

Vogel, Abigail L

From: Tyrrell House, ADM - Wallace, LaVonna <tyre.adm@algsenior.com>
Sent: Tuesday, January 26, 2021 4:28 PM
To: Vogel, Abigail L
Cc: Tyrrell House, RCC - Atkins, Tara; Nina Warwick-Joyner; Lynette Choplin; Edenton, ADM - Chamblee, Katrena
Subject: [External] Revised POC
Attachments: ALG Scans_20210126_162148.pdf

CAUTION: External email. Do not click links or open attachments unless you verify. Send all suspicious email as an attachment to [Report Spam](#).

LaVonna

LaVonna Wallace, BA. Business Administration | Executive Director | Tyrrell House Assisted Living & Memory Care | E: tyre.adm@algsenior.com | P: (252) 394-3145 C: (252) 917-3800

Reviewed and accepted with additional revisions — Abigail L. Vogel 01.26.21
Per Telephone Conversation w/ Adm on 01.26.21 @ 5:45pm
(Addendum pages 16, 23, 29 and 43)

Reviewed and Accepted with additional revisions ———— ^{1/26/2021} _{AW 01.26.21}

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 270	Continued From page 1 -Resident #1's recommended level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 01/07/20. Review of Resident #1's current care plan dated 11/24/20 revealed: -Resident #1 was always disoriented and had significant memory loss that required redirection. -Resident #1 wandered and was resistant to care. -She was ambulatory. -Resident #1 required limited assistance with eating, ambulation, and transferring, and extensive assistance with toileting, bathing, dressing, and grooming. -There was no assessment or documentation of Resident #1's needs related to supervision or fall precautions. Review of Resident #1's SCU resident profile dated 10/09/20 revealed: -Resident #1 was confused and required redirection from staff. -Resident #1 was independent with ambulation but needed staff to supervise when walking. -Resident #1 was calmed by walking up and down the hallways. Review of Resident #1's current licensed health professional support evaluation dated 06/24/20 revealed: -Resident #1 was ambulatory with a gait that leaned to the right. -Resident #1 wandered and required constant redirection from staff to keep the resident from going into other residents' rooms. Review of the facility's falls policy revealed: -This policy was used to ensure residents were	D 270	Continued from page 1 Any resident assessed as a fall risk will have emblem located on their room name plate to alert staff resident has been assessed as a possible fall risk. Facility ED, Care Manager and/or designee will assure that post fall observations are completed as part of the Falls Management Program. Facility ED, Care Manager and/or designee will assure fall interventions are utilized as applicable. Interventions will include but are not limited to Physical Therapy, In-Creased Supervision, referrals to Primary Care Physicians and/or care planning meeting with residents and families. Any interventions will be documented in residents progress notes. In-Creased supervision checks will be documented on an In-Creased Supervision form. Facility ED and/or Care Manager will review In-Creased supervision forms no less than weekly to assure completion. Facility ADO, DDCS, and/or DVPO will review In-Creased supervision documentation and incident reports weekly and during on site visits. Facility ADO, DDCS and/or DVPO will make facility rounds during on site visits. All staff In-serviced/trained on Falls Management Program, Incident reporting, In-Creased supervision documentation and 72 hour follow-up. Training conducted by DDCS, RN and DVPO, CDP Care Manager and ED In-serviced on Fall assessments and Fall Management Program In-service conducted by DDCS, RN	12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/2/2020

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER

TYRRELL HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 270	Continued From page 2 monitored and identified for risk for falls. -Residents are assessed on admission for fall using the safety history and fall evaluation as part of the fall management program. -Ongoing assessment of the resident and any falls the resident sustains will be reviewed monthly during the fall management team meeting, and appropriate interventions are implemented, as indicated and the plan of care is updated -The post fall observation is completed as part of the fall management program after a fall for further care planning. -Management will schedule care plan meetings with the resident, and family or responsible party as applicable to determine next steps and additional interventions when evaluating resident falls, which includes referral to the primary care provider (PCP) for further evaluation. Review of a progress note for Resident #1 dated 02/04/20 at 2:07pm revealed: -Resident #1 was walking continuously. -Resident #1 reported that she was tired and the medication aide (MA) and personal care aides (PCAs) laid the resident down several times, but Resident #1 kept getting up. -Staff heard a loud noise from an empty room and found Resident #1. -Staff observed bruising to the left side of Resident #1's face and lip. -Staff notified Resident #1's responsible party and monitored the resident. -It was not specified how often staff monitored Resident #1. Review of a progress note for Resident #1 dated 02/10/20 at 8:02am revealed: -Resident #1 was observed by staff trying to get up from the floor by the left side of her bed by her	D 270	Continued from page 2 All staff in-serviced/trained on Personal Care and Supervision, Incident/Accident Reporting, Falls Management Program, and Documentation. Training conducted by DDCS, RN LHPS RN DVPO, NCALA/CDP All new employees will receive training on Personal Care and Supervision, Facility Fall Management Program, Incident/Accident reporting and Documentation. (Ongoing)	12/2/2020

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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)	(X6) COMPLETE DATE
D 270	Continued From page 3 nightstand. -Staff documented, "it appeared the resident rolled out of bed". -Staff noted Resident #1 had bruising to her right shoulder area and the resident complained of right shoulder pain when staff bathed and dressed the resident. -Resident #1 was sent to the hospital for further evaluation. -Resident #1's responsible party and PCP were notified. Review of an accident/incident report for Resident #1 dated 02/10/20 at 8:03am revealed: -Staff found Resident #1 trying to get up from the floor between her bed and nightstand in her room. -Resident #1 complained of pain to her right shoulder and had bruising (location not specified). -Resident #1 was transported to the emergency room for evaluation. -Resident #1's PCP and responsible party were notified. Review of a progress note for Resident #1 dated 02/10/20 at 6:14pm revealed Resident #1 returned to the facility with a hospital discharge summary diagnoses of bilateral subdural hematoma, a closed non-displaced fracture of the right clavicle, and acute cystitis. Review of an accident/incident report for Resident #1 dated 06/28/20 at 5:30pm revealed: -Resident #1 was found by staff laying on the floor of her room struggling to get up from the floor. -Resident #1 suffered a laceration to her head and staff applied pressure to the area to stop the bleeding. -Resident #1 complained of pain and was sent to	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 270	Continued From page 4 the emergency room for treatment. -Resident #1's PCP and responsible party were notified. Review of a progress note for Resident #1 dated 06/28/20 at 6:55pm revealed: -Staff found Resident #1 in an empty room in the middle of some bedrails. -Resident #1 had hit her head and was bleeding. -Resident #1 was transported to the emergency room by emergency management services for treatment. Review of a second progress note for Resident #1 dated 06/28/20 at 10:16pm revealed: -Resident #1 returned to the facility from the emergency room with diagnoses of an accidental fall and scalp laceration. -Resident #1 needs to be monitored because she tried to remove the staples from her head used to close her scalp laceration. -Resident #1 was placed on fall prevention watch. Review of an accident/incident report for Resident #1 dated 08/01/20 at 2:04pm revealed: -Resident #1 was found alone and bleeding from a cut to the left side of her face and her head (dimensions of the cut not specified). -Resident #1 complained of pain (location not specified). -Staff applied pressure to Resident #1's cut until the resident was transported to the emergency room for treatment. -Resident #1's PCP and responsible party were notified. Review of a progress note for Resident #1 dated 08/01/20 at 2:09pm revealed: -Resident #1 was walking down the hallway and fell on the floor resulting in a laceration to her the	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

