STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026068	A. BUILDING: _____ B. WING _____	C 12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 12/18/24 - 12/20/24.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including personal care products and a pair of metal scissors that were accessible to the residents living in the special care unit (SCU). The findings are: Review of the facility's Environmental Policy for the special care unit (SCU) dated 07/26/24 revealed: -All personal care items and potentially harmful items would be kept in a secured and locked area. -Residents would have a locking box, cabinet or closet in their rooms where personal products would be kept. -The items would remain locked. -Facility team members or approved visitors would assist the resident with accessing these	D 079		

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items for personal care or by resident request.
-Upon request, a team member would assist in unlocking and providing supplies to the resident, allow time for grooming, and then resecure the items in the locked area.

Review of the facility's census report received on 12/18/24 revealed there were 22 residents living in the SCU of the facility.

Observation of the bathroom in resident room C-11 on 12/18/24 at 9:39am revealed:
-There were personal care hygiene products sitting around the edge of a sink in the resident's bathroom.
-The personal care hygiene products included antibacterial hand soap, antiperspirant deodorant, aloe moisturizing cream, diaper rash cream, and denture cleanser
-Warning labels on the products included for external use only; keep out of eyes; keep out of reach of children; and in case of ingestion get medical help right away or contact a poison control center (PCC) right away.

Interview with the resident who resided in room C-11 on 12/20/24 at 10:48am revealed she always had her body wash and other personal care products in her room.

Interview with family members of the resident who resided in C-11 on 12/20/24 at 10:48am revealed personal care products were always kept in the resident's room until the other day someone came by and said she could not have them in the room.

Observation of the bathroom in resident room C-01 on 12/18/24 at 10:20am revealed:
-There was a red basket full of persona care

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D 079	Continued From page 2	D 079		

hygiene products on the counter near the sink in the bathroom.
-The personal care hygiene products included moisturizing hand and body lotions, shampoos, conditioners, bar soap, toothpastes, antiperspirant deodorants and a pair of metal scissors.
-Warning labels on the products included: keep out of reach of children; for external use only; if swallowed get medical help or contact a PCC; avoid contact with eyes; in case of eye contact flush with water; do not drink, not edible; and harmful if ingested.

Based on observations, interviews, and record reviews, the two residents residing in room C-01 were not interviewable.

Interview with a medication aide (MA) on 12/18/24 at 10:27am revealed:
-Personal care hygiene products for residents in the SCU were usually kept locked in a closet near the nurses' station in the SCU.
-The personal care aides and MAs had a key to access the personal care products.
-The PCAs took the personal care products to the residents' rooms and the PCAs were supposed to stay with the residents while they used the products.
-Then the PCAs were supposed to take the personal care products back to the closet and lock it.
-There should not be any scissors unlocked and available to residents.
-There should not be any personal care products in residents' room currently because grooming and bathing was over with for that morning.
-The Special Care Coordinator (SCC) usually checked the residents' rooms for personal care products every morning.

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D 079	Continued From page 3 Interview with a personal care aide (PCA) on 12/18/24 at 10:38am revealed: -She had put the personal care products in the bathroom of resident room C-01 that morning because she was going to shower one of the residents in that room. -She got busy and forgot she left the personal care products in the bathroom. -The personal care products should have been locked up. Interview with the SCC on 12/18/24 at 10:40am revealed: -Personal care products in the SCU should be locked in a closet near the nurses' station. -The key to the closet was usually kept behind the nurses' station near the fire extinguisher for staff to access when needed. -Any staff who assisted the residents with personal care were supposed to take the personal care products back to the locked closet when finished with care. -Some residents were hesitant to give the personal care products back to staff to lock up. -Each PCA and she did a "sweep" after breakfast each morning to make sure personal care products were locked up. -There should not be any scissors left unattended and unlocked in the SCU. -She had started checking the rooms that morning but had not completed all the rooms, so she was not aware personal care products had been left in any resident rooms. Interview with the Administrator on 12/18/24 at 12:00pm revealed: -All personal care products in the SCU should be in baskets locked in the closet hear the nurses' station.	D 079		

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D 079	Continued From page 4 -The PCAs took the baskets with the personal care products to the resident's bathrooms when they were assisting with care. -The PCAs were supposed to return the baskets with the personal care products to the locked closet. -The SCC was responsible for doing weekly checks for any unlocked personal care products in the SCU. -No personal care products or scissors should be left unlocked in the SCU because of safety. -SCU residents could put things in their mouths and ingest personal care products. -No residents had ingested personal care products to her knowledge.	D 079		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the assessment and care plan for 1 of 5 sampled residents (#4) was signed by a physician within 15 calendar days of completion of the assessment.	D 263		

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D 263	Continued From page 5 The findings are: Review of Resident #4's current FL-2 dated 10/08/24 revealed: -Diagnoses included dementia, type 2 diabetes mellitus with chronic kidney disease, hyperlipidemia, acquired absence of kidney, open-angle glaucoma, Vitamin D deficiency, and deficiency of group B vitamins. -The resident's level of care was documented as domiciliary, memory care. -The resident was documented as being intermittently disoriented and having wandering and verbally abusive behavior. -The resident was documented as ambulatory. -The resident was documented as being continent of bowel and bladder. Review of Resident #4's admission records revealed there was no Resident Register. Review of Resident #4's Contact Information Form revealed the resident was admitted and moved into the facility on 10/10/24. Review of Resident #4's current assessment and care plan dated 11/03/24 revealed: -The resident had severe cognitive impairment and was frequently disoriented. -The resident was unable to remember or use information. -The resident may require repeated verbal prompts and/or direction. -The resident was documented as "wanders indiscriminately and frequently; may wander at night". -The resident resisted care and was verbally or physically inappropriate and required supervision. -The resident had post-traumatic stress disorder	D 263		

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and flashbacks.
-The resident was ambulatory.
-The resident required minimal assistance by staff with ambulation, transferring, grooming, dressing, toileting, and eating.
-The resident was independent with bathing.
-The resident's care plan was not signed by a physician.

Interview with the Health and Wellness Director (HWD) on 12/20/24 at 11:36am revealed:
-She was responsible for completing residents' assessments and care plans.
-Once she completed a resident's assessment and care plan, she usually sent it to the resident's provider for signature if the resident used an outside provider.
-Resident #4 was seen by a Veteran's Administration (VA) primary care provider (PCP).
-She did not remember if she sent Resident #4's assessment and care plan to the resident's VA PCP for signature.
-She had no way to check to see if the assessment and care plan had been sent to the VA PCP.

Interview with the Administrator on 12/20/24 at 11:29am revealed:
-The HWD was responsible for completing residents' assessments and care plans and getting them signed by the PCP.
-She did not know why Resident #4's assessment and care plan had not been signed by the VA PCP.
-She did not see any documentation of any attempts to get the assessment and care plan signed.
-There was currently no system to check behind the HWD to make sure the assessment and care plans were completed and signed by the PCP.

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D 263	Continued From page 7 Observation of Resident #4 on 12/18/24 at 9:48am revealed the resident was in his room lying in bed. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. Attempted telephone interviews with Resident #4's VA PCP on 12/20/24 at 10:32am and 5:05pm were unsuccessful.	D 263		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 3 of 5 sampled residents (#1, #4, #5) including failing to coordinate referrals for physical therapy (#1) urology (#4), and gero-psychiatry (#4); failing to have a resident follow-up with the primary care provider (PCP) after a hospitalization (#4); and failing to notify the PCP of heart rates below the ordered parameters (#5). The findings are: 1. Review of Resident #4's current FL-2 dated 10/08/24 revealed: -Diagnoses included dementia, type 2 diabetes mellitus with chronic kidney disease,	D 273		

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hyperlipidemia, acquired absence of kidney, open-angle glaucoma, Vitamin D deficiency, and deficiency of group B vitamins.
-The resident's level of care was documented as domiciliary, memory care.
-The resident was documented as being intermittently disoriented and having wandering and verbally abusive behavior.

Review of Resident #4's admission records revealed there was no Resident Register.

Review of Resident #4's Contact Information Form revealed the resident was admitted and moved into the facility on 10/10/24.

Review of Resident #4's current assessment and care plan dated 11/03/24 revealed:
-The resident had severe cognitive impairment and was frequently disoriented.
-The resident may require repeated verbal prompts and/or direction.
-The resident was documented as "wanders indiscriminately and frequently; may wander at night".
-The resident resisted care and was verbally or physically inappropriate and required supervision.
-The resident had post-traumatic stress disorder and flashbacks.
-The resident required minimal assistance by staff with ambulation, transferring, grooming, dressing, toileting, and eating.
-The resident was independent with bathing.

a. Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed:
-The resident was admitted to the hospital on 01/29/24.
-The resident's admitting/primary diagnosis was

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dementia with behavioral disturbances.
-The resident was admitted to the hospital from a former memory care facility following assault on staff members.
-The resident became more agitated at about one month into stay so psychiatry was consulted to assist with agitation pharmacotherapy.
-The resident was discharged from the hospital on 10/10/24.
-The resident was to follow-up with gero-psychiatry.

Telephone interview with Resident #4's family member on 12/20/24 at 11:47am revealed:
-She usually took Resident #4 to his medical appointments.
-The resident's VA gero-psychiatry provider had double booked appointments, so they called her and canceled his appointment (could not recall date).
-They were supposed to call her back with a new appointment date and time, but she had not heard back from them.
-She did not know if the facility had tried to contact the VA to set up any appointments for the resident.

Interview with the Health and Wellness Director (HWD) on 12/20/24 at 8:40am revealed:
-She was responsible for any referrals for residents.
-Resident #4 saw providers through the VA system.
-She did not remember seeing the referrals on Resident #4's hospital discharge papers when he was admitted on 10/10/24.
-She was not sure if Resident #4 had been seen by gero-psychiatry.
-The resident's family member usually took the resident to his medical appointments.

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D 273	Continued From page 10 Interview with the Administrator on 12/20/24 at 8:45am revealed: -When family members took residents to medical appointments, the family member was supposed to give any paperwork to the Resident Care Coordinator (RCC), the HWD, or the medication aide (MA) on duty. -The RCC or the HWD were responsible for making sure the paperwork was received and for processing and reviewing any paperwork. -The HWD was responsible for making sure any referrals were completed as ordered. -She did not know if Resident #4 had been seen by a VA gero-psychiatry provider. Attempted telephone interviews with Resident #4's VA providers on 12/20/24 at 10:32am and 5:05pm were unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. b. Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed: -The resident was admitted to the hospital on 01/29/24. -The resident's admitting/primary diagnosis was dementia with behavioral disturbances. -The resident had an episode of gross hematuria (blood in the urine) that resolved during this hospital stay. -The resident was discharged from the hospital on 10/10/24. -There was a referral for the resident to go back to urology due to history of nephrectomy (removal of kidney) in 2023 for renal cell carcinoma (cancer of the kidney).	D 273		

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D 273	Continued From page 11 Telephone interview with Resident #4's family member on 12/20/24 at 11:47am revealed: -She usually took Resident #4 to his medical appointments. She asked the VA to switch the resident to a VA urology provider located closer to the resident. -She was waiting for the VA to call her back about a urology provider. -She did not know if the facility had tried to contact the VA to set up any appointments for the resident. Interview with the Health and Wellness Director (HWD) on 12/20/24 at 8:40am revealed: -She was responsible for any referrals for residents. -Resident #4 saw providers through the VA system. -She did not remember seeing the referrals on Resident #4's hospital discharge papers when he was admitted on 10/10/24. -She was not sure if Resident #4 had been seen by a urology provider. -The resident's family member usually took the resident to his medical appointments. Interview with the Administrator on 12/20/24 at 8:45am revealed: -When family members took residents to medical appointments, the family member was supposed to give any paperwork to the Resident Care Coordinator (RCC), the HWD, or the medication aide (MA) on duty. -The RCC or the HWD were responsible for making sure the paperwork was received and for processing and reviewing any paperwork. -The HWD was responsible for making sure any referrals were completed as ordered. -She did not know if Resident #4 had been seen	D 273		

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by a VA urology provider.

Attempted telephone interviews with Resident #4's VA providers on 12/20/24 at 10:32am and 5:05pm were unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

c. Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed:
-The resident was admitted to the hospital on 01/29/24.
-The resident's admitting/primary diagnosis was dementia with behavioral disturbances.
-The resident was admitted to the hospital from a former memory care facility following assault on staff members.
-The resident was discharged from the hospital on 10/10/24.
-The resident was to see his VA primary care provider (PCP) within 1 to 5 days.

Telephone interview with Resident #4's family member on 12/20/24 at 11:47am revealed:
-She usually took Resident #4 to his medical appointments.
-The resident had not seen a VA PCP since he was discharged from the VA hospital on 10/10/24.
-She had asked the VA to refer the resident to a VA PCP located closer to the resident.
-She had not heard back from the VA.
-She did not know if the facility had tried to contact the VA to set up any appointments for the resident.

Interview with the Health and Wellness Director (HWD) on 12/20/24 at 8:40am revealed:

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-She was responsible for any referrals for residents.
-Resident #4 was seen by a VA PCP, not the facility's contracted PCP.
-She did not remember seeing the referrals on Resident #4's hospital discharge papers when he was admitted on 10/10/24.
-The resident's family member usually took the resident to his medical appointments.

Interview with the Administrator on 12/20/24 at 8:45am revealed:
-When family members took residents to medical appointments, the family member was supposed to give any paperwork to the Resident Care Coordinator (RCC), the HWD, or the medication aide (MA) on duty.
-The RCC or the HWD were responsible for making sure the paperwork was received and for processing and reviewing any paperwork.
-The HWD was responsible for making sure any referrals were completed as ordered.
-She did not know if Resident #4 had been seen by the VA PCP since discharge from the hospital on 10/10/24.

Attempted telephone interviews with Resident #4's VA PCP on 12/20/24 at 10:32am and 5:05pm were unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable.

2. Review of Resident #1's FL-2 dated 01/08/24 revealed diagnoses included chronic atrial fibrillation, hypertensive heart disease with heart failure, type 2 diabetes mellitus, pulmonary hypertension, and chronic respiratory failure with hypoxia.

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TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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 273	Continued From page 14 Review of Resident #1's signed physician's order dated 11/18/24 revealed there was an order for physical therapy via home health. Interview with Resident #1 on 12/20/24 revealed she was not aware a referral for physical therapy was written on 11/18/24. Interview with Resident #1's family member on 12/20/24 at 9:25am revealed: -She was aware Resident #1 had a referral for physical therapy, and it was not done. -She asked Resident #1's provider why the referral for physical therapy was not done. -She did not notify the facility to inquire about why the referral was not done because she thought she had to handle it. Interview with the Health and Wellness Director (HWD) on 12/20/24 at 8:25am revealed: -Resident #1's family member took her to all her doctor's appointments. -The referrals for the residents in the facility were supposed to come to her. -She was not aware Resident #1 had a referral for physical therapy. -She was responsible to ensure Resident #1's referral for physical therapy was completed. Interview with the Administrator on 12/20/24 at 8:27am revealed: -There was an in-house physical therapy agency the facility worked with. -She expected Resident #1's physical therapy referral to be handled by the HWD. Attempted telephone interview with Resident #1's primary care provider (PCP) on 12/20/24 at 10:59am was unsuccessful.	D 273		

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D 273	Continued From page 15 3. Review of Resident #5's current FL-2 dated 10/29/24 revealed diagnoses included hypertension, cognitive impairment, coronary artery disease, gastro-esophageal reflux disease, hypercholesterolemia, and insomnia. Review of Resident #5's signed physician orders dated 03/21/24 revealed there was an order for Metoprolol Tartrate (used to treat hypertension) 100mg tablet twice daily and hold and call if pulse less than 60 or greater than 100. Review of Resident #5's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 100mg tablet twice daily and hold and call if pulse less than 60 or greater than 100 scheduled at 8:00am and 8:00pm. -There was a second entry for vital signs that included a pulse check twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #5's pulse was checked 59 of 60 times with a pulse reading of 58 on 10/04/24 and 57 on 10/05/24. Review of Resident #5's November 2024 eMAR revealed: -There was an entry for Metoprolol Tartrate 100mg tablet twice daily and hold and call if pulse less than 60 or greater than 100 scheduled at 8:00am and 8:00pm. -There was a second entry for vital signs that included a pulse check twice daily scheduled at 8:00am and 8:00pm. -There was documentation Resident #5's pulse was checked 46 of 60 times with a pulse reading range of 62 - 98. -There was no documentation of Resident #5's	D 273		

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pulse check at 8:00pm on 11/04/24 -11/08/24, 11/11/24, 11/16/24 - 11/19/24, 11/21/24, 11/25/24, 11/27/24, and 11/30/24.

