

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026088	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/14/2025
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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 03/12/25 - 03/14/25.	{D 000}		
{D 079}	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings</p> <p>(a) Adult care homes shall</p> <p>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;</p> <p>This Rule shall apply to new and existing facilities.</p> <p>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 that were accessible to the residents living in the special care unit (SCU).</p> <p>The findings are:</p> <p>Review of the facility's Environmental Safety Policy dated 06/11/24 revealed: -The special care unit (SCU) would be assessed for items that could be misperceived by the resident as something to eat or drink and would be safely stored in locations inaccessible to residents. -All personal hygiene products/items or toiletries would be stored in a secured area unless they were labeled as "non-toxic / safe for human consumption."</p> <p>Review of the facility's census report received on 03/12/25 revealed there were 22 residents living</p>	{D 079}	<p>Divisional Care Specialist in-serviced all staff on Policy and Procedures related to ingestible items in the Special care unit as well as increased awareness related to evaluating resident safety routinely.</p> <p>MCD/Designee will audit room sweeps daily for 5 days then weekly for 2 weeks, and monthly thereafter and report any issues or concerns to the Executive Director.</p> <p>All new hire employees will be educated upon hire on policy and procedures related to ingestible items.</p> <p>Education will include location of storage and the expectation of returning and securing items after usage.</p> <p>Care Managers and Medication Aides will be responsible for completing room sweeps on their assignments to ensure the safety of residents</p>	<p>4/28/2025</p>

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Robin Yabal, Executive Director

5/6/2025

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{D 079}	<p>Continued From page 1</p> <p>in the SCU of the facility.</p> <p>Observation of the bathroom in resident room C-14 on 03/12/25 at 9:38am revealed:</p> <ul style="list-style-type: none"> -There was a bottle of shampoo with conditioner and a bottle of body lotion sitting around the edge of the sink in the resident's bathroom. -The shampoo bottle had the last name of a resident written on it. -Warning labels on the products included for external use only; keep out of eyes; if eye contact, flush eyes with water; 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. <p>Based on observations, interviews, and record reviews, the resident whose name was written on the shampoo bottle was not interviewable.</p> <p>Observation of the bathroom in resident room C-15 on 03/12/25 at 9:43am revealed:</p> <ul style="list-style-type: none"> -There was a bottle of moisturizing lotion sitting around the edge of the sink. -The unlocked storage cabinet on the wall beside the sink had a bottle of roll-on antiperspirant/deodorant and a tube of whitening toothpaste. -There was a bottle of body wash on top of the safety grab bar in the shower. -There was a tube of toothpaste on top of a storage cabinet near the toilet. -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; and if more than used for brushing is accidentally swallowed, get medical help or contact a PCC right away. <p>Interview with the resident residing in room C-15</p>	{D 079}		

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{D 079}	<p>Continued From page 2</p> <p>on 03/12/25 at 9:43am revealed: -Staff usually assisted her with bathing and brought the personal products with them when they came to bathe them. -She was unsure how long the personal care products had been left in her bathroom.</p> <p>Observation of the bathroom in resident room C-12 on 03/12/25 at 9:54am revealed: -The unlocked storage cabinet on the wall beside the sink had a deodorant stick, an antiperspirant stick, a bottle of shampoo, and a bottle of shampoo with conditioner. -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; and do not apply to broken skin.</p> <p>Interview with the resident residing in room C-12 on 03/12/25 at 9:54am revealed: -The staff usually kept his personal care hygiene products. -Staff sometimes left the products in his bathroom.</p> <p>Observation of the bathroom in resident room C-17 on 03/12/25 at 10:04am revealed: -The unlocked storage cabinet on the wall beside the sink had a bottle of lotion and a tube of toothpaste. -Warning labels on the products included: keep out of reach of children; for external use only; avoid contact with eyes; and if more than used for brushing is accidentally swallowed, get medical help or contact a PCC right away.</p> <p>Based on observations, interviews, and record reviews, the resident residing in room C-17 was not interviewable.</p>	{D 079}		

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{D 079}	Continued From page 3 Observation of the bathroom in resident room C-01 on 03/12/25 at 10:36am revealed: -The unlocked storage cabinet on the wall beside the sink had a bottle of hand lotion with aloe. -Warning labels on the products included: for external use only; and in case of eye contact, flush eyes with water. Based on observations, interviews, and record reviews, the two residents residing in room C-01 were not interviewable. Interview with a personal care aide (PCA) on 03/12/25 at 10:45am revealed: -No residents in the SCU kept personal care hygiene products in their rooms. -The personal care hygiene products were stored in a locked storage closet near the nurses' station. -The PCAs had a key to the locked closet and were supposed to take the personal care hygiene products back to the locked closet after bathing the residents. -There was no system to monitor to make sure the personal care hygiene products were not left in residents' rooms to her knowledge. -The personal care hygiene products should be locked in the SCU because the residents were confused. -She was not aware of any residents trying to ingest personal care hygiene products. Interview with a medication aide (MA) on 03/12/25 at 10:50am revealed: -No residents in the SCU were allowed to keep personal care hygiene products in their rooms. -Personal care hygiene products for residents in the SCU were usually kept locked in a closet near the nurses' station in the SCU.	{D 079}		

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{D 079}	<p>Continued From page 4</p> <ul style="list-style-type: none"> -The PCAs and MAs had a key at the nurses' station to access the personal care hygiene 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 responsible for taking the personal care products back to the locked closet after providing care to the residents. -The MAs usually checked behind the PCAs to make sure the personal care hygiene products were not left in residents' rooms. -She had not checked any residents' rooms yet that morning for personal care products. -No residents had tried to ingest any personal care hygiene products to her knowledge. <p>Interview with the Memory Care Director (MCD) on 03/12/25 at 11:15am revealed:</p> <ul style="list-style-type: none"> -Personal care hygiene products in the SCU should be locked in a storage closet near the nurses' station. -There were baskets labeled with the residents' names with their personal products. -No personal care hygiene products should be left in residents' rooms. -The key to the storage closet should be kept in the medication cart. -The PCAs got the key from the MAs and used the personal care products and then locked the products back in the storage closet. -The MAs checked behind the PCAs once the key was returned to the MAs. -She usually checked all residents' rooms twice a day at 6:00am and 11:00am to make sure no personal care hygiene products had been left in the residents' rooms. -She did not arrive at work until 7:15am that morning, 03/12/25, so she had not completed any 	{D 079}		
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{D 079}	<p>Continued From page 5</p> <p>room checks yet.</p> <p>Interview with the Administrator on 03/12/25 at 11:30am revealed:</p> <ul style="list-style-type: none"> -All personal care products in the SCU should be in labeled bins locked in the closet near the nurses' station. -The PCAs were responsible for getting the residents' bins from the locked closet when needed. -The PCAs were not supposed to leave the personal care products unattended. -The PCAs were supposed to return the bins with the personal care products to the locked closet. -The MAs were responsible for checking behind the PCAs at least by the end of each shift, depending on when showers were completed. -The MCD was responsible for doing daily checks for unsecured personal care products each morning. <p>Telephone interview with the facility's contracted primary care provider (PCP) on 03/14/25 at 4:13pm revealed:</p> <ul style="list-style-type: none"> -The residents living in the SCU could not distinguish possible hazards. -She was concerned that residents living in the SCU could possibly ingest personal care hygiene products. -Ingesting hazardous personal care hygiene products could cause vomiting and stomach upset and possibly require hospitalization. 	{D 079}		
D 125	<p>10A NCAC 13F .0403(a) Qualifications Of Medication Staff</p> <p>10A NCAC 13F .0403 Qualifications Of Medication Staff</p> <p>(a) Adult care home staff who administer</p>	D 125	<p>Divisional Care Specialist in-serviced BOM/ MCD/RCC on new hiring process. BOM/Designee will conduct an audit of all employee files to ensure all required documentation is available for review. All new hire employees will be approved by the ED/Designee prior to starting work on the units.</p>	4/28/2025

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D 125	<p>Continued From page 6</p> <p>medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 6 sampled staff (C, F) who administered medications had completed the medication clinical skills validation checklist prior to the administration of medications and passed the state-approved medication aide written exam.</p> <p>The findings are:</p> <p>1. Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 02/20/23. -Staff C signed a job description for a medication aide (MA) position on 02/27/25. -There was no documentation of a hire date as a MA in the record. -There was documentation of Staff C completing the state-approved 15-hour MA training course on 02/25/25. -There was documentation of Staff C completing the medication administration clinical skills validation checklist on 02/25/25. -There was no documentation of Staff C passing the state-approved MA written exam.</p> <p>Review of residents' January 2025 - March 2025 medication administration records (MARs) revealed Staff C documented administering medications on 01/13/25, 03/03/25 - 03/06/25,</p>	D 125	ED/HWD/BOM will ensure documentation of training, medication clinical skills validation and written examination have been completed prior to administration of medications.	
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D 125	<p>Continued From page 7 and 03/10/25 - 03/12/25.</p> <p>Telephone interview with Staff C on 03/14/25 at 6:08pm revealed:</p> <ul style="list-style-type: none"> -She started working as a MA at the facility in November 2024. -She completed the medication administration clinical skills validation checklist in November 2024 and in February 2025. -She did not know why the checklist for November 2024 was not available in her personnel record. -She had never taken the state-approved MA written exam, but she was taking it online today, 03/14/25. -She was not aware the MA written exam had to be passed within 60 days of hire as a MA. -She had administered medications since November 2024 and last administered medications at the facility this week. <p>Interview with the Administrator on 03/14/25 at 11:30am revealed:</p> <ul style="list-style-type: none"> -Staff C started working as a MA and administering medications in November 2024. -Staff C had been on leave at times so she had been on and off the schedule at various times. -The facility's former Health and Wellness Director (HWD) was a registered nurse and would have completed a medication administration clinical skills validation checklist for Staff C when Staff C was hired as a MA in November 2024. -She could not find Staff C's medication administration clinical skills validation checklist from November 2024 when an internal audit was done on the personnel files after the last state survey in December 2024. -The contact information for the former HWD was no longer active so she was unable to reach the 	D 125		

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D 125	<p>Continued From page 8</p> <p>former HWD to find out where the checklist was filed.</p> <ul style="list-style-type: none"> -Staff C had not taken the MA written exam. -They had a new medication administration clinical skills validation checklist completed for Staff C on 02/25/25 so she thought Staff C had 60 days from that date to pass the MA written exam. -She was not aware the MA written exam had to be passed within 60 days of hire as a MA. <p>2. Review of Staff F's personnel record revealed:</p> <ul style="list-style-type: none"> -Staff F was hired as a medication aide (MA) on 11/06/24. -Staff F completed the state-approved 15-hour MA training course on 11/13/24. -Staff F completed the medication administration clinical skills validation checklist on 02/25/25. -There was no documentation of the medication administration clinical skills validation checklist being completed prior to 02/25/25. -There was no documentation of Staff F passing the state-approved MA written exam. <p>Telephone interview with Staff F on 03/14/25 at 6:13pm revealed:</p> <ul style="list-style-type: none"> -She started working as a PCA and MA at the facility in November 2024. -She completed the medication administration clinical skills validation checklist in February 2025. -She did not recall if she completed the medication administration clinical skills validation checklist in November 2024 when she was first hired as a MA. -She had never taken the state-approved MA written exam. -The former Health and Wellness Director (HWD) did not say how long she had to take the exam but just told her to take it as soon as possible 	D 125		