TYRRELL HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 270	Continued From page 5 left side of Resident #1's face. -Resident #1's face was bleeding, and the resident was transported to the emergency room for treatment. -Resident #1's responsible party and PCP were notified. Review of emergency room discharge summary notes for Resident #1 dated 08/01/20 revealed: -Resident #1 was seen for an accidental fall and her diagnoses included a head injury and facial laceration. -Resident #1 required sutures to close the laceration to her face that needed to be removed within the next 7-10 days. Review of a second progress note for Resident #1 dated 08/01/20 at 5:35pm revealed: -Resident #1 returned from the emergency room with diagnoses of a head injury and a facial laceration. -There was an order for the sutures to be removed from Resident #1's face in 7-10 days. Review of a progress note for Resident #1 dated 08/15/20 at 1:32pm revealed: -Resident #1 was walking with another resident when the resident slipped and fell. -Resident #1 was assisted up by staff and was not injured. Review of a progress note for Resident #1 dated 08/30/20 at 3:02pm revealed: -Resident #1 slipped and fell on the floor in the hallway. -Resident #1 had a bump on the back of her head and was sent to the emergency room. Review of an accident/incident report for Resident #1 dated 08/30/20 at 1:49pm revealed:	D 270		

Division of Health Service Regulation

STATE FORM

0000

N5WN11

If continuation sheet 6 of 78

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1069002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925			
(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 270	Continued From page 6 -Resident #1 was sitting up in the hallway of the SCU. -Resident #1 bumped her head (front or back of head not specified) and complained of pain. -Resident #1 was transported to the emergency room for further evaluation. -Resident #1's responsible party and PCP were notified. Review of emergency room discharge summary note for Resident #1 dated 08/30/20 revealed Resident #1 was seen for an accidental fall and diagnosed with a closed fracture of her sacrum, a subdural hematoma, and a subarachnoid hemorrhage. Review of a progress note for Resident #1 dated 08/31/20 at 6:44am revealed Resident #1 was transported back to the facility from the emergency room and was diagnosed with a closed fracture of her sacrum, subdural hematoma, and subarachnoid hemorrhage. Review of an accident/incident report for Resident #1 dated 10/16/20 at 12:57pm revealed: -Resident #1 fell in the hallway and hit her head. -Resident #1 complained of pain to a bump on her head after she fell (exact location not specified). -Staff did not administer first aid for Resident #1's injury or transport the resident to the emergency room for further evaluation on 10/16/20. -Resident #1's responsible party and PCP were notified. Review of a progress note for Resident #1 dated 10/19/20 at 3:46pm revealed: -Resident #1 was walking with no complaints of pain or discomfort to her face. -Staff would continue to monitor for resident for	D 270			

Division of Health Service Regulation

PRINTED: 12/21/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 84 EAST COLUMBIA, NC 27925			
(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 270	Continued From page 7 any changes. Review of an accident/incident report for Resident #1 dated 10/24/20 at 10:35am revealed: -Another resident came and got the staff to report Resident #1 had fallen in the hallway. -Staff found Resident #1 in the hallway with a cut to her upper nose area that was bleeding. -Staff applied pressure to wound and Resident #1 was transported to the emergency room for further evaluation. -Resident #1's responsible party and PCP were notified. Review of a progress note for Resident #1 dated 10/24/20 at 10:43am revealed: -Another resident reported to staff Resident #1 had fallen and staff observed Resident #1's nose was bleeding. -Resident #1 was transported to the emergency room for evaluation. -Resident #1's responsible party and PCP were notified. Review of an emergency room discharge summary note for Resident #1 dated 10/24/20 revealed Resident #1 was treated for a fall and facial contusions. Review of a second progress note for Resident #1 dated 10/24/20 at 5:50pm revealed Resident #1 returned to the facility from the emergency room with a diagnosis of facial contusions. Review of a third progress note for Resident #1 dated 10/24/20 at 9:40pm revealed: -Staff found Resident #1 lying on the floor (of her bedroom). -There was blood on the walls, on her lamp, in the resident's bathroom (unspecified location).	D 270			

Division of Health Service Regulation
STATE FORM

0000

N5WN11

If continuation sheet 8 of 78

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 270	Continued From page 8 and all over the bedroom's floor from Resident #1's nose bleeding. -Resident #1 was transported to the emergency room by emergency management services (EMS). -An EMS worker returned and asked to see Resident #1's room. -Resident #1's responsible party and PCP were notified. Review of an accident/incident report for Resident #1 dated 10/24/20 at 9:34pm revealed: -Staff found Resident #1 lying on the floor of her bedroom with her nose bleeding. -Staff applied pressure to Resident #1's nose and the resident was transported to the emergency room for treatment. -Resident #1's responsible party and PCP were notified. Review of a second emergency room discharge summary note for Resident #1 dated 10/24/20 revealed: -Resident #1 was seen earlier for a fall at the emergency room on 10/24/20. -Resident #1 was being seen again for a second accidental fall and diagnosed with a head injury, nasal abrasion, and a urinary tract infection. -It was recommended with Resident #1's history of recurrent falls, the resident may need a higher level of care than the assisted living facility she currently resided in. Review of a fourth progress note for Resident #1 dated 10/25/20 at 1:27am revealed: -Resident #1 returned from the emergency room with diagnoses of a skin tear to her elbow (unspecified), nasal abrasion, head injury, and a urinary tract infection. -It was recommended that Resident #1 be moved	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 270	Continued From page 9 to a skilled nursing facility due to her multiple falls. Review of physician's orders for Resident #1 revealed an order dated 11/24/20 for fifteen-minute documentation for supervision for Resident #1. Observation of Resident #1 on 11/18/20 from 11:20am to 11:48 revealed Resident #1 was observed constantly walking the halls of the SCU. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's family member on 11/24/20 at 9:15am and 11/30/20 at 11:10am were unsuccessful. Telephone interview with the previous Administrator on 11/25/20 at 10:22am revealed: -He did not really know what else the facility could do regarding Resident #1's frequent falls because of her dementia. -The facility had staff to check Resident #1 every fifteen minutes after she fractured her clavicle in February 2020, but the checks were not ordered by Resident #1's PCP in February 2020 and he was the Resident Care Coordinator at the facility then. -Resident #1 did not have a physician's order for supervision to monitor for falls. -Resident #1 was not candidate for a fall mat because she "moved all of the time" and she was not a candidate for physical therapy because she would not be able to follow directions. -He had spoken with the Resident #1's family member about hiring a private sitter (time not specified).	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 270	Continued From page 10 -The facility was planning to increase staffing in the SCU in December 2020 to help accommodate for Resident #1's supervision needs. -He had not discussed his concerns regarding supervision with Resident #1's PCP, but he did not know what else to do with Resident #1. -He did not feel the facility could appropriately provide care for Resident #1 based on her needs and he had not discussed this with her PCP. -He had thought about discussing restraints with the PCP, but he believed that would make Resident #1 worse since she liked to walk constantly when she was awake. -He had planned to increase the staffing in the SCU to help with Resident #1's supervision, but that had not occurred yet. Telephone interview with a medication aide (MA) on 11/30/20 at 10:32am revealed: -If her name was on the notes then she was involved with the incident and resident's falls. -She remembered that when Resident #1 fell once 10/24/20 that she was in the dining room and another resident came and told her that Resident #1 had fallen. -The other resident nor Resident #1 were able to report how Resident #1 had fallen and Resident #1 was bleeding from her head. -Resident #1 was sent to the emergency room for her head injury and she had been sent out several times for injuries related to falls. -Resident #1 "wandered and she walked the halls of the SCU all day". -Resident #1 complained to the staff that she was tired, but she would not stop walking even when staff tried to put the resident to bed. -Resident #1 was supposed to be on fifteen-minute checks for supervision, but it was hard to keep up with Resident #1 because she	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925
---	--