Review of Resident #5's December 2024 eMAR from 12/01/24 through 12/18/24 at 8:00am revealed:
-There was an entry for Metoprolol Tartrate 100mg tablet twice daily and hold and call if pulse less than 60 or greater than 100 scheduled at 8:00am and 8:00pm.
-There was a second entry for vital signs that included a pulse check twice daily scheduled at 8:00am and 8:00pm.
-There was documentation Resident #5's pulse was checked 32 of 35 times with a pulse reading range of 62 - 98.
-There was no documentation of Resident #5's pulse check at 8:00pm on 12/03/24, 12/10/24, and 12/12/24.

Review of Resident #5's Vital Signs History notes from 10/01/24 through 12/10/24 revealed:
-There was documentation that Resident #5 refused pulse checks on 11/04/24 at 7:23pm, 11/05/24 at 8:02pm, 11/06/24 at 7:34pm, and 11/11/24 at 8:51pm.
-There was no documentation the primary care provider (PCP) had been notified of any pulse readings less than 60.

Review of Resident #5's progress notes from 06/05/24 to 12/10/24 revealed there was no documentation the PCP had been notified of any pulse readings less than than 60.

Interview with a medication aide (MA) on 12/20/24 at 10:21am revealed she would have documented in the resident's progress notes if she had contacted the PCP about the resident.

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D 273	Continued From page 17 Interview with a second MA on 12/20/24 at 10:43am revealed: -She had not contacted the PCP regarding any heart rates obtained for Resident #5. -She had not paid attention to the PCP instructions to call when the heart rate/pulse was less than 60. -She did not know who the PCP was for Resident #5. Interview with the Administrator on 12/20/24 at 10:20am revealed: -She expected the MAs to document their contacts in the resident's progress notes. -If the MAs had not documented their contacts in the resident's progress notes, she considered the contact with the PCP had not happened. Telephone interview with the PCP on 12/20/24 at 11:35am revealed: -There was no documentation in the provider notes that the facility had contacted the PCP regarding any heart rate/pulse readings obtained. -If Resident #5 only had two lower heart rate/pulse readings, she would not be concerned and would have requested monitoring of the resident if the lower heart rate/pulse readings continued.	D 273		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the	D 285		

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D 285	Continued From page 18 menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure the kitchen was stocked with a 3-day supply of perishable foods and a 5-day supply of nonperishable foods based on their census. The findings are: Review of the facility's census for 12/18/24 revealed there were 42 residents in the facility. Observation of the kitchen on 12/18/24 between 6:36am and 6:45am revealed: -There was 1 can of yams (sweet potatoes), with servings per can for 19. -According to the census of 42 and the serving size per can, the facility would use 3 cans during one meal, with a remainder of 0 can, needing an additional 14 cans for a 5-day supply. -There were 2 cans of collard greens, with servings per can for 22. -According to the census of 42 and the serving size per can, the facility would use 2 cans during one meal, with a remainder of 0 can, needing an	D 285		

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additional 10 cans for a 5-day supply.
-There were 2 cans of beets, with servings per can for 25.
-According to the census of 42 and the serving size per can, the facility would use 2 cans during one meal, with a remainder of 0 can, needing an additional 10 cans for a 5-day supply.
-There were 3 bags of instant mashed potatoes, with servings per bag for 42.
-According to the census of 42 and the serving size per bag, the facility would use 1 bag during one meal, with the remainder of 2 bags, needing an additional 2 bags for a 5-day supply.
-There were 3 cartons of cranberry juice, with servings per carton for 6.
-According to the census of 42 and the serving size per carton, the facility would use 7 cartons during one meal, with a remainder of 0 boxes, needing an additional 32 cartons for a 5-day supply.
-There were 2- 1-gallon jugs of milk, with servings per jug for 25.
-According to the census of 42 and the serving per jug, the facility would use 2 jugs during one meal, with a remainder of 0 jugs, needing an additional 6 jugs for a 3-day supply.
-The dietary aide told the Dietary Manger (DM) there were no eggs.
-There were not enough perishable food items for a 3-day supply.

Interview with the DM on 12/18/24 at 10:01am revealed:
-He was responsible for ordering the food in the kitchen.
-He used his backup food supply because it was about to expire.
-He was aware he needed a 3-day perishable and 5-day nonperishable food supply.
-He informed the Administrator he needed to

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D 285	Continued From page 20 order more food for his 3-day perishable and 5-day nonperishable food supply and was told to order what he could. -It was difficult for him to order enough food for the week's menu and a 3-day perishable and a 5-day nonperishable food supply due to his budget. Interview with the Administrator on 12/18/24 at 10:07am revealed: -The DM reported to her. -She was aware there needed to be a 3-day perishable and 5-day nonperishable food supply in the kitchen in case there was a disaster. -She did not know why there was not a 3-day supply and nonperishable food for a 5-day supply in the kitchen. -She thought there was enough perishable food for a 3-day supply and nonperishable food for a 5-day supply in the kitchen. -She expected the DM to order a 3-day perishable and a 5-day nonperishable food supply even if it meant going over the food budget.	D 285		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 358		

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D 358	Continued From page 21 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a muscle relaxant, a medication for anxiety and agitation, an eye drop for dry eye syndrome, an inhaler for breathing problems, a laxative, and an iron supplement for anemia (#6); a medication for high blood pressure, an antidepressant, and an eye drop for dry, irritated eyes (#7); and for 4 of 5 residents (#2, #3, #4, #5) sampled for record review including errors with medications for dementia (#3), seizures and mood disorders (#3), overactive bladder and kidney stones (#3), inflammation (#3), high cholesterol (#2), and a topical pain patch (#2). The findings are: 1. The medication error rate was 30% as evidenced by 9 errors out of 30 opportunities during the 8:00am/9:00am medication pass on 12/19/24. a. Review of Resident #6's current FL-2 dated 07/25/24 revealed diagnoses included vascular dementia, persistent atrial fibrillation, acute on chronic diastolic congestive heart failure, hyperlipidemia, and gout. Review of Resident #6's hospice orders dated 09/23/24 revealed an order for Cyclobenzaprine 5mg 1 tablet 3 times a day for muscle cramps. (Cyclobenzaprine is a muscle relaxant used to treat muscle spasms and pain.) Observation of the 8:00am/9:00am medication pass on 12/19/24 revealed:	D 358		

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-The medication aide (MA) prepared medications scheduled for 8:00am for Resident #6.
-Resident #6's medications were packaged in bubble cards.
-There were two different bubble cards with Cyclobenzaprine 5mg tablets.
-The MA punched one Cyclobenzaprine 5mg tablet from each bubble card for a total of 2 tablets (10mg).
-The MA administered two Cyclobenzaprine 5mg tablets along with the resident's other morning medications at 8:09am.
-The resident was administered 10mg of Cyclobenzaprine (5mg from two different bubble cards) instead of one 5mg tablet as ordered.

Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Cyclobenzaprine 5mg 1 tablet 3 times a day scheduled at 8:00am, 2:00pm, and 8:00pm.
-Cyclobenzaprine 5mg was documented as administered from 12/01/24 (2:00pm) - 12/19/24 (8:00am) except on 12/12/24 at 8:00pm, 12/18/24 at 8:00am and 2:00pm with no reasons documented.

Interview with the MA on 12/19/24 at 12:57pm revealed:
-She usually administered one Cyclobenzaprine 5mg tablet to Resident #6.
-The bubble cards for the Cyclobenzaprine were usually banded together with a rubber band.
-She did not notice when she was preparing the medications that the cards were separate, and she punched one Cyclobenzaprine 5mg tablet from each card.
-Resident #6 slept frequently during the day but would wake up around 2:00pm or 3:00pm and

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D 358	Continued From page 23 stay up all night. Observation of Resident #6's medications on hand on 12/19/24 at 1:03pm revealed: -There was a supply (card 1 of 2) of Cyclobenzaprine 5mg dispensed on 12/02/24 with instructions to take 1 tablet 3 times a day. -There were 13 of 22 tablets remaining in card 1 of 2. -There was a supply (card 2 of 2) of Cyclobenzaprine 5mg dispensed on 12/02/24 with instructions to take 1 tablet 3 times a day. -There were 15 of 23 tablets remaining. Observation of Resident #6 on 12/19/24 at 9:40am revealed: -The MA entered the resident's room to apply a pain patch. -The resident was sitting in her wheelchair in her room asleep with her head leaning down. -The MA called the resident's name 3 times and then lightly touched the resident's shoulder to wake her up. -The resident told the MA she was sleepy. -The MA then applied the resident's pain patch. Second observation of Resident #6 on 12/19/24 at 2:28pm revealed: -The resident was sitting in her wheelchair in her room asleep. -The resident's body was leaning to the left in the wheelchair. -The resident's name had to be called twice to wake her up. Interview with Resident #6 on 12/19/24 at 2:28pm revealed she felt okay except she was sleepier than normal today. Interview with the Resident Care Coordinator	D 358		

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(RCC) on 12/19/24 at 1:17pm revealed:
-The MAs had been trained to read the medication labels and the eMARs and administer the medications according to the orders.
-Resident #6 should not have received a double dose of Cyclobenzaprine that morning.
-There should have only been one card of Cyclobenzaprine 5mg in the medication cart.
-The extra card should have been stored in the backup supply of medications in the medication room.

Interview with the Health and Wellness Director (HWD) on 12/19/24 at 2:06pm revealed:
-The MAs should read the medication label and administer the medication according to the order.
-Resident #6 should have been administered one Cyclobenzaprine 5mg tablet instead of 2 tablets.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-The MAs had been trained to do 3 checks of the labels and eMARs before administering medications.
-Resident #6 should have received one Cyclobenzaprine 5mg tablet as ordered.

Interview with Resident #6's primary care provider (PCP) on 12/19/24 at 9:46am revealed:
-Resident #6 should have received one Cyclobenzaprine 5mg tablet.
-A double dose of the Cyclobenzaprine could cause the resident to have severe sedation.

b. Review of Resident #6's prescription dated 07/31/24 revealed an order for Lorazepam 0.5mg take 1 tablet twice a day as needed for agitation or anxiety. (Lorazepam is a controlled substance used to treat anxiety and agitation.)

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Review of Resident #6's hospice orders dated 09/23/24 revealed an order for Lorazepam 0.5mg 1 tablet twice a day for anxiety.

Review of Resident #6's mental health provider (MHP) visit note dated 11/14/24 revealed:
-The resident had dementia with behavioral disturbance that was chronic and unstable.
-The facility staff reported that the resident was easily agitated in the afternoon.
-There was evidence of cognitive decline.
-There was an order to increase Lorazepam to 0.5mg 3 times a day.

Observation of the 8:00am/9:00am medication pass on 12/19/24 revealed:
-The medication aide (MA) prepared and administered Resident #6's medications scheduled for 8:00am at 8:09am.
-The MA did not offer or prepare Lorazepam 0.5mg to Resident #6 during the morning medication pass.
-The resident did not receive Lorazepam 0.5mg as ordered.

Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Lorazepam 0.5mg 1 tablet every 4 hours as needed (prn) for anxiety or agitation.
-The prn Lorazepam was documented as administered on 4 occasions: 12/14/24 at 9:31am, 12/16/24 at 9:45am, 12/17/24 at 12:43pm, and 12/18/24 at 11:42am.
-There was an entry for Lorazepam 0.5mg 1 tablet 3 times a day scheduled at 8:00am, 12:00pm, and 5:00pm.
-Lorazepam 0.5mg 3 times a day was documented as administered from 12/01/24 -

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12/07/24 (8:00am), except for refusals on 12/01/24 at 8:00am and 12/06/24 at 12:00pm.
-Lorazepam 0.5mg 3 times a day was documented as discontinued from 12/07/24 at 12:00pm - 12/31/24 at 8:00pm.

Review of Resident #6's physician's orders revealed there was no order to discontinue Lorazepam 0.5mg 3 times a day.

Interview with the MA on 12/19/24 at 12:57pm revealed:
-She was not aware of a scheduled Lorazepam order for Resident #6 because it did not show up on the eMAR system when she administered morning medications.
-The resident usually got agitated in the evenings after supper.
-The resident was more confused in the evenings.
-The resident thought the staff were her family members and the resident would curse at staff in the evenings.

Observation of Resident #6's medications on hand on 12/19/24 at 12:58pm revealed:
-There was a supply of Lorazepam 0.5mg tablets dispensed on 07/31/24 with instructions to take 1 tablet every 4 hours as needed for anxiety or agitation.
-There were 34 of 60 tablets remaining in the card dispensed on 07/31/24.
-There was a supply of Lorazepam 0.5mg tablets dispensed on 11/26/24 with instructions to take 1 tablet every 4 hours as needed for anxiety or agitation.
-There were 55 of 60 tablets remaining in the card dispensed on 11/26/24.
-There was a supply of Lorazepam 0.5mg tablets dispensed on 12/02/24 with instructions to take 1

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TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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tablet every 4 hours as needed for anxiety or agitation.
-There were 60 of 60 tablets remaining in the card dispensed on 12/02/24.
-There was no supply of Lorazepam 0.5mg tablets with instructions to take 3 times a day.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at 11:11am revealed:
-The pharmacy staff usually entered medication orders into the eMAR system for the facility.
-The facility staff was responsible for reviewing and approving the orders before they became active in the eMAR system.
-The pharmacy received Resident #6's order dated 11/14/24 for Lorazepam 0.5mg 1 tablet 3 times a day.
-She could see the order for Lorazepam 0.5mg tablets in the pharmacy's eMAR system.
-She did not see an order to discontinue the Lorazepam 0.5mg 1 tablet 3 times a day.
-She did not know why the there was a stop date in the facility's eMAR system because she could not see a stop date in the pharmacy's eMAR system.

Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 1:17pm revealed:
-The pharmacy usually entered the orders into the eMAR system.
-The third shift MA, the Health and Wellness Director (HWD), or she had access to and were responsible for reviewing and approving orders in the eMAR system to activate the orders.
-They could also enter orders into the eMAR system if needed.
-She could only see the prn order for Lorazepam in the facility's active eMAR system.
-She did not know why the scheduled Lorazepam

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order for 3 times a day was stopped in the active eMAR system.

Interview with the HWD on 12/19/24 at 2:06pm revealed:
-The RCC, Administrator, or she had access to review and approve orders in the eMAR system.
-If one of them printed or removed the new status from an order without communicating it to each other, then an order could potentially be overlooked.
-There was not a system to check behind each other to make sure orders were reviewed accurately and approved.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-Resident #6's scheduled Lorazepam should be administered at 8:00am, 2:00pm, and 8:00pm.
-Resident #6's Lorazepam was increased to 3 times a day because the resident was agitated, verbally aggressive, and throwing things like bingo cards and plates on the floor.
-The pharmacy usually entered orders into the eMAR system but the facility had to approve the orders to activate them.
-The MAs, the RCC, and the HWD had access to approve medication orders.
-The MAs scanned orders to the RCC or HWD.
-The RCC or HWD were responsible for sending orders to the pharmacy.
-The third shift MA was responsible for verifying to make sure medications matched when they checked in the delivered medications.

