Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092207	A. BUILDING: ______ B. WING ______	R 03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The adult care licensure section conducted an annual survey and a follow up survey on March 26-27, 2025.	D 000	10A NCAC 13F.0505 Diabetic Training On 3/27/25, resident #7's physician was notified of the insulin variance. No new orders were received. The DHW performed medication pass observation with all medication aides to ensure insulin were being administered accurately, including priming the insulin pen and not administering expired insulin Date of completion 4/30/25. The executive director (ED), business office manager (BOM) or designee will ensure all future medication aides receive diabetic training during their orientation period. On 3/27/25, the director of health and wellness (DHW) inserviced all medication aides on diabetic education to include priming the insulin pen with 2 units and wasting, then drawing up the dose ordered by the physician, and not administering expired insulin. Beginning 4/4/25, the DHW, resident care coordinator, memory care director or designee will conduct random weekly x 4 medication pass observations to observe for proper insulin administration, including priming the pen with 2 units and wasting before drawing up the dose ordered by the physician and not administering expired insulin. This monitoring will then occur routinely on an ongoing basis.	4/30/25
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer	D 164		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin Jabor
TITLE: Executive Director
(X6) DATE: 5/6/2025

Reviewed and acknowledged on 05/09/25 by Joyce Johnston

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D 164	Continued From page 1 medications as ordered for 1 of 3 residents (#7) observed during the medication passes including errors with insulin (#7). The findings are: The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 7:00am - 9:00am medication pass on 03/26/25 and the 7:00am-9:00am medication pass on 03/27/25. Review of Resident #7's current FL-2 dated 01/27/25 revealed: -Diagnoses included atrial fibrillation, benign prostatic hypertrophy, diabetes mellitus, hypertension, insomnia, and major depressive disorder. -There was an order for Lantus Solostar insulin, inject 50 units twice a day with breakfast and dinner. (Lantus is long-acting insulin used to lower blood sugar. According to the manufacturer, the Lantus Solostar should be primed with a 2-unit air dose before each use to ensure the insulin is flowing through the needle and to remove any air bubbles.) -There was an order for Novolog Flex pen, inject 5 units 2 times a day before breakfast and lunch. (Novolog is rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Novolog Flex pen should be primed with a 2-unit air dose before each use to ensure the insulin is flowing through the needle and to remove any air bubbles.) -After 28 days after opening, throw the opened Lantus pen away-even if it still has insulin in it. Observation of the 8:00am medication pass on 03/27/25 revealed: -Resident #7's blood sugar was 170 at 8:06am.	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 164	Continued From page 2 -The medication aide (MA) removed a Lantus Solostar insulin pen from the medication cart. -The MA dialed the Lantus Solostar insulin pen to 52 units and administered it to the resident at 8:07am. -The MA did not prime the insulin pen with a 2-unit air shot. -The MA did not check the insulin label prior to administering the insulin. -The label on the insulin pen documented that the pen was opened on 02/25/25 and expired on 03/25/25. -The medication aide (MA) removed a ASPA Insulin Flex pen from the medication cart. -The MA dialed the ASPA Insulin Flex pen to 7 units and administered it to the resident at 8:08am. -The MA did not prime the insulin pen with a 2-unit air shot. -The MA did not check the insulin label prior to administering the insulin. -The label on the insulin pen documented that the pen expired on 03/25/25. Review of Resident #7's March 2025 electronic medication administration record (eMAR) revealed: -There as an entry for Lantus Solostar insulin, inject 50 units twice a day with breakfast and dinner. -There was an entry for insulin ASPA Flex pen, inject 5 units 2 times a day before breakfast and lunch with scheduled administration times of 8:00am and 12:00pm and discard 28 days after opening. -There was an entry for insulin ASPA Flex pen, inject 8 units every day at dinner with scheduled administration times of 5:00pm. -Dial a test dose of 2 Units. -Hold pen with the needle pointing up and lightly	D 164		

