PRINTED: 04/01/2024
FORM APPROVED

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
	HAL036023	A. BUILDING: _____ B. WING _____	R 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Gaston County Department of Social Services conducted an annual survey, follow-up survey, and complaint investigation from 03/12/24 to 03/13/24. The complaint investigation was initiated by the Gaston County Department of Social Services on 01/19/24.	D000	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider.	
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to ensure 2 of 8 exit doors that were accessible to two residents (#1 and #3) who were known to be disoriented and exhibit wandering behaviors, were equipped with sounding devices when the exit doors were opened to alert staff. The findings are:	D067	**Action Plan** It is this Provider's intent and normal practice to assure a safe environment free of elopement for all residents. The Resident Care Director and Executive Director will provide ongoing training and supervision to all staff regarding wandering behaviors and our elopement policy. The Resident Care Director will continue to do quarterly elopement assessments for all residents. The Provider's Executive Director, Resident Care Director, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited to elopement policy, wandering behaviors, and door alarms. Quality assurance monitoring and training records are some examples of various components utilized to comply with wandering behaviors and elopements. **Corrective Measures** The Provider immediately appointed a one-on-one sitter for resident #1 and resident #3 prior to the DHSR survey. The physician for resident #1 and resident #3 were notified. Discharge notices were issued to resident #1 and resident #3. Elopement training was completed for all care staff. Immediately following the survey, this provider assigned a door/alarm monitor at the front desk for 24/7 monitoring until door alarms meet state requirements. Job description and training provided to staff for the door monitor position. Door alarms have been ordered for all doors and will be installed upon arrival. The front door wander guard system is in proper working order and wander guard bracelets have been ordered.	4/12/24

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

C. Stein-Martin LPN/Administrator 4/23/24

Reviewed and Acknowledged by SSD on 05/13/24 Sharon Dunton RN

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D 067	Continued From page 1 Observation of the facility's entrance/exit doors on 01/19/24, 01/24/24, 01/29/24, 02/02/24, 02/07/24, 02/20/24, 03/12/24, & 3/13/24 revealed there was no audible sounding device heard when the front entrance/exit and kitchen back entrance/exit doors were opened. 1. Review of Resident #3's current FL2 dated 09/25/23 revealed: -Diagnoses included memory changes and failure to thrive. -Level of care was assisted living. Review of Resident #3's record revealed he was admitted to the facility on 09/25/23. -He wandered around in the facility at night and went into other residents' room. -Resident #3's family member contacted the facility and stated her phone alerted her Resident #3 was walking but not inside the facility. -The facility staff started an inside and outside facility search. -The facility staff was unable to locate the resident. -911 communications called the facility and reported to the staff the address to where the resident was located. -The resident was found across the street at an	D067	**Monitoring-** As part of the Quality Assurance and Performance Improvement (QAPI) process, the ED, RCD or designee will continue to monitor and review door/alarm monitors performance and audit their response efforts to alarming doors weekly for accuracy for the next two weeks, then monthly for the next 2 months if applicable. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff.	

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D 067	Continued From page 2 apartment complex. Review of Resident #3's facility notes revealed: -On 01/21/24 Resident #3 was wandering around in the facility and had to be redirected by staff. -On 01/29/24 Resident #3 was confused and went into other residents' rooms telling the resident to get off of his property. -After much coaching Resident #3 was redirected to his room. -On 02/04/24 Resident #3 walked away from the facility and was located across the street. Interview with the RCD on 03/13/24 at 12:50pm revealed: -On 02/04/24 at 6:15pm Resident #3 exited through the front door of the facility. -There was no alarm on the front door. -Residents entered and exited the facility's front door without staff noticing. -There were no staff located at the facility's front	D067		
	and exits the facility. Interview with the Administrator on 02/09/24 at 9:55am revealed: -Once Resident #3 was admitted, staff noticed signs of his increased desire to leave. -There was no plan in place to monitor wandering residents except for staff to keep an eye on the residents. -There was no alarm on the facility's front entrance/exit door. 2. Review of Resident #1's current FL2 dated 12/27/23 revealed: -Diagnoses included memory loss and anxiety. -She was constantly disoriented. -She was ambulatory. -Level of care was assisted living.			

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D 067	Continued From page 3 Review of Resident #1's care plan dated 01/11/24 revealed: -She had wandering behaviors that resulted in her going into other residents' rooms. -She had to be redirected. -She was always disoriented. -She had significant memory loss. Review of Resident # 1's accident/incident report dated 01/01/24 at 9:30pm revealed: -The report was completed by the Resident Care Director (RCD). -Resident #1 had increased anxiety -Resident #1 managed to exit the facility today 01/01/24. -Resident #1 exited out of the 200-hall door close to the parking lot. -Resident #1 would be monitored. Review of Resident #1's incident report on 01/19/24 revealed: -Resident #1 exited the facility at 6:00am with clothes in arms. -Resident #1 was located in the facility back parking lot. Interview with the RCD on 02/20/24 at 11:00am revealed: -Resident #1 had exit seeking behaviors since she was admitted to the facility. -Resident #1 wandered into other residents' rooms. -She informed staff to keep Resident #1 with them or in their eyesight. -There was no actual written plan on how to monitor wandering residents. -When staff heard an exit door alarm sound, staff would rush to the exit doors to see who went out. -There were no alarms on the front door.	D067		

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D 067	Continued From page 4 Interview with the Administrator on 02/09/24 at 9:45am revealed: -When Resident #1 was admitted she was a little confused and they thought it was from the change of her environment. -The confusion increased quickly. -She wandered daily looking for a family member. -There was no discussion regarding Resident #1 having a sitter. -There were no indictors that Resident #1 would possibly elope. -On 01/19/24 she was notified by the RCD that Resident #1 was out of the facility. -Another resident observed Resident #1 go out an exit door. -Two staff members on duty got Resident #1 back into the facility. Interview with the Administrator on 03/12/24 at 5:00pm revealed: -The front door did not have an alarm to notify the staff when somebody entered or exited the door. -The back kitchen door also did not have an alarm. -There were eight exit doors total and two of the doors did not alarm when they were opened. Observation on 03/13/24 at 10:30am revealed: -The maintenance staff opened the activity room door to demonstrate if the alarm could be heard while Department of Health Service Regulation (DHSR) staff and a personal care aide (PCA) were in room #318. -Room #318 was approximately 212 feet from the central alarm panel where the alarm sounded. [illegible] the door shut and the alarm was not audible. Interview with the PCA on 03/13/24 at 10:40am	D067		

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D 067	Continued From page 5 12:00pm revealed: -She could not hear the door alarm while in room #318 with the door closed. -When she heard the door alarm sound, she had to walk to the front reception desk where the door alarm panel was located to observe which door was alarming. -When she heard the door alarms sound, she turned off the alarm, because there were no residents in the facility on supervision. -The front door did not alarm so she would not know if a resident went out the front door. -The RCD had instructed staff to keep an eye on residents with wandering or exit seeking behaviors. -When the exit door alarms sounded, staff went to the alarm panel (front reception area) to check which door was indicated as opened on the panel. -When staff were in residents' room with the door closed, they could not hear the exit door alarm sounding. Interview with a second PCA on 03/13/24 at 11:45am revealed: -There was no alarm on the front entrance/exit door. -The Medication Aide (MA) Supervisor had instructed staff to keep an eye on the residents and ensure the exit doors were locked. - The MA Supervisor said to observe and redirect residents who went to the exit doors and stood by the exit door. -When the exit door alarms sound, she went to the panel to see what exit door was opened and then she went to see if a resident went out the door. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2	D067		