(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 270	Continued From page 11 was constantly moving (time not specified). -The personal care aides (PCAs) were supposed to do the fifteen minute checks on Resident #1 and report their checks back to the MAs to document on Resident #1's electronic medication administration record (eMAR). -The MA only documented Resident #1's fifteen-minute checks once a shift on Resident #1's eMAR. -The SCU was usually staffed with one MA and two personal care aides (PCAs) to take care of eighteen residents. -There was at least one other resident in the SCU who needed total care and required two-person assistance for personal care, so it was hard to supervise Resident #1 and manage the care of the residents in the SCU. -She had tried to walk with Resident #1 to calm her down, but the resident would not stop. -She did not think the facility was appropriate to care for the needs of Resident #1. Telephone interview with a second MA on 11/30/20 at 11:24am revealed it was hard for staff to keep check of Resident #1 every fifteen minutes "because she (Resident #1) walked all day". Telephone interview with the Memory Care Manager (MCM) on 11/24/20 at 1:23pm revealed: -Resident #1 had a history of frequent falls. -Resident #1 walked the halls of the SCU all day and would not sit down. -If staff tried to get Resident #1 to sit down, it made her agitated. -She knew from working on the floor that Resident #1 walked constantly and then staff would find Resident #1 after she had fallen in her bedroom or in a spare room. -Staff had found Resident #1 bleeding and "blood	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 270	Continued From page 12 was everywhere on her last fall on 10/24/20". -We can not physically restrain her (Resident #1) and Resident #1's walking helped to calm her down." -She had suggested to the previous Administrator (dated not specified) for the SCU to have more staff to monitor the halls when Resident #1 was walking. -The SCU was currently staffed with 1 MA and 2 PCAs to monitor the residents. -Resident #1 was currently under fifteen-minute supervision checks and the facility had imposed these checks in February 2020 because of Resident #1's falls. -PCAs did the fifteen minute checks and reported them to the MA to document once a shift on Resident #1's eMAR. -With other residents, we could try fall mats, call bells" but for Resident #1 "there was nothing in place". -She and the previous Administrator had discussed Resident #1's falls but they did not reach out to Resident #1's PCP related to interventions for increased supervision related to her falls. -Resident #1's PCP had not been previously contacted about interventions to prevent Resident #1's falls. -The facility did not have solution in place that fit Resident #1 because of her constant walking and her dementia to prevent the resident's falls. Telephone interview with the current Administrator on 11/26/20 at 3:25pm revealed: -She did not know what supervision was provided to Resident #1 by staff or what the facility's supervision policy was. -She "had only been working at the facility for two weeks" and she did not about Resident #1 since she had not reviewed Resident #1's record yet.	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	---	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925
---	--

(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 270	Continued From page 13 -She became aware of the problems with Resident #1's falls and supervision on today and she did not know how many falls Resident #1 had. -She did not know what the facility's supervision policy consisted of. Telephone Interview with Resident #1's PCP on 11/25/20 at 1:52pm revealed: -Resident #1 had a problem with frequent falls and the resident walked constantly even when she was tired. -Resident #1 had suffered numerous injuries since she had been at the facility related to her falls, like lacerations, a fractured clavicle, and a fractured sacrum since she was admitted to the facility. -He had tried physical therapy with Resident #1 but that did not work because of her dementia. -"Short of putting the resident in wheelchair" he did not know what else to do to keep Resident #1 from falling. -Resident #1 was at the point that she needed a higher level of care and she needed someone to literally walk with her to ensure her safety. -This had not been discussed as a plan for Resident #1 at the facility. The facility failed to provide supervision to a resident (#1) who suffered multiple falls and injuries including a fractured right clavicle, a fractured sacrum, facial contusions, and multiple head injuries including a scalp laceration, subdural hematomas, and subarachnoid hemorrhage. The failure of the facility to provide supervision to the resident resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925			
(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 270	Continued From page 14 accordance with G.S. 131D-34 on 11/25/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2020.	D 270			
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 2 of 5 sampled residents regarding one resident who sustained three falls in one week (#6) and a resident who was experiencing impaired visual perception. The finding are: 1. Review of Resident #6's current FL-2 dated 10/13/20 revealed: -Diagnoses included Alzheimer's disease and dementia, hypertension, osteoarthritis and displaced fracture left femur. -Resident #6's recommended level of care was Special Care Unit (SCU). Review of the facility's Fall Management Program policy dated 08/16/20 revealed the procedures staff were to follow included to contact the primary care provider (PCP) after a fall.	D 273	10A NCAC 13F .0902(b) Health Care Facility will assure referral and follow-up to meet the routine and acute health care needs of residents. Facility has implemented Daily Stand-Up Meeting, Weekly At Risk Meetings and Monthly QA meetings. Meetings will include all facility Management staff and outside providers when available. Resident personal care needs, all falls, changes in residents conditions, resident appointments, and/or any needed follow-up on routine/acute care needs are discussed during these meetings. Facility has implemented a Quality Assurance(QA) 24 hour Communication Log to assure staff are communicating any routine, upcoming appointments, falls and/or acute health care needs from shift to shift. Facility QA 24 Communication Log is to be completed by the Medication Staff and/or SIC prior to the end of shift and is reviewed by on coming Medication Staff and/or SIC Facility QA 24 Communication Log will be reviewed daily by ED and MCM during daily stand up meeting and address any resident routine and/or acute needs, appointments, or noted concerns.	1/14/2021 12/30/2020 12/30/2020 1/14/2021 1/14/2021	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha088002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	Continued From page 15 Review of a progress note for Resident #6 dated 11/15/20 at 6:03pm revealed: -Staff found Resident #6 sitting on the floor in the resident's room. -Staff documented the resident reported slipping on the floor while trying to get into bed. -Staff noted Resident #6 complained of hip pain. -Staff documented no visible bruises and would continue to monitor. Review of an accident/incident report for Resident #6 dated 11/15/20 at 5:56pm revealed: -Staff found Resident #6 sitting on the floor in the resident's room. -Staff noted Resident #6 complained of hip pain. -Staff documented Resident #6 had no injuries noted. -Resident #6 was not sent to the hospital for further evaluation. -Staff documented Resident #6's responsible party was notified on 11/19/20 at 6:14pm. -Staff documented Resident #6's PCP was notified on 11/15/20 at 6:00pm. Review of an accident/incident report for Resident #6 dated 11/18/20 at 2:02pm revealed: -Staff found Resident #6 on the floor in the resident's room. -Staff documented Resident #6 had tried to transfer. -Staff noted Resident #6 did not complain of pain. -Staff documented Resident #6 had no injuries noted. -Resident #6 was not sent to the hospital for further evaluation. -Staff documented Resident #6's responsible party was notified on 11/18/20 at 1:54pm. -Staff documented Resident #6's PCP was notified on 11/18/20 at 1:49pm.	D 273	Continued from page 15 Facility ADO, DDCS, ED and MCM have completed an audit of resident records for any outstanding acute and routine health care needs. Any outstanding acute and/or routine health care needs have been addressed with residents Primary Care Provider(PCP). Facility ED, Memory Care Manager and Med Tech Staff have been trained/in-serviced on on Healthcare Notification, 24 hour QA Communication Log and change in condition. Training/in-service provided by LHPS RN On 11.27.20 and 12.02.20 All facility staff have been trained on reporting of any change in condition. Training provided by DDCS, RN and LHPS, RN	1/14/2021 ~~11/27/2020~~ and 12/2/2020 12/2/2020	AW

Addendum per telephone conversation w Adm on 01.26.21 @ 5:45pm AW

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal088002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 84 EAST
COLUMBIA, NC 27925