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D 125	<p>Continued From page 9</p> <p>when the HWD completed her medication administration clinical skills validation checklist in February 2025. -She had administered medications since November 2024.</p> <p>Interview with the Administrator on 03/14/25 at 11:30am revealed: -Staff F was hired as a MA in November 2024 and started administering medications on 11/13/24. -Staff F had worked as a MA since being hired in November 2024. -The facility's former HWD was a registered nurse and would have completed a medication administration clinical skills validation checklist for Staff F when Staff F was hired as a MA in November 2024. -She could not find Staff F's medication administration clinical skills validation checklist from November 2024 when an internal audit was done on the personnel files after the last state survey in December 2024. -The contact information for the former HWD was no longer active so she was unable to reach the former HWD to find out where the checklist was filed. -Staff F had not taken the MA written exam. -They had a new medication administration clinical skills validation checklist completed for Staff F on 02/25/25 so she thought Staff F had 60 days from that date to pass the MA written exam. -She was not aware the MA written exam had to be passed within 60 days of hire as a MA.</p> <p>Refer to interview with the Administrator on 03/14/25 at 11:30am.</p> <p>_____</p> <p>Interview with the Administrator on 03/14/25 at</p>	D 125		

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D 125	Continued From page 10 11:30am revealed: -The Business Office Manager (BOM) was responsible for maintaining the personnel records. -The BOM was currently on leave and unavailable for interview. -The Administrator was responsible for checking personnel files upon hire.	D 125		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a) (1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 161	Divisional Care Specialist in-serviced BOM/MCD/ RCC on new hiring process. BOM/Designee will conduct an audit of all employee files to ensure all required documentation is available for review. All new hire employees will be approved by the ED/Designee prior to starting work on the units. ED/HWD/BOM will ensure LHPS tasks competency evaluation and validation has been completed prior to tasks being performed on a resident.	4/28/2025

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D 161	<p>Continued From page 11</p> <p>facility failed to ensure 2 of 6 sampled staff (B, F) had a competency evaluation and validation for licensed health professional support tasks prior to the tasks being performed.</p> <p>The findings are:</p> <p>1. Review of Staff F's personnel record revealed: -Staff F was hired as a medication aide (MA) and personal care aide (PCA) on 11/06/24. -There was no documentation of a licensed health professional support (LHPS) competency validation being completed for Staff F.</p> <p>Telephone interview with Staff F on 03/14/25 at 6:13pm revealed: -She started working as a PCA and MA at the facility in November 2024. -She did not recall having an LHPS competency validation completed. -She assisted residents with LHPS tasks such as ambulation using assistive devices, transferring, and oxygen.</p> <p>Interview with the Administrator on 03/14/25 at 11:30am revealed: -Staff F was hired in November 2024 and should have an LHPS competency validation that was completed at that time. -She was unable to locate Staff F's LHPS competency validation. -Staff F was responsible for performing LHPS tasks for residents at the facility.</p> <p>Refer to interview with the Administrator on 03/14/25 at 11:30am.</p> <p>2. Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA) and personal care aide (PCA) on 05/08/24.</p>	D 161		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 161	Continued From page 12 -There was no documentation of a licensed health professional support (LHPS) competency validation being completed for Staff B. Interview with the Administrator on 03/14/25 at 11:30am revealed: -Staff B was hired in May 2024 and should have an LHPS competency validation checklist that was completed at that time. -She was unable to locate Staff B's LHPS competency validation. -Staff B was responsible for performing LHPS tasks for residents at the facility. Refer to interview with the Administrator on 03/14/25 at 11:30am. Interview with the Administrator on 03/14/25 at 11:30am revealed: -The Business Office Manager (BOM) was responsible for maintaining the personnel records. -The BOM was currently on leave and unavailable for interview. -The Administrator was responsible for checking personnel files upon hire.	D 161		
{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: TYPE A2 VIOLATION	{D 273}	Regional Director of Resident Care in-serviced MCD/RCC/Med Aides on order processing, review of post hospitalization d/c orders. Divisional Care specialist/ Designee will audit all charts to ensure all orders/labs have been completed and all discrepancies will be reported to the Executive Director. MCD/Designee will bring all new orders to stand up for follow up and review <i>ongoing</i> . All new hire Med Aide will receive additional handouts related to order processing, review of post hospitalization and d/c orders, order clarification.	4/13/2025

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{D 273}	<p>Continued From page 13</p> <p>Based on interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 2 of 5 sampled residents (#4, #5) including failing to coordinate labwork ordered to screen for prostate cancer (#5) and failing to follow-up and coordinate lab testing to monitor for therapeutic effectiveness of a blood thinning medication (#4).</p> <p>The findings are:</p> <p>1. Review of Resident #4's FL-2 dated 10/24/24 revealed: -Diagnoses included paroxysmal atrial fibrillation, atrial flutter, presence of prosthetic heart valve, heart failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, muscle weakness, and abnormalities of gait and mobility. -There was an order for Warfarin 1mg 1 tablet at 9:00pm. (Warfarin is a blood thinner used to treat and prevent blood clots. INR (International Normalized Ratio) is a value used to monitor Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations. The target INR is generally recommended to be 2.5 - 3.5 for individuals with mechanical heart valves.)</p> <p>Review of Resident #4's cardiologist visit note dated 01/16/25 revealed: -The resident had a history of mitral valve replacement with a mechanical valve in December 2010. -The resident's target INR level was 2.5 - 3.00. -The cardiologist noted the resident lived in an assisted living facility where checking her INR frequently had been a challenge. -The cardiologist noted to follow-up in 6 months and closely monitor INR.</p>	{D 273}	<p>Continued ^{Review} audits of the order processing system to ensure healthcare follow-up will be conducted by the ED/HWD as part of the Community QA program. ^{during}</p> <p>each management morning stand up meeting going forward.</p>	

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{D 273}	<p>Continued From page 14</p> <p>-The order did not specify how often the resident's INR should be checked.</p> <p>Review of Resident #4's primary care provider (PCP) annual wellness visit dated 01/21/25 revealed the PCP noted the resident was receiving Warfarin and the cardiologist handled INR labs as well as medication.</p> <p>Review of Resident #4's acute Care Coordinator note at the PCP's office dated 01/21/25 revealed:</p> <ul style="list-style-type: none"> -The Care Coordinator called and spoke with the cardiologist's office. -The cardiologist's office confirmed the resident's Warfarin dosage. -The cardiologist's office asked the Care Coordinator to return their call and let them know if the resident had an INR drawn. -The resident was supposed to have an INR drawn today, 01/21/25. -The PCP had ordered it; left message letting cardiologist's office know the INR had been ordered. -The Care Coordinator also left a message for a return call to confirm the INR process or if they would like the PCP to also order weekly INRs. <p>Review of Resident #4's lab reports for January 2025 revealed there was no INR lab checked on 01/21/25.</p> <p>Review of Resident #4's lab report dated 01/30/25 revealed the resident's INR was collected on 01/29/25 with a result of 1.14 (below target range).</p> <p>Review of Resident #4's hospital discharge summary dated 02/04/25 revealed:</p> <ul style="list-style-type: none"> -The resident was admitted to the hospital on 01/30/25. 	{D 273}		

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{D 273}	<p>Continued From page 15</p> <ul style="list-style-type: none"> -Admission condition and diagnoses included subtherapeutic (below target range) INR, chronic atrial fibrillation, and history of mitral valve replacement with mechanical valve. -The resident's cardiologist advised to send the resident to the hospital due to the subtherapeutic INR. -The resident was treated with three blood thinners at the hospital including Warfarin, Heparin, and Lovenox. (Warfarin, Heparin, and Lovenox are all blood thinners used to treat and prevent blood clots.) -The hospitalist noted the resident's goal INR level at the hospital was 2.5 - 3.5. -There was an order for Warfarin 2mg take 1 ½ tablets (3mg) once a day and the last documented dose of 3mg was administered at the hospital on 02/04/25 at 5:40pm. -There was an order to check INR daily until INR stabilized. <p>Review of Resident #4's lab reports for February 2025 revealed there was no documentation of any daily INRs being checked from 02/05/25 - 02/10/25.</p> <p>Review of Resident #4's cardiologist order dated 02/10/25 revealed an order for INR lab draw on Mondays, Wednesdays, and Fridays to monitor INR stability.</p> <p>Review of Resident #4's lab report dated 02/12/25 revealed:</p> <ul style="list-style-type: none"> -The resident's INR was collected on 02/11/25 with a result of 3.62 (above target range). -There were handwritten notes at the bottom of the page to continue same dose of Warfarin at 2mg daily and recheck INR on 02/14/25. <p>Review of Resident #4's lab report dated</p>	{D 273}		

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{D 273}	<p>Continued From page 16</p> <p>02/13/25 revealed: -The resident's INR was collected on 02/12/25 (Wednesday) with a result of 3.23 (above target range). -There was a handwritten note by the PCP to please fax results to the cardiologist if not already done. -The handwritten note was signed and dated 02/18/25 by the PCP.</p> <p>Review of Resident #4's lab report dated 02/15/25 revealed: -The resident's INR was collected on 02/14/25 (Friday) with a result of 2.89 (within target range). -There was a handwritten note to continue same dose of 2mg once daily.</p> <p>Review of Resident #4's February 2025 lab reports revealed no documentation of an INR being checked on 02/17/25 (Monday).</p> <p>Review of Resident #4's lab report dated 02/20/25 revealed: -The resident's INR was collected on 02/19/25 (Wednesday) with a result of 3.44 (above target range). -There were handwritten notes at the bottom of the page to continue same dose of Warfarin at 2mg daily.</p> <p>Review of Resident #4's lab report dated 02/22/25 revealed the resident's INR was collected on 02/21/25 (Friday) with a result of 3.00 (within target range).</p> <p>Review of Resident #4's PCP verbal order dated 02/22/25 revealed: -There was an order to discontinue INR labs 3 times a week. -There was an order to change to weekly INR</p>	{D 273}		

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{D 273}	<p>Continued From page 17</p> <p>labs starting on 03/03/25.</p> <p>Review of Resident #4's March 2025 lab reports revealed no documentation of an INR being checked on 03/03/25 as ordered.</p> <p>Review of Resident #4's cardiologist order dated 03/03/25 revealed: -There was an order to continue Warfarin 2mg 1 tablet once daily at bedtime. -There was an order to draw INR labs weekly until further notice.</p> <p>Review of Resident #4's lab report dated 03/06/25 revealed: -The resident's INR was collected on 03/06/25 with a result of 1.52 (below target range). -There was a handwritten verbal order at the bottom of the page to take Warfarin 4mg today and 4mg tomorrow, then resume normal dose of 2mg daily and recheck INR in 1 week.</p> <p>Review of Resident #4's lab report dated 03/13/25 revealed: -The resident's INR was collected on 03/12/25 with a result of 4.56 (above target range). -There was a handwritten verbal order at the bottom of the page to hold Warfarin for 1 day then continue with same dose of 2mg daily and recheck INR in 1 week.</p> <p>Interview with Resident #4 on 03/14/25 at 6:33pm revealed: -She took a blood thinner and she did not know if she had missed any doses. -Her labwork was checked but she was unsure how often or the last time it was checked. -She denied any current symptoms of bleeding or bruising.</p>	{D 273}		

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{D 273}	<p>Continued From page 18</p> <p>Interview with the Memory Care Director (MCD) on 03/14/25 at 2:15pm revealed: -She did not know anything about Resident #4's Warfarin and INR orders. -She had been in training as the MCD and she just started processing orders on 03/01/25. -She did not know why the resident's INRs were not checked as ordered. -The Resident Care Coordinator (RCC) or the former Health and Wellness Director (HWD) would have been responsible for processing orders while she was in training.</p> <p>Interview with the RCC on 03/14/25 at 2:58pm revealed: -She had a book she used to file Warfarin orders and INR labs. -She did not have a system to track the Warfarin orders and INRs; she just filed them.</p> <p>Interview with the Administrator on 03/14/25 at 2:45pm revealed: -The RCC and the former HWD were responsible for tracking Resident #4's Warfarin orders and INR labs. -She was not sure why some of Resident #4's INRs were not done. -Resident #4 was in the hospital and returned to the facility on 02/05/25. -The facility could not accommodate daily INRs because the contracted lab provider usually came to the facility about once a week. -The former HWD should have contacted the resident's cardiologist to get a verbal order to change daily INR checks when the resident returned from the hospital on 02/05/25.</p> <p>Telephone interview with a Medical Administrator at the facility's contracted lab provider on 03/17/25 at 8:41am revealed:</p>	{D 273}		