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D 067	Continued From page 6 Violation)] The facility failed to ensure the alarms on 2 of 8 exit doors in the facility had an audible sounding device when activated. These doors were accessed by 2 residents who had wandering behaviors, were constantly or intermittently disoriented, including Resident #3 who had eloped from the facility and was found across the street and Resident #1 who had eloped 2 times. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with GS. 131D-34 on March 13, 2024. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 27, 2024.	D 067		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & immunization 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:	D234		

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D 234	Continued From page 7 Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#5) 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 #5's current FL2 dated 10/03/23 revealed diagnoses included dementia, hyperlipidemia, osteoarthritis, hyperthyroidism, and hypertension. Review of the Resident #5's Resident Register revealed an admission date of 12/01/17. Review of Resident #5's record revealed there was no documentation of any 2-step TB skin testing completed for Resident #5. Interview with the Resident Care Director (RCD) on 03/13/24 at 11:15am revealed: -She and the Administrator were responsible for completing the first step TB prior to a resident's admission. -She was not here when Resident #5 was admitted to the facility. -All residents were required to have the first step TB skin test prior to admission. -The second step TB was to be completed 2 weeks after admission. -She completed an audit in February 2023 on all resident's records and did not find any missing TB skin tests. -She was not aware there was documentation of the required TB skin tests for Resident #5. Interview with the Administrator on 03/13/24 at 2:55pm revealed:	0234	Disclaimer The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. Action Plan It is this Provider's intent and normal practice to assure that all residents have the first step PPD documented upon admission and the second step PPD after 2 weeks of move-in. The Resident Care Director will be responsible for obtaining new residents PPD records, administering the second step and keeping the charts immunization records up to date. The Provider's Executive Director will provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited Tuberculosis Test and Immunizations. Quality assurance monitoring and training records are some examples of various components utilized to comply with Tuberculosis Test and Immunizations. Corrective Measures The Resident Care Director immediately notified the residents medical provider, but administering a ppd was declined at this time due to the resident's treatment preferences but a chest xray has been ordered to rule out and concerns. Immediately following the survey, the Resident Care Director did a chart audit of all resident's Immunization records. A separate binder has been created for a copy of all residents TB test to prevent accidental thinning of records from the chart. Monitoring- As part of the Quality Assurance and Performance Improvement (QAPI) process, the RCD or designee will continue to monitor and review immunizations records for all residents.	4/12/24

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D 234	Continued From page 8 -She and the RCD were responsible for completing the first step TB prior to a resident's admission and a second step TB skin test 2 weeks after admission. -All residents were required to have the first step TB skin test prior to admission. -She was not aware Resident #5 did not have the required 2-step TB skin tests.	D234	The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff.	
D 270	1QA NCAC 13F .0901(b) Personal Care and Supervision 1QA 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 observations, record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 & #3) were properly supervised resulting in the two residents leaving the facility without staff knowledge. Observation on 01/29/24, at 12:50pm, staff sounded the door alarms to demonstrate for the Adult Home Specialist (AHS), the exit door alarms could not be heard when residents room doors were closed. 1. Review of Resident #3's current FL2 dated 09/25/23 revealed: -Diagnoses included memory changes and failure	D270		

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D 270	Continued From page 9 to thrive. -Level of care was assisted living. Review of Resident #3's care plan dated 10/16/23 revealed: -He had wandering behaviors. -He was sometimes disoriented. -He wandered around in the facility at night and went into other residents' room. Review of Resident# 3's Accident/Incident Report dated 02/04/24 revealed: -The report was completed by the Resident Care Director (RCD). -The report was sent to the Department of Social Services on 02/04/24. -Resident #3's family member contacted the facility and stated her phone alerted her Resident #3 was walking but not inside the facility. -The facility staff started an inside and outside facility search. -The facility staff was unable to locate the resident. -911 communications called the facility and reported to the staff the address to where the resident was found. -The resident was located across from the facility at an apartment complex. -The resident received a 24-hour sitter and every 30 minutes checks. Review of the local weather report the temperature in the area on 02/04/24 at 6:00pm was 41 degrees and the sun went down at 5:56pm that day (02/04/24). Review of Resident #3's facility notes revealed: -On 01/21/24 Resident #3 was wandering around in the facility and had to be redirected by staff. -On 01/29/24 Resident #3 was confused and	D270	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. **Action Plan** It is this Provider's intent and normal practice to assure a safe environment free of elopement for all residents. The Resident Care Director and Executive Director will provide ongoing training and supervision to all staff regarding wandering behaviors and our elopement policy. The Resident Care Director will continue to do quarterly elopement assessments for all residents. The Provider's Executive Director, Resident Care Director, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited to elopement policy, wandering behaviors, and door alarms. Quality assurance monitoring and training records are some examples of various components utilized to comply with wandering behaviors and elopements. **Corrective Measures** The Provider immediately appointed a one-on-one sitter for resident #1 and resident #3 prior to the DHSR survey. The physician for resident #1 and resident #3 were notified. Discharge notices were issued to resident #1 and resident #3. Elopement training was completed for all care staff. Immediately following the survey, this provider assigned a door/alarm monitor at the front desk for 24/7 monitoring until door alarms meet state requirements. Job description and training provided to staff for the door monitor position. Door alarms have been ordered for all doors and will be installed upon arrival. The front door wander guard system is in proper working order and wander guard bracelets have been placed on appropriate residents.	4/12/24

			Monitoring- As part of the Quality Assurance and Performance Improvement (QAPI) process, the ED, RCD or designee will continue to monitor and review door/alarm monitors performance and audit their response efforts to alarming doors weekly for accuracy for the next two weeks, then monthly for the next 2 months if applicable. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff.	

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D 270	Continued From page 10	D270		

went into other residents' rooms telling the resident to get off of his property.
-After much coaching Resident #3 was redirected to his room.
-The RCD and Resident #3's Primary Care Provider (PCP) were made aware of the behavior.
-On 02/01/24 the PCP increased Resident #3's trazadone (used to treat insomnia) to 50mg.
-On 02/04/24 Resident #3 walked away from the facility and was located across the street.

Interview with Resident #3's PCP on 02/09/24 at 10:50am revealed:
-Resident #3 displayed some dementia upon admission.
-Resident #3 wandered in the facility often at night.
-Resident #3 experienced sundowner's syndrome (a state of confusion occurring in the late afternoon and lasting into the night).
-Sundowning can cause different behaviors, such as confusion, anxiety, aggression or ignoring directions.
-Sundowning can also lead to pacing or wandering.
-Resident #3 was prescribed seroquel (used to treat psychosis)100mg, trazadone (used to treat insomnia) 50mg, and remeron (used to treat depression) 30mg.
-Medications were adjusted several times per family request due to Resident #3 being too drowsy during the day.
-Medications were decreased and Resident #3 was wandering more and calling family in the middle of the night.
-Per family request medications were increased in January 2024 and again after the elopement on 02/04/24.
-After the elopement Resident #3 was assigned a

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D 270	Continued From page 11 24-hour sitter. Review of Resident #3's neurologist's orders dated 01/23/24 revealed: -A diagnoses of moderate late onset Alzheimer's disease. -Resident #3 was prescribed namenda (prescribed to slow the progression of moderate to severe Alzheimer's disease)10mg twice a day. Interview with the RCD on 02/07/24 at 10:00am revealed: -On 02/04/24 at 6:15pm Resident #3 walked out of the front door of the facility. -The front door did not have an exit alarm. -A family member called the facility and stated her phone alerted her the resident was walking but not in the facility. -The facility started a search inside and outside of the facility. -Staff were unable to locate the resident. -Staff were calling 911 communications when the facility received a call from 911 communications. -The 911 communicator stated someone called from the apartments nearby stating a person was in their lobby, that could possibly be a resident of the facility. -A staff member went to the apartments to ensure it was their resident and returned the resident back to the facility. -Resident #3 crossed over four (4) lanes of traffic to get to the apartments. Interview with Resident #3's family member on 02/08/2024 at 9:00am revealed: -He was contacted by another family member regarding the elopement. -The family member stated Resident #3 had crossed the road, which was four (4) lanes of traffic.	D270		