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 16 Review of a progress note for Resident #6 dated 11/20/20 at 1:11am revealed: -Staff documented Resident #6 crawled down in the floor and was looking for her dentures. -Staff documented Resident #6 hit her head on something while crawling in the floor, the was looking for her resident reported slipping on the floor while trying to get into bed. -Staff noted Resident #6 had a small mark on her head. Review of an accident/incident report for Resident #6 dated 11/20/20 at 7:55am revealed: -Staff documented Resident #6 got down on the floor in her room to look for her teeth and bumped her head on something but did not say what. -Resident #6 did not complain of pain. -Staff documented Resident #6 had an injury, an abrasion. -Resident #6 was not sent to the hospital for further evaluation. -Staff documented Resident #6's responsible party was notified on 11/20/20 at 8:08am. -Staff documented Resident #6's PCP was notified on 11/20/20 at 7:58am. Interview with a medication aide (MA) on 11/19/20 at 4:21pm revealed: -She had completed the incident report for the fall on 11/18/20. -Resident #6 had an unwitnessed fall in her bedroom on 11/18/20 at 9:30am. -The personal care aide (PCA) found the resident on the floor. -The resident was trying to transfer from her recliner to her wheelchair and fell. -Resident #6 complained of hip pain. -She did not ask the resident her pain level, but the resident had facial grimacing due to pain. -She did not call Resident #6's PCP to inform	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 17 them of the fall. -She had documented in the accident/incident report, she did not notify Resident #6's PCP of the fall. -She did not call the PCP because when the family advised not to send Resident #6 to the hospital, she thought she did not have to call the PCP. Interview with a PCA on 11/20/20 at 2:17pm revealed: -She found the resident on the floor on 11/18/20. -Resident #6 was trying to get in her wheelchair. -The resident complained of hip pain. -She looked at the resident and knew she was in pain. -The MAs were responsible for calling the PCP when a resident had a fall. Telephone interview with Resident #6's PCP on 11/25/20 at 1:52pm revealed: -He did not know Resident #6 had a fall on 11/15/20, 11/18/20 and 11/20/20. -The facility notified him of the 3 falls on 11/22/20. -He wanted to be notified of all falls. -He expected to be notified of all falls within 24 hours of the fall. Interview with the Memory Care Manager (MCM) on 11/20/20 at 2:53pm revealed: -Resident #6 had a fall on 11/18/20. -She did not know the PCP had not been notified of Resident #6's fall on 11/18/20. -MAs were responsible for contacting the PCP after a fall. Telephone interview with the current Administrator on 11/26/20 at 3:25pm revealed: -She did not know about Resident #6's falls. -The PCP should have been notified of the falls	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	Continued From page 18 within 24 hours of the fall. -The MAs were responsible for contacting the PCP related to the fall. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. 2. Review of Resident #1's current FL-2 dated 01/07/20 revealed: -Diagnoses included dementia, hypertension, anxiety, elevated cholesterol, and lipoprotein deficiency. -Resident #1 wandered, was constantly disoriented, and ambulatory. -Resident #1's recommended level of care was Special Care Unit (SCU). Review of the Resident Register for Resident #1 revealed there was no documentation that Resident #1 had worn eyeglasses prior to her admission to the facility. Review of Resident #1's current care plan dated 11/24/20 revealed her vision was limited and she was able to see only large objects, but there was no reference to the resident's need for eyeglasses. Review of the facility's health care referral and follow-up policy revealed it was the facility's policy to assure referral and follow-up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident record. Review of a progress note for Resident #1 dated 03/22/20 at 1:47pm revealed: -Resident #1 was walking in the hallway. -Resident #1 sometimes walked into the walls,	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 273	Continued From page 19 staff, and other residents as if she could not see. -Staff would continue to monitor resident. Review of a progress note for Resident #1 dated 03/30/20 at 1:42pm revealed: -Resident #1 was having a difficult time seeing objects without walking into them. -Staff would continue to monitor resident for safety. Review of a progress note for Resident #1 dated 05/19/20 at 11:49pm revealed: -Resident #1 was walking down the hall and ran into a door and hit her right side. -Staff administered pain medication to Resident #1 because the resident was holding onto the right side. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Attempted telephone interview with Resident #1's family member on 11/24/20 at 9:15am and 11/30/20 at 11:10am were unsuccessful. Telephone interview with a medication aide (MA) on 11/30/20 at 10:32am revealed: -Resident #1 had some problems with her vision. -Sometimes, Resident #1 would look at staff, but the resident still would not see the staff and walked into the staff. -She did not know if Resident #1 had ever worn eyeglasses or the last time Resident #1's eyes had been checked. -She had not mentioned her concerns about Resident #1's vision to anyone. Telephone interview with the Memory Care Manager (MCM) on 11/24/20 at 1:23pm revealed:	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	Continued From page 20 -She thought sometimes that Resident #1 could not see because she walked into doors in the SCU. -Resident #1 would sometimes bump into visible objects when she was walking just like she could not see them. -She and the previous Administrator had not reached out to Resident #1's PCP related to concerns about Resident #1's vision. -She could not give a reason why Resident #1's PCP had not been contacted about Resident #1's vision. Telephone interview with the previous Administrator on 11/25/20 at 10:22am revealed: -Resident #1 had some problems with her vision. -Resident #1 had worn eyeglasses prior to her admission to the facility, but her eyeglasses had been lost prior to her coming to the facility. -The family had not replaced Resident #1's lost eyeglasses and he had not mentioned Resident #1's problem seeing to her PCP. -He could not specify why he had not discussed Resident #1's vision problems with her PCP. Telephone interview with Resident #1's PCP on 11/25/20 at 1:52pm revealed no one at the facility had notified him that Resident #1 had any problem with her vision or needed eyeglasses. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.	D 273			
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276	10A NCAC 13F .0902(c) (3-4) Health Care		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST

COLUMBIA, NC 27925

(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 276	Continued From page 21 (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 sampled residents related to a resident (#6) who had diarrhea and was ordered (#6) for obtaining a stool specimen for a lab as ordered on 4 separate occasions. The findings are: Review of Resident #6's current FL-2 dated 10/13/20 revealed: -Diagnoses included Alzheimer's disease and dementia, hypertension, osteoarthritis and displaced fracture left femur. -Resident #6's recommended level of care was Special Care Unit (SCU). Review of a primary care provider's (PCP's) consultation note for Resident #6 dated 10/27/20 revealed: -Resident #6 was seen by the PCP on 10/27/20	D 276	Continued from page 21 Facility will assure written procedures, treatments or orders are implemented as prescribed by physician or licensed health professional Facility has implemented Daily Stand-Up Meeting, Weekly At Risk Meetings and Monthly QA meetings. Meetings will include all facility Management staff and outside providers when available. Resident personal care needs, all falls, changes in residents conditions, resident appointments, and/or any needed follow-up on routine/acute care needs are discussed during these meetings. Facility has implemented a Quality Assurance(QA) 24 hour Communication Log to assure staff are communicating any routine, upcoming appointments, falls, changes in residents condition and/or acute health care needs from shift to shift. Facility QA 24 Communication Log is to be completed by the Medication Staff and/or SIC prior to the end of shift and is reviewed by on coming Medication Staff and/or SIC Facility QA 24 Communication Log will be reviewed daily by ED and MCM during daily stand up meeting and address any resident routine and/or acute needs, appointments, or noted concerns. Facility ADO, DDCS, ED and MCM have completed an audit of resident records for any outstanding acute and routine health care needs. Any outstanding acute and/or routine health care needs have been addressed with residents Primary Care Provider(PCP).	1/14/2021 12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/30/2020