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D 164	Continued From page 3 tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. -Push the end of the pen to clear the air. -You may need to do this more than one time to see the insulin come out of the needle. -Insulin in your pen expires about 28 days after opening. Interview with Resident #7 on 03/27/25 at 8:45am revealed: -He had been living at the facility for a couple of months. -He received his FSBS before his meals and before bed. -He received 2 types of insulin but did not know the exact names of them. -He received his insulins before meals and at bedtime. -He was not sure of the amounts of insulin he received. -He had not had any problems with his FSBS being too high or too low that he was aware of since he came to live at the facility. Interview with a MA on 03/27/25 at 9:45am revealed: -The MAs were supposed to perform an air shot of 2 units of the insulin to make sure the air was out of the needle. -They were not supposed to add the 2 units to the dosage the resident was to get administered as this would be a wrong dose being given to the resident. Interview with the Health and Wellness Director (HWD) on 03/27/25 at 2:37pm revealed: -She started with the facility 5 months ago. -The MA should perform an air shot of 2 units of the insulin to make sure the air was out of the	D 164		

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D 164	Continued From page 4 needle. -They should never add the 2 units to the dosage the resident was to get administered since that would have the resident getting more than the ordered dose of insulin. -The resident could have a drop in his blood sugar from getting more insulin than was ordered if the 2 units were added to the dosage. -Not performing the air shot could cause the resident to not get enough insulin if there was air in the needle. Interview with the Assistant Executive Director on 03/27/25 at 2:13pm revealed: -The MAs should perform an air shot of 2 units prior administering the residents' insulin to clear the air form the needle. -Not performing the air shot could cause the resident to get too much or not enough insulin. Interview with the Executive Director on 03/27/25 at 3:00pm revealed: -The HWD was responsible for ensuring the MAs had received all the appropriate training prior to being placed on the medication cart to administer medications. -She expected all MAs to follow the directions for insulin pens which included performing the 2-unit air shot. -They should never add the 2 units intended to be the air shot to the amount of insulin ordered for the resident. -She was concerned about the MA not performing the air shot prior to administering the insulin as the resident would not be receiving the correct ordered amount of insulin. Attempted telephone interview with Resident #7's primary care provider (PCP) on 03/27/25 at 10:45am was unsuccessful.	D 164		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 1 of 3 residents (#7) observed during the medication passes including error with insulin (#7). The findings are: The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 7:00am - 9:00am medication pass on 03/26/25 and the 7:00am-9:00am medication pass on 03/27/25 which included not performing an air shot of the insulin pens to prime the pen before insulin administration and the administration of expired insulin past 28 days after opening. Review of Resident #7's current FL-2 dated 01/27/25 revealed: -Diagnoses included atrial fibrillation, benign prostatic hypertrophy, diabetes mellitus, hypertension, insomnia, and major depressive disorder.	D 358	10A NCAC 13F.1004 Medication Administration On 3/27/25, Resident #7's insulin was discarded and a new flexpen was ordered from the pharmacy. The DHW performed medication pass observation with all medication aides to ensure insulin were being administered accurately, including priming the insulin pen and not administering expired insulin Date of completion 4/30/25. The executive director (ED), business office manager (BOM) or designee will ensure all future medication aides receive diabetic training during their orientation period. On 3/27/25, the director of health and wellness (DHW) in serviced all medication aides on diabetic education to include priming the insulin pen with 2 units and wasting, then drawing up the dose ordered by the physician, and not administering expired insulin. Beginning 4/4/25, the DHW, resident care coordinator, memory care director or designee will conduct random weekly x 4 medication pass observations to observe for proper insulin administration , including priming the pen with 2 units and wasting before drawing up the dose ordered by the physician and not administering expired insulin. This monitoring will then occur routinely on an ongoing basis.	4/30/25

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Continued From page 6

-There was an order for Lantus Solostar insulin, inject 50 units twice a day with breakfast and dinner. (Lantus is long-acting insulin used to lower blood sugar. According to the manufacturer, the Lantus Solostar should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)
-There was an order for Novolog Flexpen, inject 5 units 2 times a day before breakfast and lunch. (Novolog is rapid-acting insulin used to lower blood sugar. According to the manufacturer, the Novolog Flexpen should be primed with a 2-unit air dose before each use to assure the insulin is flowing through the needle and to remove any air bubbles.)