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _____	COMPLETED
	HAL036023	B. WING _____	R 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

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D 270	Continued From page 12 -When the elopement occurred around 6:30pm, it was dark outside and Resident #3 had on dark clothing. -On 02/05/24 he spoke to the facility Administrator to find out how Resident #3 was able to walk out the facility without being noticed. -Resident #3 was admitted into the facility in September 2023 on the assumption the facility would have a Special Care Unit (SCU) opening in November 2023. -He decided since Resident #3 was able to walk out of the facility without being noticed, he looked for Resident #3 a facility with a SCU. -Resident #3 moved to another facility on 02/10/24. Interview with a second family member for Resident #3 on 02/06/2024 at 2:55pm revealed: indicating Resident #3 was moving. -She had a location sharing application feature on her phone and the phone of Resident #3. -She looked at the phone and observed a shoe icon indicating Resident #3 was walking, but not in the facility. -According to the location sharing application Resident #3 was walking towards an apartment complex. -She called the facility and asked if she could speak to Resident #3 and asked if Resident #3 was in the facility. - The MA responded, "I guess". -She stated her phone was indicating Resident #3 was not on the facility property. -The MA yelled to another staff member to check Resident #3's room to see if he was in his room. -The facility staff called 911, and other staff that lived nearby to search and be on the lookout for Resident #3. -Resident #3 called her from his cell phone	D 270		

Division of Health Service ReQulation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
	HAL036023	A. BUILDING: _____ B. WING _____	R 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

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D 270	Continued From page 13 crying, stating he was lost. -She told Resident #3 not to move, to stay where he was. -A person at the apartments told her the police were called and he would stay with Resident #3 until the police arrived. -The police and a staff member arrived at the location of Resident #3. -Resident #3 was returned to the facility by the staff member. Interview with a MA Supervisor on 02/09/24 at 10:20am revealed: -Resident #3 came to dinner late on 02/04/24. -Resident #3 was confused because he asked for a plate for him and his spouse, although his spouse was not currently in the facility. -After dinner Resident #3 usually asked for his medications, but that day she was not by the medications cart after dinner. -She received a call from a family member stating her phone alerted her that Resident #3 was walking, but not in the facility. -She told another staff member and they both went to Resident #3's room. -Resident #3 was not in the room. -She and three more staff members on duty started searching inside and outside of the facility. -The staff were texting each other once an area was cleared and Resident #3 was not located. -She called the RCD and informed her Resident #3 was missing. -One staff member rode around the neighborhood looking for Resident #3. -Another staff member called another staff member to also be on the lookout for Resident #3. . . . Resident #3 was found.	D270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036023	A. BUILDING: _____ B. WING _____	R 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
D270	Continued From page 14	D270		

-The police called and asked if they had a resident missing.
-When she confirmed there was a missing resident, the police gave the address where Resident #3 was located.
-Resident #3 was at the apartment complex across from the facility.
-Resident #3 crossed a four-lane road to get to the apartment complex.
-A staff member arrived at the location and returned Resident #3 to the facility.
-Resident #3 was assigned a sitter starting the night of 02/04/24.

Interview with a MA on 03/05/24 at 3:30pm revealed:
-On 02/04/24 Resident #1 wandered away from the facility.
-Staff searched for Resident #1 inside and outside of the facility.
-Resident #3 had wandering behaviors.
-Resident #3 had to be redirected from going into other residents' rooms.
-Resident #3 was able to walk out of the facility unnoticed.
-Resident #3 was located across the street from the facility at an apartment complex.

Interview with a personal care aide (PCA) on 02/21/24 at 3:20pm revealed:
-Resident #3 required assistance with personal care.
-Resident #3 was ambulatory.
-Resident #3 had wandering behaviors.
-Resident #3 would wander into other residents' rooms.
-The RCD informed staff to keep an eye on him and redirect him.
-Resident #3 was redirected back into his room.
-Resident #3 would pack his belonging wanting to

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D 270	Continued From page 15 leave the facility. -On 02/04/24 after supper, Resident #3 walked out the facility's front door. -She was told to ride around the neighborhood looking for Resident #3. -Resident #3 was located across the street from the facility at an apartment complex. -There was no actual plan on how to monitor residents who could not leave the facility without assistance or alone. Interview with another PCA on 02/21/24 at 3:35pm revealed: -Resident #3 required assistance with personal care, getting dressed for bed, and ensuring he was in bed. -Resident #3 had wandering behaviors. -Resident #3 was confused all the time. -Resident #3 was redirected daily. -Resident #3 was redirected to his room or to sit in the facility lobby. -Staff were told by the RCD to keep an eye on Resident #3 because he had wandering behaviors. -On 02/04/24, Resident #3 walked away from the facility. -Staff searched for him. -Resident #3 was located about 20 minutes later. -Resident #3 was located across the street at an apartment complex. -Resident #3 was brought back to the facility. Interview with the Administrator on 02/09/24 at 9:55am revealed: -During his home assessment Resident #3 was alert & oriented. -She was told Resident #3 had no diagnoses of dementia. -Once Resident #3 was admitted, staff noticed signs of his increased desire to leave.	D 270		

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D 270	Continued From page 16 -There was no plan in place to monitor wandering residents except for staff to keep an eye on the residents. -There was no discussion regarding Resident #3 having a sitter. -On 02/04/24, she was notified by the RCD, Resident #3 was missing from the facility. -The police were notified that Resident #3 was missing. -Resident #3 crossed four (4) lanes of traffic and was located at an apartment complex across from the facility. 2. Review of Resident #1's current FL2 dated 12/27/23 revealed: -Diagnoses included memory loss and anxiety. -She was constantly disoriented. -She was ambulatory. -Level of care was assisted living. Review of Resident #1's Resident Register revealed: -Date of admission was not indicated. -Resident #1 had a guardian. Review of Resident #1's care plan dated 01/11/24 revealed: -She had wandering behaviors that led to her going into other residents' rooms. -She had to be redirected. -She was always disoriented. -She had significant memory loss. Review of Resident# 1's Accident/Incident report dated 01/01/24 at 9:30pm revealed: -The report was completed by the Resident Care Director (RCD). -Resident #1 had increased anxiety -Resident #1 managed to exit the facility today 01/01/24.	D270		

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D 270	Continued From page 17 -Resident #1 exited out of the 200 hall door close to the parking lot. -The RCD and Administrator were notified. -Resident #1's responsible person and primary care physician were notified. -Resident #1 would be monitored. -The report was sent to the Department of Social Services on 01/03/24. Review of the local weather report the temperature in the area on 01/19/24 at 5:45am was 39 degrees and sunrise was 7:33am that day (01/19/24). Review of Resident #1's 30 minutes checks tracker revealed: -Staff started documenting 30 minutes checks on 01/05/24 at 5:00pm and stopped on 01/23/24 at 11:00am. -Staff did not document the 30 minutes checks six (6) times on 01/05/24 between 5:00pm-11:30pm. -Staff did not document the 30 minutes checks four (4) times on 01/09/24 between 2:30pm-4:00pm. -Staff did not document the 30 minutes checks 17 times on 01/11/24 between 3:30pm-11:30pm. -Staff did not document the 30 minutes checks 14 times on 01/12/24 between 2:30pm-11:30pm. -Staff did not document the 30 minutes checks 30 times on 01/13/24 between 12:00am-2:30pm. -There was no documentation of 30 minutes checks on 01/14/24. -Staff did not document the 30 minutes checks 16 times on 01/15/24 between 12:00pm-6:30pm and 9:00pm-11:30pm. -Staff did not document the 30 minutes checks 17 times on 01/16/24 between 3:00am-5:30am, 7:00am-7:30am, 6:30pm-10:30pm. -Staff did not document the 30 minutes checks 16	D270		