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{D 273}	<p>Continued From page 19</p> <ul style="list-style-type: none"> -They usually received lab orders either through an electronic telemedicine system and/or via emails from providers or the facility. -They did not receive any orders for Resident #4's INR to be checked daily in February 2025. -They had collectors who went to the facility to draw blood for labwork. -They attempted to draw an INR on 01/16/25 but were told by facility staff that the resident was at a medical appointment. -If they were unable to obtain a blood draw while at the facility, they canceled the order in their system. -The facility was responsible for reaching out to the provider to get a new order or reaching out to them to reinstate the order. <p>Telephone interview with Resident #4's PCP on 03/14/25 at 4:35pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's cardiologist oversaw the resident's Warfarin and INR checks. -In January 2025, the Care Coordinator at her office arranged communication between the office and the cardiologist's office for the Warfarin and INRs. -She still needed to document and follow the resident's Warfarin and INRs since she was the resident's PCP. -The PCP's Care Coordinator would fax INR results to the cardiologist's office (Warfarin Clinic) and the cardiologist's office would send orders to the facility. -At the end of January 2025, the resident had a critically low INR lab value and was sent to the hospital by the cardiologist. -At that time the facility's former HWD was giving INR results to her and uploading them in the telemedicine system. -The resident also had a critically high INR lab value this week on 03/13/25. 	{D 273}		

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{D 273}	<p>Continued From page 20</p> <ul style="list-style-type: none"> -The INR results from 03/13/25 were faxed to the cardiologist's office and orders to hold the Warfarin were sent to the facility. -There was an order prior to the resident being in the hospital on 01/03/25 for the resident's INR to be checked weekly. -She saw Resident #4 for a PCP visit on 01/07/25 and noticed there was no INR for January 2025 in the resident's record so she reordered an INR check. -She did not see in her records where an INR was checked after she reordered it on 01/07/25. -The lab provider documented on 01/17/25, the resident was in the hospital and the lab was canceled by the lab provider. -No one at the facility contacted her about the resident's INR not being checked. -She could not get a clear answer from facility staff as to why the INR was not done so she had the Care Coordinator at her office to contact the cardiologist's office. -The Care Coordinator at her office spoke with the cardiologist's office on 01/21/25 to clarify the Warfarin dosage and to make sure the INR was ordered again. -The resident's INR was checked on 01/29/25 and resulted on 01/30/25 at 1.14 (below target range). -The Care Coordinator at her office called the cardiologist's office on 01/30/25 and the cardiologist's office said the resident needed to go to the hospital emergency room (ER). -A low INR level put the resident at risk of her blood not being thin enough, which could cause her mechanical heart valve not to be able to work. -The resident had atrial fibrillation and having a low INR level put the resident at risk of having a blood clot that could cause a stroke or heart attack. -A high INR level put the resident at risk of 	{D 273}		

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{D 273}	<p>Continued From page 21</p> <p>bleeding out.</p> <p>Attempted telephone interview with Resident #4's cardiology provider on 03/14/25 at 3:06pm was unsuccessful.</p> <p>2. Review of Resident #5's current FL-2 dated 07/02/24 revealed diagnoses included Alzheimer's disease, hypertension, hyperlipidemia, and gastroesophageal reflux disease.</p> <p>Review of Resident #5's Resident Register revealed: -The resident was admitted to the facility on 05/14/24. -The resident required assistance with scheduling appointments and orientation to time and place. -The resident had significant memory loss and must be directed.</p> <p>Review of Resident #5's current assessment and care plan dated 10/15/24 revealed: -The resident had wandering behaviors. -The resident was always disoriented, had significant memory loss, and must be directed. -The resident was independent with eating, toileting, ambulation, and transferring. -The resident required supervision by staff with bathing, dressing, and grooming.</p> <p>Review of Resident #5's primary care provider (PCP) visit note dated 01/30/25 revealed: -The resident was seen by the PCP for an annual wellness visit. -There was an order to check the resident's PSA (prostate-specific antigen) level. (A PSA test measures the amount of PSA in the blood. Elevated PSA levels may indicate prostate cancer or other prostate conditions.)</p>	{D 273}		

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{D 273}	<p>Continued From page 22</p> <p>Review of Resident #5's lab results for January 2025 - March 2025 revealed there was no documentation of a PSA level being checked as ordered on 01/30/25.</p> <p>Interview with Resident #5 on 03/14/25 at 6:29pm revealed: -He did not know if he had any recent labwork completed. -He denied any urinary or prostate symptoms.</p> <p>Interview with the Memory Care Director (MCD) on 03/13/25 at 1:58pm revealed: -She had been the MCD since 01/12/25 but had been in training and just started dealing with the orders on 03/01/25. -The MCD, Resident Care Coordinator (RCC), Health and Wellness Director (HWD), Administrator, or the medication aides (MAs) were responsible for sending lab orders to the facility's contracted lab when the order was received. -Once the lab order was sent to the contracted lab provider, the order was filed in the resident's record and a lab book. -The facility's contracted lab usually came to the facility to draw labwork either the same day or the next day. -She thought the facility usually sent lab results to the PCP and held for further instructions. -She was the MCD in January 2025 when Resident #5 had an order to get his PSA level checked but she was not handling orders at that time since she was in training. -The former HWD, RCC, or Administrator would have processed lab orders in January 2025 when Resident #5's order was received. -She was not aware of the 01/30/25 order for PSA level to be checked for Resident #5 until it was</p>	{D 273}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331		
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{D 273}	<p>Continued From page 23</p> <p>brought to their attention by the surveyor.</p> <ul style="list-style-type: none"> -She had not had a chance to put a system in place to check to make sure lab orders were done since she started processing orders on 03/01/25. -She had the resident's PSA level drawn today, 03/13/25. <p>Telephone interview with a Medical Administrator at the facility's contracted lab provider on 03/17/25 at 8:41am revealed:</p> <ul style="list-style-type: none"> -They usually received lab orders either through an electronic telemedicine system and/or via emails from the provider or facility. -They did not receive an order dated 01/30/25 for a PSA level for Resident #5. -She received a phone call from facility staff on 03/12/25 inquiring about the PSA level. -The facility staff faxed the order to them on 03/13/25 and the labwork was collected on 03/13/25. <p>Review of Resident #5's lab results dated 03/14/25 revealed:</p> <ul style="list-style-type: none"> -The resident's blood was collected on 03/13/25 for a PSA test. -The reference range for the PSA level was 0 - 4. -The resident's PSA level was 6.431 and flagged as high. <p>Interview with the Administrator on 03/14/25 at 2:45pm revealed:</p> <ul style="list-style-type: none"> -The RCC, MCD, and the HWD were responsible for tracking orders and labs. -The HWD position was currently vacant, so the RCC and MCD were responsible for making sure lab orders were completed. -She was not sure why Resident #5's PSA was not done when ordered on 01/30/25. 	{D 273}		

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{D 273}	<p>Continued From page 24</p> <p>Telephone interview with Resident #5's PCP on 03/14/25 at 4:13pm revealed:</p> <ul style="list-style-type: none"> -She or the facility could send orders for labwork to the facility's contracted lab provider. -She usually reviewed lab results during her weekly visits to the facility unless the lab was a critical value, then the facility should contact her immediately. -She ordered a PSA level to be checked for Resident #5 on 01/30/25 for health screening purposes. -The resident did not have a history of prostate cancer and was not having prostate-related issues to her knowledge. -The PSA level should have been checked when it was ordered in January 2025 for screening purposes. -She had not been notified of the results of the PSA level drawn on 03/13/25 and was not aware the PSA level was high. -Given the resident's age, she would refer the resident to a urology provider for evaluation. -She anticipated a possible biopsy and/or a repeat PSA level would be done. <p>The facility failed to ensure health care referral and follow-up for Resident #4 and Resident #5. Resident #4, who received a blood thinner for atrial fibrillation and a mechanical heart valve did not have labwork as ordered to monitor the therapeutic effectiveness of a blood thinner. Resident #4 was hospitalized on 01/30/25 due to subtherapeutic levels of the blood thinner putting the resident at risk of having blood clots and at risk of the mechanical heart valve not working. Resident #4 did not have labwork completed as ordered after the hospitalization and some labs that were completed continued to be out of the resident's target range putting the resident at risk of blood clots that could cause a stroke or heart</p>	{D 273}		

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{D 273}	Continued From page 25 attack or at risk of bleeding. Resident #5 did not get routine labwork used to screen for prostate cancer as ordered on 01/30/25 resulting in a delay in the labwork being completed which indicated the resident's lab for prostate screening was high. Resident #5's primary care provider (PCP) was going to order a urology referral and anticipated a possible biopsy and/or a repeat lab level would be needed for evaluation. The failure of the facility to provide health care coordination and follow-up put the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/14/25 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 13, 2025.	{D 273}		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	D 344	Regional Director of Resident Care in-serviced MCD/RCC/Med Aides on order processing, review of post hospitalization d/c orders, order clarification. Divisional Care specialist/ Designee will audit all physician orders and obtain clarification orders as needed; all discrepancies will be reported to the Executive Director. MCD/Designee will bring all new orders to stand up for follow up and review All new hire Med Aide will receive additional handouts related to order processing, review of post hospitalization and d/c orders, order clarification. ED/DHW will monitor process to ensure clarification of orders documentation is in the resident record.	4/28/2025

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D 344	<p>Continued From page 26</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medication orders were clarified for 1 of 5 sampled residents (#4) for a topical pain patch.</p> <p>The findings are:</p> <p>Review of Resident #4's FL-2 dated 02/04/25 revealed: -Diagnoses included chest pain, chronic midline low back pain without sciatica, and arthralgia of the feet. -There was an order for Lidocaine patch 5% apply 1 patch topically daily, remove and discard within 12 hours. (Lidocaine patch is a topical medication used to treat pain, including nerve pain.) -The order did not specify where the patch was to be applied.</p> <p>Review of Resident #4's medication orders revealed no clarification order for the Lidocaine patch.</p> <p>Review of Resident #4's February 2025 medication administration record (MAR) revealed: -There was an entry for Lidocaine patch 5% apply 1 patch to skin once daily scheduled at 8:00am. -There was no information regarding when the Lidocaine patch was to be removed. -The Lidocaine patch was documented as administered daily from 02/06/25 - 02/28/25.</p> <p>Review of Resident #4's March 2025 MAR revealed: -There was an entry for Lidocaine patch 5% apply 1 patch topically once a day for 12 hours then</p>	D 344	<p>All admissions to Community will be prepared for and followed up utilizing the "New Admission Clinical Checklist" which includes ensuring clarification of orders as required. This checklist is reviewed by clinical team and EB during each morning stand up meeting to ensure ongoing compliance. This process will be in place going forward.</p>	

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D 344	<p>Continued From page 27</p> <p>remove (12 hours on / 12 hours off). -The Lidocaine patch was scheduled at 8:00am and 8:00pm but it did not specify which time to apply the patch and which time to remove the patch. -There was no documentation to indicate where the patch was applied. -Lidocaine patch was initialed at 8:00am on 03/01/25 - 03/03/25 and 03/05/25 - 03/14/25, -Lidocaine patch was initialed at 8:00pm on 03/01/25, 03/03/25 - 03/06/25 and 03/08/25 - 03/13/25.</p> <p>Observation of Resident #4's medications on hand on 03/14/25 at 1:41pm revealed: -There was a box of Lidocaine 5% patches dispensed on 01/25/25. -The instructions were to apply 1 patch topically once a day for 12 hours then remove (12 hours on/12 hours off).</p> <p>Interview with Resident #4 on 03/14/25 at 6:33pm revealed: -The MAs usually put the Lidocaine patch on her lower back. -She was not sure when the patch was applied or removed.</p> <p>Interview with a medication aide (MA) on 03/14/25 at 1:28pm revealed: -She was not sure where Resident #4's Lidocaine patch was supposed to be applied so she had asked the former Health and Wellness Director (HWD) to clarify the order (could not recall date she asked). -At that time, the MAs were not allowed to clarify orders and she never heard back from the former HWD. -She usually put the Lidocaine patch on the resident's mid, lower back because that was</p>	D 344		