Telephone interview with Resident #6's MHP on 12/20/24 at 10:16am revealed:
-Resident #6's Lorazepam was increased due to increased agitation.
-The resident was sundowning and "trashing" her

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room.
-Some of the resident's agitation could have been prevented if she received the scheduled Lorazepam 3 times a day as ordered.

c. Review of Resident #6's current FL-2 dated 07/25/24 revealed:
-There was an order for Symbicort inhaler 160-4.5mcg inhale 2 puffs twice a day.
(Symbicort is combination inhaler that contains Budesonide and Formoterol Fumarate Dihydrate. Breyna is another brand name used for Symbicort and is the same as Symbicort. Symbicort and Breyna are used to treat breathing problems such as chronic obstructive pulmonary disease.)

Review of Resident #6's hospice orders dated 09/23/24 revealed an order for Symbicort 160-4.5mcg inhale 2 puffs twice a day, rinse mouth after use.

Observation of the 8:00am/9:00am medication pass on 12/19/24 revealed:
-The medication aide (MA) prepared and administered Resident #6's medications scheduled for 8:00am at 8:09am.
-The MA did not offer or prepare Symbicort (Breyna) 160-4.5mcg inhaler to Resident #6 during the morning medication pass.
-The resident did not receive Symbicort (Breyna) 160-4.5mcg inhaler as ordered.

Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Breyna 160-4.5mcg inhaler (Budesonide-Formoterol Fumarate Dihydrate) inhale 2 puffs twice daily, rinse mouth after use.
-Breyna inhaler was scheduled to be

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administered at 8:00am and 8:00pm.
-Breyna inhaler was documented as administered from 12/03/24 - 12/17/24.
-Breyna inhaler was documented as not administered at 8:00am on 12/18/24 due to "other" with no specific reason documented.
-Documentation for Breyna inhaler on 12/19/24 at 8:00am had a hyphen with no reason documented.

Interview with the MA on 12/19/24 at 12:57pm revealed:
-She saw Resident #6's Symbicort inhaler in the medication cart but she did not realize it was the same as Breyna inhaler.
-She did not notice the generic name (Budesonide-Formoterol Fumarate Dihydrate) on Resident #6's Symbicort inhaler matched the generic name of the Breyna inhaler listed on the eMAR.
-Resident #6 had shortness of breath when she was agitated, usually in the evenings.

Observation of Resident #6's medications on hand on 12/19/24 at 1:08pm revealed:
-There was a Symbicort 160-4.5mcg inhaler "brand for Budesonide-Formoterol Fumarate Dihydrate", dispensed on 08/23/24.
-The instructions were to take 2 puffs twice daily, rinse mouth after use.
-There was a handwritten note on the box with and open date of 08/29/24.
-There were 52 of 120 puffs remaining in the inhaler.
-There was a second Symbicort 160-4.5mcg inhaler "brand for Budesonide-Formoterol Fumarate Dihydrate", dispensed on 11/07/24.
-The instructions were to take 2 puffs twice daily, rinse mouth after use.
-The box for the Symbicort inhaler dispensed on

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D 358	Continued From page 31 11/07/24 was sealed and had not been opened. Interview with Resident #6 on 12/19/24 at 2:28pm revealed -She sometimes received an inhaler in the morning and in the evenings. -She did not receive the inhaler that morning, 12/19/24. -She had no shortness of breath lately. Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 1:17pm revealed: -The MAs had been trained to read the medication labels and the eMARs and administer the medications according to the orders. -If the MAs had a question about a medication including questions about brand names and generic names, the MA should come to her or the Health and Wellness Director (HWD). Interview with the HWD on 12/19/24 at 2:06pm revealed: -The MA should read the medication label and administer the medication according to the order. -If the MA could not find a medication, they should check the backup supply. -If the MA still could not find a medication, the MA should notify the RCC. Interview with the Administrator on 12/19/24 at 1:39pm revealed: -The MAs had been trained to do 3 checks of the labels and eMARs before administering medications. -If the MA could not find a medication, the MA should notify the RCC or HWD to get assistance. Interview with Resident #6's primary care provider (PCP) on 12/19/24 at 9:46am revealed: -Resident #6 should have received the Symbicort	D 358		

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(Breyna) inhaler as ordered.
-Not receiving the inhaler as ordered could cause shortness of breath or worsening chronic obstructive pulmonary disease.

d. Review of Resident #6's current FL-2 dated 07/25/24 revealed an order for Cyclosporine Ophthalmic 0.05% one drop in both eyes twice a day. (Cyclosporine Ophthalmic is a prescription eye drop used to reduce inflammation in the eyes to treat dry eye syndrome.)

Observation of the 8:00am/9:00am medication pass on 12/19/24 revealed:
-The medication aide (MA) prepared and administered Resident #6's medications scheduled for 8:00am at 8:09am.
-The MA did not offer or prepare Cyclosporine Ophthalmic 0.05% solution to Resident #6 during the morning medication pass.
-The resident did not receive Cyclosporine Ophthalmic 0.05% solution as ordered.

Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Cyclosporine Ophthalmic 0.05% 1 drop in both eyes every 12 hours scheduled at 8:00am and 8:00pm.
-Cyclosporine eye drops were documented as administered from 12/01/24 (8:00pm) - 12/18/24 except on 12/12/24 at 8:00pm, 12/18/24 at 8:00am, and 12/19/24 at 8:00am with no reasons documented.

Interview with the MA on 12/19/24 at 12:57pm revealed:
-She overlooked the box with Resident #6's Cyclosporine eye drops that morning because the side of the box with the label was face down in

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the medication cart.
-She overlooked the eye drops but should have checked the label and administered the eye drops.

Observation of Resident #6's medications on hand on 12/19/24 at 1:03pm revealed:
-There was a supply Cyclosporine Ophthalmic 0.05% eye drops dispensed on 11/07/24.
-The instructions were to place 1 drop in both eyes every 12 hours.

Interview with Resident #6 on 12/19/24 at 2:28pm revealed:
-She was supposed to get eye drops every morning, but she did not receive eye drops that morning.
-Her eyes felt dry today.

Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 1:17pm revealed:
-The MAs had been trained to read the medication labels and the eMARs and administer the medications according to the orders.
-The MAs should double check the medication cart if they could not find a medication.
-The MAs could get another MA or her to check the medication cart with them.
-The MAs should also check the backup supply of medication if a medication was not in the medication cart.

Interview with the Health and Wellness Director (HWD) on 12/19/24 at 2:06pm revealed:
-The MAs should make sure they were not looking in the wrong place if they could not find a medication.
-If a medication was not in the medication cart, the MAs should check the backup supply.
-If the MAs could not find the medication, the MAs

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D 358	Continued From page 34 should notify the RCC. Interview with the Administrator on 12/19/24 at 1:39pm revealed: -The MAs had been trained to do 3 checks of the labels and eMARs before administering medications. -If the MA could not find a medication, the MA should notify the RCC or HWD to get assistance. Interview with Resident #6's primary care provider (PCP) on 12/19/24 at 9:46am revealed: -Resident #6 should have received the Cyclosporine eye drops as ordered. -Not receiving the Cyclosporine eye drops as ordered could cause eye irritation and excessive tearing of the eyes. e. Review of Resident #6's current FL-2 dated 07/25/24 revealed an order for Senna Plus 8.6mg-50mg 1 tablet once daily. (Senna Plus is a combination stool softener and laxative used to treat and prevent constipation.) Review of Resident #6's hospice orders dated 09/23/24 revealed an order for Senna Plus 8.6-50mg 1 tablet once daily for constipation. Observation of the 8:00am/9:00am medication pass on 12/19/24 revealed: -The medication aide (MA) prepared and administered Resident #6's medications scheduled for 8:00am at 8:09am. -The MA did not offer or prepare Senna Plus to Resident #6 during the morning medication pass. -The resident did not receive Senna Plus as ordered. Review of Resident #6's December 2024 electronic medication administration record	D 358		

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(eMAR) revealed:
-There was an entry for Senna Plus 8.6-50mg 1 tablet once daily scheduled at 8:00am.
-Senna Plus was documented as administered from 12/02/24 - 12/17/24.
-Senna Plus was documented as not administered on 12/18/24 and 12/19/24 with no reasons noted.

Interview with the MA on 12/19/24 at 12:57pm revealed:
-She did not administer Senna Plus to Resident #6 that morning because she did not see the Senna Plus in the medication cart.
-She found Resident #6's Senna Plus in the medication cart in the wrong place mixed with another resident's medications later that morning.
-She did not administer the Senna Plus when she found it because it was too late to administer it.

Observation of Resident #6's medications on hand on 12/19/24 at 12:58pm revealed:
-There was a supply of Senna Plus tablets dispensed on 10/31/24 with instructions to take 1 tablet once daily.
-There were 23 of 30 tablets remaining.

Interview with Resident #6 on 12/19/24 at 2:28pm revealed:
-She was not sure if she received medication for constipation.
-She denied any current issues with constipation.

Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 1:17pm revealed:
-The MAs should double check the medication cart if they could not find a medication.
-The MAs could get another MA or her to check the medication cart with them.
-The MAs should also check the backup supply of

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medication if a medication was not in the medication cart.

Interview with the Health and Wellness Director (HWD) on 12/19/24 at 2:06pm revealed:
-The MAs should make sure they were not looking in the wrong place if they could not find a medication.
-If a medication was not in the medication cart, the MAs should check the backup supply.
-If the MAs could not find the medication, the MAs should notify the RCC.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-The MAs had been trained to do 3 checks of the labels and eMARs before administering medications.
-If the MA could not find a medication, the MA should notify the RCC or HWD to get assistance.

Interview with Resident #6's primary care provider (PCP) on 12/19/24 at 9:46am revealed:
-Resident #6 should have received the Senna Plus as ordered.
-Not receiving the Senna Plus as ordered could cause constipation.

f. Review of Resident #6's current FL-2 dated 07/25/24 revealed an order for Hemocyte Plus 1 tablet once daily. (Hemocyte Plus is used to treat iron deficiency anemia.)

Observation of the 8:00am/9:00am medication pass on 12/19/24 revealed:
-The medication aide (MA) prepared and administered Resident #6's medications scheduled for 8:00am at 8:09am.
-The MA did not offer or prepare Hemocyte Plus to Resident #6 during the morning medication

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pass.
-The resident did not receive Hemocyte Plus as ordered.

Review of Resident #6's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Hemocyte Plus 1 capsule once daily scheduled at 8:00am.
-Hemocyte Plus was documented as administered from 12/02/24 - 12/17/24.
-Hemocyte Plus was documented as not administered on 12/18/24 and 12/19/24 with no reasons noted.

Interview with the MA on 12/19/24 at 12:57pm revealed:
-She did not administer Hemocyte Plus to Resident #6 that morning because she did not see the Hemocyte Plus in the medication cart.
-She found Resident #6's Hemocyte Plus in the medication cart in the wrong place mixed with another resident's medications later that morning.
-She did not administer the Hemocyte Plus when she found it because it was too late to administer it.

Observation of Resident #6's medications on hand on 12/19/24 at 12:58pm revealed:
-There was a supply of Hemocyte Plus capsules dispensed on 10/31/24 with instructions to take 1 capsule once daily.
-There were 19 of 30 capsules remaining.

Interview with Resident #6 on 12/19/24 at 2:28pm revealed:
-She was not sure if she received medication for anemia.
-She felt good today.

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Interview with the Resident Care Coordinator (RCC) on 12/19/24 at 1:17pm revealed:
-The MAs should double check the medication cart if they could not find a medication.
-The MAs could get another MA or her to check the medication cart with them.
-The MAs should also check the backup supply of medication if a medication was not in the medication cart.

Interview with the Health and Wellness Director (HWD) on 12/19/24 at 2:06pm revealed:
-The MAs should make sure they were not looking in the wrong place if they could not find a medication.
-If a medication was not in the medication cart, the MAs should check the backup supply.
-If the MAs could not find the medication, the MAs should notify the RCC.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-The MAs had been trained to do 3 checks of the labels and eMARs before administering medications.
-If the MA could not find a medication, the MA should notify the RCC or HWD to get assistance.

Interview with Resident #6's primary care provider (PCP) on 12/19/24 at 9:46am revealed:
-Resident #6 should have received the Hemocyte Plus as ordered.
-She was not concerned of any potential outcomes to the resident if she only missed the one dose.

g. Review of Resident #7's current FL-2 dated 10/29/24 revealed:
-Diagnoses included hypertension, dementia, pulmonary fibrosis, hypercholesterolemia,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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anemia, and insomnia.
-There was an order for Amlodipine 5mg 1 tablet once daily. (Amlodipine lowers blood pressure.)

Observation of the 8:00/9:00am medication pass on 12/19/24 revealed:
-The medication aide (MA) prepared and administered medications scheduled for 8:00am/9:00am for Resident #7 at 9:08am.
-The MA did not prepare and administer Amlodipine 5mg when the resident's other morning medications were administered at 9:08am.
-Amlodipine was not administered as ordered.

Review of Resident #7's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Amlodipine 5mg 1 tablet once daily scheduled at 8:00am.
-Amlodipine was documented as administered daily at 8:00am on 12/01/24 - 12/09/24, 12/14/24, 12/17/24, and 12/18/24.
-Amlodipine was documented as not administered on 12/09/24 - 12/13/24, 12/15/24, 12/16/24, and 12/19/24 due to "drug not given" and "drug not available".
-The resident's blood pressure was documented daily at 8:00am and ranged from 96/65 - 162/76 from 12/01/24 - 12/19/24.

Review of Resident #7's pharmacy dispensing records dated 09/01/24 - 12/19/24 revealed:
-There were 30 Amlodipine 5mg tablets dispensed on 09/02/24.
-There were 30 Amlodipine 5mg tablets dispensed on 10/06/24.

Review of the facility's Medication Reorder / Refills Only Form dated 12/05/24 revealed:

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D 358	Continued From page 40 -There was a pre-printed sticker with Resident #7's name, a prescription number, and Amlodipine printed on the sticker. -There was a handwritten note at the top of the page with "scanned already". -There was no other documentation on the form to indicate if the refills had been received. Interview with the MA on 12/19/24 at 9:13am revealed: -Resident #7's Amlodipine was not available to administer. -She could not locate it in the medication cart or in the back up supply of medication. -The medications were supposed to be on a monthly cycle fill from the pharmacy. -Some medications did not come in the cycle fill, but she was not sure which ones. -Once the medications got to the colored strip on the bubble card, they could be reordered. -The MAs put the stickers from the bubble card on the reorder forms and then scanned the form to the computer for the Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD). -The MAs were not allowed to fax the reorder forms to the pharmacy. -The RCC or HWD faxed reorder forms to the pharmacy. -After she finished the morning medication pass, she would verbally notify the RCC or the HWD of the unavailable medication. Second interview with the MA on 12/19/24 at 11:51am revealed: -Medications were usually delivered to the facility at night so she was not sure when Resident #7's Amlodipine would be available. -Resident #7's blood pressure was usually "good" when she checked it.	D 358		

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D 358	Continued From page 41 Interview with the RCC on 12/19/24 at 1:17pm revealed: -The MAs were responsible for refills by putting stickers on the reorder form, then scanning the form to her email and notifying her. -There was an electronic fax system that she used to fax the reorder forms to the pharmacy. -If there were no refills, the MA would write the name of the resident and the name of the medication with no refills and give it to her so she could contact the provider. -She had not seen Resident #7's Amlodipine on the reorder log until now. -She must have overlooked it. -The Amlodipine had no refills so she would contact the provider for a new order. Interview with HWD on 12/19/24 at 2:06pm revealed: -If a medication was not available on the medication cart, the MA should check to make sure it was not put in the wrong location on the medication cart. -The MAs should also check the backup medication supply to see if the medication was being stored there. -The MAs should notify the RCC who would contact the pharmacy to get refills or contact the provider to get a new order. -If a medication had no refills, the MAs could contact the providers to get refills. -She was responsible for doing medication cart audits. -She had done some cart audits and pulled some expired medications recently (could not recall when). -She had not done full cart audits to check to see if medications were available because she had not had time to do it.	D 358		

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-Each MA should be doing mini-cart audits every shift to make sure they had medications available.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-The facility usually received monthly cycle fills from the pharmacy for oral scheduled medications.
-The MAs were responsible for ordering other medications not on the cycle fills such as eye drops before they ran out.
-The MAs should notify the RCC or HWD if medications were unavailable.
-The RCC and HWD were responsible for contacting the provider if a new order for refills was needed.
-The HWD was responsible for doing weekly medication cart audits to make sure medications were available for administration.

