. -None of the staff knew how Resident #4's hand	D 438		

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had become bruised and swollen.
-No one reported a fall involving Resident #4.
-Resident #4 did not report pain or act like she was in pain on 03/16/24 at 6:40pm.
-She obtained an order from Resident #4's PCP for a mobile x-ray of the right hand on 03/16/24 as soon as she became aware of the bruising and swelling of the hand.
-On the morning of 03/17/24, she worked as the MA on the special care unit, and she noticed Resident #4's hand "looked worse."
-She immediately contacted Resident #4's PCP and the PCP did a televisit with Resident #4.
-During the televisit, additional bruising was noted on Resident #4's right thigh and right knee.
-Resident #4 was sent out to the local ED via emergency medical services (EMS) after the televisit.
-Mobile x-ray did not arrive to perform the x-ray of Resident #4's hand until after the resident had already been sent out for evaluation.

Interview with the Administrator on 03/21/24 at 8:43am revealed:
-He was responsible for completing all HCPR reports and investigations.
-He did not complete a 24 hour HCPR report for the injuries of unknown origin for Resident #4 discovered 03/16/24.
-He did initiate an investigation into Resident #4's injuries but found no evidence of abuse or neglect.
-"We presume" Resident #4's injuries occurred during an unwitnessed fall.
-He had no suspicions of abuse or neglect.
-Under his understanding of the regulations, HCPR reporting was not required unless there was suspicion of abuse or neglect.

Review of the HCPR initial allegation report dated

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D 438	Continued From page 37 03/21/24 revealed: -The incident date was 03/16/24. -The date the facility became aware of the incident was 03/16/24. -The time the facility became aware of the incident was 7:00pm. -The date the report was signed by the Administrator was 03/21/24.	D 438		