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D 344	<p>Continued From page 28</p> <p>where the resident complained of pain.</p> <ul style="list-style-type: none"> -The entry on the MAR was confusing to her and she was never really sure if she should apply the patch at 8:00am or remove it because the MAR did not specify. -Sometimes, the resident already had a Lidocaine patch on her back when she went in to apply the patch in the mornings. -That was another reason she was not sure when to apply or remove it because she thought maybe evening shift was applying it or maybe they just forgot to remove it. -She had not asked for any further assistance by anyone with clarifying the order and she was not sure why. <p>Interview with the Memory Care Director (MCD) on 03/14/25 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -Either she or the Resident Care Coordinator (RCC) were responsible for clarifying medication orders. -She had just started clarifying orders in March 2025 after her orientation. -She was not aware Resident #4's Lidocaine patch order was incomplete and needed clarifying. -The order should specify where the patch should be applied. -The MAR should note when to apply and when to remove the patch. -The MAs should let her or the RCC know if they needed assistance with any unclear orders. <p>Telephone interview with Resident #4's PCP on 03/14/25 at 4:35pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's Lidocaine patch should be applied to her lower back. -If the Lidocaine patch was not removed, it could cause redness, irritation, and possibly lower heart rate. 	D 344		

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D 344	Continued From page 29 -The facility staff could contact her anytime to clarify any unclear orders. Interview with the Administrator on 03/13/25 at 4:52pm revealed: -The MCD and RCC were responsible for clarifying medication orders. -Resident #4's Lidocaine patch order should have been clarified.	D 344		
{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: FOLLOW-UP TO TYPE A1 VIOLATION. Based on these findings, the previous Type A1 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#6) observed during the medication pass including errors with medications for blood circulation, constipation, and seasonal allergies; and for 2 of 5 residents (#4, #5) sampled for record review including errors with a blood thinner (#4), a medication for mild to moderate pain (#5),	{D 358}	Regional Director of Resident Care/ Designee provided additional training to MCD/RCC/Med Aides on medication administration process, medication administration guidelines related to non - oral medications and medication scheduling guidelines. Regional Director of Resident Care/ Designee completed Med aide skills competency verification on all Med aides. All new hire Med Aide will receive additional handouts related to medication administration process, medication administration guidelines. As of 4/28/25 DHW/Designee will observe random medication passes 2 times a week for 4 weeks and then randomly there after. Any issues will be immediately corrected/retrained and reported to the Executive Director DHW/ED will ensure continued education and med pass observations are conducted as part of the Community QA process.	3/18/2025

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{D 358}	<p>Continued From page 30 and a topical pain patch (#5).</p> <p>The findings are:</p> <p>1. The medication error rate was 11% as evidenced by 3 errors out of 27 opportunities during the 8:00am/9:00am medication pass on 03/13/25.</p> <p>a. Review of Resident #6's current FL-2 dated 11/21/24 revealed: -Diagnoses included vascular dementia without disturbances, allergic rhinitis, vasomotor rhinitis, constipation, essential hypertension, hyperlipidemia, gastroesophageal reflux disease, depression, and muscle weakness. -There was an order for Azelastine 0.15% Nasal Spray, instill 2 sprays in each nostril twice daily for allergy/nasal congestion. (Azelastine Nasal Spray is an antihistamine used to relieve allergy symptoms such as stuffy or runny nose, itching, and sneezing.)</p> <p>Review of Resident #6's primary care provider (PCP) order dated 02/18/25 revealed an order to discontinue Azelastine 0.15% Nasal Spray twice day and change to prn (as needed).</p> <p>Review of Resident #6's hospital discharge summary dated 03/07/25 revealed: -The resident was admitted to the hospital on 03/02/25 due to an unwitnessed fall. -The resident was discharged on 03/07/25. -There was an order for Azelastine 0.1% Nasal Spray administer 1 spray into each nostril 2 times a day.</p> <p>Review of Resident #6's medication clarification orders dated 03/13/25 revealed an order to continue Azelastine 0.1% Nasal Spray instill 1</p>	{D 358}	<p><i>A med pass observation will be completed by a licensed nurse quarterly ongoing for each medication aide.</i></p>	
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{D 358}	<p>Continued From page 31</p> <p>spray into each nostril twice a day.</p> <p>Review of Resident #6's March 2025 electronic medication administration record (eMAR) dated 03/03/25 - 03/13/25 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Azelastine 0.1% Nasal Spray, instill 1 spray in each nostril twice daily scheduled at 8:00am and 8:00pm. -Azelastine 0.1% Nasal Spray 1 spray in each nostril was documented as administered from 03/08/25 - 03/13/25. <p>Observation of the 8:00am/9:00am medication pass on 03/13/25 revealed:</p> <ul style="list-style-type: none"> -The medication aide (MA) handed the Azelastine 0.1% Nasal Spray bottle to Resident #6 and instructed the resident to use 2 sprays in each nostril. -The resident instilled 2 sprays in each nostril of Azelastine 0.1% Nasal Spray at 8:25am instead of 1 spray in each nostril as ordered. <p>Observation of Resident #6's medications on hand on 03/13/25 at 12:45pm revealed:</p> <ul style="list-style-type: none"> -There was a bottle of Azelastine Nasal Spray 0.1% dispensed on 03/07/25. -The instructions were to instill 1 spray in each nostril twice daily. <p>Interview with the MA on 03/13/25 at 12:43pm revealed:</p> <ul style="list-style-type: none"> -She had always administered or instructed Resident #6 to use 2 sprays in each nostril of the Azelastine Nasal Spray. -She had not noticed the new instructions on the eMAR and medication label were to use 1 spray in each nostril. -She overlooked the medication change. <p>Interview with Resident #6 on 03/13/25 at 4:21pm</p>	{D 358}		

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{D 358}	<p>Continued From page 32</p> <p>revealed:</p> <ul style="list-style-type: none"> -She usually used 2 sprays in each nostril of the Azelastine Nasal Spray. -It usually helped with her seasonal allergies. -She denied any side effects from using the Azelastine Nasal Spray. <p>Interview with the Resident Care Coordinator (RCC) on 03/13/25 at 1:23pm revealed:</p> <ul style="list-style-type: none"> -The MAs had been trained to read the eMARs and medication labels prior to administering medications. -The MAs should administer medications based on the instructions on the eMAR and medication labels, not from memory because orders changed. <p>Interview with the Administrator on 03/13/25 at 1:34pm revealed:</p> <ul style="list-style-type: none"> -The MAs were trained to read the eMARs and medication labels and administer medications as ordered. -Resident #6 should have received 1 spray in each nostril of the Azelastine Nasal Spray. <p>Telephone interview with Resident #6's PCP on 03/14/25 at 4:13pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 should only use 1 spray in each nostril of the Azelastine Nasal Spray. -Using too much Azelastine Nasal Spray could cause side effects such as runny nose. <p>b. Review of Resident #6's current FL-2 dated 11/21/24 revealed an order for Pentoxifylline ER 400mg 1 tablet twice daily, take with food.) (Pentoxifylline ER is used to treat poor blood circulation by improving the flow of blood through vessels. According to the manufacturer, Pentoxifylline ER should be taken with meals to lessen the chance of stomach upset.)</p>	{D 358}		

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{D 358}	<p>Continued From page 33</p> <p>Review of Resident #6's hospital discharge summary dated 03/07/25 revealed: -The resident was admitted to the hospital on 03/02/25 due to an unwitnessed fall. -The resident was discharged on 03/07/25. -There was an order for Pentoxifylline ER 400mg 1 tablet twice daily with meals.</p> <p>Review of Resident #6's March 2025 electronic medication administration record (eMAR) dated 03/03/25 - 03/13/25 revealed: -There was an entry for Pentoxifylline ER 400mg 1 tablet twice daily with meals scheduled at 8:00am and 5:00pm. -Pentoxifylline ER 400mg was documented as administered from 03/08/25 - 03/13/25.</p> <p>Interview with the medication aide (MA) on 03/13/25 at 8:05am revealed breakfast was usually served in the dining room between 7:00am and 8:00am each day.</p> <p>Observation of the 8:00am/9:00am medication pass on 03/13/25 revealed: -The MA administered Pentoxifylline ER 400mg to Resident #6 at 8:24am. -At 8:24am, the resident stated she had not eaten breakfast yet but she was planning to eat breakfast in her room once her meal tray was delivered. -The resident's Pentoxifylline ER 400mg was administered before the meal instead of with the meal as ordered.</p> <p>Observation of Resident #6 on 03/13/25 from 8:33am - 8:37am revealed: -The resident's breakfast meal was delivered to her room at 8:33am. -The food and beverages were placed on a dining</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331		
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{D 358}	Continued From page 34 table in the resident's room. -The resident then went and sat in a chair at the table. -The resident started eating at 8:37am. Observation of Resident #6's medications on hand on 03/13/25 at 12:43pm revealed: -There was a supply of Pentoxifylline ER 400mg tablets dispensed on 02/28/25. -The instructions were to take 1 tablet twice daily, take with food. Interview with the MA on 03/13/25 at 12:43pm revealed: -Resident #6 was usually already eating breakfast in her room when she administered the resident's morning medications. -She was not sure why Resident #6 did not have her breakfast yet that morning, 03/13/25. -She thought medications ordered with meals could be administered 15 to 30 minutes prior to the resident eating. Interview with Resident #6 on 03/13/25 at 4:21pm revealed: -She liked to take her medications after she ate her meals, but she sometimes received her medications before her meals. -She denied any stomach upset from taking the medications before breakfast that morning, 03/13/25. Interview with the Resident Care Coordinator (RCC) on 03/13/25 at 1:23pm revealed: -If a medication was ordered with meals, the resident could not take the medication on an empty stomach. -Medications ordered with meals should be administered after the resident had eaten and had food on their stomach.	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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{D 358}	<p>Continued From page 35</p> <p>Interview with the Administrator on 03/13/25 at 1:34pm revealed: -If a medication was ordered with meals or with food, the facility's policy was to administer the medication with food. -Medications ordered with meals should not be administered before a resident had eaten.</p> <p>Telephone interview with Resident #6's primary care provider (PCP) on 03/14/25 at 4:13pm revealed: -She wanted the resident's Pentoxifylline ER administered with meals, so it did not cause gastrointestinal upset. -It could also cause gastrointestinal ulcers if administered on an empty stomach.</p> <p>c. Review of Resident #6's current FL-2 dated 11/21/24 revealed an order for Miralax mix 17 grams in suitable liquid and drink once daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.)</p> <p>Review of Resident #6's hospital discharge summary dated 03/07/25 revealed: -The resident was admitted to the hospital on 03/02/25 due to an unwitnessed fall. -The resident was discharged on 03/07/25. -Miralax was not included in the discharge medication list.</p> <p>Review of Resident #6's medication clarification orders dated 03/13/25 revealed: -Miralax was listed as medications discontinued from the hospital and there was a check mark in the "yes" box beside the Miralax.</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331		
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{D 358}	<p>Continued From page 36</p> <p>-The PCP signed the clarification orders on 03/13/25.</p> <p>Review of Resident #6's March 2025 electronic medication administration record (eMAR) dated 03/03/25 - 03/13/25 revealed:</p> <p>-There was an entry for Miralax mix 17 grams in suitable liquid and drink once daily scheduled at 8:00am.</p> <p>-Miralax was documented as administered from 03/08/25 - 03/13/25.</p> <p>Observation of the 8:00am/9:00am medication pass on 03/13/25 revealed:</p> <p>-There was a white section lining the inside of the purple cap on the Miralax bottle.</p> <p>-There was "17g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap.</p> <p>-The medication aide (MA) poured the Miralax powder halfway below the marking for the 17g dose.</p> <p>-The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water.</p> <p>-The MA mixed the Miralax powder in water and gave it to Resident #6 to take with her oral medications at 8:24am.</p> <p>-The resident drank all the water with Miralax.</p> <p>-The resident did not receive the full dosage of Miralax.</p> <p>Observation of Resident #6's medications on hand on 03/13/25 at 12:47pm revealed:</p> <p>-There was a bottle of Miralax powder dispensed on 09/16/24.</p> <p>-The instructions were to mix 17 grams in suitable liquid and drink once daily.</p>	{D 358}		