Interview with Resident #7's primary care provider (PCP) on 12/19/24 at 9:46am revealed:
-The facility had not notified her that Resident #7 needed a new prescription for Amlodipine prior to today.
-The facility could send refill request through the telemedicine portal.
-She was concerned the missed doses of Amlodipine could cause the resident to have elevated blood pressure and possible chest pains.

Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable.

h. Review of Resident #7's provider progress note dated 11/14/24 revealed:
-The resident's major depressive disorder was

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chronic and stable.
-The resident was receiving Sertraline 25mg daily for mood support. (Sertraline is an antidepressant.)

Review of Resident #7's physician's order dated 11/16/24 revealed an order for Sertraline 50mg 1 tablet once daily.

Observation of the 8:00/9:00am medication pass on 12/19/24 revealed:
-The medication aide (MA) prepared and administered medications scheduled for 8:00am/9:00am for Resident #7 at 9:08am.
-The MA did not prepare and administer Sertraline 50mg when the resident's other morning medications were administered at 9:08am.
-Sertraline was not administered as ordered.

Review of Resident #7's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Sertraline 50mg 1 tablet once daily scheduled at 8:00am.
-Sertraline was documented as administered daily at 8:00am on 12/01/24 - 12/07/24, 12/14/24, 12/17/24, and 12/18/24.
-Sertraline was documented as not administered on 12/08/24 - 12/13/24, 12/15/24, 12/16/24, and 12/19/24 due to "drug not given" and "drug not available".

Review of Resident #7's pharmacy dispensing records dated 09/01/24 - 12/19/24 revealed:
-There were 30 Sertraline 25mg tablets dispensed on 09/02/24.
-There were 30 Sertraline 25mg tablets dispensed on 10/06/24.
-There were 30 Sertraline 50mg tablets

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D 358	Continued From page 44 dispensed on 11/17/24. Review of the facility's Medication Order Log dated 12/05/24 revealed: -There was a handwritten note with Resident #7's name, the name of the facility's contracted pharmacy, Sertraline 50mg and "new order needed. -The sections on the form for date ordered, initials of staff ordering, date received, and initials of staff receiving were blank. Interview with the MA on 12/19/24 at 9:13am revealed: -Resident #7's Sertraline was not available to administer. -She could not locate it in the medication cart or in the back up supply of medication. -The medications were supposed to be on a monthly cycle fill from the pharmacy. -Some medications did not come in the cycle fill, but she was not sure which ones. -Once the medications got to the colored strip on the bubble card, they could be reordered. -The MAs pulled the stickers from the bubble card and put on the reorder forms and then they scanned the form to the computer for the Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD). -The MAs were not allowed to fax the reorder forms to the pharmacy. -The RCC or HWD faxed reorder forms to the pharmacy. -After she finished the morning medication pass, she would verbally notify the RCC or the HWD of the unavailable medication. Second interview with the MA on 12/19/24 at 11:51am revealed: -Medications were usually delivered to the facility	D 358		

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D 358	Continued From page 45 at night so she was not sure when Resident #7's Sertraline would be available. -Resident #7 was usually in a good mood. Interview with the RCC on 12/19/24 at 1:17pm revealed: -The MAs were responsible for refills by putting stickers on the reorder form, then scanning the form to her email and notifying her. -There was an electronic fax system that she used to fax the reorder forms to the pharmacy. -If there were no refills, the MA would write the name of the resident and the name of the medication with no refills and give it to her so she could contact the provider. -She had not seen Resident #7's Sertraline on the reorder log until now. -She must have overlooked it. -The Sertraline had no refills so she would contact the provider for a new order. Interview with the HWD on 12/19/24 at 2:06pm revealed: -If a medication was not available on the medication cart, the MA should check to make sure it was not put in the wrong location on the medication cart. -The MAs should also check the backup medication supply to see if the medication was being stored there. -The MAs should notify the RCC who would contact the pharmacy to get refills or contact the provider to get a new order. -If a medication had no refills, the MAs could contact the providers to get refills. -She was responsible for doing medication cart audits. -She had done some cart audits and pulled some expired medications recently (could not recall when).	D 358		

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D 358	Continued From page 46 -She had not done full cart audits to check to see if medications were available because she had not had time to do it. -Each MA should be doing mini-cart audits every shift to make sure they had medications available. Interview with the Administrator on 12/19/24 at 1:39pm revealed: -The facility usually received monthly cycle fills from the pharmacy for oral scheduled medications. -The MAs were responsible for ordering other medications not on the cycle fills such as eye drops before they ran out. -The MAs should notify the RCC or HWD if medications were unavailable. -The RCC and HWD were responsible for contacting the provider if a new order for refills was needed. -The HWD was responsible for doing weekly medication cart audits to make sure medications were available for administration. Interview with Resident #7's primary care provider (PCP) on 12/19/24 at 9:46am revealed: -The facility had not notified her that Resident #7 needed a new prescription for Sertraline prior to today. -The facility could send refill request through the telemedicine portal. -She was concerned the missed doses of Sertraline could cause the resident to have withdrawal symptoms such as feeling doom, panic attacks, sweats, tremors, poor appetite, and changes in vital signs. -The resident could also go back into a depressive state without taking Sertraline daily as ordered.	D 358		

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D 358	Continued From page 47 Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable. i. Review of Resident #7's current FL-2 dated 10/29/24 revealed an order for Refresh Tears 0.5% ophthalmic solution instill 1 drop in each eye every day. (Refresh Tears is used to relieve dry, irritated eyes.) Observation of the 8:00/9:00am medication pass on 12/19/24 revealed: -The medication aide (MA) prepared and administered medications scheduled for 8:00am/9:00am for Resident #7 at 9:08am. -The MA did not prepare and administer Refresh Tears 0.5% when the resident's other morning medications were administered at 9:08am. -Refresh Tears were not administered as ordered. Review of Resident #7's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Refresh Tears 0.5% instill 1 drop in each eye every day scheduled at 9:00am. -Refresh Tears was documented as administered from 12/01/24 - 12/18/24. -Refresh Tears was documented as not administered on 12/19/24 due to the medication being unavailable. Review of Resident #7's pharmacy dispensing records dated 09/01/24 - 12/19/24 revealed there was no documentation of any Refresh Tears being dispensed for Resident #7 from 09/01/24 - 12/19/24. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at	D 358		

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D 358	Continued From page 48 11:11am revealed: -The pharmacy last dispensed Refresh Tears for Resident #7 on 05/10/23. -There had been no request to refill the Refresh Tears in over a year, since 05/10/23. Interview with the MA on 12/19/24 at 9:13am revealed: -Resident #7's Refresh Tears were not available to administer. -She could not locate it in the medication cart or in the back up supply of medication. -The medications were supposed to be on a monthly cycle fill from the pharmacy. -Some medications did not come in the cycle fill but she was not sure which ones. -Once the medications got to the colored strip on the bubble card, they could be reordered. -The MAs pulled the stickers from the bubble card and put on the reorder forms and then they scanned the form to the computer for the Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD). -The MAs were not allowed to fax the reorder forms to the pharmacy. -The RCC or HWD faxed reorder forms to the pharmacy. -After she finished the morning medication pass, she would verbally notify the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD) of the unavailable medication. Second interview with the MA on 12/19/24 at 11:51am revealed: -Medications were usually delivered to the facility at night so she was not sure when Resident #7's Refresh Tears would be available. -Resident #7 did not complain of dry eyes to her knowledge.	D 358		

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D 358	Continued From page 49 Interview with the RCC on 12/19/24 at 1:17pm revealed: -The MAs were responsible for refills by putting stickers on the reorder form, then scanning the form to her email and notifying her. -There was an electronic fax system that she used to fax the reorder forms to the pharmacy. -If there were no refills, the MA would write the name of the resident and the name of the medication with no refills and give it to her so she could contact the provider. -She had not seen anything on any forms about Resident #7's Refresh Tears. -No one notified her until today, 12/19/24, that Resident #7 did not have any Refresh Tears. Interview with the HWD on 12/19/24 at 2:06pm revealed: -If a medication was not available on the medication cart, the MA should check to make sure it was not put in the wrong location on the medication cart. -The MAs should also check the backup medication supply to see if the medication was being stored there. -The MAs should notify the RCC who would contact the pharmacy to get refills or contact the provider to get a new order. -If a medication had no refills, the MAs could contact the providers to get refills. -She was responsible for doing medication cart audits. -She had done some cart audits and pulled some expired medications recently (could not recall when). -She had not done full cart audits to check to see if medications were available because she had not had time to do it. -Each MA should be doing mini-cart audits every shift to make sure they had medications	D 358		

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available.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-The facility usually received monthly cycle fills from the pharmacy for oral scheduled medications.
-The MAs were responsible for ordering other medications not on the cycle fills such as eye drops before they ran out.
-The MAs should notify the RCC or HWD if medications were unavailable.
-The RCC and HWD were responsible for contacting the provider if a new order for refills was needed.
-The HWD was responsible for doing weekly medication cart audits to make sure medications were available for administration.

Interview with Resident #7's primary care provider (PCP) on 12/19/24 at 9:46am revealed:
-The facility had not notified her that Resident #7 did not have any Refresh Tears.
-The facility could send refill request through the telemedicine portal.
-Missed doses of Refresh Tears could cause eye irritation which could cause excessive tearing of the eyes.

Based on observations, interviews, and record review, it was determined that Resident #7 was not interviewable.

2. Review of Resident #4's current FL-2 dated 10/08/24 revealed:
-Diagnoses included dementia, type 2 diabetes mellitus with chronic kidney disease, hyperlipidemia, acquired absence of kidney, open-angle glaucoma, Vitamin D deficiency, and deficiency of group B vitamins.

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-The resident's level of care ws documented as domiciliary and "memory care".

Review of Resident #4's Contact Information Form revealed the resident was admitted and moved into the facility on 10/10/24.

Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed:
-The resident was admitted to the hospital on 01/29/24.
-The resident's admitting/primary diagnosis was dementia with behavioral disturbances.
-The resident was admitted to the hospital from a former memory care facility following assault on staff members.
-The resident became more agitated at about one month into the stay so psychiatry was consulted to assist with agitation pharmacotherapy.
-The resident was discharged from the hospital on 10/10/24.

a. Review of Resident #4's current FL-2 dated 10/08/24 revealed an order for Brexpiprazole 2mg 1 tablet daily. (Brexpiprazole is an antipsychotic used to treat agitation associated with dementia.)

Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed an order to continue Brexpiprazole 2mg daily (started 03/29/24) for agitation (of note, he will discharge with a 15-day supply of the 1mg tablets to take with him, when a new order of 2mg tablets arrive, those will be mailed to him).

Review of Resident #4's facility progress notes revealed:
-On 10/11/24 at 11:06pm, the resident would leave from his room and wander in the halls; the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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resident had rapid mood changes between aggressive and then cheerful within one conversation; resident was safe in the quiet room and next shift was made aware.
-On 10/13/24 at 10:35am, the resident followed the caregiver to the laundry room and asked to help; when the caregiver put clothes in the washing machine, the resident accused her of stealing his wallet; the resident backed the caregiver into the corner and yelled that he would "blow her brains out"; the resident was redirected by another caregiver.

Review of Resident #4's VA emergency department (ED) discharge note dated 10/22/24 revealed:
-The resident was admitted to the ED on 10/22/24.
-The resident's discharge diagnosis on 10/22/24 was agitation related to dementia.

Review of Resident #4's facility progress notes revealed:
-On 10/25/24 at 10:22am, the resident was speaking to himself in a manner that was undetermined by words; the resident was requesting to purchase metal and he was pacing back and forth; the resident gave an unpleasant stare; the resident was given a prn medication.
-On 11/04/24 at 3:10pm, the resident was in another room and when a personal care aide (PCA) tried to help move the resident out, the resident grabbed the PCA's hands and started to squeeze very tight and did not want to let go; when two other staff tried to help, the resident stood up and grabbed the PCA again and squeezed even tighter.

Review of Resident #4's October 2024 24-hour shift report forms used as handwritten October

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D 358	Continued From page 53 2024 medication administration records (MARs) revealed: -The administration of Resident #4's medications for 10/13/24 - 10/24/24 were handwritten and documented on 24-hour shift report forms. -There was no documentation of administration of any medications from 10/10/24 (admission date) - 10/12/24. -There was a handwritten entry for Brexpiprazole 1mg take 2 tablets every day for dementia and it was scheduled at 8:00am. -Brexpiprazole was documented as administered on 9 occasions at 8:00am including 10/13/24 - 10/15/24 and 10/17/24 - 10/22/24. -There was no documentation of the administration of Brexpiprazole on 10/16/24, 10/23/24, and 10/24/24, with no reasons noted. Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed: -Documentation for the administration of medications did not start until 10/24/24. -Documentation for the administration of medications prior to 10/24/24 were grayed out with no initials. -There was no entry for Brexpiprazole and none documented as administered. Review of Resident #4's November 2024 eMAR revealed there was no entry for Brexpiprazole and none documented as administered. Review of Resident #4's December 2024 eMAR dated 12/01/24 - 12/18/24 revealed there was no entry for Brexpiprazole, and none documented as administered. Review of Resident #4's physician's orders revealed no orders to discontinue Brexpiprazole.	D 358		

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D 358	Continued From page 54 Review of Resident #4's pharmacy dispensing record dated 09/01/24 - 12/19/24 from the facility's contracted pharmacy revealed there were no Brexpiprazole tablets dispensed by the facility's contracted pharmacy. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at 10:57am revealed: -They usually entered orders into the eMAR system and the facility was responsible for reviewing and approving the orders prior to the orders becoming active in the eMAR system. -They entered Resident #4's orders into the eMAR system on 10/11/24, so the facility staff should have been able to access and enter medication administration on the eMAR for the resident at that time. -She was not aware Resident #4 had handwritten MARs prior to 10/24/24. -They had not dispensed any Brexpiprazole for Resident #4. -It appeared in the eMAR system that the resident became "profile only" on 10/23/24, meaning they would only enter orders into the eMAR system for Resident #4. -They would only dispense medications for Resident #4 if the facility requested it. Observation of Resident #4's medications on hand on 12/19/24 at 12:23pm revealed: -All of Resident #4's medications were observed including medications stored in the medication cart and in the backup supply in the medication room. -There was no Brexpiprazole available for administration for Resident #4. Interview with a medication aide (MA) on	D 358		

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D 358	Continued From page 55 12/19/24 at 11:55am revealed: -Resident #4's medications were dispensed by a VA pharmacy. -The MAs usually let the resident's family member know before the resident ran out of medication, usually when there were about 10 pills remaining in the supply. -The resident's family member usually picked up the medication refills and brought them to the facility. -The MAs also let the resident's family member know after the medication ran out if they still did not have it on hand. -The MAs were supposed to document what medications were brought into the facility by the family member. -She was not sure why Resident #4 had paper/handwritten MARs when he was first admitted to the facility. -She could not recall if the resident missed any doses of medications when he was first admitted to the facility. -She did not recall if the resident received Brexpiprazole but there was none currently available in the facility for administration. Telephone interview with Resident #4's family member on 12/18/24 at 3:39pm revealed: -Resident #4 was inpatient at a VA hospital for about a year prior to being admitted to the facility. -She picked up the resident from the hospital on 10/10/24 and transported the resident to the facility that same day. -She picked up all the resident's medications from the VA hospital pharmacy on 10/10/24 and took them to the facility with the resident on 10/10/24. -She gave the medications and the paperwork to the Administrator when the resident was admitted to the facility on 10/10/24.	D 358		

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-About 2 weeks after the resident was admitted to the facility, she received a call from the Health and Wellness Director (HWD) that Resident #4 had gone into the wrong room and struck the HWD.
-The HWD reported that she was calling the police.
-When she arrived at the facility, the resident was no longer in the wrong room and the resident was transported to the hospital by emergency medical services (EMS).
-The resident's medications were adjusted and he was sent back to the facility.