Division of Health Service Regulation

STATE FORM

0009

N5VN11

If continuation sheet 22 of 78

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HaJ039002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 276	Continued From page 22 for two weeks follow up. -Resident #6 had a diagnosis of diarrhea. -There was an order to obtain a stool specimen for a lab to test for clostridium difficile (C-Diff) (C-Diff is a spore forming bacteria that causes severe diarrhea). -Resident #6 had left flank tenderness. Review of a PCP's consultation note for Resident #6 dated 11/17/20 revealed: -Resident #6 had a diagnosis of diarrhea. -There was an order to obtain a stool specimen for a lab to test for C-Diff related to diarrhea. -A family member stated Resident #6 was having diarrhea all the time. Review of a PCP orders for Resident #6 dated 10/28/20, 11/10/20 and 11/17/20 revealed orders to obtain a stool specimen for a lab to test for C-Diff. Review of Resident #6's progress notes revealed: -On 10/29/20 at 9:04am, the resident had been having diarrhea. -Staff documented notifying the Memory Care Manager (MCM) of the concerns on 10/29/20 at 9:04am. -On 11/05/20 at 7:00am, Resident #6 had excessive diarrhea and needed attention. -Resident #6 reported having diarrhea for about a week on 11/05/20 at 7:00am. -On 11/09/20 at 6:49am, Resident #6 has loose runny stool and could barely eat. -On 11/12/20 at 11:38pm, Resident #6 had using the bathroom (pooping) for 3 weeks. -Resident #6 stool had been loose and mucus-like and she had been complaining of stomach pain and pain in her bottom on 11/20/20 at 11:38pm. -On 11/16/20 at 11:14pm, Resident #6 had	D 276	Continued from page 22 Facility has reimplemented "Bucket List" system to assure timely and proper follow-up on any written procedures, treatments, or orders perscribed by physician or licensed health professional. Facility Memory Care Manager(MCM) will monitor "Bucket List" process no less than daily. Facility ED will follow-up with MCM daily to assure orders are processed and follow-up is implemented timely. Facility ED and/or MCM will review residents progress notes daily for the pervious day to assure proper documentation of any health care referral and/or follow-up has been documented. Facility ADO, DDCS and/or DDCS will pull and review progress notes, incident/accident reports weekly for one month, then radomly there after. ED, Memory Care Manager and Med Techs have been in-serviced/trained on "Bucket List" system Training conducted by LHPS RN and DDCS, RN on 11.27.20 and 12.02.20 Facility ED, Memory Care Manager and Med Tech Staff have been trained/in-serviced on on Healthcare Notification, 24 hour QA Communication Log, Documentation, and change in condition. Training/in-service provided by LHPS RN All facility staff have been trained on reporting of any change in condition, Training provided by DDCS, RN and LHPS, RN	1/14/2021 1/14/2021 11/14/2021 1/14/2021 11/27/2020 and 12/2/2020 12/2/2020 12/2/2020

Division of Health Service Regulation
STATE FORM

0099

N5WN11

If continuation sheet 23 of 78

Addendum per telephone conversation to Adm on 01.26.21 @ 5:45pm *AW*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal000002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 84 EAST
COLUMBIA, NC 27925

(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 276	Continued From page 23 diarrhea that was dark green and watery, one episode after the other. -The personal care aide (PCA) had changed Resident #6 four to five times in the last few minutes and the resident was very weak on 11/18/20 at 11:14pm. -On 11/17/20 at 9:51am, Resident #6 had diarrhea and a "hat" was placed in the resident's commode to collect a stool specimen to be sent off. -On 11/18/20 at 4:36pm, Resident #6 was still having diarrhea. -On 11/19/20 at 3:10pm, Resident #6 was sent to the emergency room (ER) per the family's request to have labs completed. -On 11/19/20 at 11:17pm, Resident #6 returned from the ER with diagnoses of diarrhea and hypokalemia. Review of Resident #6's hospital discharge dated 11/19/20 revealed no documentation of a stool specimen being collected and no lab for C-Diff being obtained. Review of Resident #6's record revealed no documentation for a successful collection of a stool specimen. Telephone interview with a medication aide (MA) on 11/30/20 at 10:32am revealed: -She was informed Resident #6 needed a stool specimen on the day the lab person was coming to get labs (11/17/20). -She was busy and asked the PCA to collect the stool specimen. -The PCA was not able to collect the specimen because the resident had emptied the specimen in the commode. -She was only asked one time to collect the stool specimen and that was on 11/17/20.	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27926		
(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 278	Continued From page 24 Telephone interview with a PCA on 11/30/20 at 11:24am revealed: -She did not know a stool specimen needed to be collected for Resident #6. -She was never asked to collect a stool specimen from Resident #6. Telephone interview with Resident #6's family member on 11/23/20 at 1:09pm revealed: -She talked to Resident #6 multiple times a day every day. -Staff called her all the time about Resident #6's diarrhea. -Resident #6 health condition had been declining over the past two to three weeks. -Resident #6 had been miserable due to stomach pain and diarrhea. -Resident #6 had been having been having diarrhea for the last three weeks. -Resident #6 had to get up in the middle of the night and shower because she would be covered in feces from the diarrhea. -Resident #6 had been rating her pain as a 9 or a 10 for the last couple of days. -She knew labs had been ordered for Resident #6. -She went to the facility on 11/17/20 to watch the lab person obtain the labs and to speak to the PCP. -She witnessed the lab person obtain blood for Resident #6's labs. -She knew Resident #6 had and ordered labs to test her stool for possible cause of diarrhea, but she did not see a stool specimen. -She called the facility on 11/19/20 to get the lab results because Resident #6 was feeling horrible and she was told by the Memory Care Manager (MCM) that the labs that were taken could not be used and the labs would have to be retaken next	D 278		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 276	Continued From page 25 week due to a lab mix up. -She told the MCM to send Resident #6 to the hospital to have the labs obtained. -Resident #6 had already been waiting three weeks for the labs and she did not want Resident #6 to have to wait any longer for the labs. Telephone interview with Resident #6's PCP on 11/25/20 at 1:52pm revealed: -Resident #6 had been seen for diarrhea on 10/27/20 and 11/17/20. -Resident #6 had orders to test for C-Diff on 10/28/20, 11/10/20 and 11/17/20 related to diagnosis of diarrhea. -He was informed of the facility's inability to obtain the stool specimen on 11/17/20 for the order written for 10/28/20. -He was not notified of the facility's inability to obtain the stool specimen for the order written for 11/17/20. -He expected his orders to be followed as written. Telephone interview with the MCM on 11/24/20 at 1:21pm revealed: -She knew Resident #6 had been having diarrhea and orders for labs to test for C-Diff. -The C-Diff lab was not collected nor completed on 11/17/20 and 11/23/20. -She thought Resident #6 had been tested for C-Diff while at the ER on 11/19/20. -The C-Diff lab had not been collected by the facility as of 11/24/20. -The first order for labs to test for C-Diff was on 10/28/20 and was not completed. -She notified the PCP of facility's inability to collect the stool specimen on 11/17/20 and requested another order for the lab test. -The second order for labs to test for C-Diff was on 11/17/20 and was not completed. -She notified the PCP a second time on 11/24/20	D 276		