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{D 358}	<p>Continued From page 37</p> <p>Interview with the MA on 03/13/25 at 12:43pm revealed: -She usually measured Resident #6's Miralax powder to the groove about halfway of the white lining inside the cap. -She had not noticed the marking for 17g pointing to the top of the inner white lining of the cap. -She thought the marking for 17g was the groove below the "17g" marking. -The resident had not complained about any current issues with constipation or diarrhea.</p> <p>Interview with Resident #6 on 03/13/25 at 4:21pm revealed: -She did not know if she received Miralax. -She was not currently having any issues with constipation or diarrhea.</p> <p>Interviews with the Resident Care Coordinator (RCC) on 03/13/25 at 1:19pm and 1:23pm revealed: -She had just recently started taking on the responsibility of clarifying medication orders. -When a resident returned from the hospital, she usually filled out a medication clarification form using the hospital discharge summary and put it in the facility's contracted primary care provider's (PCP) folder. -The PCP usually came to the facility once a week and reviewed information in the folder. -She did not usually send clarifications to the PCP prior to the weekly visit. -She thought if a medication was left off the discharge summary, it meant the medication was to be discontinued. -She sent the clarification form for Resident #6's hospital discharge summary (dated 03/07/25) today, 03/13/25. -The MAs had been trained on how to measure medications including Miralax powder.</p>	{D 358}		

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{D 358}	<p>Continued From page 38</p> <ul style="list-style-type: none"> -The Miralax lid had a marking on the inner white lining for 17 grams. -The MAs should measure the Miralax powder to the top of the white inner lining, which was the marking for 17 grams. -Resident #6 had not experienced any current issues with constipation or diarrhea to her knowledge. <p>Interview with the Administrator on 03/13/25 at 1:34pm revealed:</p> <ul style="list-style-type: none"> -The RCC and Memory Care Director (MCD) were responsible for obtaining clarification of medication orders. -Medication order clarifications should be sent to the PCP as soon discrepancies were identified and should not be placed in the PCP folder to wait for weekly visits. -The MAs should use the correct marking for 17 grams to measure the correct amount of Miralax for Resident #6. <p>Telephone interview with Resident #6's PCP on 03/14/25 at 4:13pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 was receiving Miralax to keep her bowels regular. -Receiving half the dosage of Miralax could cause the resident to have worsening constipation. -She was not aware of the resident having any current complaints of constipation. <p>2. Review of Resident #4's FL-2 dated 10/24/24 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included paroxysmal atrial fibrillation, atrial flutter, presence of prosthetic heart valve, heart failure, chronic obstructive pulmonary disease, acute respiratory failure with hypoxia, muscle weakness, and abnormalities of gait and mobility. -There was an order for Warfarin 1mg 1 tablet at 	{D 358}		

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{D 358}	<p>Continued From page 39</p> <p>9:00pm. (Warfarin is a blood thinner used to treat and prevent blood clots. International Normalized Ratio (INR) is a lab value used to monitor Warfarin therapy. The target INR range is generally recommended to be 2.0 - 3.0 for most clinical situations. The target INR is generally recommended to be 2.5 - 3.5 for individuals with mechanic heart valves.)</p> <p>Review of Resident #4's cardiologist visit note dated 01/16/25 revealed: -The resident had a history of mitral valve replacement with a mechanical valve in December 2010. -The resident's target INR level was 2.5 - 3.00.</p> <p>Review of Resident #4's physician's order dated 11/01/24 revealed an order for Warfarin 2mg 1 tablet daily at bedtime.</p> <p>Interview with the Administrator on 03/14/25 at 6:50pm revealed: -She was unable to provide a copy of Resident #4's November 2024 medication administration record (MAR). -She did not have access to the November 2024 MARs due to the facility being under different ownership at that time and the previous company took those records when the ownership changed.</p> <p>Review of Resident #4's lab report dated 12/12/24 revealed: -The resident's INR was collected on 12/11/24 with a result of 4.41 (above target range). -There were handwritten notes at the bottom of the page to hold Warfarin then restart Warfarin on 12/16/24 at 2mg once a day and recheck INR on 12/23/25.</p> <p>Review of Resident #4's lab report dated</p>	{D 358}		

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{D 358}	<p>Continued From page 40</p> <p>12/19/24 revealed: -The resident's INR was collected on 12/18/24 with a result of 1.28 (below target range). -There were handwritten orders at the bottom of the page to take Warfarin 6mg today, 4mg tomorrow, then 2mg daily and recheck INR on 12/26/25.</p> <p>Review of Resident #4's lab report dated 12/26/24 revealed: -The resident's INR was collected on 12/25/24 with a result of 1.57 (below target range). -There were handwritten orders at the bottom of the page to increase Warfarin to 4mg once a day and recheck INR on 12/31/25.</p> <p>Review of Resident #4's December 2024 electronic MAR revealed: -There was an entry for Warfarin 2mg 1 tablet at bedtime scheduled at 8:00pm. -Warfarin 2mg was documented as administered at 8:00pm from 12/01/24 - 12/11/24, 12/16/24 - 12/20/24, and 12/23/24. -Warfarin 6mg should have been administered on 12/19/24 and 4mg on 12/20/24 but only 2mg were documented as administered on each of those days. -Warfarin 2mg should have been administered on 12/21/24 and 12/22/24 but none was administered on those days. -Warfarin 2mg at 8:00pm was documented as not administered from 12/12/24 - 12/15/24 and 12/21/24 - 12/22/24 due to "drug not given" and/or "drug not available". -Warfarin 2mg at 8:00pm was documented as discontinued on 12/24/24. -There was a total of 17 Warfarin 2mg tablets documented as administered from 12/01/24 - 12/23/24. -There was a second entry for Warfarin 2mg 1</p>	{D 358}		

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{D 358}	<p>Continued From page 41</p> <p>tablet once daily scheduled at 8:00pm with a documented start date of 12/24/24.</p> <p>-Warfarin 2mg once daily was documented as administered on 12/24/24 and 12/25/24.</p> <p>-Warfarin 2mg once daily was documented as discontinued on 12/26/24.</p> <p>-There were a total of 2 Warfarin 2mg tablets documented as administered from 12/24/24 - 12/25/24.</p> <p>-There was a third entry for Warfarin 4mg 1 tablet once daily on 12/24/24 only scheduled or administration at 8:00pm.</p> <p>-Warfarin 4mg was documented as administered on 12/24/24 - 12/25/24.</p> <p>-Warfarin 4mg was documented as discontinued on 12/26/24.</p> <p>-There was a total of 2 Warfarin 4mg tablets documented as administered from 12/24/24 - 12/25/24.</p> <p>-Warfarin 2mg should have been administered on 12/24/24 and 12/25/24 but 6mg was documented as administered on both of those days.</p> <p>-There was a total 6mg of Warfarin documented as administered on 12/24/24 - 12/25/24.</p> <p>-There was a fourth entry for Warfarin 4mg 1 tablet once daily scheduled at 8:00pm.</p> <p>-Warfarin 4mg was documented as administered from 12/26/24 - 12/28/24.</p> <p>-There was a total of 3 Warfarin 4mg tablets documented as administered from 12/26/24 - 12/28/24.</p> <p>-Warfarin 4mg was not documented as administered from 12/29/24 - 12/31/24 due to the resident being on a leave of absence.</p> <p>-There was a total of 19 Warfarin 2mg tablets and 5 Warfarin 4mg tablets documented as administered from 12/01/24 - 12/31/24.</p> <p>Review of Resident #4's January 2025 paper MAR revealed:</p>	{D 358}		

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{D 358}	<p>Continued From page 42</p> <ul style="list-style-type: none"> -There was an entry for Warfarin 4mg 1 tablet once daily scheduled at 8:00pm. -Warfarin 4mg was documented as administered at 8:00pm from 01/01/25 - 01/13/25, 01/15/25, 01/16/25, 01/20/25, 01/24/25, 01/28/25, and 01/29/25. -Warfarin 4mg at 8:00pm was documented as not administered on 01/14/25, 01/17/25 - 01/19/25, 01/21/25 - 01/23/25, and 01/25/25 - 01/27/25 due to "drug not given" and/or "drug not available". -Warfarin 4mg at 8:00pm was documented as not administered on 01/30/25 - 01/31/25 due to the resident being out of the facility. -There was a total of 19 Warfarin 4mg tablets documented as administered from 01/01/25 - 01/31/25. -There were 11 doses of Warfarin not administered in January 2025. <p>Review of Resident #4's lab report dated 01/30/25 revealed the resident's INR was collected on 01/29/25 with a result of 1.14 (below target range).</p> <p>Review of Resident #4's hospital discharge summary dated 02/04/25 revealed:</p> <ul style="list-style-type: none"> -The resident was admitted to the hospital on 01/30/25. -Admission condition and diagnoses included subtherapeutic (below target range) INR, chronic atrial fibrillation, and history of mitral valve replacement with mechanical valve. -The resident's cardiologist advised to send the resident to the hospital due to the subtherapeutic INR. -The resident was treated with three blood thinners at the hospital including Warfarin, Heparin, and Lovenox. -The hospitalist noted the resident's goal INR level at the hospital was 2.5 - 3.5. 	{D 358}		
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{D 358}	<p>Continued From page 43</p> <p>-There was an order for Warfarin 2mg take 1 ½ tablets (3mg) once a day and the last documented dose of 3mg was administered at the hospital on 02/04/25 at 5:40pm.</p> <p>-There was an order to check INR daily until INR stabilized.</p> <p>Review of Resident #4's cardiologist order dated 02/10/25 revealed an order for INR lab draw on Mondays, Wednesdays, and Fridays to monitor INR stability.</p> <p>Review of Resident #4's lab report dated 02/12/25 revealed:</p> <p>-The resident's INR was collected on 02/11/25 with a result of 3.62 (above target range).</p> <p>-There were handwritten notes at the bottom of the page for Warfarin 2mg daily and recheck INR on 02/14/25.</p> <p>Review of Resident #4's lab report dated 02/13/25 revealed:</p> <p>-The resident's INR was collected on 02/12/25 with a result of 3.23 (above target range).</p> <p>-There was a handwritten note by the PCP to please fax results to the cardiologist if not already done.</p> <p>-The handwritten note was signed and dated 02/18/25 by the primary care provider (PCP).</p> <p>Review of Resident #4's lab reports dated 02/15/25 revealed:</p> <p>-The resident's INR was collected on 02/14/25 with a result of 2.89 (within target range).</p> <p>-There was a handwritten note to continue same dose of 2mg once daily.</p> <p>Review of Resident #4's cardiologist order dated 02/18/25 revealed a clarification order to discontinue Warfarin 4mg.</p>	{D 358}		