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D 270	Continued From page 18 times on 01/18/24 between 3:30pm-11:00pm. -Staff did not document the 30 minutes checks 12 times on 01/19/24 between 5:30pm-11:00pm. -On 01/19/24 Resident #1 was documented to exit the facility at 5:30am and was back in the facility at 6:00am. Interview with RCD on 01/03/24 at 10:05am revealed: -Resident #1 exited the facility on 01/01/24. -Resident #1 was quickly observed by staff on the sidewalk by the 200 hall exit door. -Resident #1 was brought back into the facility. Review of Resident #1's Accident/Incident report on 01/19/24 revealed: -Resident #1 exited the facility at 6:00am with clothes in arms. -Resident #1 was located in the facility back parking lot. -Resident #1 was on 30 minutes checks and they would continue. -A sitter was arranged for 3rd shift from Friday -Sunday. -Administrator would contact family member. Interview with Resident #1's family member on 02/16/24 at 9:15am revealed: -Prior to moving into the facility Resident #1 lived alone. -After the resident moved into the facility she asked to go home frequently. -Resident #1 would set off the facility door alarms because she wanted to leave. Interview with another resident on 02/02/24 at 12:25pm revealed: -He opened his room door, and observed a	D270		

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D 270	Continued From page 19 resident going out the exit door. -He observed the resident walking close to the side of the facility. -He was going to go out to get the resident but realized they both would be locked outside. -He found a MA passing medications on the next hall and told her which door the resident went out. -The staff members got the resident back into the facility. Interview with a MA supervisor on 01/22/24 at 4:35pm revealed: -She and a PCA were the only staff on duty on 01/19/24 during the end of third shift. -She was on 200 hall administering medications. -The PCA was assisting a resident on 300 hall with a shower. -She heard the door alarm sounding. -She went down 200 hall and a resident met her stating Resident #1 went out the back door. -She ran to 300 hall and told the PCA they needed to go and find the resident. -The MA and PCA exited the facility leaving the other residents in the facility alone. -She ran out the front door, hoping Resident #1 had not walked towards the main road. -The PCA went out the facility back door near the activity room and kitchen. -The MA and PCA went out two different exit doors to prevent the resident from hopefully leaving the facility property. -The PCA found Resident #1 at the back of the facility near the kitchen area. -Resident #1 was brought back into the facility and sat in the recliner in her room. -The resident who observed what door Resident #1 went out of saved her and the PCA some time, because they would have had to go to the front of the facility to observe the alarm panel to know which exit door had been opened.	D270		

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D 270	Continued From page 20 -Upon admission she noticed Resident #1 was an elopement risk. -Staff was told by the RCD to keep an eye on Resident #1. -Resident #1 did not sleep well and wandered into other residents' rooms. -Resident #1 would say she had to go to work. Interview with PCA on 01/23/24 at 9:20am revealed: -She was getting ready to assist a resident with a shower on the 300 hall. -The MA came to her and stated Resident #1 went out of the facility. -Staff were not able to hear the door alarms sound when they were in a residents' room with the resident's door shut. -She ran out the door on 300 hall to the back of	D270		
	-She did not see Resident #1, so she ran back towards the front of the facility. -She found Resident #1 at the back of the facility near the kitchen area. -Resident #1 had clothes in her arms. -Resident #1 was fully dressed because she sometimes slept in her recliner in her clothes. -It took about 15 minutes to get Resident #1 back into the facility. -Resident #1 was not wearing a coat. -Resident #1 was cold to the touch. -She and the MA got Resident #1 into her recliner and wrapped her in blankets. -When Resident #1 was admitted into the facility she wandered around in the hallways. Interview with another PCA on 02/21/24 at 3:20pm revealed: -Resident #1 required assistance with personal care. -Resident #1 was ambulatory.			

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D 270	Continued From page 21 -Resident #1 had wandering behaviors. -Resident #1 would wander into other residents' rooms. -Resident #1 was on 30 minutes checks since resident had eloped once before. -The RCD informed staff to keep an eye on her and redirect her. -Resident #1 was redirected back into her room. Interview with another PCA on 02/21/24 at 3:35pm revealed: -Resident #1 was confused all the time. -Resident #1 had wandering behaviors. -Resident #1 wandered in the hallways and into other residents' rooms. -Staff were informed by the RCD if a resident had exit seeking behaviors. -Staff were told by the RCD Resident #1 had wandering behaviors and for staff to keep an eye on her all the time. -Resident #1 was on 30 minutes checks after resident had eloped once before. -Resident #1 was redirected to her room or in the	0270		
	-There was no actual plan on how to monitor Resident #1 who could not leave the facility without assistance or alone. Interview with the RCD on 01/19/24 at 3:30pm revealed: -There was a MA Supervisor and a PCA on duty when Resident #1 eloped from the facility. -The MA Supervisor notified her by phone about 6:00am on 01/19/24 that Resident #1 had walked out of the facility. -Another resident had observed Resident #1 go -The resident was able to inform two staff members which door had been opened. -Both staff members went out and found Resident			

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D 270	Continued From page 22 #1. -Resident #1 was taken to her room. -They left the other residents alone and went to find Resident #1. Interview with the RCD on 02/20/24 at 11:00am revealed: -Resident #1 had exit seeking behaviors since was admitted to the facility. -Resident #1 wandered into other residents' rooms. -She informed staff to keep Resident #1 with them or in their eyesight. -Staff had Resident #1 in their eyesight at all times after the first time she eloped. -There was no discussion with upper management regarding Resident #1 having a daily sitter prior to second elopement. -Resident #1 did not like being in her room. -Staff redirected residents exhibiting wandering behaviors from the doors and other resident rooms. -Staff knew residents had exit seeking behaviors by their change in behaviors such as walking the halls more, talking confused, or saying they wanted to go home. -Residents were observed for wandering, sundowning, and anything unusual. -Staff was to report anything unusual to a MA and her. -There was no actual written plan on how to monitor wandering residents. -When staff heard an exit door alarm sound, staff would rush to the exit doors to see who went out. -There were no alarms on the front door. Interview with the Administrator on 02/09/24 at 9:45am revealed: -When Resident #1 was admitted she was a little confused and they thought it was from the	D270		

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D 270	Continued From page 23 change of her environment -She wandered daily looking for a family member. -There was no discussion regarding Resident #1 having a sitter. -There were no indictors that Resident #1 would possibly elope. -On 01/19/24 she was notified by the RCD that Resident #1 was out of the facility. -Another resident observed Resident #1 go out the exit door. -Two staff members on duty got Resident #1 back into the facility. The facility failed to ensure two residents (#1 & #2) who had diagnoses of memory loss and exit seeking behaviors were not left unsupervised twice after staff was not aware that she left creating substantial risk of physical harm to the residents. The facility provided a Plan of Protection in accordance with G.S. 1310-34 on March 13, 2024. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 12, 2024.	D 270		

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TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