According to the manufacturer, the Lantus Solostar instructions were:
-Dial a test dose of 2 Units.
-Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose.
-Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test.
-If no insulin comes out, repeat the test 2 more times. If there is still no insulin coming out, use a new needle and do the safety test again.
-After 28 days after opening, throw the opened Lantus pen away-even if it still has insulin in it.

Review of Resident #7's March 2025 electronic medication administration record (eMAR) revealed:
-There as an entry for Lantus Solostar insulin, inject 50 units twice a day with breakfast and dinner.

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D 358	Continued From page 7 -There was an entry for insulin ASPA Flex pen, inject 5 units 2 times a day before breakfast and lunch with scheduled administration times of 8:00am and 12:00pm. -There was an entry for insulin ASPA Flex pen, inject 8 units every day at dinner with scheduled administration times of 5:00pm. -Dial a test dose of 2 Units. -Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. -Push the end of the pen to clear the air. -You may need to do this more than one time to see the insulin come out of the needle. -Insulin in your pen expires about 28 days after opening. Observation of the 8:00am medication pass on 03/27/25 revealed: -Resident #8's blood sugar was 170 at 8:06am. -The medication aide (MA) removed a Lantus Solostar insulin pen from the medication cart. -The MA dialed the Lantus Solostar insulin pen to 52 units and administered it to the resident at 8:07am. -The MA did not prime the insulin pen with a 2-unit air shot. -The MA did not check the insulin label prior to administering the insulin. -The label on the insulin pen documented that the pen was opened on 02/25/25 and expired on 03/25/25. -The medication aide (MA) removed a ASPA Insulin Flex pen from the medication cart. -The MA dialed the ASPA Insulin Flex pen to 7 units and administered it to the resident at 8:08am. -The MA did not prime the insulin pen with a 2-unit air shot.	D 358		

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-The MA did not check the insulin label prior to administering the insulin.
-The label on the insulin pen documented that the pen expired on 03/25/25.

Interview with Resident #7 on 03/27/25 at 8:45am revealed:
-He had been living at the facility for a couple of months.
-He received his FSBS before his meals and before bed.
-He received 2 types of insulin but did not know the exact names of them.
-He received his insulins before meals and at bedtime.
-He was not sure of the amounts of insulin he received.
-He had not had any problems with his FSBS being too high or too low that he was aware of since he came to live at the facility.

Attempted telephone interview with Resident #7's primary care provider (PCP) on 03/27/25 at 10:45am was unsuccessful.

Interview with a MA on 03/27/25 at 9:45am revealed:
-The MAs were supposed to perform an air shot of 2 units of the insulin to make sure the air was out of the needle.
-They were not supposed to add the 2 units to the dosage the resident was to get administered as this would be a wrong dose being given to the resident.

Interview with the Health and Wellness Director on 03/27/25 at 2:37pm revealed:
-She started with the facility 5 months ago.
-The MA should perform an air shot of 2 units of the insulin to make sure the air was out of the

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needle.
-They should never add the 2 units to the dosage the resident was to get administered since that would have the resident getting more than the ordered dose of insulin.
-The resident could have a drop in his blood sugar from getting more insulin than was ordered if the 2 units were added to the dosage.
-Not performing the air shot could cause the resident to not get enough insulin if there was air in the needle.

Interview with the Assistant Executive Director on 03/27/25 at 2:13pm revealed:
-The MAs should perform an air shot of 2 units prior administering the residents' insulin to clear the air form the needle.
-Not performing the air shot could cause the resident to get too much or not enough insulin.