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{D 358}	<p>Continued From page 44</p> <p>Review of Resident #4's lab report dated 02/20/25 revealed: -The resident's INR was collected on 02/19/25 with a result of 3.44 (above target range). -There were handwritten notes at the bottom of the page to continue same dose of Warfarin at 2mg daily.</p> <p>Review of Resident #4's lab report dated 02/22/25 revealed the resident's INR was collected on 02/21/25 with a result of 3.00 (within target range).</p> <p>Review of Resident #4's February 2025 paper MAR revealed: -There was an entry for Warfarin 4mg 1 tablet once daily scheduled at 8:00pm. -Warfarin 4mg was not documented as administered from 02/01/25 - 02/04/25 due to the resident being out of the facility. -Warfarin 4mg at 8:00pm was documented as administered on 02/05/25 and 02/07/25 but there was no current order to receive Warfarin 4mg. -Warfarin 4mg was documented as not administered on 02/06/25 due to "order clarification". -Documentation was blank on 02/08/25 and there was a circle with a line in the middle documented for 02/09/25, with no reasons noted. -Documentation for Warfarin 4mg at 8:00pm was blank from 02/10/25 - 02/28/25 with no reasons noted. -There was a total of 2 Warfarin 4mg tablets documented as administered from 02/01/25 - 02/28/25. -There was a second handwritten entry for Warfarin 2mg 1 tablet once daily (1 ½ was marked through and replaced with 1 tablet). -Warfarin 2mg was scheduled for administration</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 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}	<p>Continued From page 45</p> <p>at 8:00pm.</p> <ul style="list-style-type: none"> -Warfarin 2mg was documented as administered from 02/05/25 - 02/28/25. -Warfarin 2mg 1 ½ tablets (3mg) was ordered to be administered from 02/05/25 - 02/11/25. -There was a total of 24 Warfarin 2mg tablets documented as administered from 02/01/25 - 02/28/25. <p>Review of Resident #4's March 2025 paper MAR dated 03/01/25 - 03/02/25 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Warfarin 2mg 1 tablet at bedtime scheduled at 8:00pm. -There was no Warfarin documented as administered on 03/01/25 with a line marked through that date and no reason noted. -Warfarin 2mg was documented as administered on 03/02/25. -One Warfarin 2mg tablet was documented as administered from 03/01/25 - 03/02/25. <p>Review of Resident #4's cardiologist order dated 03/03/25 revealed:</p> <ul style="list-style-type: none"> -There was an order to continue Warfarin 2mg 1 tablet once daily at bedtime. -There was an order to draw INR labs weekly until further notice. <p>Review of Resident #4's lab report dated 03/06/25 revealed:</p> <ul style="list-style-type: none"> -The resident's INR was collected on 03/06/25 with a result of 1.52 (below target range). -There was a handwritten verbal order at the bottom of the page to take Warfarin 4mg today and 4mg tomorrow, then resume normal dose of 2mg daily and recheck INR in 1 week. <p>Review of Resident #4's lab report dated 03/13/25 revealed:</p> <ul style="list-style-type: none"> -The resident's INR was collected on 03/12/25 	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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{D 358}	<p>Continued From page 46</p> <p>with a result of 4.56 (above target range). -There was a handwritten verbal order at the bottom of the page to hold Warfarin for 1 day then continue with same dose of 2mg daily and recheck INR in 1 week.</p> <p>Review of Resident #4's March 2025 eMAR dated 03/03/25 - 03/14/25 revealed: -There was an entry for Warfarin 2mg 1 tablet at bedtime scheduled at 8:00pm. -Warfarin 2mg was documented as administered from 03/03/25 - 03/06/25 and 03/09/25 - 03/12/25. -There were 8 Warfarin 2mg tablets documented as administered from 03/01/25 - 03/14/25. -There was no Warfarin documented as administered on 03/13/25 due to "suspended" due to physician's order. -There was a second entry for Warfarin 4mg 1 tablet daily for 2 days due to INR levels and it was scheduled at 8:00pm. -Warfarin 4mg was documented as administered on 03/07/25 and 03/08/25. -There was a total of 2 Warfarin 4mg tablets documented as administered from 03/01/25 - 03/14/25.</p> <p>Interview with Resident #4 on 03/14/25 at 6:33pm revealed: -She took a blood thinner and she did not know if she had missed any doses. -She denied any current symptoms of bleeding or bruising.</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/14/25 at 5:17pm revealed: -They dispensed 30 Warfarin 2mg tablets on 11/01/24. -They dispensed 14 Warfarin 2mg tablets on</p>	{D 358}		
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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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{D 358}	<p>Continued From page 47</p> <p>12/23/24. -They dispensed 7 Warfarin 4mg tablets on 12/26/24. -They dispensed 30 Warfarin 2mg tablets on 03/01/25 (from an order sent by the prescriber). -No other Warfarin had been dispensed by the pharmacy for Resident #4.</p> <p>Review of Resident #4's pharmacy dispensing records dated 11/01/24 - 03/14/25 revealed: -There were 30 Warfarin 2mg tablets dispensed on 11/01/24. -There were 14 Warfarin 2mg tablets dispensed on 12/23/24. -There were 7 Warfarin 4mg tablets dispensed on 12/26/24. -There were 30 Warfarin 2mg tablets dispensed on 03/01/25.</p> <p>Observation of Resident #4's medications on hand on 03/14/25 at 1:32pm revealed: -There was a supply of Warfarin 2mg tablets dispensed on 03/01/25. -The instructions were to take 1 tablet at bedtime. -Staff initialed and dated beside the first dose used from the medication bubble card as 03/03/25. -There were 18 of 30 tablets remaining. -A total of 12 Warfarin 2mg tablets had been used from the medication bubble card from 03/03/25 - 03/13/25. -There was no other supply of Warfarin for Resident #4 available for administration.</p> <p>Observations, interviews, and record reviews for Resident #4's Warfarin revealed: -The pharmacy dispensed 74 Warfarin 2mg tablets from 11/01/24 - 03/14/25. -On 03/14/25, there were still 18 of the 74 Warfarin 2mg tablets available for administration,</p>	{D 358}		

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{D 358}	<p>Continued From page 48</p> <p>indicating only 56 Warfarin 2mg tablets had been administered from 11/01/25 - 03/14/25, a 134-day time period.</p> <ul style="list-style-type: none"> -Documentation of Warfarin administration was not available for November 2024, therefore, it could not be determined how many Warfarin were documented as administered during that 30 day period when 30 Warfarin 2mg tablets would have been needed to administer to the resident. -The facility documented 52 Warfarin 2mg tablets were administered from 12/01/24 - 03/14/25, a 104-day time period. -The pharmacy dispensed 7 Warfarin 4mg tablets from 11/01/24 - 03/14/25. -There was documentation indicating Warfarin 4mg tablets were administered 28 times from 12/01/24 - 03/14/25 but only 7 Warfarin 4mg tablets were dispensed. <p>Interview with a medication aide (MA) on 03/14/25 at 6:25pm revealed:</p> <ul style="list-style-type: none"> -If there were no Warfarin 4mg tablets available, she used two Warfarin 2mg tablets to equal 4mg and administered them to Resident #4. -She remembered administering two Warfarin 2mg tablets each on 03/07/25 and 03/08/25 because there were no 4mg tablets available. <p>Interview with the Memory Care Director (MCD) on 03/14/25 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -She did not remember Resident #4's Warfarin being unavailable. -She did not know anything about Resident #4's Warfarin orders. -She had been in training as the MCD and she just started processing orders on 03/01/25. -The Resident Care Coordinator (RCC) or the former Health and Wellness Director (HWD) would have been responsible for processing orders while she was in training. 	{D 358}		

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{D 358}	<p>Continued From page 49</p> <ul style="list-style-type: none"> -On 02/06/25, she requested the former HWD to clarify the resident's Warfarin order so she could not administer Warfarin until she got an answer. -She never got an answer from the former HWD. -The resident had Warfarin 2mg tablets and she had only administered 2mg tablets to the resident. -She did not know why she double documented it. <p>Interview with the RCC on 03/14/25 at 2:58pm revealed:</p> <ul style="list-style-type: none"> -The MAs usually ordered medications and the MAs were supposed to let her know if a medication was not received after it was ordered. -She was not aware Resident #4 missed any doses of Warfarin due to the medication being unavailable. -She had a book she used to file Warfarin orders and INR labs. -She did not have a system to track the Warfarin orders and INRs; she just filed them. <p>Telephone interview with Resident #4's PCP on 03/14/25 at 4:35pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's cardiologist oversaw the residents Warfarin and INR checks. -In January 2025, the Care Coordinator at her office arranged communication between the office and the cardiologist's office for the Warfarin and INRs. -She still needed to document and follow the resident's Warfarin and INRs since she was the resident's PCP. -At the end of January 2025, the resident had a critically low INR lab value and was sent to the hospital by the cardiologist. -She was not aware the resident had missed doses of Warfarin. -A low INR level put the resident at risk of her blood not being thin enough, which could cause 	{D 358}		

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{D 358}	<p>Continued From page 50</p> <p>her mechanical heart valve not to be able to work. -The resident had atrial fibrillation and having a low INR level put the resident at risk of having a blood clot that could cause a stroke or heart attack. -The resident also had a critically high INR lab value this week on 03/12/25. -The INR results from 03/12/25 were faxed to the cardiologist's office and orders to hold the Warfarin were sent to the facility. -A high INR level put the resident at risk of bleeding out.</p> <p>3. Review of Resident #5's current FL-2 dated 07/02/24 revealed diagnoses included Alzheimer's disease, hypertension, hyperlipidemia, and gastroesophageal reflux disease.</p> <p>a. Review of Resident #5's primary care provider (PCP) order dated 01/30/25 revealed an order to initiate Lidocaine patch 4% to be applied to lower back with 12 hours on, 12 hours off. (Lidocaine patch is a topical medication used to treat pain, including nerve pain.)</p> <p>Review of Resident #5's PCP order dated 02/04/25 revealed a second order to start Lidocaine patch 4% for additional pain management to lower back, on 12 hours and off 12 hours.</p> <p>Review of Resident #5's PCP order dated 03/07/25 revealed an order to change Lidocaine patch to prn (as needed).</p> <p>Review of Resident #5's January 2025 paper medication administration record (MAR) revealed there was no entry for Lidocaine patch 4% to be applied to lower back with 12 hours on, 12 hours</p>	{D 358}		

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{D 358}	<p>Continued From page 51</p> <p>off.</p> <p>Review of Resident #5's February 2025 paper MAR revealed:</p> <ul style="list-style-type: none"> -There was a handwritten entry for Lidocaine patch 4% apply 1 patch to lower back every 12 hours scheduled to put on at 8:00am and to be taken off at 8:00pm. -There was a horizontal line drawn across the blocks for 02/01/25 - 02/05/25 with no reason documented. -Documentation for the administration of the Lidocaine patch did not start until 2/06/25 at 8:00am. -The Lidocaine patch was documented as being applied daily at 8:00am and removed at 8:00pm from 02/06/25 - 02/28/25. -There was no reason for the delay in starting the administration of the Lidocaine patch 4% noted. <p>Review of Resident #5's March 2025 paper MAR dated 03/01/25 - 03/02/25 revealed:</p> <ul style="list-style-type: none"> -There was a computer-printed entry for Lidocaine patch 4% apply 1 patch to skin on lower back once a day, on every 12 hours and off every 12 hours. -The Lidocaine patch was scheduled to be put on at 8:00am and to be taken off at 8:00pm. -The Lidocaine patch was documented as being applied daily at 8:00am from 03/01/25 - 03/02/25. -Documentation for the removal of the Lidocaine patch at 8:00pm was blank on 03/01/25 - 03/02/25 with no reasons noted. <p>Review of Resident #5's March 2025 electronic medication administration record (eMAR) dated 03/03/25 - 03/12/25 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Lidocaine patch 4% apply 1 patch to skin on lower back once a day, on every 12 hours and off every 12 hours. 	{D 358}		
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{D 358}	<p>Continued From page 52</p> <ul style="list-style-type: none"> -The Lidocaine patch was scheduled at 8:00am and 8:00pm but it did not specify which time to apply the patch and which time to remove the patch. -The Lidocaine patch was initialed at 8:00am and 8:00pm from 03/03/25 - 03/09/25. -There was a second entry for Lidocaine patch 4% apply 1 patch to skin once a day for 12 hours then remove (12 hours on/12 hours off) to lower back as needed. -There was no prn Lidocaine patch documented as administered. <p>Observation of Resident #5's medications on hand on 03/13/25 at 12:02pm revealed there were no Lidocaine 4% patches available for administration in the facility for Resident #5.</p> <p>Review of Resident #5's pharmacy dispensing records dated 01/01/25 - 03/12/25 revealed:</p> <ul style="list-style-type: none"> -There were 30 Lidocaine 4% patches dispensed on 02/05/25. -There were no Lidocaine 4% patches dispensed prior to 02/05/25. <p>Interview with Resident #5 on 03/14/25 at 6:29pm revealed:</p> <ul style="list-style-type: none"> -He thought staff used to take off the Lidocaine patch in the mornings, but he was not sure. -He did not know the last time he used a Lidocaine patch. -His back pain was better, but it still hurt some days. -His back was currently "tingling" right now. <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/14/25 at 5:17pm revealed:</p> <ul style="list-style-type: none"> -They never received an order for Lidocaine patch dated 01/30/25 for Resident #5. 	{D 358}		
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{D 358}	<p>Continued From page 53</p> <ul style="list-style-type: none"> -They received an order dated 02/05/25 for Lidocaine patch on 02/05/25. -They dispensed Lidocaine patches on 02/05/25 and they would have been delivered to the facility either the night of 02/05/25 or early morning on 02/06/25. <p>Interview with a medication aide (MA) on 03/13/25 at 12:05pm revealed:</p> <ul style="list-style-type: none"> -She could not locate any Lidocaine patches in the medication cart or in the back-up supply for Resident #5. -Resident #5's Lidocaine patches were last ordered on 03/09/25 so she did not know why she could not find the patches. -She would contact the pharmacy. <p>Interview with the Memory Care Director (MCD) on 03/13/25 at 1:58pm revealed:</p> <ul style="list-style-type: none"> -Either she or the MAs were responsible for sending orders, including new orders to the pharmacy. -New medication orders should be started within 24 hours of receiving the order. -She was not sure why there was a delay in starting Resident #5's order for Lidocaine 4% patches. -She had not noticed there was a delay in starting Resident #5's Lidocaine patch order. -The Lidocaine patch had been changed recently from scheduled to prn. <p>Telephone interview with Resident #5's PCP on 03/14/25 at 4:13pm revealed:</p> <ul style="list-style-type: none"> -Around the end of January 2025 and first part of February 2025, the resident was not moving as well because of discomfort caused by osteoarthritis pain in his back. -When she ordered Resident #5's Lidocaine patch on 01/30/25, she expected it to be 	{D 358}		