Division of Health Service Regulation

STATE FORM

8009

N5WN11

If continuation sheet 26 of 78

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 276	Continued From page 26 of the facility's inability to collect a specimen. -She was responsible for approving orders. Telephone interview with the MCM on 11/30/20 at 1:31pm revealed: -Resident #6's labs were obtained by the lab company on 1/17/20, but the stool specimen was not included in the labs collected. -The MAs and the PCAs were responsible for collecting Resident #6's stool specimen. -She was responsible for informing staff of needed specimens. Telephone interview with the current Administrator on 11/25/20 at 3:25pm revealed: -She did not know Resident #6's lab orders for C-Diff had not been completed. -She was informed by the MCM today, 11/25/20 that the orders to test for C-Diff had not been completed. -She expected the MAs to contact the PCP if the labs were not completed and get a discontinue order. -She expected staff to notify the PCP within three days if the orders for labs could not be completed and document in the resident's progress notes. -She expected all lab ordered to be completed as ordered. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. The facility failed to ensure physician orders were implemented for Resident #6 who had 4 separate orders to obtain a stool specimen to test Resident #6 for C-Diff because she was experiencing severe diarrhea for over three resulting in continual episodes of loose stool and increased risk of dehydration. The facility's failure was	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAI089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER
TYRRELL HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE
**950 HWY 84 EAST
COLUMBIA, NC 27925**

(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 276	Continued From page 27 detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/30/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2021.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #6) including one resident with a history of falls with injuries receiving inappropriate administration of an as needed (PRN) controlled substance used for pain management for behavioral issues for one resident (#1) and a second resident who missed at least one dose of a Fentanyl patch and had her Fentanyl patch administered more frequently than ordered (#6).	D 358	10A NCAC 13F.1004(a) Medication Administration Facility has implemented system to assure the preparation and administration of medications, prescriptions and non-prescriptions, and treatments are in accordance with Licensed prescribing practitioner, and facility's policies and procedures. Facility ADO, DDCS, ED and MCM have completed an audit of resident records, medication administration records, and medication carts. Facility has contacted licensed prescribing practitioner of any missed or inappropriate medication administration. Facility has reimplemented "Bucket List" system to assure accuracy of all medication orders prescribed by physician or licensed health professional. Facility Memory Care Manager(MCM) will monitor "Bucket List" process no less than daily. Facility ED will follow-up with MCM daily to assure all medication orders are accurate and available.	1/14/2021 12/30/2020 1/14/2021 1/14/2021

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal069002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 28 The findings are: 1. Review of Resident #1's current FL-2 dated 01/07/20 revealed: -Diagnoses included dementia, hypertension, anxiety, elevated cholesterol, and lipoprotein deficiency. -Resident #1 wandered, was constantly disoriented, and ambulatory. -Resident #1's recommended level of care was Special Care Unit (SCU). Review of Resident #1's physician orders dated 04/12/20 and 10/13/20 revealed there were medication orders for morphine 100mg/5ml - give 0.5ml sublingual every 2 hours as needed (PRN) for pain or shortness of breath (Morphine is a controlled substance used to relieve moderate to severe pain and to treat shortness of breath). Review of Resident #1's electronic medication administration record (eMAR) for June 2020 revealed: -There was an entry for morphine 100mg/5ml - take 0.5ml sublingual every 2 hours PRN for pain or shortness of breath. -Morphine was documented as administered on 06/08/20 at 12:11pm for behavioral issues and the medication was documented as administered by the MCM. Review of Resident #1's eMAR for August 2020 revealed: -There was an entry for morphine 100mg/5ml - take 0.5ml sublingual every 2 hours PRN for pain or shortness of breath. -Morphine was documented as administered on 08/17/20 at 11:42am for behavioral issues and the medication was documented as administered by a medication aide (MA).	D 358	Continued from page 28 Facility ED and/or MCM will pull/review Medication compliance reports daily to assure accuracy. Should medication error be noted facility MCM, ED and/or Medication Staff will immediately notify prescribing physician, complete medication error report, and notify ADO, DDCS. Facility ADO, DDCS and/or DDCS will pull and review Medication Compliance Reports weekly for one month, then randomly thereafter. Facility ED and/or MCM will review medication compliance reports, new admissions and/or re-admissions orders for residents daily during stand-up meetings. Facility ED, MCM and/or designee will assure medication carts audits are performed no less than weekly. ADO, DDCS and/or DVPO will review medication cart audits weekly for one month and then randomly thereafter during on-site visits. Facility MCM and ED have been in-serviced on the importance of clarification of orders, Bucket List system, medication cart audits and how to review/pull medication compliance reports. Training was conducted by DDCS RN and LHPS RN On 11.27.20 and 12.02.20 Facility medication staff have been trained on Medication Error, Documentation, Medication Storage, Bucket List system and Medication Cart audits. Training conducted by DDCS RN and LHPS RN	1/14/2021 1/14/2021 1/14/2021 1/14/2021 1/14/2021 ~~11/27/2020~~ and ~~12/2/2020~~ 12/2/2020	