Telephone interview with a contact representative with pharmacy customer care at Resident #4's VA pharmacy provider on 12/20/24 at 10:39am revealed:
-He was unable to give specific details about the resident's medication due to VA policies.
-Brexpiprazole was dispensed on 10/09/24.
-He was unable to give the strengths or quantity of medication dispensed on 10/09/24.
-All the medications dispensed on 10/09/24 were picked up but he was unable to give the specific date of pick up.

Interviews with the HWD on 12/20/24 at 8:40am and 11:36am revealed:
-Resident #4 had paper MARs when he was first admitted because there was a problem with the facility being able to see his orders in the eMAR system.
-The pharmacy could see them on their end but the facility could not see them.
-She was new at the facility at that time and she did not know how to enter orders into the eMAR system.
-She could not locate paper MARs for 10/10/24 - 10/12/24 but she felt sure the medications were

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administered on those days.
-She did not recall Resident #4 missing any doses of medication when he was admitted to the facility.
-She was responsible for checking the MARs daily and doing medication cart audits, but she had not had time to do a complete MAR or cart audit.
-She was not aware of the discrepancy with Resident #4's Brexpiprazole.
-She did not know why Brexpiprazole was stopped and not administered.
-She did not recall if she received medications or paperwork from Resident #4's family member when the resident was admitted to the facility on 10/10/24.
-She could not locate any documentation of the names or quantities of medications brought in the facility for Resident #4 when he was admitted on 10/10/24.

Interviews with the Administrator on 12/20/24 at 8:45am and 11:29am revealed:
-All MAs knew how to enter orders into the eMAR system.
-Resident #4's medication administration should have been documented in the eMAR system when he was admitted to the facility.
-When a resident's family took them to a provider or brought them back from the hospital, the family was supposed to give any paperwork to the MA, Resident Care Coordinator (RCC), or HWD.
-The MA would give the paperwork to the RCC or HWD, who were responsible for reviewing and processing the paperwork, including any orders.
-She did not recall Resident #4's family member giving her any paperwork or medications when the resident was admitted.
-The facility was responsible for ordering Resident #4's medications.

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-The MAs should notify the RCC or HWD before a medication ran out.
-The RCC and HWD were responsible for reordering medications and sending orders to the pharmacy.
-If a medication was not received, the RCC or HWD should contact the pharmacy or the provider.

Attempted telephone interviews with Resident #4's primary care VA provider on 12/20/24 at 10:32am and 5:05pm were unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

b. Review of Resident #4's current FL-2 dated 10/08/24 revealed an order for Risperidone 0.5mg 1 tablet twice a day as needed (prn) first line for agitation. (Risperdal is an antipsychotic used to treat agitation and mood disorders.)

Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed an order for Risperidone 1mg take ½ tablet two times a day as needed (prn) first line for agitation.

Review of Resident #4's facility progress notes revealed:
-On 10/11/24 at 11:06pm, the resident would leave from his room and wander in the halls; the resident had rapid mood changes between aggressive and then cheerful within one conversation; resident was safe in the quiet room and next shift was made aware.
-On 10/13/24 at 10:35am, the resident followed the caregiver to the laundry room and asked to help; when the caregiver put clothes in the

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washing machine, the resident accused her of stealing his wallet; the resident backed the caregiver into the corner and yelled that he would "blow her brains out"; the resident was redirected by another caregiver.

Review of Resident #4's VA emergency department (ED) discharge note dated 10/22/24 revealed:
-The resident was admitted to the ED on 10/22/24.
-The resident's discharge diagnosis on 10/22/24 was agitation related to dementia.
-There was an order to continue with scheduled Risperdal 0.5mg twice daily.

Review of Resident #4's facility progress notes revealed:
-On 10/25/24 at 10:22am, the resident was speaking to himself in a manner that was undetermined by words; the resident was requesting to purchase metal and he was pacing back and forth; the resident gave an unpleasant stare; the resident was given a prn medication.
-On 11/04/24 at 3:10pm, the resident was in another room and when a personal care aide (PCA) tried to help move the resident out, the resident grabbed the PCA's hands and started to squeeze very tight and did not want to let go; when two other staff tried to help, the resident stood up and grabbed the PCA again and squeezed even tighter.

Review of Resident #4's October 2024 24-hour shift report forms used as handwritten October 2024 medication administration records (MARs) revealed:
-The administration of Resident #4's medications for 10/13/24 - 10/24/24 were handwritten and documented on 24-hour shift report forms.

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D 358	Continued From page 60 -There was no documentation of administration of any medications from 10/10/24 (admission date) - 10/12/24. -There was a handwritten entry for Risperidone 0.5mg 1 tablet twice daily prn agitation. -The prn Risperidone was documented as administered on 10/13/24 at 9:00am and 4:00pm; 10/14/24 during 7am - 3pm shift (no specific time noted); 10/15/24 at 8:00am and 4:50pm; 10/16/24 during 7am - 3pm shift (no specific time noted); 10/17/24 during 7am - 3pm shift (no specific time noted); 10/18/24 at 8:00am; 10/19/24 at 9:30am; 10/20/24 at 10:00am; 10/21/24 during 7am - 3pm shift (no specific time noted); 10/22/24 at 7:45am; 10/23/24 during 3pm - 11pm shift (no specific time noted); and 10/23/24 during 3pm - 11pm shift (no specific time noted). -There was no entry for scheduled Risperdal twice daily as ordered on 10/22/24 and none was documented as administered. Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed: -Documentation for the administration of medications did not start until 10/24/24. -Documentation for the administration of medications prior to 10/24/24 were grayed out with no initials. -There was an entry for Risperidone 0.5mg take 1 tablet twice daily prn first line for agitation. -The prn Risperidone was documented as administered 3 times: on 10/25/24 at 5:35pm, 10/28/24 at 7:42pm, and 10/31/24 at 4:00pm. -There was no entry for scheduled Risperidone as ordered on the ED discharge note dated 10/22/24. Review of Resident #4's November 2024 eMAR revealed:	D 358		

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-There was an entry for Risperidone 0.5mg take 1 tablet twice daily prn first line for agitation.
-The prn Risperidone was documented as administered 2 times: on 11/01/24 at 7:37pm and 11/05/24 at 12:29pm.
-There was no entry for scheduled Risperidone as ordered on the ED discharge note dated 10/22/24.

Review of Resident #4's December 2024 eMAR dated 12/01/24 - 12/18/24 revealed:
-There was an entry for Risperidone 0.5mg take 1 tablet twice daily prn first line for agitation.
-There was no prn Risperidone documented as administered in December 2024.
-There was no entry for scheduled Risperidone as ordered on the ED discharge note dated 10/22/24.

Review of Resident #4's pharmacy dispensing record dated 09/01/24 - 12/19/24 from the facility's contracted pharmacy revealed there were 30 Risperidone 0.5mg tablets dispensed on 10/11/24.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at 10:57am revealed:
-They usually entered orders into the eMAR system and the facility was responsible for reviewing and approving the orders prior to the orders becoming active in the eMAR system.
-They entered Resident #4's orders into the eMAR system on 10/11/24, so the facility staff should have been able to access and enter medication administration on the eMAR for the resident at that time.
-She was not aware Resident #4 had handwritten MARs prior to 10/24/24.
-They also dispensed a partial month's supply for

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several of the resident's medications on 10/11/24.
-It appeared in the eMAR system that the resident became "profile only" on 10/23/24, meaning they would only enter orders into the eMAR system for Resident #4.
-They would only dispense medications for Resident #4 if the facility requested it.

Review of Resident #4's VA pharmacy receipts dated 10/22/24 revealed:
-There were 14 Risperidone 1mg tablets dispensed and picked up at the outpatient pharmacy window on 10/22/24.
-The instructions were to take ½ tablet (0.5mg) twice daily (scheduled) for agitation related to dementia.

Observation of Resident #4's medications on hand on 12/19/24 at 12:23pm revealed:
-All of Resident #4's medications were observed including medications stored in the medication cart and in the backup supply in the medication room.
-There was no Risperidone, scheduled or prn, available for administration for Resident #4.

Interview with a medication aide (MA) on 12/19/24 at 11:55am revealed:
-Resident #4's medications were dispensed by a VA pharmacy.
-The resident had been out of prn Risperidone for about 3 weeks and there was still none available today, 12/19/24.
-There had been at least two occasions the resident was agitated while she was working and needed prn Risperidone but none was available to administer.
-The resident was "real agitated"; the resident was cursing, would not follow directions, and would not let staff toilet him.

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D 358	Continued From page 63 -In the past, prn Risperidone had helped with those symptoms. -The MAs usually let the resident's family member know before the resident ran out of medication, usually when there were about 10 pills remaining in the supply. -The resident's family member usually picked up the medication refills and brought them to the facility. -The MAs also let the resident's family member know after the medication ran out if they still did not have it on hand. -She was not sure why Resident #4 had paper/handwritten MARs when he was first admitted to the facility. -She could not recall if the resident missed any doses of medications when he was first admitted to the facility. Telephone interview with Resident #4's family member on 12/18/24 at 3:39pm revealed: -Resident #4 was inpatient at a VA hospital for about a year prior to being admitted to the facility. -She picked up the resident from the hospital on 10/10/24 and transported the resident to the facility that same day. -She picked up all the resident's medications from the VA hospital pharmacy on 10/10/24 and took them to the facility with the resident on 10/10/24. -She gave the medications and the VA paperwork to the Administrator when the resident was admitted to the facility on 10/10/24. -About 2 weeks after the resident was admitted to the facility, she received a call from the Health and Wellness Director (HWD) that Resident #4 was in the wrong room and had struck the HWD. -The HWD reported that she was calling the police. -When she arrived at the facility, the resident was	D 358		

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no longer in the wrong room and the resident was transported to the hospital by EMS.
-The resident's medications were adjusted and he was sent back to the facility.
-The resident's Risperidone was changed to scheduled and prn; she picked up the medication from the VA hospital and took the medication and the paperwork and gave it to a MA when she returned the resident to the facility on 10/22/24.
-She went to the facility the next day and a MA reported to her that the resident had not received his medications for 2 weeks.
-She spoke with the Administrator and the HWD and they reported the resident had been getting his medications.
-One day while she was visiting the resident at the facility (could not recall date), the resident was sundowning and getting agitated.
-She asked the MA to give the resident some Risperidone, but the MA said the resident was out of Risperidone.
-The MA then went and looked in another medication cart and found the Risperidone in the other cart.

Second telephone interview with Resident #4's family member on 12/19/24 at 5:42pm revealed:
-She was at the facility today, 12/19/24, to visit the resident.
-The MA told her today that Resident #4 was currently out of two medications, which included Risperidone.
-She was not aware prior to today that the resident was currently out these medications.
-She had been unable to get a straight answer from facility staff about who was supposed to order the resident's medications.
-If the facility staff would let her know, she could order the medications.

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TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

(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 358	Continued From page 65 Telephone interview with a contact representative with pharmacy customer care at Resident #4's VA pharmacy provider on 12/20/24 at 10:39am revealed: -He was unable to give specific details about the resident's medication due to VA policies. -Risperidone was dispensed on 10/09/24. -He was unable to give the strengths or quantities of medications dispensed on 10/09/24. -All the medications dispensed on 10/09/24 were picked up but he was unable to give the specific date of pick up. Interviews with the HWD on 12/20/24 at 8:40am and 11:36am revealed: -Resident #4 had paper MARs when he was first admitted because there was a problem with the facility being able to see his orders in the eMAR system. -The pharmacy could see them on their end, but the facility could not see them. -She was new at the facility at that time, and she did not know how to enter orders into the eMAR system. -She could not locate paper MARs for 10/10/24 - 10/12/24 but she felt sure the medications were administered on those days. -She did not recall if she received medications or paperwork from Resident #4's family member when the resident was admitted to the facility on 10/10/24. -She did not recall Resident #4 missing any doses of medication when he was admitted to the facility. -She was responsible for checking the MARs daily and doing medication cart audits, but she had not had time to do a complete MAR or cart audit. -She was not aware Resident #4 was currently out of Risperidone, and she did not know why the	D 358		

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scheduled Risperidone order was not entered into the eMAR system.

Interviews with the Administrator on 12/20/24 at 8:45am and 11:29am revealed:
-All MAs knew how to enter orders into the eMAR system.
-Resident #4's medication administration should have been documented in the eMAR system when he was admitted to the facility.
-When a resident's family took them to a provider or brought them back from the hospital, the family was supposed to give any paperwork to the MA, Resident Care Coordinator (RCC), or HWD.
-The MA would give the paperwork to the RCC or HWD, who were responsible for reviewing and processing the paperwork, including any orders.
-She did not recall Resident #4's family member giving her any paperwork or medications when the resident was admitted.
-The facility was responsible for ordering Resident #4's medications.
-The MAs should notify the RCC or HWD before a medication ran out.
-The RCC and HWD were responsible for reordering medications and sending orders to the pharmacy.
-If a medication was not received, the RCC or HWD should contact the pharmacy or the provider.

Attempted telephone interviews with Resident #4's primary care VA provider on 12/20/24 at 10:32am and 5:05pm were unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

c. Review of Resident #4's current FL-2 dated

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10/08/24 revealed an order for Melatonin 3mg in the evening. (Melatonin is used to treat insomnia.)

Review of Resident #4's veteran's administration (VA) hospital discharge summary dated 10/10/24 revealed an order to continue Melatonin 3mg nightly for sleep.

Review of Resident #4's October 2024 24-hour shift report forms used as handwritten October 2024 medication administration records (MARs) revealed:
-The administration of Resident #4's medications for 10/13/24 - 10/24/24 were handwritten and documented on 24-hour shift report forms.
-There was no documentation of administration of any medications from 10/10/24 (admission date) - 10/12/24.
-There was a handwritten entry for Melatonin 3mg 1 tablet every night for sleep scheduled at 8:00pm.
-Melatonin 3mg was documented as administered at 8:00pm on 7 occasions from 10/13/24 - 10/24/24.
-Melatonin was documented as not administered on 10/18/24 due to the medication not being on the cart.
-Melatonin was documented as refused on 10/14/24 and 10/19/24.

Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed:
-Documentation for the administration of medications did not start until 10/24/24.
-Documentation for the administration of medications prior to 10/24/24 were grayed out with no initials.
-There was an entry for Melatonin 3mg 1 tablet

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every evening scheduled at 8:00pm.
-Melatonin 3mg was documented as administered at 8:00pm from 10/27/24 - 10/31/24.
-Melatonin was documented as not administered on 10/26/24 due to refusing and 10/25/24 with the reason of "other".