Interview with the Executive Director on 03/27/25 at 3:00pm revealed:
-The HWD was responsible for ensuring the MAs had received all the appropriate training prior to being placed on the medication cart to administer medications.
-She expected all MAs to follow the directions for insulin pens which included performing the 2-unit air shot.
-They should never add the 2 units intended to be the air shot to the amount of insulin ordered for the resident.
-She was concerned about the MAs not performing the air shot prior to administering the insulin as the resident would not be receiving the correct ordered amount of insulin.

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D 371	10A NCAC 13F .1004(n) Medication Administration	D 371		

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D 371	Continued From page 10 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 03/26/25 by 1 of 3 medication aides. The findings are: Review of the facility's medication handling policy dated 06/11/24 revealed: -Medication aides (MAs) will follow a consistent workflow to ensure medications were handled properly and accordance with state regulations and community policy. -If a medication is contaminated such as being dropped, getting wet, etc. note the contamination on the Medication Administration Record (MAR) and use the next available dose, then contact the pharmacy for a replacement medication if necessary. Review of the Medication Administration 10/15-Hour Training Course for Adult Care Homes Student Manual Section G - Infection Prevention Practices Content Important Infection Control Concepts During Administration of Medication revealed: -Use sanitary technique when pouring or preparing medications into appropriate container.	D 371	10A NCAC 13F.1004(n) Medication Administration On 3/26/25, the medication aide was inserviced by the DHW on following proper infection control techniques during a medication pass which included not popping medications directly into her bare hand, performing proper hand hygiene during medication and popping medications and placing directly in medication cup for administration to the resident. The executive director (ED), business office manager (BOM) or designee will ensure all future medication aides receive training on following proper infection control during medication administration during their orientation. On 4/25/25, the area nurse completed an inservice to all medication aides on observing proper infection control during medication administration. Beginning, 4/4/25, the DHW or designee will observe random medication pass observations on all shifts x 4 weeks and routinely thereafter.	4/30/25

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D 371	Continued From page 11 -Do not touch or handle medications but pour medication from the original medication container into a new, appropriate medication container. -Never use your own hands to administer medications and never require resident to have to use his/her own hands to receive medications. -Medications are provided to the resident in clean and appropriate medication containers. Observation of a MA during the 9:00am medication pass on 03/26/25 from 9:13am - 9:19am revealed: -The MA prepared medications for a resident from the "bubble" packs by popping the medication from the card into her bare hand and then placed the medication into the medication cup. -The MA removed the resident's medication bubble packs from the cart and scanned the barcode on the pack, then the MA popped the medication tablets and capsules into her bare hand and then placed them into the medication cup for administration to the resident. -The MA administered all the medications to the resident and then returned to the medication cart to document without performing hand hygiene. Interview with a MA on 03/26/25 at 10:45am revealed: -The MAs were supposed to 'pop' the medicine out of the pack into the medication cup, pour liquids into a separate cup from the pills and a clean spoon to stir crushed or powdered medicines into applesauce or the water to give to the resident. -They were not supposed to touch the residents' medications with their bare hands due to infection control. -The MA should wear gloves whenever giving medications like lotions, eye drops, nasal sprays	D 371		

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TERRABELLA NORTHRIDGE	600 NEWTON ROAD RALEIGH, NC 27609

(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 371	Continued From page 12 etc.. Interview with the Health and Wellness Director (HWD) on 03/27/25 at 2:37pm revealed: -She started with the facility 5 months ago. -The MA should never touch the residents' medications with a bare hand. -Touching medications with bare hands could transmit infections or diseases. Interview with the Assistant Executive Director on 03/27/25 at 2:15pm revealed: -The MAs had received infection control training, but she was not sure of the exact date. -The MAs were supposed to wash or sanitize their hands between each resident when administering medications. -The MAs should always wear gloves when administering medications like eye drops, nasal sprays, and lotions. -When the MAs remove their gloves, they should use sanitizers or wash their hands. -The MAs should never touch a resident's medication due to contamination. Interview with the Executive Director on 03/27/25 at 3:00pm revealed: -She expected all MAs to follow infection control policies. -They should wash their hands before administering medications to the residents. -They should never touch the residents' medications with their bare hands. -She was concerned about Infection control.	D 371		