Addendum per telephone conversation w Adm on 01.26.21 @ 5:45pm. NW

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 29 Review of Resident #1's eMAR for September 2020 revealed: -There was an entry for morphine 100mg/5ml - take 0.5ml by sublingual every 2 hours PRN for pain or shortness of breath. -Morphine was documented as administered on 09/03/20 at 5:18pm for behavioral issues and the medication was documented as administered by the same MA. -Morphine was documented as administered on 09/14/20 at 1:13pm for behavioral issues and the medication was documented as administered by the same MA. -Morphine was documented as administered on 09/27/20 at 7:42pm for behavioral issues and the medication was documented as administered by the same MA. Review of the facility's medication administration policy (no date) revealed: -The reason for a PRN medication to be administered is to be indicated in the resident's medication order. -Staff were to administer PRN medication when a resident needs the medication. Telephone interview with a pharmacist from the facility's pharmacy on 11/25/20 at 11:53am revealed: -Resident #1 had an order for morphine 100mg/5ml - administer 0.5ml every 2 hours PRN for pain or shortness of breath. -Morphine was a controlled substance that was used to treat pain and sometimes shortness of breath. -He was not sure how morphine could be used for behavioral issues unless it was being used for sedation.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 Telephone interview with a MA on 11/30/20 at 10:32am revealed: -She was the MA who administered morphine to Resident #1 in August 2020 and September 2020 because of behavioral issues. -Resident #1 "wandered and walked the halls of the SCU all day". -Resident #1 would tell the staff that she was tired, but the resident never stopped walking except briefly to eat her meals. -Resident #1 had another medication that staff used for agitation and Resident #1's morphine was supposed to be used for pain. -She sometimes administered morphine to Resident #1 to help the resident to calm down. -The MCM told her to use morphine to calm Resident #1 and she told the MCM that she did not feel comfortable administering morphine to Resident #1 when she last administered morphine to Resident #1 in September 2020. -She knew when she administered morphine to Resident #1 that it increased the resident's risk for falls because it caused Resident #1 to have some sedation. Telephone interview with the MCM on 11/30/20 at 1:36pm revealed: -She did not remember administering morphine to Resident #1 for behavioral issues. -She would be concerned about Resident #1 being administered morphine for behavioral issues because the resident walked a lot in the SCU. -If Resident #1 was given morphine for behavioral issues, it could cause sedation and cause Resident #1 to fall. -Morphine was a medication that was supposed to be used for pain and should not be used for behavioral issues.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31 Telephone interview with Resident #1's primary care provider (PCP) on 11/25/20 at 1:52pm revealed: -He expected for Resident #1's morphine to be used for pain as it was ordered. -Morphine should not be used for behavioral issues. -If staff were administering morphine to Resident #1 for behavioral issues, it could cause the resident to lose her balance or increase her risk for falls. Review of Resident #1's accident/incident reports from June 2020 to September 2020 revealed Resident #1 suffered 3 falls. Telephone interview with the MCM on 11/24/20 at 2:48pm revealed: -She "did not have a clue why staff would use morphine for behaviors" for Resident #1 until about a month ago. -The MAs were currently going through training to understand on what to do to deal with residents' behaviors. -The MAs should not give PRN medication to "put them out", it was against the residents' rights. -She knew the MAs were not giving the residents medication as indicated per the order about a month ago. -Staff had two trainings about medication administration during the previous week with the Director of Clinical Instruction to address problems with administration of PRN medications by staff. Telephone interview with the Director of Clinical Instruction on 11/30/20 at 12:45pm revealed: -She was last at the facility for training on 10/06/20 for medication administration. -She usually went to the facility about once a	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha069002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 32 quarter due to the pandemic for training with the staff. -No staff from the facility had contacted her regarding concerns or the need for additional training regarding problems about MAs administering PRN medications to the residents outside of their indicated use. -She did not know about any problems with the MAs administering PRN medications outside their indicated use at the facility. Telephone Interview with the Administrator on 11/25/20 at 3:26pm revealed: -She did not know the MAs were administering PRN medications for uses that were not ordered by the PCP. -She had only been working at the facility for two weeks and had not reviewed the residents' records yet. -She would be concerned if residents were administered PRN medications for outside of their prescribed use because "it could cause a bad reaction; it could cause the resident to fall or die". Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. 2. Review of Resident #6's current FL-2 dated 10/13/20 revealed: -Diagnoses included Alzheimer's disease and dementia, hypertension, osteoarthritis and displaced fracture left femur. -Resident #6's recommended level of care was Special Care Unit (SCU). Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 10/12/20.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 33 a. Review of Resident #6's physician orders dated 10/27/20 revealed there were medication orders for Fentanyl 50 mcg/hour one patch apply to skin as directed; rotate patch, remove old patch and apply new patch every 72 hours dated 10/27/20 (Fentanyl is a controlled substance used to relieve moderate to severe pain). Review of Resident #6's pharmacy dispensing records revealed Fentanyl mcg/hour one patch with a quantity of 10 patches dispensed (30-day supply) on 10/27/20. Review of Resident #6's electronic medication administration record (eMAR) for October 2020 revealed: -There was an entry for Fentanyl 50 mcg/hour remove old patch and apply one patch every 72 hours. -Fentanyl was documented as refused by the Memory Care Manager (MCM) on 10/26/20. Review of Resident #6's October 2020 controlled substance log labeled for Fentanyl 50 mcg/hour revealed: -There were 4 patches of Fentanyl 50 mcg/hour available for administration on 10/12/20. -There were 4 doses of Fentanyl 50 mcg/hour documented as administered from 10/14/20 through 10/23/20. -There was no documentation of Fentanyl mcg/hour was administered on 10/26/20. Telephone interview with a medication aide (MA) on 11/30/20 at 3:12pm revealed: -Resident #6 was supposed to receive the Fentanyl patch every three days. -She was responsible for weekly cart audits. -She informed the MCM that Resident #6 only had two Fentanyl patches left when she did a cart	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 34 audit on 10/20/20 or 10/21/20. -Resident #6 ran out of Fentanyl patches in October 2020 because she only had 4 Fentanyl patches which she brought with her upon admission on 10/12/2020. -The MCM was responsible for contacting the primary care provider (PCP) and requesting new prescriptions for controlled substances. Telephone interview with the MCM on 11/30/20 at 1:31pm revealed: -She had documented Resident #6 had refused the Fentanyl patch on 10/26/20 when the medication was not available, or the medication was not in the facility and documented the medication order had been sent to the pharmacy. -She did not know why she documented Resident #6 refused the medication when the medication was not available in the facility. -She should have documented the Fentanyl was unavailable for administration for Resident #6 on 10/26/20. -The lead MA and MAs were responsible for informing her when Fentanyl needed to be reordered. Telephone interview with Resident #6's PCP on 11/25/20 at 1:52pm revealed: -He did not know Resident #6 had missed a dose of the Fentanyl on 10/26/20 or she ran out of Fentanyl on 10/23/20. -He did not write the new prescription for Resident #6's Fentanyl until 10/28/20. -There was potential for Resident #6 to suffer withdrawal symptoms from missing a dose of her Fentanyl. Telephone interview with the current Administrator on 11/25/20 at 3:25pm revealed: -She did not know Resident #6 had missed any	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAI089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 84 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 358	Continued From page 35 dose of the medication due the medication not being in the facility on 10/26/20. -The MCM and the lead MA were responsible for cart audits weekly. -The MCM was responsible for notifying the PCP if the medication was not in the facility. -The MCM was responsible for getting a new prescription and a refill. Telephone interview with the previous Administrator on 11/24/20 at 10:22am revealed: -He was the Administrator when Resident #6 was admitted to the facility. -He lasted worked at the facility as the Administrator on 11/06/20. -He did not know Resident #6 had ran out of the Fentanyl and missed a dose of the medication. -He did not know the MCM had documented that Resident #6 had refused the medication when the medication was not in the facility on 10/26/20. -The MCM informed him the morning of 11/24/20 about her documentation of Fentanyl refusal for Resident #6. -The MCM was responsible for contacting the PCP and requesting refills for controlled substances. -He expected the MCM to contact the PCP and request a refill of the Fentanyl prior to Resident #6 running out of medication. -The MCM should not have documented Resident #6 refused the Fentanyl patch when the medication was not available in the facility. -The MCM should have contacted the PCP if the medication was not available and gotten a hold order for the medication on 10/26/20 until it was available. -He expected the MCM to request a refill for the Fentanyl patches when there were 3 patches in the facility.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 36 Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. b. Review of Resident #6's physician orders dated 10/27/20 revealed there were medication orders for Fentanyl 50 mcg/hour one patch apply to skin as directed; rotate patch, remove old patch and apply new patch every 72 hours dated 10/27/20 (Fentanyl is a controlled substance used to relieve moderate to severe pain). Review of Resident #6's pharmacy dispensing records revealed Fentanyl 50 mcg/hour one patch with a quantity of 10 patches dispensed (30-day supply) on 10/27/20. Review of Resident #6's electronic medication administration record (eMAR) for October 2020 revealed: -There was an entry for Fentanyl 50 mcg/hour remove old patch and apply one patch every 72 hours. -Fentanyl was documented as administered on 10/14/20, 10/17/20, 10/20/20, 10/23/20, 10/28/20, 10/29/20, 10/30/20, and 10/31/20. Review of Resident #6's control substance log for October 2020 revealed: -The directions documented on the control log were to administer Fentanyl once a day every 3 days. -One Fentanyl patch was documented as administered on 10/14/20 at 8:42am. -One Fentanyl patch was documented as administered on 10/17/20 at 8:48am. -One Fentanyl patch was documented as administered on 10/20/20 at 7:41am. -One Fentanyl patch was documented as administered on 10/23/20 at 7:52am.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha000002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 37 -One Fentanyl patch was documented as administered on 10/28/20 at 2:04pm. -One Fentanyl patch was documented as administered on 10/29/20 at 8:01am. -One Fentanyl patch was documented as administered on 10/30/20 at 7:55am. -One Fentanyl patch was documented as administered on 10/31/20 at 9:20am. Review of Resident #6's eMAR for 11/01/20 through 11/19/20 revealed: -There was an entry for Fentanyl 50 mcg/hour remove old patch and apply one patch every 72 hours. -Fentanyl patch was documented as administered on 11/01/20, 11/02/20, 11/03/20, and 11/05/20. Review of Resident #6's control substance log for 11/01/20 through 11/19/20 revealed: -One Fentanyl patch was documented as administered on 11/01/20 at 9:39pm. -One Fentanyl patch was documented as administered on 11/02/20 at 8:05am. -One Fentanyl patch was documented as administered on 11/03/20 at 7:48am. -One Fentanyl patch was documented as administered on 11/05/20 at 9:18am. Telephone interview with a medication aide (MA) on 11/30/20 at 10:32am revealed: -Resident #6 had received the Fentanyl patches on consecutive days. -She was informed by another MA on 10/29/20 that Resident #6 had been receiving daily doses of the Fentanyl. -She administered Resident #6's Fentanyl on 10/30/20, 11/05/20 and 11/23/20. -She did not pay attention to when the last Fentanyl patch was applied, so when the system said to apply the patch, she removed the old	D.358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27926		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38 patch and applied a new patch. -She informed the MCM when she found out (date not specified). -The MCM was supposed to fix the order in the system so that the Fentanyl would not show to be administered every day. Telephone Interview with second MA on 11/30/20 at 11:24am revealed: -She administered Resident #6's Fentanyl patch on 10/31/20 and 11/01/20. -She did not know Resident #6 had received Fentanyl doses on consecutive days. Telephone Interview with a third MA on 11/30/20 at 3:12pm revealed: -Resident #6 was supposed to receive the Fentanyl patch every three days. -Resident #6 received the Fentanyl patch daily. -She administered the Fentanyl patch on 10/29/20. -The MAs were supposed to date the Fentanyl patch when it was applied. -If the Fentanyl patch was not dated you do not know when the patch was applied. -The MCM informed her about the medication error around the end of October 2020. -The MCM was responsible for contacting the primary care provider (PCP) and requesting the controlled substances refills. Telephone Interview with a fourth MA on 11/30/20 at 4:44pm revealed: -Resident #6 was supposed to receive the Fentanyl patch every three days. -Resident #6 received the medication daily. -The system would show the medication was due to be administered daily and not every 3 days. -She did not administer the medication. -She informed the MCM each time she saw the	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 39 error. -The MCM always said she was going to fix the order error in the system. -The MCM was responsible for entering the orders into the computer system. Telephone interview with the MCM on 11/24/20 at 1:21pm revealed: -She was responsible for entering the orders into the system. -There was a medication error when Resident #6's Fentanyl order changed. -A new order was put in the system when the last patch was applied. -The new order was entered into the system incorrectly and resulted in a medication error for 10/29/30, 10/31/20 and 11/01/20. -Resident #6's Fentanyl patches should have been changed every 3 days. -Resident #6's Fentanyl patches should not have been administered on consecutive days. -On 11/06/20, she was informed by a MA that Resident #6's Fentanyl was showing on the eMAR to be administered daily instead of every 72 hours as ordered. -She tried to fix the order in the system, but she did not notify Resident #6's PCP. -She did not know the Fentanyl patches had been given on consecutive days prior to 11/06/20. Telephone interview with a pharmacist from the facility's pharmacy on 11/25/20 at 11:53am revealed: -Resident #6 had an order for Fentanyl 50 mcg/hour remove old patch and apply one patch every 72 hours. -Fentanyl was a controlled substance that was used to treat pain for up to 12 hours after removal.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 358	Continued From page 40 Telephone interview with Resident #6's PCP on 11/25/20 at 1:52pm revealed: -He expected for Resident #6's Fentanyl to be applied one patch every 72 hours and remove the old patch as it was ordered. -He did not know Resident #6 was administered consecutive doses of the Fentanyl in October 2020 and November 2020. Telephone interview with the previous Administrator on 11/24/20 at 10:22am revealed: -He was the Administrator when Resident #6 was admitted to the facility. -He expected the MAs to administer all medication as the indicated by the order. -He did not know Resident #6's Fentanyl patches had not been administered as ordered. -He did not know Resident #6 had received the Fentanyl patches on consecutive days in October 2020 and November 2020 until the MCM informed him the morning of 11/24/20. -The MCM was responsible for chart audits that should be completed at least monthly to ensure the accuracy of medication orders being entered into the eMAR system. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. The facility failed to administer medications as ordered for two residents (#1, #6) that resulted in staff inappropriately administering a PRN controlled substance used for pain to Resident #1, with a history of falls with injury, for behavioral issues; and staff administering consecutive daily doses of Fentanyl, a controlled substance, to Resident #6 that was ordered to be administered every three days and failing to administer at least 1 dose of Fentanyl due to the lack of available	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27026