Review of Resident #4's November 2024 eMAR revealed:
-There was an entry for Melatonin 3mg 1 tablet every evening scheduled at 8:00pm.
-Melatonin 3mg was documented as administered at 8:00pm from 11/01/24 - 11/30/24 except two refusals on 11/03/24 and 11/05/24.

Review of Resident #4's December 2024 eMAR dated 12/01/24 - 12/18/24 revealed:
-There was an entry for Melatonin 3mg 1 tablet every evening scheduled at 8:00pm.
-Melatonin 3mg was documented as administered at 8:00pm from 12/01/24 - 12/13/24 and 12/16/24 - 12/17/24.
-Melatonin 3mg was documented as not being administered on 12/14/24 and 12/15/24 due to the medication being unavailable.

Review of Resident #4's pharmacy dispensing record dated 09/01/24 - 12/19/24 from the facility's contracted pharmacy revealed there were no Melatonin tablets dispensed by the facility's contracted pharmacy.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at 10:57am revealed:
-They usually entered orders into the eMAR system and the facility was responsible for reviewing and approving the orders prior to the orders becoming active in the eMAR system.
-They entered Resident #4's orders into the

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eMAR system on 10/11/24, so the facility staff should have been able to access and enter medication administration on the eMAR for the resident at that time.
-They also dispensed a partial month's supply for several of the resident's medications on 10/11/24.
-It appeared in the eMAR system that the resident became "profile only" on 10/23/24, meaning they would only enter orders into the eMAR system for Resident #4.
-They would only dispense medications for Resident #4 if the facility requested it.

Observation of Resident #4's medications on hand on 12/19/24 at 12:23pm revealed:
-All of Resident #4's medications were observed including medications stored in the medication cart and in the backup supply in the medication room.
-There was no Melatonin available for administration for Resident #4.

Interview with a medication aide (MA) on 12/19/24 at 11:55am revealed:
-Resident #4's medications were dispensed by a VA pharmacy.
-The MAs usually let the resident's family member know before the resident ran out of medication, usually when there were about 10 pills remaining in the supply.
-The resident's family member usually picked up the medication refills and brought them to the facility.
-The MAs also let the resident's family member know after the medication ran out if they still did not have it on hand.
-The MAs were supposed to document what medications were brought into the facility by the family member.
-She was not sure why Resident #4 had

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paper/handwritten MARs when he was first admitted to the facility.
-She could not recall if the resident missed any doses of medications when he was first admitted to the facility.
-She could not locate any Melatonin for the resident currently.

Telephone interview with Resident #4's family member on 12/18/24 at 3:39pm revealed:
-Resident #4 was inpatient at a VA hospital for about a year prior to being admitted to the facility.
-She picked up the resident from the hospital on 10/10/24 and transported the resident to the facility that same day.
-She picked up all the resident's medications from the VA hospital pharmacy on 10/10/24 and took them to the facility with the resident on 10/10/24.
-She gave the medications and the paperwork to the Administrator when the resident was admitted to the facility on 10/10/24.

Second telephone interview with Resident #4's family member on 12/19/24 at 5:42pm revealed:
-She was at the facility today, 12/19/24, to visit the resident.
-The MA told her today that Resident #4 was currently out of two medications, which included Melatonin.
-She was not aware prior to today that the resident was out of these medications.
-She had been unable to get a straight answer from facility staff about who was supposed to order the resident's medications.
-If the facility staff would let her know, she could order the medications.

Telephone interview with a contact representative with pharmacy customer care at Resident #4's VA

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pharmacy provider on 12/20/24 at 10:39am revealed:
-He was unable to give specific details about the resident's medication due to VA policies.
-Melatonin was dispensed on 10/09/24.
-He was unable to give the strength or quantity of medication dispensed on 10/09/24.
-All the medications dispensed on 10/09/24 were picked up but he was unable to give the specific date of pick up.

Interviews with the HWD on 12/20/24 at 8:40am and 11:36am revealed:
-Resident #4 had paper MARs when he was first admitted because there was a problem with the facility being able to see his orders in the eMAR system.
-The pharmacy could see them on their end, but the facility could not see them.
-She was new at the facility at that time, and she did not know how to enter orders into the eMAR system.
-She could not locate paper MARs for 10/10/24 - 10/12/24 but she felt sure the medications were administered on those days.
-She did not recall if she received medications or paperwork from Resident #4's family member when the resident was admitted to the facility on 10/10/24.
-She did not recall Resident #4 missing any doses of medication when he was admitted to the facility.
-She was responsible for checking the MARs daily and doing medication cart audits, but she had not had time to do a complete MAR or cart audit.
-She was not aware Resident #4 was currently out of Melatonin.

Interviews with the Administrator on 12/20/24 at

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8:45am and 11:29am revealed:
-All MAs knew how to enter orders into the eMAR system.
-Resident #4's medication administration should have been documented in the eMAR system when he was admitted to the facility.
-When a resident's family took them to a provider or brought them back from the hospital, the family was supposed to give any paperwork to the MA, Resident Care Coordinator (RCC), or HWD.
-The MA would give the paperwork to the RCC or HWD, who were responsible for reviewing and processing the paperwork, including any orders.
-She did not recall Resident #4's family member giving her any paperwork or medications when the resident was admitted.
-The facility was responsible for ordering Resident #4's medications.
-The MAs should notify the RCC or HWD before a medication ran out.
-The RCC and HWD were responsible for reordering medications and sending orders to the pharmacy.
-If a medication was not received, the RCC or HWD should contact the pharmacy or the provider.

Attempted telephone interviews with Resident #4's primary care VA provider on 12/20/24 at 10:32am and 5:05pm were unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

d. Review of Resident #4's current FL-2 dated 10/08/24 revealed an order for Prazosin 1mg 1 capsule every 12 hours, hold for systolic blood pressure (SBP) less than (<) 90, diastolic blood pressure (DBP) <60, or heart rate <60. (Prazosin

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D 358	Continued From page 73 lowers blood pressure and heart rate. Prazosin may also be used to treat symptoms associated with post-traumatic stress disorder.) Review of Resident #4's veteran administration (VA) hospital discharge summary dated 10/10/24 revealed an order for Prazosin 1mg take 1 capsule every 12 hours for post-traumatic stress disorder; set administration time for 8:00am and 8:00pm; hold for SBP <90, DBP <60, heart rate <60. Review of Resident #4's VA emergency department (ED) discharge note dated 10/22/24 revealed: -The resident was admitted to the ED on 10/22/24. -The resident's discharge diagnosis on 10/22/24 was agitation related to dementia. Review of Resident #4's October 2024 24-hour shift report forms used as handwritten October 2024 medication administration records (MARs) revealed: -The administration of Resident #4's medications for 10/13/24 - 10/24/24 were handwritten and documented on 24-hour shift report forms. -There was no documentation of administration of any medications from 10/10/24 (admission date) - 10/12/24. -There was a handwritten entry for Prazosin 1mg 1 capsule every 12 hours, hold for SBP <90, DBP <60, heart rate <60 and scheduled for 8:00am and 8:00pm. -Prazosin was documented as administered on 10/15/24 at 8:00pm but there was no heart rate documented to determine if the medication should have been held. -Prazosin was documented as administered on 10/17/24 at 8:00am when the resident's heart rate	D 358		

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was 58 so it should have been held.
-Prazosin was documented as administered on 10/18/24 at 8:00am when the resident's heart rate was 57 so it should have been held.
-Prazosin was documented as administered on 10/19/24 at 8:00pm but there was no heart rate documented to determine if the medication should have been held.
-Prazosin was documented as administered on 10/20/24 at 8:00am when the resident's heart rate was 59 so it should have been held.
-Prazosin was not documented as administered on 10/21/24 at 8:00pm with no reason noted.
-Prazosin was documented as administered on 10/22/24 at 8:00pm but there was no heart rate documented to determine if the medication should have been held.
-Prazosin was not documented as administered on 10/23/24 at 8:00am with no reason noted.
-Prazosin was documented as administered on 10/23/24 at 8:00pm but there was no heart rate documented to determine if the medication should have been held.
-Prazosin was not documented as administered on 10/24/24 at 8:00am with no reason noted.
-Prazosin was documented as administered on 10/24/24 at 8:00pm but there was no heart rate documented to determine if the medication should have been held.

Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed:
-Documentation for the administration of medications did not start until 10/24/24.
-Documentation for the administration of medications prior to 10/24/24 were grayed out with no initials.
-There was an entry for Prazosin 1mg 1 tablet every 12 hours, hold for SBP <90, DBP <60,

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heart rate <60 and scheduled for 8:00am and 8:00pm.
-Prazosin was documented as administered on 16 occasions from 10/24/24 (8:00pm) - 10/31/24 (8:00pm) except one refusal on 10/26/24 at 8:00pm.
-There was no documentation of the resident's blood pressure or heart rate being checked twice a day at 8:00am and 8:00pm to determine if the Prazosin should have been held.
-There was not documentation of any blood pressure or heart rate checks on the October 2024 eMAR.

Review of Resident #4's November 2024 eMAR revealed:
-There was an entry for Prazosin 1mg 1 tablet every 12 hours, hold for SBP <90, DBP <60, heart rate <60 and scheduled for 8:00am and 8:00pm.
-Prazosin was documented as administered every 12 hours from 11/01/24 - 11/30/24 except for two refusals on 11/03/24 and 11/05/24 at 8:00pm.
-There was no documentation of the resident's blood pressure or heart rate being checked twice a day at 8:00am and 8:00pm to determine if the Prazosin should have been held.
-The resident's blood pressure was documented as being checked twice at 8:00pm in November 2024.
-The resident's blood pressure was 137/63 on 11/26/24 and 128/70 on 11/29/24.
-The resident's heart rate was documented as being checked once on 11/29/24 at 8:00pm and it was 71.

Review of Resident #4's December 2024 eMAR dated 12/01/24 - 12/18/24 revealed:
-There was an entry for Prazosin 1mg 1 tablet

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every 12 hours, hold for SBP <90, DBP <60, heart rate <60 and scheduled for 8:00am and 8:00pm.
-Prazosin was documented as administered every 12 hours from 12/01/24 - 12/18/24 (8:00am).
-There was no documentation of the resident's blood pressure or heart rate being checked twice a day at 8:00am and 8:00pm to determine if the Prazosin should have been held.
-The resident's blood pressure was documented as being checked once at 8:00pm in December 2024.
-The resident's blood pressure was 142/71 on 12/06/24.
-There were no heart rates documented for December 2024.

Review of Resident #4's pharmacy dispensing record dated 09/01/24 - 12/19/24 from the facility's contracted pharmacy revealed there were 46 Prazosin 1mg capsules dispensed on 10/11/24.

Observation of Resident #4's medications on hand on 12/19/24 at 12:23pm revealed:
-All of Resident #4's medications were observed including medications stored in the medication cart and in the backup supply in the medication room.
-There was a supply of Prazosin 1mg capsules dispensed on 10/09/24 by the resident's VA pharmacy provider.
-The instructions were to take 1 capsule every 12 hours for post-traumatic stress disorder; please set administration time for 8:00am and 8:00pm; hold for SBP <90, DBP <60, heart rate <60.
-There were 112 of 180 capsules remaining.

Interview with a medication aide (MA) on

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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 358	Continued From page 77 12/19/24 at 11:55am revealed: -She checked the resident's blood pressure and heart rate if it came up on the eMAR when she was administering medications. -She did not know why it did not come up on the eMAR to check the resident's blood pressure and heart rate prior to administering the Prazosin. -She had not noticed the parameters listed with the Prazosin on the eMAR system. Interview with the Health and Wellness Director (HWD) on 12/19/24 at 2:06pm and 12/20/24 at 11:36am revealed: -The MAs had been trained to read the medication labels and eMAR and administer according to the orders. -Resident #4's blood pressure and heart rate should be checked prior to administering the Prazosin. -She did not know why it was not set up in the eMAR system to document the resident's blood pressure and heart rate with the Prazosin. -She was responsible for reviewing the eMARs daily and doing cart audits, but she had not had time to complete a full eMAR or cart audit. Interview with the Administrator on 12/19/24 at 1:39pm revealed: -All MAs knew to read the medication labels and eMAR to ensure medications were administered as ordered. -The HWD was responsible for weekly cart audits and MAR audits. Attempted telephone interviews with Resident #4's primary care VA provider on 12/20/24 at 10:32am and 5:05pm were unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #4 was	D 358		

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	HAL026068	A. BUILDING: _____ B. WING _____	C 12/20/2024

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D 358	Continued From page 78 not interviewable. e. Review of Resident #4's current FL-2 dated 10/08/24 revealed an order for Senna S take 2 tablets daily as needed (prn), give in no bowel movement in greater than (>) 3 days. (Senna S is a laxative and stool softener used to treat and prevent constipation.) Review of Resident #4's veteran administration (VA) hospital discharge summary dated 10/10/24 revealed an order for Senna S take 2 tablets two times a day for constipation. Review of Resident #4's October 2024 24-hour shift report forms used as handwritten October 2024 medication administration records (MARs) revealed: -The administration of Resident #4's medications for 10/13/24 - 10/24/24 were handwritten and documented on 24-hour shift report forms. -There was no documentation of administration of any medications from 10/10/24 (admission date) - 10/12/24. -There was a handwritten entry for Senna Plus 2 tablets once daily prn if no bowel movement in > 3 days. -There was no prn Senna Plus documented as administered on the handwritten MARs from 10/13/24 - 10/24/24. -There was no entry for scheduled Senna Plus 2 tablets twice daily as ordered on 10/10/24 and none was documented as administered. Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed: -Documentation for the administration of medications did not start until 10/24/24. -Documentation for the administration of	D 358		

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D 358	Continued From page 79	D 358		

medications prior to 10/24/24 were grayed out with no initials.
-There was no entry for Senna S and none documented as administered on the October 2024 eMAR.

Review of Resident #4's November 2024 eMAR revealed there was no entry for Senna S and none documented as administered on the November 2024 eMAR.

Review of Resident #4's December 2024 eMAR dated 12/01/24 - 12/18/24 revealed there was no entry for Senna S and none documented as administered on the December 2024 eMAR.

Review of Resident #4's pharmacy dispensing record dated 09/01/24 - 12/19/24 from the facility's contracted pharmacy revealed there were 30 Senna Plus tablets dispensed on 10/11/24.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at 10:57am revealed:
-They usually entered orders into the eMAR system and the facility was responsible for reviewing and approving the orders prior to the orders becoming active in the eMAR system.
-They entered Resident #4's orders into the eMAR system on 10/11/24, so the facility staff should have been able to access and enter medication administration on the eMAR for the resident at that time.
-They also dispensed a partial month's supply for several of the resident's medications on 10/11/24.

Observation of Resident #4's medications on hand on 12/19/24 at 12:26pm revealed:
-All of Resident #4's medications were observed

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including medications stored in the medication cart and in the backup supply in the medication room.
-There was a supply of Senna Plus tablets dispensed on 10/11/24 by the facility's contracted pharmacy.
-The instructions were to take 2 tablets once daily prn if no bowel movement in > 3 days.
-There were 28 of 30 tablets remaining.
-There was a supply of Senna Plus tablets dispensed on 10/09/24 by the resident's VA pharmacy provider.
-The instructions were to take 2 tablets two times a day for constipation.
-There were 178 of 180 tablets remaining.

Interview with a medication aide (MA) on 12/19/24 at 11:55am revealed:
-The MAs did not enter orders into the eMAR system.
-The MAs forwarded orders to the Resident Care Coordinator (RCC) or Health and Wellness Director (HWD).
-She did not know why Resident #4's order for Senna Plus was not on the eMARs.
-Resident #4 had Senna Plus in the medication cart that was dispensed by the facility's contracted pharmacy.