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{D 358}	<p>Continued From page 54</p> <p>implemented when it was ordered.</p> <p>-A delay in receiving the Lidocaine patch could increase the resident's discomfort and pain.</p> <p>b. Review of Resident #5's current FL-2 dated 07/02/24 revealed an order for Acetaminophen 500mg 1 tablet every 6 hours as needed (prn) pain. (Acetaminophen is used for mild to moderate pain.)</p> <p>Review of Resident #5's primary care provider (PCP) order dated 01/30/25 revealed an order to initiate Acetaminophen 500mg 1 tablet twice a day for arthritis in lower back.</p> <p>Review of Resident #5's PCP verbal orders dated 02/03/25 revealed:</p> <p>-There was an order for Acetaminophen 500mg twice a day for back pain.</p> <p>-There was an order for Acetaminophen 500mg every 6 hours prn pain, not to exceed 3000mg per day of Acetaminophen.</p> <p>Review of Resident #5's January 2025 paper medication administration record (MAR) revealed:</p> <p>-There was no entry for Acetaminophen 500mg twice a day for back pain.</p> <p>-There was no entry for Acetaminophen 500mg every 6 hours prn pain, not to exceed 3000mg per day.</p> <p>Review of Resident #5's February 2025 paper MAR revealed:</p> <p>-There was a handwritten entry for Acetaminophen 500mg 1 tablet twice daily scheduled for 8:00am and 8:00pm.</p> <p>-There was a horizontal line drawn across the blocks for 02/01/25 - 02/03/25 and documentation for 02/04/25 and 02/05/25 were blank with no reasons documented.</p>	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331		
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{D 358}	<p>Continued From page 55</p> <ul style="list-style-type: none"> -Documentation for the administration of Acetaminophen 500mg 1 tablet twice daily did not start until 2/06/25 at 8:00am. -Acetaminophen 500mg was documented as administered twice daily from 02/06/25 - 02/28/25. -There was no reason for the delay in starting the administration of scheduled Acetaminophen noted. -There was a second handwritten entry for Acetaminophen 500mg 1 tablet every 6 hours as needed, not to exceed 3000mg in 24 hours. -There was no prn Acetaminophen documented as administered in February 2025. <p>Review of Resident #5's March 2025 paper MAR dated 03/01/25 - 03/02/25 revealed:</p> <ul style="list-style-type: none"> -There was a computer-printed entry for Acetaminophen 500mg 1 tablet twice daily scheduled for 8:00am and 8:00pm. -Acetaminophen 500mg was documented as administered twice daily from 03/01/25 - 03/02/25. -There was a computer-printed entry for Acetaminophen 500mg 1 tablet every 6 hours as needed, not to exceed 3000mg in 24 hours from all sources. -There was no prn Acetaminophen documented as administered from 03/01/25 - 03/02/25. <p>Review of Resident #5's March 2025 electronic MAR dated 03/03/25 - 03/12/25 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Acetaminophen 500mg 1 tablet twice daily scheduled for 8:00am and 8:00pm. -Acetaminophen 500mg was documented as administered from 03/03/25 - 03/12/25 (8:00am). -There was an entry for Acetaminophen 500mg 1 tablet every 6 hours as needed, not to exceed 3000mg in 24 hours from all sources. 	{D 358}		

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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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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}	<p>Continued From page 56</p> <p>-There was no prn Acetaminophen documented as administered from 03/03/25 - 03/12/25.</p> <p>Observation of Resident #5's medications on hand on 03/13/25 at 12:02pm revealed:</p> <p>-There was a supply of Acetaminophen 500mg tablets dispensed on 03/02/25 with instructions to take 1 tablet twice a day.</p> <p>-There were 9 of 31 tablets remaining.</p> <p>-There was a second supply of Acetaminophen 500mg tablets dispensed on 02/03/25 with instructions to take 1 tablet every 6 hours prn, not to exceed 3000mg of Acetaminophen in 24 hours from all sources.</p> <p>-There were 28 of 30 tablets remaining.</p> <p>Review of Resident #5's pharmacy dispensing records dated 01/01/25 - 03/12/25 revealed:</p> <p>-There were 56 Acetaminophen 500mg tablets (for scheduled dose) dispensed on 02/03/25.</p> <p>-There were 30 Acetaminophen 500mg tablets (for prn dose) dispensed on 02/03/25.</p> <p>-There were 62 Acetaminophen 500mg tablets (for scheduled dose) dispensed on 02/28/25.</p> <p>Interview with Resident #5 on 03/14/25 at 6:29pm revealed:</p> <p>-He was unsure if he took Acetaminophen for pain.</p> <p>-His back pain was better, but it still hurt some days.</p> <p>-His back was currently "tingling" right now.</p> <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/14/25 at 5:17pm revealed:</p> <p>-They received an order from the PCP on 02/03/25 for Acetaminophen 500mg scheduled and prn for Resident #5.</p> <p>-The pharmacy dispensed Acetaminophen</p>	{D 358}		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/14/2025
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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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{D 358}	<p>Continued From page 57</p> <p>500mg on 02/03/25 and it would have been delivered to the facility that night likely during third shift.</p> <p>Interview with the Memory Care Director (MCD) on 03/13/25 at 1:58pm revealed: -Either she or the MAs were responsible for sending orders, including new orders to the pharmacy. -New medication orders should be started within 24 hours of receiving the order. -She had not noticed there was a delay in starting Resident #5's Acetaminophen order. -She was not sure why there was a delay in starting Resident #5's order for Acetaminophen.</p> <p>Telephone interview with Resident #5's PCP on 03/14/25 at 4:13pm revealed: -Around the end of January 2025 and first part of February 2025, the resident was not moving as well because of discomfort caused by osteoarthritis pain in his back. -When she ordered Resident #3's Acetaminophen in February 2025, she expected it to be implemented when it was ordered. -A delay in receiving the Acetaminophen could increase the resident's discomfort and pain.</p> <p>The facility failed to administer medications as ordered to 1 of 3 residents observed during the morning medication pass on 03/13/25 resulting in an 11% medication error rate with 3 errors out of 27 opportunities. The 3 medication errors with Resident #6's medications including being administered too much of an allergy nasal spray; a medication for blood circulation given on an empty stomach instead of with a meal; and the wrong amount of a laxative being administered due to it being measured incorrectly. Resident #4 missed multiple doses of Warfarin, a blood</p>	{D 358}		

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{D 358}	Continued From page 58 thinner, resulting in the resident being hospitalized for a week and having to receive 3 blood thinning medications while in the hospital due to a subtherapeutic INR (lab value used to monitor Warfarin therapy). Resident #4 had atrial fibrillation and a mechanical heart valve and was ordered to receive Warfarin to prevent blood clots. The low INR could cause the resident's blood to not be thin enough, which could cause her mechanical heart valve not to work or cause a blood clot that could lead to a stroke or heart attack. The failure of the facility to administer medications as ordered resulted in serious neglect and constitutes an Unabated Type A1 Violation.	{D 358}		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a	D 367	Regional Director of Resident Care/ Designee provided additional training to MCD/RCC/Med Aides on medication administration process, medication administration guidelines related to non - oral medications and medication scheduling guidelines. Regional Director of Resident Care/ Designee completed Med aide skills competency verification on all Med aides. Regional Director of Resident Care/ Designee re-educated MCD/RCC/Med Aides on EMAR system. All new hire Med Aide will receive additional handouts related to medication administration process, medication administration guidelines.	3/18/2025

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D 367	<p>Continued From page 59</p> <p>signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 4 of 5 sampled residents (#2, #3, #4, #5) for a rapid-acting insulin (#2), a medication for pulmonary hypertension (#3), a medication for breathing problems (#4), and a controlled substance for anxiety and agitation (#5).</p> <p>The findings are:</p> <p>1. Review of Resident #5's current FL-2 dated 07/02/24 revealed: -Diagnoses included Alzheimer's disease, hypertension, hyperlipidemia, and gastroesophageal reflux disease. -There was an order for Lorazepam 0.5mg 1 tablet twice a day as needed (prn) for anxiety / agitation. (Lorazepam is a controlled substance used to treat anxiety and agitation.)</p> <p>Review of Resident #5's physician's order dated 02/05/25 revealed an order for Lorazepam 1mg 1 tablet 3 times a day as needed for agitation and anxiety.</p> <p>Review of Resident #5's January 2025 medication administration record (MARI) revealed: -There was an entry for Lorazepam 0.5mg 1 tablet twice a day prn for anxiety or agitation. -The prn Lorazepam was documented as</p>	D 367	<p>ED/DHW will monitor EMAR system to ensure MARS are accurate to include documentation of PRN medication administration as part of the Community QA process</p> <p><i>MAR to cart audit will be completed at least monthly by DHW/RCC/MCDP designee going forward.</i></p> <p><i>All residents' MARS will be reviewed monthly by DHW/RCC/MCDP/designee going forward.</i></p> <p><i>Resident MARS with sliding scale or orders for parameters will be reviewed weekly by DHW/RCC/MCDP</i></p>	
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TERRABELLA FAYETTEVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE
**1164 71ST SCHOOL ROAD
CUMBERLAND, NC 28331**

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D 367	<p>Continued From page 60</p> <p>administered 13 times from 01/01/25 - 01/31/25. -There was no documentation of the time, reason, or resulting effect for the administration of the prn Lorazepam for 13 of 13 occasions it was documented as administered.</p> <p>Review of Resident #5's February 2025 MAR revealed: -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily prn for anxiety or agitation. -The prn Lorazepam was initiated as administered 18 times from 02/01/25 - 02/28/25. -There was no documentation of the time of administration for 17 of 18 occasions. -There was no documentation of the reason for administration or the resulting effects for 6 of 18 occasions.</p> <p>Interview with a medication aide (MA) on 03/13/25 at 12:02pm revealed: -She usually documented the time, reason, and effectiveness of prn medications. -She was not sure why the prn documentation for Resident #5's Lorazepam was incomplete.</p> <p>Interview with the Memory Care Director (MCD) on 03/13/25 at 1:58pm revealed: -The MAs had been trained and were supposed to include prn documentation on the MARs. -She started checking the MARs for accuracy last week and had noticed some issues with omissions. -She did not notice the MAs had forgotten to include prn documentation for Resident #5's Lorazepam.</p> <p>Interview with the Administrator on 03/13/25 at 4:52pm revealed: -The MAs were responsible for documenting accurately on the MARs, including prn</p>	D 367	<i>designee on an ongoing basis</i>	