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D 296	Continued From page 24 diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was a therapeutic diet menu for food service guidance for 2 of 2 sampled residents (#8 & #10) with physicians' orders for consistent carbohydrate diet. The findings are: Review of the therapeutic diet menus posted in the kitchen on 03/12/24 revealed there was no therapeutic diet menu for a consistent carbohydrate diet. 1. Review of Resident #B's current FL2 dated 12/13/23 revealed diagnoses included diabetes mellitus, heart disease and hypertension. Review of Resident #B's signed therapeutic diet orders dated 11/09/23 revealed a physician's order for a consistent carbohydrate diet. Review of the therapeutic diet menus posted in the kitchen on 03/12/24 revealed there was no therapeutic diet menu for a consistent carbohydrate diet. Review of the regular diet menu for lunch on 03/12/24 revealed residents on a regular diet were to be served pork loin, roasted potatoes,	D296	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. **Action Plan** It is this Provider's intent and normal practice to ensure that there are therapeutic diet menus for food service guidance easily visible for all staff to view. The therapeutic diet menu will consist of all therapeutic diets which include but not limited to a consistent carbohydrate diet. The Dietary Manager and Executive Director will provide ongoing training and supervision to all staff regarding therapeutic diets. The dietary manager will be responsible for keeping a clean, clear copy of the therapeutic diet menus posted in the kitchen for all staff to see at all times. The Provider's Executive Director, Dietary Manager, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited to Therapeutic Diets. Quality assurance monitoring and training records are some examples of various components utilized to comply. **Corrective Measures** The Dietary Manager immediately posted a clear copy of therapeutic diet menus in the kitchen for all staff to see. An Inservice was provided for all kitchen staff by the Executive Director. Spot checks will be conducted by the Executive Director to ensure that the therapeutic diet menu is in plain site for all staff to see. Spot checks will be completed monthly for 2 months then annually.	4/12/24

			Monitoring- As part of the Quality Assurance and Performance Improvement (QAPI) process, the ED, Dietary Manager or designee will continue to assess for an accurate, visible therapeutic diet menu in the kitchen once a month for 2 months then annually. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff.	

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D 296	Continued From page 25 squash, dinner roll and apple pie. Observation of the lunch meal service on 03/12/24 from 12:00pm to 12:35pm revealed: -Resident #8 was served pork loin, roasted potatoes, squash, a sugar free cookie and iced tea. -Resident #8 ate 100% of the pork loin, roasted potatoes, 75% of the squash and 100% of the sugar free cookie. Based on observation of the lunch meal service on 03/12/24, it could not be determined if Resident #8 was served the correct therapeutic diet due to no consistent carbohydrate diet menu available for staff guidance. Review of the regular diet menu for lunch on 03/13/24 revealed residents were to be served turkey, corn, brussels sprouts, dinner roll and chocolate pudding. Observation of the lunch meal service on 03/13/24 from 12:05pm to 12:35pm revealed: -Resident #8 was served turkey, gravy, corn, brussels sprouts, dinner roll and sugar free vanilla pudding. -Resident #8 ate 100% of the turkey, gravy, corn, brussels sprouts, plus a second helping of brussels sprouts, sugar free pudding and did not consume her dinner roll. Based on observation of the lunch meal service on 03/13/24, it could not be determined if Resident #8 was served the correct therapeutic diet due to no consistent carbohydrate diet menu available for staff guidance. Interview with Resident #8 on 3/13/24 at 12:35pm revealed she did not want to eat her dinner roll	D296		

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D 296	Continued From page 26	D 296		

because it had a lot of carbohydrates.

Refer to the Interview with the dietary aide on 03/12/24 at 4:45pm.

Refer to the interview with a dietary aide on 03/13/24 at 1:15pm.

Refer to the interview with the cook on 03/12/24 at 11:30am.

Refer to the interview with a cook on 03/13/24 at 8:40am.

Refer to the interview with the Dietary Manager on 3/13/24 at 9:10am.

Refer to the interview with the Resident Care Director on 03/13/24 at 4:20pm.

Refer to the interview with the Administrator on 03/13/24 at 4:30pm.

2. Review of Resident #1O's current FL2 dated 01/04/24 revealed diagnoses included dementia, type II diabetes, hypertriglyceridemia waist, heart disease and hypertension.

Review of Resident #1O's signed therapeutic diet orders dated 01/05/24 revealed a physician's order for a consistent carbohydrate diet.

Review of the therapeutic diet menus posted in the kitchen on 03/12/24 revealed there was no therapeutic diet menu for a consistent carbohydrate diet.

Review of the regular diet menu for lunch on 03/12/24 revealed residents on a regular diet were to be served pork loin, roasted potatoes,

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D 296	Continued From page 27 squash, dinner roll and apple pie. Observation of Resident #10's meal tray on 03/12/24 at 12:30pm revealed: -Resident #10 was served pork loin, roasted potatoes, squash, a sugar free cookie. -Resident #10 ate in her room. -Resident #10 meal tray was removed before observation of consumption. Based on observation of the lunch meal service on 03/12/24, it could not be determined if Resident #8 was served the correct therapeutic diet due to no consistent carbohydrate diet menu available for staff guidance. Review of the regular diet menu for lunch on 03/13/24 revealed residents were to be served turkey, corn, brussels sprouts, dinner roll and chocolate pudding. Observation of Resident #10's lunch meal tray on 03/13/24 at 12:45pm revealed: -Resident #10 ate in her room. -Resident #10 was served turkey, gravy, brussels sprouts, dinner roll and sugar free pudding and unsweetened tea. -Resident #10 meal tray was removed before observation of consumption. Based on observation of the lunch meal service on 03/13/24, it could not be determined if Resident #8 was served the correct therapeutic diet due to no consistent carbohydrate diet menu available for staff guidance. Interview with Resident #10 on 3/13/24 at 1:10pm revealed: -She ate "most of her lunch". -She was unaware if she was on a special diet	D296		

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D 296	Continued From page 28 and just tried to "watch it" and not eat a lot. Refer to the interview with the dietary aide on 03/12/24 at 4:45pm. Refer to the interview with a dietary aide on 03/13/24 at 1:15pm. Refer to the interview with the cook on 03/12/24 at 11:30am Refer to the interview with a cook on 03/13/24 at 8:40am. Refer to the interview with the Dietary Manager on 3/13/24 at 9:10am. Refer to the interview with the Resident Care Director on 03/13/24 at 4:20pm. Refer to the interview with the Administrator on 03/13/24 at 4:30pm. _____ Interview with a dietary aide on 03/12/24 at 4:45pm revealed: -She had the dinner menu hanging in the preparation area for a regular diet menu. -She was serving broccoli soup, mixed vegetables, grilled cheese and fruit cups. -She thought the therapeutic menus were in the Dietary Managers office and she did not have the key. -She tried to remember what to do for residents that were diabetic as she had been in this profession for eight years and had most of it memorized. -The residents on a consistent carbohydrate diet would receive whole wheat bread instead of white	D296		

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D 296	Continued From page 29 bread for their grilled cheese as she thought this was a healthier option. -They did not have the regular diet cycle menu for 2024 and are going by the regular diet cycle menu for 2023. Interview with a dietary aide on 03/13/24 at 1:15pm revealed: -She had been at the facility since June of 2023 and had not had any therapeutic menus. -She would not give a Resident bread and limit their potatoes if on a consistent carbohydrate diet. -Every therapeutic diet should be on the menu for guidance. Interview with a cook on 03/12/24 at 11:30am revealed: -We have a list of residents on therapeutic diets. -She looked at the regular menu and made sure residents on consistent carbohydrate diet did not get sugar. -One of the medication aides would guide her on what to feed the residents. Interview with a cook on 03/13/24 at 8:40am revealed: -The cooks automatically fix something that is low in sugar for residents on a consistent carbohydrate diet for their dessert. -The lunch menu dessert for 03/13/24, residents on a consistent carbohydrate diet would be served sugar free vanilla pudding instead of the regular diet menu dessert of chocolate pudding. Interview with the Dietary Manager on 03/13/24 at 9:10am revealed: -The menu came from the facility's contracted food supplier. -He had not received the menus for 2024 and	0296		