Telephone interview with Resident #4's family member on 12/18/24 at 3:39pm revealed:
-Resident #4 was inpatient at a VA hospital for about a year prior to being admitted to the facility.
-She picked up the resident from the hospital on 10/10/24 and transported the resident to the facility that same day.
-She picked up all the resident's medications from the VA hospital pharmacy on 10/10/24 and took them to the facility with the resident on 10/10/24.

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D 358	Continued From page 81 -She gave the medications and the paperwork to the Administrator when the resident was admitted to the facility on 10/10/24. Telephone interview with a contact representative with pharmacy customer care at Resident #4's VA pharmacy provider on 12/20/24 at 10:39am revealed: -He was unable to give specific details about the resident's medication due to VA policies. -Senna Plus was dispensed on 10/09/24. -He was unable to give the strength or quantity of medications dispensed on 10/09/24. -All the medications dispensed on 10/09/24 were picked up but he was unable to give the specific date of pick up. Interview with the RCC on 12/19/24 at 1:17pm revealed: -The pharmacy usually entered the orders into the eMAR system. -The third shift MA, the HWD, or she had access to and were responsible for reviewing and approving orders in the eMAR system to activate the orders. -They could also enter orders into the eMAR system if needed. Interview with the HWD on 12/19/24 at 2:06pm revealed: -The RCC, Administrator, or she had access to review and approve orders in the eMAR system. -If one of them printed or removed the new status from an order without communicating it to each other, then an order could potentially be overlooked. -There was no system to check behind each other to make sure orders were reviewed accurately and approved to her knowledge. -She did not know why Resident #4's Senna Plus	D 358		

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D 358	Continued From page 82 was not on the eMARs. Interview with the Administrator on 12/19/24 at 1:39pm revealed: -The pharmacy usually entered orders into the eMAR system but the facility had to approve the orders to activate them. -The MAs, the RCC, and the HWD had access to approve medication orders. -The MAs scanned orders to the RCC or HWD. -The RCC or HWD were responsible for sending orders to the pharmacy. -The third shift MA was responsible for verifying to make sure medications matched when they checked in the delivered medications. Attempted telephone interviews with Resident #4's primary care VA provider on 12/20/24 at 10:32am and 5:05pm were unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable. f. Review of Resident #4's current FL-2 dated 10/08/24 revealed an order for Acetaminophen 975mg every 8 hours as needed (prn) a pain score greater than (>) 0. (Acetaminophen is used to treat mild to moderate pain.) Review of Resident #4's veteran administration (VA) hospital discharge summary dated 10/10/24 revealed an order for Acetaminophen 325mg take 3 tablets two times a day for pain (maximum daily recommended dose was 3000mg). Review of Resident #4's October 2024 24-hour shift report forms used as handwritten October 2024 medication administration records (MARs) revealed:	D 358		

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D 358	Continued From page 83 -The administration of Resident #4's medications for 10/13/24 - 10/24/24 were handwritten and documented on 24-hour shift report forms. -There was no documentation of administration of any medications from 10/10/24 (admission date) - 10/12/24. -There was a handwritten entry for Acetaminophen 325mg take 3 tablets every 8 hours prn pain. -There was no prn Acetaminophen documented as administered on the handwritten MARs from 10/13/24 - 10/24/24. -There was no entry for scheduled Acetaminophen 325mg 3 tablets twice a day as ordered on 10/10/24 and none was documented as administered. Review of Resident #4's October 2024 electronic medication administration record (eMAR) revealed: -Documentation for the administration of medications did not start until 10/24/24. -Documentation for the administration of medications prior to 10/24/24 were grayed out with no initials. -There was an entry for Acetaminophen 325mg take 3 tablets (975mg) every 8 hours as needed (prn)for a pain score >0. -The prn Acetaminophen was documented as administered on one occasion on 10/25/24 at 5:35pm. -There was no entry for scheduled Acetaminophen twice a day as ordered on the hospital discharge summary dated 10/10/24. Review of Resident #4's November 2024 eMAR revealed: -There was an entry for Acetaminophen 325mg take 3 tablets (975mg) every 8 hours as needed (prn)for a pain score >0.	D 358		

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D 358	Continued From page 84 -There was no prn Acetaminophen documented as administered in November 2024. -There was no entry for scheduled Acetaminophen twice a day as ordered on the hospital discharge summary dated 10/10/24. Review of Resident #4's December 2024 eMAR dated 12/01/24 - 12/18/24 revealed: -There was an entry for Acetaminophen 325mg take 3 tablets (975mg) every 8 hours as needed (prn)for a pain score >0. -There was no prn Acetaminophen documented as administered in December 2024. -There was no entry for scheduled Acetaminophen twice a day as ordered on the hospital discharge summary dated 10/10/24. Review of Resident #4's pharmacy dispensing record dated 09/01/24 - 12/19/24 from the facility's contracted pharmacy revealed there were 90 Acetaminophen 325mg tablets dispensed on 10/11/24. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/20/24 at 10:57am revealed: -They usually entered orders into the eMAR system and the facility was responsible for reviewing and approving the orders prior to the orders becoming active in the eMAR system. -They entered Resident #4's orders into the eMAR system on 10/11/24, so the facility staff should have been able to access and enter medication administration on the eMAR for the resident at that time. -She was not aware Resident #4 had handwritten MARs prior to 10/24/24. -They also dispensed a partial month's supply for several of the resident's medications on 10/11/24.	D 358		

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D 358	Continued From page 85 Observation of Resident #4's medications on hand on 12/19/24 at 12:26pm revealed: -All of Resident #4's medications were observed including medications stored in the medication cart and in the backup supply in the medication room. -There was a supply of Acetaminophen 325mg tablets dispensed on 10/11/24 by the facility's contracted pharmacy. -The instructions were to take 3 tablets (975mg) every 8 hours prn pain. -There were 81 of 90 tablets remaining. -There was a supply of Acetaminophen 325mg tablets dispensed on 10/09/24 by the resident's VA pharmacy provider. -The instructions were to take 3 tablets two times a day for pain; each tablet contains 325mg of Acetaminophen; maximum daily dose is 3000mg. -There were 270 of 270 tablets remaining. Interview with a medication aide (MA) on 12/19/24 at 11:55am revealed: -The MAs did not enter orders into the eMAR system. -The MAs forwarded orders to the Resident Care Coordinator (RCC) or Health and Wellness Director (HWD). -She did not know why Resident #4's order for scheduled Acetaminophen was not on the eMARs. Telephone interview with Resident #4's family member on 12/18/24 at 3:39pm revealed: -Resident #4 was inpatient at a VA hospital for about a year prior to being admitted to the facility. -She picked up the resident from the hospital on 10/10/24 and transported the resident to the facility that same day. -She picked up all the resident's medications from the VA hospital pharmacy on 10/10/24 and	D 358		

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took them to the facility with the resident on 10/10/24.
-She gave the medications and the paperwork to the Administrator when the resident was admitted to the facility on 10/10/24.

Interview with the RCC on 12/19/24 at 1:17pm revealed:
-The pharmacy usually entered the orders into the eMAR system.
-The third shift MA, the HWD, or she had access to and were responsible for reviewing and approving orders in the eMAR system to activate the orders.
-They could also enter orders into the eMAR system if needed.

Interview with the HWD on 12/19/24 at 2:06pm revealed:
-The RCC, Administrator, or she had access to review and approve orders in the eMAR system.
-If one of them printed or removed the new status from an order without communicating it to each other, then an order could potentially be overlooked.
-There was no system to check behind each other to make sure orders were reviewed accurately and approved to her knowledge.
-She did not know why Resident #4's scheduled Acetaminophen was not on the eMARs.

Interview with the Administrator on 12/19/24 at 1:39pm revealed:
-The pharmacy usually entered orders into the eMAR system but the facility had to approve the orders to activate them.
-The MAs, the RCC, and the HWD had access to approve medication orders.
-The MAs scanned orders to the RCC or HWD.
-The RCC or HWD were responsible for sending

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orders to the pharmacy.
-The third shift MA was responsible for verifying to make sure medications matched when they checked in the delivered medications.

Attempted telephone interviews with Resident #4's primary care VA provider on 12/20/24 at 10:32am and 5:05pm were unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #4 was not interviewable.

3. Review of Resident #3's FL-2 dated 09/24/24 revealed diagnoses included type 2 dementia, sarcoidosis, Vitamin D deficiency, major depressive disorder and front temporal disorder.

a. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Divalproex Sodium Dr 250mg tab, 1 tab at bedtime. (Divalproex is used to treat seizures and the manic phase of bipolar disorder and to help prevent migraine headaches).

Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Divalproex Sodium Dr 250mg tablet, 1 tablet scheduled for 8:00pm.
-On 12/01/24 to 12/12/24 the Divalproex Sodium Dr was documented as administered.
-On 12/13/24, 12/16/24, and 12/19/24 at 8:00pm the Divalproex Sodium Dr was documented as drug not given (DNG).
-On 12/14/24, 12/15/24, 12/17/24, and 12/18/24 at 8:00pm the Divalproex Sodium Dr was documented as drug not available (DNA).

Review of Resident #3's medication dispensing

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records revealed:
-Divalproex Sodium Dr 250mg was last dispensed on 10/08/24 for 30 days with a total of 30 tablets.
-The prescriber no longer saw Resident #3.

Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed Divalproex Sodium Dr 250mg was not in the medication cart and available for administration.

Telephone interview with the facility's contracted pharmacist on 12/19/24 at 1:23pm revealed:
-There was a previous order for Resident #3 for Divalproex Sodium DR 250mg, 1 tab at bedtime.
-Resident #3's Divalproex was last dispensed on 10/08/24 with a 30-day supply.
-The facility requested a refill on 12/01/24 but the provider denied the order stating that Resident #3 was no longer under their care.

Interview with Resident #3's primary care provider (PCP) on 12/19/24 at 10:13am revealed:
-She did not originally prescribe the Divalproex for Resident #3.
-She was not sure why Resident #3 was prescribed the Divalproex.
-The Divalproex was used to treat seizures, but Resident #3 had no previous history of seizures.
-She thought the Divalproex could be used for Resident #3's mood.
-Resident #3's family was supposed to send her Resident #3's previous medical records so she could determine why Resident #3 was prescribed the Divalproex.

b. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Donepezil HCL 10mg tab, 1 tab at bedtime. (Donepezil is used to treat dementia).

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D 358	Continued From page 89 Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Donepezil HCL 10mg tablet, 1 tablet scheduled for 8:00pm. -On 12/01/24 to 12/04/24 the Donepezil HCL was documented as administered. -On 12/05/24, 12/14/24, 12/15/24, 12/17/24, and 12/18/24 at 8:00pm the Donepezil HCL was documented as drug not available (DNA). -On 12/07/24 to 12/10/24, 12/12/24, 12/13/24, 12/16/24, and 12/19/24 at 8:00pm Donepezil HCL was documented as drug not given (DNG). Review of Resident #3's medication dispensing records revealed: -Donepezil HCL 10mg was last dispensed on 11/20/24 for 13 days with a total of 13 tablets. -The prescriber no longer saw Resident #3. Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed Donepezil HCL 10mg was not in the medication cartand available for administration. Telephone interview with the facility's contracted pharmacist on 12/19/24 at 1:23pm revealed: -There was an unsigned order for Donepezil HCL 10mg, 1 tab at bedtime written on 11/20/24. -The Donepezil HCL 10mg was dispensed on 11/20/24 with a 13-day supply. c. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Levetiracetam 500mg tab, 1 tab twice per day. (Levetiracetam is used to control seizures). Review of Resident #3's December 2024 electronic medication administration record	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA FAYETTEVILLE	1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331

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(eMAR) revealed:
-There was an entry for Levetiracetam 500mg tab, 1 tablet twice per day scheduled for 8:00am and 8:00pm.
-On 12/01/24 to 12/18/24 the Levetiracetam 500mg was documented as administered at 8:00am and 8:00pm.
-On 12/19/24 the Levetiracetam 500mg was documented at 8:00am as other.
-On 12/19/24 the Levetiracetam 500mg was documented at 8:00pm as drug not given (DNG).

Review of Resident #3's medication dispensing records revealed:
-Levetiracetam 500mg was last dispensed on 10/08/24 for 30 days with a total of 60 tablets.
-The prescriber no longer saw Resident #3.

Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed Levetiracetam 500mg was not in the medication cart and available for administration.

Telephone interview with the facility's contracted pharmacist on 12/19/24 at 1:23pm revealed:
-There was a previous order for Resident #3 for Levetiracetam 500mg, 1 tab twice per day.
-Resident #3's Levetiracetam was last dispensed on 10/08/24 with a 30-day supply.
-The facility requested a refill on 12/01/24 but the provider denied the order stating that Resident #3 was no longer under their care.

Interview with Resident #3's primary care provider (PCP) on 12/19/24 at 10:13am revealed:
-She did not originally prescribe Levetiracetam for Resident #3.
-She was not sure why Resident #3 was prescribed the Levetiracetam.
-The Levetiracetam was used to treat seizures,

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but Resident #3 had no previous history of seizures.
-She thought the Levetiracetam could be used for Resident #3's mood.
-Resident #3's family was supposed to send her Resident #3's previous medical records so she could determine why Resident #3 was prescribed the Levetiracetam.

d. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Memantine HCL tab, 1 tab twice per day. There was no dosage indicated. (Memantine is used to treat dementia).

Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Memantine HCL 10mg tablet, 1 tablet twice per day scheduled for 8:00am and 8:00pm.
-On 12/01/24 to 12/04/24 the Memantine HCL 10mg was documented as administered.
-On 12/05/24, 12/14/24, 12/15/24, 12/17/24, and 12/18/24 at 8:00am the Memantine HCL 10mg was documented as drug not available (DNA).
-On 12/08/24, 12/09/24, 12/10/24, 12/13/24, 12/16/24, 12/19/24 the Memantine HCL 10mg was documented as drug not given (DNG).

Review of Resident #3's medication dispensing records revealed Memantine 10mg was last dispensed on 11/20/24 for 13 days with a total of 26 tablets.

Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed the Memantine 10mg was not in the medication cart and available for administration.

Telephone interview with the facility's contracted

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pharmacist on 12/19/24 at 1:23pm revealed:
-There was an unsigned order for Memantine 10mg, 1 tab twice per day on 11/20/24.
-Resident #3's Memantine was last dispensed on 11/20/24 with a 13-day supply.
-The facility requested a refill on 12/01/24 but the provider denied the order stating that Resident #3 was no longer under their care.

Interview with Resident #3's primary care provider (PCP) on 12/19/24 at 10:13am revealed:
-The Memantine was used for dementia to help slow down the progression of the disease.
-Resident #3's memory could be affected and her daily living tasks if she missed doses of the medication.

e. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Myrbetriq ER 25mg tab, 1 tab daily. (Myrbetriq is used to treat overactive bladder).

Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Myrbetriq 25mg tablet, 1 tablet scheduled at 8:00am.
-On 12/01/24 to 12/15/24 the Myrbetriq 25mg was documented as administered.
-On 12/16/24 the Myrbetriq 25mg was documented as drug not available (DNA).

Review of Resident #3's medication dispensing records revealed the Myrbetriq 25mg was last dispensed on 10/08/24 for 30 days with a total of 30 tablets.

Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed Myrbetriq 25mg was not in the medication cart and

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D 358	Continued From page 93 available for administration. Telephone interview with the facility's contracted pharmacist on 12/19/24 at 1:23pm revealed: -There was a previous order for Myrbetriq 25mg, 1 tab per day. -Resident #3's Myrbetriq was last dispensed on 10/08/24 with a 30-day supply. -The facility requested a refill on 12/01/24 but the provider denied the order stating that Resident #3 was no longer under their care. Interview with Resident #3's primary care provider (PCP) on 12/19/24 at 10:13am revealed: -Myrbetriq was used to treat Resident #3's bladder. - If Resident #3 missed doses of Myrbetriq it placed her at risk of incontinence which placed her at higher risk of skin breakdown. f. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Prednisone 2.5mg tab, 1 tab daily. (Prednisone is used to decrease inflammation). Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Prednisone 2.5mg tablet, 1 tablet scheduled at 8:00am. -On 12/01/24 to 12/15/24, 12/17/24, and 12/18/24 the Prednisone 2.5mg was documented as administered. -On 12/16/24 and 12/19/24 the Prednisone 2.5mg was documented as drug not available (DNA). Review of Resident #3's medication dispensing records revealed Prednisone 2.5mg was last dispensed on 10/08/24 for 30 days with a total of 30 tablets.	D 358		

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D 358	Continued From page 94 Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed Prednisone 2.5mg was not in the medication cart and available for administration. Telephone interview with the facility's contracted pharmacist on 12/19/24 at 1:23pm revealed: -There was a previous order for Prednisone 2.5mg, 1 tab per day. -Resident #3's Prednisone was last dispensed on 10/08/24 with a 30-day supply. -The facility requested a refill on 12/01/24 but the Provider denied the order stating that Resident #3 was no long under their care. Interview with Resident #3's primary care provider (PCP) on 12/19/24 at 10:13am revealed: -Resident #3 was placed on Prednisone after she was discharged from the hospital due to her diagnosis of sarcoidosis. -If Resident #3 missed doses of the Prednisone it could cause shortness of breath, and her oxygen levels would drop. -A drop in Resident #3's oxygen level could cause respiratory distress because she would not be getting enough oxygen. g. Review of Resident #3's FL-2 dated 09/24/24 revealed there was an order for Tamsulosin HCL 0.4mg cap, 1 cap at bedtime. (Tamsulosin is used to relax the muscles in the prostate and the bladder). Review of Resident #3's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Tamsulosin 0.4mg capsule, 1 capsule scheduled at 8:00pm. -On 12/01/24 to 12/03/24, 12/07/24, 12/11/24,	D 358		

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12/17/24 the Tamsulosin 0.4mg was documented as administered.
-On 12/04/24, 12/08/24 to 12/10/24, 12/12/24, 12/13/24, 12/16/24, 12/19/24, the Tamsulosin 0.4mg was documented as drug not given (DNG).
-On 12/09/24, 12/14/24, 12/15/24, 12/18/24 the Tamsulosin 0.4mg was documented as drug not available (DNA).

Review of Resident #3's medication dispensing records revealed the Tamsulosin 0.4mg was last dispensed on 11/20/24 for 13 days with a total of 13 tablets.

Observation of Resident #3's medications on hand on 12/19/24 at 10:00am revealed Tamsulosin 0.4mg was not in the medication cart and available for administration.

Telephone interview with the facility's contracted pharmacist on 12/19/24 at 1:23pm revealed:
-There was an unsigned order for Tamsulosin 0.4mg, 1 tab twice per day on 11/20/24.
-Resident #3's Tamsulosin 0.4mg was last dispensed on 11/20/24 with a 13-day supply.
-The facility requested a refill on 12/01/24 but the provider denied the order stating that Resident #3 was no longer under their care.

Interview with Resident #3's primary care provider (PCP) on 12/19/24 at 10:13am revealed:
-Resident #3 had a history of kidney stones.
-The Tamsulosin helped the kidney stones pass easier.
-If Resident #3 missed doses of the Tamsulosin it placed her at risk of stone obstruction which could cause kidney damage.

Interview with a medication aide (MA) on 12/19/24 at 10:00am revealed:

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D 358	Continued From page 96 -She pulled the sticker from the medication cards, put the sticker on a refill order form, informed the Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD), and scanned the refill order log to the RCC and HWD. -She notified the RCC and HWD when there were 10 days remaining of the medications. -She did not follow up with the RCC or HWD to inquire about why the medications for Resident #3 had not arrived. Interview with the RCC on 12/19/24 at 11:00am revealed: -Residents' medications were reordered when the medication card was at the blue line which indicated 10 doses were left. -She checked the eMAR system to determine if the resident had any refills. -If there were no refills from the eMAR system, she requested a prescription from the provider. -The MAs notified her when a resident was almost out of medication. -She was aware Resident #3 was out of her medications. -She sent notification to Resident #3's provider requesting a prescription for the medications she was out of, but she was not sure when she sent it. -She did not follow up with Resident #3's provider to ensure the facility received an order for the medications the resident was out of. Interview with the HWD on 12/19/24 at 1:38pm revealed: -She had been working with the facility for 4 months. -She was not aware Resident #3 was out of a lot of her medications. -The MAs were responsible for scanning the refill form to the RCC and the HWD.	D 358		

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D 358	Continued From page 97 -She was responsible for ensuring the residents' medications were in the facility. -She expected the MAs to notify her when a residents' medications were not in the facility. 4. Review of Resident #2's current FL-2 dated 10/29/24 revealed: -Diagnoses included dementia, hypertension, and hyperlipidemia. -The resident received hospice services. -There was a physician's order for Atorvastatin Calcium (used to lower high cholesterol levels) 40mg tablet daily at bedtime. Review of a hospice provider physician's order for Resident #2 dated 11/18/24 revealed there was a physician's order to discontinue the Atorvastatin. Review of Resident #2's November 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Atorvastatin Calcium 40mg tablet take one tablet at bedtime scheduled for administration at 8:00pm daily. -Atorvastatin 40mg tablet was documented as administered at 8:00pm on 11/19/24 through 11/30/24 except for a documented refusal on 11/23/24. Review of Resident #2's December 2024 eMARs revealed: -There was an entry for Atorvastatin Calcium 40mg tablet take one tablet at bedtime scheduled for administration at 8:00pm daily. -There was documentation of administration that Atorvastatin 40mg tablet was administered at 8:00pm on 12/01/24 through 12/16/24. -There was documentation the Atorvastatin was not administered on 12/17/24 due to drug not available.	D 358		

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D 358	Continued From page 98 Observation of Resident #2's medications on hand on 12/18/24 at 3:30pm revealed there were no Atorvastatin 40mg tablets on hand in the medication cart for administration. Observation of Resident #2's medications on hand on 12/19/24 at 11:19am revealed: -There was a pharmacy labeled blister package of Atorvastatin 40mg tablets, quantity of 30 tablets dispensed on 12/03/24. -There were 29 of the Atorvastatin 40mg tablets on hand. Interview with the medication aide (MA) on 12/19/24 at 11:19am revealed: -She removed Resident #2's Atorvastatin 40mg blister package of medication from the backup medication cabinet the morning of 12/19/24. -She administered one of the Atorvastatin 40mg tablets to Resident #2 on 12/19/24 in the morning. -She administered medication according to eMARs. -If a medication was on hold or discontinued, she would know only when the order changed on the eMAR. -She did not ever see the hard copy of physician orders. -The Health and Wellness Director (HWD) and Resident Care Coordinator (RCC) were responsible for completing orders. -She did not know how the HWD or RCC received physician orders. Interview with the RCC on 12/19/24 at 11:26am revealed: -She was responsible for verifying new orders. -The HWD and 3rd shift supervisor/medication aide assisted with verification of new orders.	D 358		

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D 358	Continued From page 99 -If a resident received hospice services, the hospice agency scanned the new order to the contracted provider pharmacy. -The hospice nurse "usually" called the facility with notification of new orders. -The contracted provider pharmacy was responsible for transcription of new orders to the eMARs. -She did not know Resident #2's order for Atorvastatin 40mg tablet at bedtime had been discontinued on 11/18/24. -Either she or the HWD would receive the physician orders. -She had no idea how the physician's order to discontinue the Atorvastatin 40mg tablet got filed in Resident #2's record. -She was responsible for filing in the resident's record. -She was recently promoted into the RCC position and had only been in the position "maybe one or two months". Interview with the HWD on 12/19/24 at 12:05pm revealed: -She was responsible for physician orders. -She and the RCC sent orders to the pharmacy. -She did not think there had been another physician's order to restart Atorvastatin 40mg for Resident #2. Telephone interview with the hospice agency Clinical Manager on 12/19/24 at 12:23pm revealed: -Resident #2 was currently receiving hospice services from their agency. -On 11/18/24, the Atorvastatin 40mg tablet was discontinued. -If Resident #2 was still being administered the Atorvastatin 40mg tablet, it would not affect the resident negatively.	D 358		

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D 358	Continued From page 100 -Resident #2 was in "active decline". Telephone interview with the contracted pharmacy provider on 12/19/24 at 2:13pm revealed: -There was a current physician's order for Atorvastatin 40mg tablet at bedtime for Resident #2. -He did not have a physician's order to discontinue Resident #2's Atorvastatin 40mg tablet. -The pharmacy received physician orders via fax from the facility and by e-script from the primary care provider. -There would not be any effect to the resident if the Atorvastatin was continued after being discontinued unless the resident was having muscle pain which would have occurred within the first week of starting the medication. Interview with the Administrator on 12/19/24 at 2:28pm revealed the medication should not be administered by the facility once the primary care provider (PCP) discontinued the medication. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. 5. Review of Resident #5's current FL-2 dated 10/29/24 revealed diagnoses included hypertension, cognitive impairment, gastroesophageal reflux disease, hypercholesterolemia, insomnia, and coronary artery disease. a. Review of a physician's order for Resident #5 dated 10/29/24 revealed there was a physician's order for Aspercreme (Lidocaine HCL) 4% topical (used to treat pain) apply a small amount to the	D 358		

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D 358	Continued From page 101 left knee twice a day. Review of Resident #5's November 2024 electronic medication administration records (eMARs) revealed: -There was an entry for Aspercreme 4% topical cream spread a small amount topically to knees twice daily scheduled for 8:00am and 8:00pm. -The Aspercreme 4% topical cream was not documented as administered at 8:00pm on 11/09/24 and 11/14/24. -The Aspercreme 4% topical cream was documented as not available at 8:00pm on 11/17/24, 11/18/24, 11/19/24, 11/21/24, 11/27/24, and 11/30/24. Review of Resident #5's December 2024 eMARs revealed: -There was an entry for Aspercreme 4% topical cream spread a small amount topically to knees twice daily scheduled for 8:00am and 8:00pm. -The Aspercreme 4% topical cream was documented as not administered at 8:00am on 12/12/24 and at 8:00pm on 12/09/24, 12/10/24, and 12/12/24. -The Aspercreme 4% topical cream was documented as not available at 8:00am on 12/09/24. Observation of Resident #5's medication on hand on 12/18/24 at 4:00pm revealed there was no Aspercreme 4% topical cream on hand in the medication cart for administration. Interview with the medication aide (MA) on 12/18/24 at 4:00pm revealed: -Resident #5's Aspercreme was "usually" available. -The Aspercreme was administered on the first (7:00am - 3:00pm) shift.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026068	A. BUILDING: _____ B. WING _____	C 12/20/2024

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D 358	Continued From page 102 -She did not know too much about what happened on first and second shifts because she worked on third shift. Interview with a second MA on 12/19/24 at 11:21am revealed: -The MAs prepared a medication order form when residents medications needed to be refilled. -The MAs scanned the medication reorder form to the Resident Care Coordinator (RCC). -The RCC and Health and Wellness Director (HWD) were responsible for ordering medications. Interview with the RCC on 12/19/24 at 11:26am revealed: -She was responsible for reordering medications. -She called or faxed to the contracted provider pharmacy when medications needed to be reordered. -The contracted pharmacy provider delivered medications to the facility during the third shift (11:00pm - 7:00am). -The MA working on the third shift received the medications and made sure the medications received matched the medications ordered. Interview with a third MA on 12/19/24 at 1:25pm revealed: -Resident #5 was not administered the Aspercreme 4% topical cream on 12/19/24 at 8:00am. -There was not any Aspercreme 4% topical to apply topically to Resident #5's left knee. -She was not sure if the Aspercreme 4% topical cream had been reordered. -She had not reordered the Aspercreme 4% topical cream and had not yet informed the RCC or HWD of medications needed. -She last administered the Aspercreme 4%	D 358		

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D 358	Continued From page 103	D 358		

topical cream on 12/08/24 and documented on 12/09/24 that the Aspercreme 4% topical cream was not available.
-She did not remember if she told anyone on 12/09/24 about the need for the Aspercreme 4% topical cream needing to be reordered.
-Resident #5 complained of back pain over a week ago but no complaints of knee pain.

Interview with Resident #5 on 12/19/24 at 1:37pm revealed:
-He was not being administered the Aspercreme 4% topical cream.
-He did not remember the last time the Aspercreme 4% topical cream had been applied.
-He remembered getting the cream but did not know what the cream was for.
-He did not know the names of his medications.

Telephone interview with the pharmacist at the contracted provider pharmacy on 12/19/24 at 1:53pm revealed:
-There was an active order for Resident #5 for Aspercreme 4% topical cream apply a small amount to the left knee twice daily.
-The Aspercreme 4% topical cream was last dispensed on 06/16/24, quantity of 76.5 grams.
-He could not predict how long the Aspercreme would have lasted because he did not know what a small amount was.
-If the Aspercreme topical cream was being used, it probably would not be available but could be purchased over the counter.
-There had been a previous prescription filled on 05/30/24 for the Aspercreme when there was an order for Aspercreme application to both knees.

Interview with the HWD on 12/19/24 at 12:05pm revealed:
-She was responsible for physician orders.

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D 358	Continued From page 104 -She and the RCC sent orders to the pharmacy. Interview with the Administrator on 12/19/24 at 2:28pm revealed she expected medications to be in the facility and available for administration at all times if there was a physician's order for the medication. Telephone interview with Resident #5's primary care provider (PCP) on 12/20/24 at 12:10pm revealed: -She had no idea the Aspercreme 4% topical cream was not available. -Resident #5 had mentioned aches in his lower back. -She would be concerned that the Aspercreme was not available if the resident was complaining of arthritis. -Staff had not reported any complaints of pain. -Resident #5 liked to stay in bed, but she did not think it was related to pain. _____ The facility failed to administer medications as ordered to 2 of 3 residents observed during the morning medication pass on 12/19/24 resulting in a 30% medication error rate with 9 errors out of 30 opportunities. Resident #6 received a double dose of a muscle relaxant resulting in the resident being extremely sleepy and difficult to awaken on at least two occasions that day. Resident #6 also did not receive a controlled substance for agitation and anxiety as ordered resulting in the resident continuing to experience sundowning (behaviors that can occur in dementia patients such as confusion and pacing) and agitation in the evenings. Resident #6 did not receive an inhaler for breathing problems as ordered putting the resident at risk of shortness of breath and worsening chronic obstructive pulmonary disease. Resident #4 who had a diagnosis of	D 358		

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D 358	Continued From page 105 dementia and a history of behavioral disturbances did not receive two antipsychotic medications as ordered and required a hospital emergency room visit related to symptoms of agitation and hitting a staff member. Resident #3 did not receive 7 medications as ordered due to the medications being unavailable for several days for administration. This included not receiving medications for dementia that could lead to further memory decline and affect the resident's ability with activities of daily living; a medication for overactive bladder putting the resident at risk for incontinence which could lead to skin breakdown; a medication for inflammation which could cause shortness of breath and low oxygen levels; medication for kidney stones that put the resident at risk for kidney stone obstruction or kidney damage; and medications that could affect the resident's mood. Resident #2's cholesterol medication was not discontinued as ordered putting the resident at risk for muscle pain. The failure of the facility to administer medications as ordered resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/19/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 19, 2025.	D 358		