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D 367	<p>Continued From page 61</p> <p>documentation.</p> <ul style="list-style-type: none"> -The RCC and MCD were responsible for checking the MARs for accuracy daily. -Documentation for Resident #5's prn Lorazepam should have been complete and included the required information. <p>2. Review of Resident #4's FL-2 dated 02/04/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included acute respiratory failure with hypoxia (low oxygen levels), acute respiratory failure, and congestive heart failure. -There was an order for Duoneb 1 vial via nebulizer every 6 hours as needed (prn) for wheezing. (Duoneb is a combination medication used to treat and prevent breathing problems.) <p>Review of Resident #4's February 2025 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> -There was a handwritten entry for Duoneb prn for wheezing. -The entry did not include how often the prn medication could be administered. -There was no Duoneb documented as administered in February 2025. <p>Review of Resident #4's March 2025 MAR revealed there was no entry for Duoneb on the MAR.</p> <p>Observation of Resident #4's medications on hand on 03/14/25 at 1:28pm revealed:</p> <ul style="list-style-type: none"> -There was a box of Duoneb vials dispensed on 02/04/25 with instructions to use 1 vial via nebulizer every 6 hours prn wheezing. -The box was unopened and none had been used. <p>Interview with a medication aide (MA) on 03/14/25 at 1:28pm revealed:</p>	D 367		

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D 367	<p>Continued From page 62</p> <ul style="list-style-type: none"> -She had not noticed the resident's prn Duoneb was not listed on the MAR. -There was a supply of Duoneb in the medication cart but the resident had not needed to use any to her knowledge. -She was not aware of the resident having any current issues with wheezing. -She did not know why Duoneb prn was not included on the March 2025 MAR. <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/14/25 at 5:17pm revealed:</p> <ul style="list-style-type: none"> -The facility usually faxed hospital discharge paperwork to the pharmacy. -The discharge paperwork they received when Resident #4 returned from the hospital on 02/05/25 did not have a prescribing practitioner's signature so they could not use the document to enter orders into the eMAR system. -The pharmacy sent a fax to the facility on 02/05/25 and let the facility staff know the pharmacy needed a copy with the prescriber's signature. -They never received anything back from the facility. -The facility also had access to enter orders into the electronic MAR system. <p>Interview with the Memory Care Director (MCD) on 03/13/25 at 1:58pm revealed:</p> <ul style="list-style-type: none"> -Either she or the MAs were responsible for sending orders to the pharmacy. -The pharmacy usually entered orders into the electronic MAR system but she and the RCC also had access to enter orders as well. -She did not know why Resident #4's Duoneb was not entered on the March 2025 MAR. -She started checking the MARs for accuracy last week and had noticed some issues with 	D 367		

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D 367	<p>Continued From page 63</p> <p>omissions.</p> <p>-She had noticed Resident #4's prn Duoneb was not included on the electronic MAR for March 2025.</p> <p>-The facility had just changed to electronic MARs at the beginning of March 2025 so that may have caused the problem.</p> <p>Interview with the Administrator on 03/13/25 at 4:52pm revealed the RCC and MCD were responsible for checking the MARs for accuracy daily.</p> <p>3. Review of Resident #2's current FL-2 dated 12/20/24 revealed:</p> <p>-Diagnoses included diabetes mellitus type 2, chronic heart failure, hypertension, atrial fibrillation, chronic respiratory failure, cardiac pacemaker, and major depressive disorder.</p> <p>-There was an order for Humalog KwikPen sliding scale insulin (SSI): 0 -199=0 units (U), 200-250=2U, 251-300=3U, 301-350 =4U 351-400=5U; 401-450=6U, 451-500=7U, greater than (>) 500 notify primary care provider (PCP). (Humalog is rapid-acting insulin used to lower blood sugar.)</p> <p>Review of Resident #2's January 2025 medication administration record (MAR) revealed:</p> <p>-There was an entry for Humalog KwikPen SSI for fingerstick blood sugars (FSBS) before meals and at bedtime according to the following scale: 0-199=0U, 200-250=2U, 251-300=3U, 301-350 =4U 351-400=5U; 401-450=6U, 451-500=7U, and > 500 notify PCP.</p> <p>-On 01/17/25 at 6:30am, FSBS was documented as 202 but no units were documented as administered.</p> <p>-On 01/04/25 at 11:00am, FSBS was documented as 201 but no units were documented as</p>	D 367		

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D 367	<p>Continued From page 64</p> <p>administered.</p> <p>-On 01/06/25 at 11:00am, FSBS was documented as 261 but no units were documented as administered.</p> <p>-On 01/17/25 at 11:00am, FSBS was documented as 232 but no units were documented as administered.</p> <p>-On 01/20/25 at 11:00am, FSBS was documented as 202 but no units were documented as administered.</p> <p>-On 01/26/25 at 11:00am, FSBS was documented as 210 but no units were documented as administered.</p> <p>-On 01/17/25 at 4:00pm, FSBS was documented as 222 but no units were documented as administered.</p> <p>-On 01/23/25 at 4:00pm, FSBS was documented as 206 but no units were documented as administered.</p> <p>-On 01/27/25 at 4:00pm, FSBS was documented as 245 but no units were documented as administered.</p> <p>-On 01/31/25 at 4:00pm, FSBS was documented as 212 but no units were documented as administered.</p> <p>-On 01/03/25 at 8:00pm, FSBS was documented as 234 but no units were documented as administered.</p> <p>-On 01/13/25 at 8:00pm, FSBS was documented as 254 but no units were documented as administered.</p> <p>-On 01/17/25 at 8:00pm, FSBS was documented as 207 but no units were documented as administered.</p> <p>-On 01/23/25 at 8:00pm, FSBS was documented as 224 but no units were documented as administered.</p> <p>-On 01/27/25 at 8:00pm, FSBS was documented as 206 but no units were documented as administered.</p>	D 367		

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D 367	<p>Continued From page 65</p> <p>Review of Resident #2's February 2025 MAR revealed: -There was an entry for Humalog KwikPen SSI for FSBS before meals and at bedtime according to the following scale: 0-199=0U, 200-250=2U, 251-300=3U, 301-350 =4U 351-400=5U; 401-450=6U, 451-500=7U, and > 500 notify PCP. -On 02/08/25 at 7:30am, FSBS was documented as 251 but no units were documented as administered. -On 02/14/25 at 7:30am, FSBS was documented as 200 but no units were documented as administered. -On 02/13/25 at 11:30am, FSBS was documented as 222 but no units were documented as administered. -On 02/18/25 at 11:30am, FSBS was documented as 264 but no units were documented as administered.</p> <p>Review of Resident #2's March 2025 electronic MAR revealed: -There was an entry for Humalog KwikPen SSI for FSBS before meals and at bedtime according to the following scale: 0-199=0U, 200-250=2U, 251-300=3U, 301-350 =4U 351-400=5U; 401-450=6U, 451-500=7U, and > 500 notify PCP. -On 03/12/25 at 11:00am, FSBS was documented as 206 but no units were documented as administered. -On 03/01/25 at 4:00pm, FSBS was documented as 232 but 0U was documented as administered.</p> <p>Telephone interview with a medication aide (MA) on 03/14/25 at 7:20pm revealed: -If Resident #2's FSBS was below 200, she did not administer any Humalog SSI to the resident. -If documentation on the MAR was blank, it meant no units were given because the FSBS</p>	D 367		

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D 367	<p>Continued From page 66</p> <p>was below 200.</p> <ul style="list-style-type: none"> -She should have documented on Resident #2's MAR how many units of Humalog SSI were administered including 0U if none was administered. -She could not say why she did not document the number of Humalog SSI units administered on the MARs. <p>Interview with the Resident Care Coordinator (RCC) on 03/14/25 at 12:55pm revealed:</p> <ul style="list-style-type: none"> -She was not aware the MAs were not documenting how many units of Humalog SSI were administered to Resident #2 on the MARs. -The MAs should document how many units of Humalog SSI they administered to Resident #2, including 0 units if none was administered. -The Health and Wellness Director (HWD) was responsible for teaching the MAs how to administer the medication and how to document SSI units on the MAR. <p>Interview with the Administrator on 03/14/25 at 1:15pm revealed:</p> <ul style="list-style-type: none"> -She was not aware the MAs were not documenting the amount of SSI administered on the MAR. -She expected the MAs to document the number of units of SSI administered each time. -The RCC and the Memory Care Director (MCD) were responsible for daily checks of the MARs to ensure medication accuracy on the MARS. -The HWD was responsible for checking behind the RCC and MCD to ensure medication accuracy on the MARs. <p>4. Review of Resident #3's current FL-2 dated 01/31/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included systemic sclerosis with lung involvement, malignant neoplasm of the lung, 	D 367		

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D 367	<p>Continued From page 67</p> <p>chronic respiratory failure with hypoxia, and hypertensive heart disease with heart failure. -There was an order for Sildenafil 20mg 1 tablet 3 times a day. [Sildenafil is used to treat pulmonary hypertension (high blood pressure in the lungs)].</p> <p>Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed: -Documentation for Sildenafil 25mg was blank from 02/16/25 through 02/28/25. -There was no reason for the omissions documented.</p> <p>Review of Resident #3's March 2025 eMAR revealed: -There was an entry for Sildenafil 25mg, take 1 tablet three times a day scheduled at 9:00am, 3:00pm, and 9:00pm. -Sildenafil 25mg was documented as administered from 9:00am on 03/01/25 through 9:00am on 03/12/25.</p> <p>Observation of Resident #3's medication on hand on 03/14/25 at 1:55pm revealed: -There was a supply of Sildenafil 25mg tablets dispensed on 02/17/25 with instructions to take 1 tablet 3 times a day. -There were 33 of 42 tablets remaining. -There was a supply of Sildenafil 25mg tablets dispensed on 02/28/25 with instructions to take 1 tablet 3 times a day. -There were 31 of 48 tablets remaining.</p> <p>Interview with a medication aide (MA) on 03/13/25 at 11:35am revealed: -She administered Sildenafil as ordered to Resident #3. -She could not say why there were omissions on the February 2025 MAR.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL026068	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 03/14/2025
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NAME OF PROVIDER OR SUPPLIER TERRABELLA FAYETTEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1164 71ST SCHOOL ROAD CUMBERLAND, NC 28331
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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 367	<p>Continued From page 68</p> <p>Interview with the Resident Care Coordinator (RCC) on 03/13/25 at 4:45pm revealed: -She was not aware of the inaccurate documentation for Resident #3's Sildenafil on the February 2025 MAR. -She expected the MAs to administer the medication according to the physician's order and document the administration on the MARs.</p> <p>Second interview with the RCC on 03/14/25 at 12:55pm revealed: -The Health and Wellness Director (HWD) and Memory Care Director (MCD) were responsible for daily checks of the MAs to ensure medication accuracy on the med cart and documentation on the MARS. -She was responsible for checking behind the HWD and MCD to ensure medication accuracy on the med cart and documentation on the MARs. -Cart audits consisted of reviewing the MARs to see if the medication matched with the FL-2 and documentation accuracy.</p> <p>Interview with the Administrator on 03/14/25 at 1:30pm revealed: -She expected the MAs to administer the medication per the physician order. -The HWD and MCD were responsible for daily checks of the MAs to ensure medication accuracy on the med cart and on the MARs. -The RCC was responsible for checking behind the HWD and MCD to ensure medication accuracy on the med cart and on the MARs.</p>	D 367		