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D 296I	Continued From page 30 was using the cycle menu for 2023. -The cycle menu was for regular diets. -He told the staff what to serve the residents on therapeutic diets if he was not available. -He sent an email (date unknown) to the facility's contracted food supplier to obtain the 2024 menus but had not received them. -Today he found the email response with an attachment dated January 17th, 2024. -The attachment included the 2024 menus with diet extensions, shopping list and recipes. -He was unable to download the 2024 menu with the diet extensions, shopping list and recipes due to his computer settings. Interview with the Resident Care Director on 03/13/24 at 4:20pm revealed: -The Dietary Manager was responsible for obtaining the therapeutic menus from the facilities food supplier's dietician. -She thought the issue of therapeutic menus had been resolved as the facility had put a plan into place several months ago. -She expected the therapeutic menus to be followed for each therapeutic diet. Interview with the Administrator on 03/13/24 at 4:30pm revealed: -She expected the residents are being served the diet as ordered. -Therapeutic menus need to be posted and followed. Attempted telephone interview with the facilities contracted dietician on 03/13/24 at 5:07pm was unsuccessful.	D296	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. **Action Plan** It is this Provider's intent and normal practice to ensure that there are therapeutic diet menus for food service guidance easily visible for all staff to view. The therapeutic diet menu will consist of all therapeutic diets which include but not limited to a consistent carbohydrate diet. The Dietary Manager and Executive Director will provide ongoing training and supervision to all staff regarding therapeutic diets. The dietary manager will be responsible for keeping a clean, clear copy of the therapeutic diet menus posted in the kitchen for all staff to see at all times. The Provider's Executive Director, Dietary Manager, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited to Therapeutic Diets. Quality assurance monitoring and training records are some examples of various components utilized to comply. **Corrective Measures** The Dietary Manager immediately posted a clear copy of therapeutic diet menus in the kitchen for all staff to see. An inservice was provided for all kitchen staff by the Executive Director. Spot checks will be conducted by the Executive Director to ensure that the therapeutic diet menu is in plain site for all staff to see. Spot checks will be completed monthly for 2 months then annually.	4/12/24
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service	D310		

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D 310	Continued From page 31 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure 2 of 2 sampled residents (#8 and #10) were served a Consistent Carbohydrate Diet. The findings are: 1. Review of Resident #B's current FL2 dated 12/13/23 revealed diagnoses included diabetes mellitus, heart disease and hypertension. Review of Resident #B's signed therapeutic diet orders dated 11/09/23 revealed a physician's order for a consistent carbohydrate diet. Review of the therapeutic diet list posted in the kitchen on 03/12/24 revealed Resident #8 was to be served a consistent carbohydrate diet. Review of the therapeutic diet menus posted in the kitchen on 03/12/24 revealed there were no therapeutic menus for a consistent carbohydrate diet available. Review of the regular diet menu for lunch on 03/12/24 revealed residents were to be served pork loin, roasted potatoes, squash, and apple pie. Observation of the lunch meal service on 03/12/24 from 12:00pm to 12:35pm revealed Resident #8 was served pork loin, roasted	D 310	Monitoring- As part of the Quality Assurance and Performance Manager or designee will continue to assess for an accurate, visible therapeutic diet menu in the kitchen once a month for 2 months then annually. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff.	

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D 310	Continued From page 32 potatoes, squash, a sugar free cookie and iced tea. Review of the regular diet menu for lunch on 03/13/24 revealed residents were to be served turkey, gravy, corn, brussels sprouts, dinner roll and chocolate pudding. Observation of the lunch meal service on 03/13/24 from 12:05pm to 12:35pm revealed Resident #8 was served turkey, gravy, corn, brussels sprouts, dinner roll and sugar free vanilla pudding and iced tea. Interview with Resident #8 on 3/13/24 at 12:35pm revealed: -She did not want to eat her dinner roll because it had a lot of carbohydrates. -She was unsure if her tea was unsweetened but maybe half sweetened and half unsweetened but was not sure. Interview with a dietary aide on 03/13/24 at 1:15pm revealed she did not know Resident #8 was on a consistent carbohydrate diet and thought she was on a diabetic diet. Refer to the interview with a dietary aide on 03/12/24 at 4:45pm. Refer to the interview with a dietary aide on 03/13/24 at 1:15pm. Refer to the interview with a cook on 03/12/24 at 11:30am. Refer to the interview with a cook on 03/13/24 at 8:40am. Refer to the interview with the Dietary Manager	D 310		

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D 310	Continued From page 33 Refer to the interview with the Resident Care Director on 03/13/24 at 4:20pm. Refer to interview with the Administrator on 03/13/24 at 4:30pm. 2. Review of Resident #10's current FL2 dated 01/04/24 revealed diagnoses included dementia, type II diabetes, hypertriglyceridemia waist, heart disease and hypertension. Review of Resident #10's signed therapeutic diet orders dated 01/05/24 revealed a physician's order for a consistent carbohydrate diet. Review of the therapeutic diet list posted in the kitchen on 03/12/24 revealed Resident #10 was to be served a consistent carbohydrate diet. Review of the therapeutic diet list posted in the kitchen on 03/12/24 revealed there were no therapeutic menus for a consistent carbohydrate diet available. Review of the regular diet menu for lunch on 03/12/24 revealed residents were to be served pork loin, roasted potatoes, squash, and apple pie. Observation of Resident #10's lunch meal tray on 03/12/24 at 12:30pm revealed Resident #10 was served pork loin, roasted potatoes, squash, a sugar free cookie. Review of the regular diet menu for lunch on 03/13/24 revealed residents were to be served turkey, gravy, corn, brussels sprouts, dinner roll and chocolate pudding.	D 310		

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D 310	Continued From page 34 Observation of Resident #10's lunch meal tray on 03/13/24 at 12:45pm revealed: -Resident #10 ate in her room. -Resident #10 was served turkey, gravy, brussels sprouts, dinner roll and sugar free pudding and unsweetened tea.	D 310		
	03/13/24 at 4:30pm. Interview with a dietary aide on 03/12/24 at 4:45pm revealed: -She was serving broccoli soup, mixed vegetables, grilled cheese and fruit cups for the dinner meal service on 03/12/24			

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	provides it on a consistent carbohydrate diet. Interview with a cook on 03/12/24 at 11:30am revealed: -She looked at the regular menu and made sure residents on consistent carbohydrate diet did not get sugar. -One of the medication aides would tell her what to feed the residents. [illegible] [illegible] Interview with the Dietary Manager on 03/13/24 at 9:10am revealed: -The 2023 cycle menu he had been using was for regular diets. -He was usually cooking side by side the cooks and would show them what to serve residents on different therapeutic menus. -He had to hire several new staff and train them on what to serve residents on therapeutic diets. -He told the staff what to serve the residents on			

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D 310	Continued From page 35 would have whole wheat bread instead of white bread for their grilled cheese. Interview with a dietary aide on 03/13/24 at 1:15pm revealed: -She had been at the facility since the summer of 2023 and there had not been any therapeutic menus. -Every diet should be on the menu for guidance. -She did not give a resident bread and limit their potatoes if on a consistent carbohydrate diet. Interview with a cook on 03/12/24 at 11:30am revealed: -She looked at the regular menu and made sure residents on consistent carbohydrate diet did not get sugar. -One of the medication aides would tell her what to feed the residents. Interview with a cook on 03/13/24 at 8:40am revealed: -She would automatically fix something that is diabetic for dessert. -The lunch menu dessert for 03/13/24, residents on consistent carbohydrate diet would be served [illegible] menu dessert of chocolate pudding that was not sugar free. Interview with the Dietary Manager on 03/13/24 at 9:10am revealed: -The 2023 cycle menu he had been using was for regular diets. -He was usually cooking side by side the cooks and would show them what to serve residents on different therapeutic menus. -He had to hire several new staff and train them on what to serve residents on therapeutic diets. -He told the staff what to serve the residents on	D 310		

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(X4)ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 36 therapeutic diets if he was not going to be available. Interview with the Resident Care Director on 03/13/24 at 4:20pm revealed -The Dietary Manager was responsible for obtaining the therapeutic menus from the facilities food supplier's dietician. -She was unaware their were no therapeutic menus available for food service guidance. -She expected the residents to get the correct diet based on their prescribed therapeutic diet. Interview with the Administrator on 03/13/24 at 4:30pm revealed: -She was unaware their were no therapeutic menus and thought this had been corrected when hiring the new Dietary Manager in September of 2023. -She expected residents to have their diets served as ordered. Attempted telephone interview with the facilities contracted dietician on 03/13/24 at 5:07pm was unsuccessful.	D 310		
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.	D358		

PRINTED: 04/01/2024
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	HAL036023	A. BUILDING: _____ B. WING _____	R 03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

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D 358	Continued From page 37 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to administer medications as ordered to 1 of 7 residents (#8) related to a medication to treat pain. The findings are: Review of the facility's undated Medication Administration Errors policy and procedure revealed: -Unauthorized drug errors included the administration of a medication without a physician's order. -Medication administration errors were to be reported to the resident's physician, family/responsible party, pharmacy provider and the Administrator or designee. -A Medication Error Report was to be completed. Review of Resident #8's current FL2 dated 12/13/23 revealed diagnoses included hypertension and diabetes mellitus. Review of Resident #8's Primary Care Provider's (PCP) orders dated 02/27/24 revealed: -There was an order for acetaminophen extended release (ER) (a medication to treat pain) 650mg, two tablets twice daily. -There was no order for acetaminophen 500mg as needed for Resident #8. Review of Resident #8's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for acetaminophen ER 650mg, two tablets twice daily at 8:00am and 8:00pm -Acetaminophen 650mg was documented as administered from 03/01/24 to 03/12/24 at	D 358		

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D 358	Continued From page 38 8:00am and 8:00pm and on 03/13/24 at 8:00am. -There was no entry for acetaminophen 500mg as needed for Resident #8. Review of Resident Incident Report dated 03/13/24 at 9:30am revealed: -Resident #8 asked the medication aide (MA) for acetaminophen due to knee pain. -The MA administered acetaminophen 500mg, one tablet to Resident #8. -Resident #8 did not have an order for acetaminophen 500mg, one tablet. -The MA informed Resident #B's PCP of the medication error. -Resident #B's PCP gave a one time order for acetaminophen 500mg, one tablet. Interview with the MA on 03/13/24 at 11:20am revealed: -He administered acetaminophen ER 650mg, two tablets to Resident #8 before breakfast that morning (03/13/24). -After breakfast, Resident #8 requested an additional acetaminophen tablet because she was having knee pain. (PRN) acetaminophen. -He borrowed acetaminophen 500mg, two tablets from another resident and administered one tablet to Resident #8 at approximately 9:32am that morning (03/13/24). -He knew he was not to administer medications without an order. Telephone interview with Resident #S's PCP on 03/13/24 at 12:16pm revealed: -She was informed by the MA he administered acetaminophen 500mg, one tablet to Resident #8 that morning (03/13/24) without an order. -MAs were not to administer medications without	D 358	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. **Action Plan** It is this Provider's intent and normal practice to ensure all employees designated to administer medications are properly trained of all policies and procedures. The Resident Care Director and Executive Director will provide ongoing training and supervision to all staff regarding medication administration. The Resident Care Director will do random medication pass observations with our Medication Aides. The Provider's Executive Director, Resident Care Director, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited to medication administration policy. Quality assurance monitoring and training records are comply with medication administration. **Corrective Measures** The Medication Aide immediately notified the physician of the medication error and completed the required medication error form then notified the RCD. One-on-one counseling was done with the medication aide at fault within 24 hours of the medication error. A mandatory Inservice was completed for all Medication Aides to review the proper medication administration policies and procedures completed. **Monitoring-** As part of the Quality Assurance and Performance Improvement (QAPI) process, the RCD or designee will conduct weekly medication pass observations to	4/12/24

			ensure all medication aides are following policies and procedures when administering medications. After 4 weeks of observations without medication error, observations will be completed randomly thereafter. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff	

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TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

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D 358	Continued From page 39 an order. -Administering a medication without an order was a medication error and she instructed the MA to follow facility protocol for medication errors. -She gave a one time order for acetaminophen 500mg, one tablet for Resident #8. Interview with the Resident Care Director (RCD) on 03/13/24 at 4:49pm revealed: -MAs were trained during the MA training course and upon hire to not administer a medication to a resident without an order. -The facility utilized standing orders and she expected the MA to see if Resident #8 had a standing order for acetaminophen prior to activating the order and administering the medication. -She expected MAs to reach out to the PCP for any resident concerns or if an order for medication was needed. Interview with the Administrator on 03/13/24 at 5:03pm revealed: -The MAs were not to administer medications to a resident without an order. -All MAs were trained upon hire regarding the policies and procedures for medication administration. -She expected MAs to reach out to the resident's PCP if a medication order was needed.	D358		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from	D 363		

PRINTED: 04/01/2024
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TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

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D 363	Continued From page 40 contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications prepared for administration in advance were identified by name and strength up to the point of administration and protected from contamination and spillage for 1 of 1 resident (Resident #7).	D363	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. **Action Plan** It is this Provider's intent and normal practice to ensure all employees designated to administer medications are properly trained of all policies and procedures. The Resident Care Director and Executive Director will provide ongoing training and supervision to all staff regarding medication administration. The Resident Care Director will do random medication pass observations with our Medication Aides. The Provider's Executive Director, Resident Care Director, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring including but not limited to medication administration policy. Quality assurance monitoring and training records are some examples of various components utilized to comply with medication administration. **Corrective Measures** The Medication Aide immediately notified the physician of the medication error and completed the required medication error form then notified the RCD. One-on-one counseling was done with the medication aide at fault within 24 hours of the medication error. A mandatory Inservice was completed for all Medication Aides to review the proper medication administration policies and procedures completed. **Monitoring-** As part of the Quality Assurance and Performance Improvement (QAPI) process, the RCD or designee will conduct weekly medication pass observations to ensure all medication aides are following policies and	4/12/24

			procedures when administering medications. After 4 weeks of observations without medication error, observations will be completed randomly thereafter. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff	

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _____	COMPLETED
	HAL036023	B. WING _____	R 03/13/2024

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D 363	Continued From page 41 The findings are: Review of Resident #7's current FL2 dated 08/14/23 revealed: -Diagnoses included intervertebral disc degeneration (breakdown of one or more discs that separate the bones of the spine). -There was an order for hydrocodone-acetaminophen 10-325mg (a medication to treat pain), one tablet every four hours as needed (PRN). -There was an order for clonazepam 1mg (a medication to treat anxiety), one tablet every 8 hours. Review of Resident #7's current Primary Care Provider's (PCP) orders dated 02/27/24 revealed: -There was an order for hydrocodone-acetaminophen 10-325mg, one tablet every four hours PRN for chronic pain and degenerative disc disease. -There was an order for clonazepam 1mg, one tablet three times daily. Review of Resident #7's hydrocodone-acetaminophen 10-325mg controlled substance count sheet (CSCS) on 03/13/24 at 11:20am revealed: -There was hydrocodone-acetaminophen 10-325mg, one tablet signed out on 03/13/24 at 2:00pm. -There were 25 tablets remaining. Observation of Resident #7's hydrocodone-acetaminophen 10-325mg bubble pack on 03/13/24 at 11:20am revealed there were 25 tablets remaining. Review of Resident #7's clonazepam 1mg CSCS on 03/13/24 at 11:20am revealed:	D 363		

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D 363	Continued From page 42 -There was clonazepam 1mg, one tablet signed out on 03/13/24 at 2:00pm. -There were 88 tablets remaining. Observation of Resident #7's clonazepam 1mg bubble pack on 03/13/24 at 11:20am revealed there were 88 tablets remaining. Interview with the Medication Aide (MA) on 03/13/24 at 11:20am revealed he had pre-poured Resident #7's 2:00pm medications because the resident always arrived promptly at 2:00pm and wanted his medication. Observation on 03/13/24 at 11:20am of medications in a folded over white paper pill cup revealed: -It was in the MA's hand in his right jacket pocket. -It contained two medication tablets. -The markings on a blue tablet identified the medication as clonazepam 1mg. -The markings on a white rectangular tablet identified the medication as acetaminophen 500mg. -There were no markings identifying the resident's name, the name of the medication, strength, or time due on the medication cup. Observation of the 400-hall medication cart on 03/13/24 at 11:20am revealed: -There was a folded over white paper pill cup in another resident's medication area of the medication cart. -The pill cup contained one white rectangular tablet. -The markings on the tablet identified the medication as hydrocodone-acetaminophen 10-325mg. -There were no markings identifying the resident's name, the name of the medication,	D363		

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D 363	Continued From page 43 strength, or time due on the medication cup. Interview with the MA on 03/13/24 at 11:20am and 2:35pm revealed: -He only pre-poured Resident #7's 2:00pm medications because the resident had gotten upset in the past when he had to wait for his medication. -He was preparing Resident #7's medications when another resident requested acetaminophen for knee pain. -He dispensed acetaminophen 500mg, two tablets into two medication cups, each containing one tablet. -He administered one of the cups containing acetaminophen 500mg, one tablet to the second resident. -He planned to save the second medication cup containing acetaminophen 500mg, one tablet in case the resident requested something for pain later that day. -He must have accidentally placed the clonazepam 1mg tablet in the medication cup containing the acetaminophen 500mg, one tablet. -He placed the medication cup containing hydrocodone-acetaminophen 10-325mg, one tablet into the second resident's area of the medication cart, thinking it was acetaminophen 500mg. -He usually kept Resident #7's pre-poured 2:00pm medications in the top drawer of the medication cart but he removed them and placed them in his pocket when Department of Health Service Regulation (DHSR) staff wanted to view medications in the medication cart. -He did not mark the medication cup with the resident's name or medication because he knew who it belonged to because he did not pre-pour any other medications.	D 363		

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D 363	Continued From page 44 Interview with the Resident Care Director (RCD) on 03/13/24 at 4:49pm revealed: -MAs were trained upon hire that resident medications were not to be pre-poured. -She expected the MAs to follow their training and not pre-pour any medications. Interview with the Administrator on 03/13/24 at 5:03pm revealed: -The MAs were trained to not pre-pour resident [redacted] each MA upon hire and the MAs were specifically trained to not pre-pour resident medications.	D363		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly, and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were borrowed only in an emergency and replaced promptly for 1 of 1 resident (#8) with orders for a medication to treat pain. The findings are: Review of the facility's undated Medication Administration Procedures revealed medications for one resident should not be given to any other	D 372		

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D 372	Continued From page 45 resident. Review of Resident #8's current FL2 dated 12/13/23 revealed diagnoses included hypertension, diabetes mellitus, and ischemic heart disease (when blood flow is restricted due to narrowing of the arteries of the heart). Review of Resident #8's Primary Care Provider's (PCP) orders dated 02/27/24 revealed: -There was an order for acetaminophen extended release (ER) 650mg, two tablets twice daily for pain. -There was no as-needed (PRN) order for acetaminophen for Resident #8. Review of Resident #8's March 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry for acetaminophen ER 650mg, two tablets twice daily at 8:00am and [illegible] -Acetaminophen ER 650mg was documented as administered at 8:00am and 8:00pm from 03/01/24 through 03/12/24 and at 8:00am on 03/13/23. -There was no entry for PRN acetaminophen for Resident #8. Interview with a Medication Aide (MA) on 03/13/24 at 11:20am and 2:35pm revealed: -Resident #8 received her scheduled acetaminophen ER 650mg, two tablets between 7:00am and 8:00am that morning. -At approximately 9:32am, Resident #8 requested an additional acetaminophen tablet because she had knee pain. -Resident #8 did not have an order for PRN acetaminophen. -He borrowed acetaminophen 500mg, two tablets	D372	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. **Action Plan** It is this Provider's intent and normal practice to ensure all employees designated to administer medications are properly trained of all policies and procedures. The Resident Care Director and Executive Director will provide ongoing training and supervision to all staff regarding medication administration. The Resident Care Director will do random medication pass observations with our Medication Aides. The Provider's Executive Director, Resident Care Director, and others provide Quality Assurance and Performance Improvement (QAPI) monitoring policy. Quality assurance monitoring and training records are some examples of various components utilized to comply with medication administration. **Corrective Measures** The Medication Aide immediately notified the physician of the medication error and completed the required medication error form then notified the RCD. One-on-one counseling was done with the medication aide at fault within 24 hours of the medication error. A mandatory Inservice was completed for all Medication Aides to review the proper medication administration policies and procedures completed.	4/12/24

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D 372	Continued From page 46 from another resident and administered acetaminophen 500mg, one tablet to Resident #8. -He borrowed another resident's medication because if he administered from Resident #8's schedule acetaminophen, she would run out of medication before it was time to refill. -Resident #8 rarely asked for additional medication for pain and when she did, he offered the PRN pain patch for which she had an order. -He offered the PRN pain patch that morning but Resident #8 declined, asking for an additional acetaminophen tablet. -He knew he was not to give medication without an order, but he was nervous because Department of Health Service Regulation (DHSR) staff were in the building. -He was taught by a prior facility nurse to not borrow medications from other residents. Interview with the Resident Care Director (RCD) on 03/13/24 at 4:49pm revealed: -Borrowing medication for administration to another resident was not a good practice and should only be done in an extreme emergency. -She expected to be notified prior to a MA borrowing medication from a resident. Interview with the Administrator on 03/13/24 at 5:03pm revealed: -MAs were trained upon hire to not borrow medications. -She expected MAs to utilize other resources, such as the back-up pharmacy, prior to considering borrowing medications from another resident. -If medication was not available to administer, the MAs were to reach out to the PCP for guidance.	0372	Monitoring- As part of the Quality Assurance and Performance Improvement (QAPI) process, the RCD or designee will conduct weekly medication pass observations to ensure all medication aides are following policies and procedures when administering medications. After 4 weeks of observations without medication error, observations will be completed randomly thereafter. The QAPI committee will review audit results for at least the next 2 quarters. Any findings which are not consistent with Provider's policy/procedure or accepted standard of care will result in re-training of applicable staff	