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 41 doses in the facility. The facility's failure was detrimental to the health, safety and welfare of resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/30/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2021.	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 signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367	10A NCAC 13F .1004(j) Medication Administration Facility has implemented systems to assure medication administration records are accurate. Facility ADO, DDCS, ED and MCM have completed an audit of resident records, and medication administration records to assure accuracy and include all of the required information. Facility has reimplemented "Bucket List" system to assure accuracy of all medication orders prescribed by physician or licensed health professional. Facility ED and/or MCM will pull/review Medication compliance reports daily to assure accuracy Facility ADO, DDCS and/or DDCS will pull and review Medication Compliance Reports weekly for one month, then randomly thereafter.	1/14/2021 12/30/220 1/14/2021 1/14/2021 1/14/2021

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925		
(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	Continued From page 42 This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure the electronic Medication Administration Records (eMARs) were accurate for 1 of 5 sampled residents (#6) related to correctly entering, scheduling, and documenting administration of medications according to physician's orders. The findings are: Review of the facility's medication administration policy (no date) revealed staff were to verify that the medication dose was correct. Review of the facility's clinical standard operating procedure dated July 2020 revealed the standard of the facility was to ensure medication orders are processed and implemented based on physician/provider orders. Review of Resident #6's current FL-2 dated 10/13/20 revealed: -Diagnoses included Alzheimer's disease and dementia, hypertension, osteoarthritis and displaced fracture left femur. -Resident #6's recommended level of care was Special Care Unit (SCU). Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility	D 367	Continued from page 42 Facility MCM and ED have been in-serviced on the importance of clarification of orders, Bucket List system, medication cart audits, how to review/pull medication compliance reports, and the importance of assuring accuracy of EMAR Training was conducted by DDCS RN and LHPs RN Facility Medication Staff have been in-serviced/ trained on documentation, importance of assuring accuracy of medication records, notification of physicians and medication cart audits. Training conducted by DDCS, RN and LHPs RN <i>on 11.27.20 and 12.02.20</i>	11/27/2020 and 12/2/2020 <i>11/27/2020 and 12/2/2020</i>

Division of Health Service Regulation
STATE FORM

0000

N5WN11

If continuation sheet 43 of 78

Addendum per telephone conversation c Adm on 01.26.21 @ 5:45 pm AW

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAI039002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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	Continued From page 43 on 10/12/20. Review of Resident #6's physician orders dated 10/27/20 revealed there were medication orders for Fentanyl 50 MCG/hour one patch apply to skin as directed; rotate patch, remove old patch and apply new patch every 72 hours (Fentanyl is a controlled substance used to relieve moderate to severe pain). Review of Resident #6's pharmacy dispensing records revealed Fentanyl mcg/hour one patch with a quantity of 10 patches dispensed (30-day supply) on 10/27/20. Review of Resident #6's electronic medication administration records (eMAR) for October 2020 revealed: -There was an entry for Fentanyl 50 MCG/hour remove old patch and apply one patch every 72 hours. -Fentanyl was documented as administered on 10/14/20, 10/17/20, 10/20/20, 10/23/20, 10/26/20, 10/29/20, 10/30/20, and 10/31/20. -Fentanyl should have been administered only on 10/26/20 and 10/29/20. -Fentanyl was documented as refused by the Memory Care Manager on 10/26/20. Review of Resident #6's control substance log for October 2020 revealed: -Four Fentanyl patches were documented as received on 10/12/20 at 5:37pm. -One Fentanyl patch was documented as administered on 10/14/20 at 8:42am. -One Fentanyl patch was documented as administered on 10/17/20 at 8:48am. -One Fentanyl patch was documented as administered on 10/20/20 at 7:41am. -One Fentanyl patch was documented as	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925
---	--

(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	Continued From page 44 administered on 10/23/20 at 7:52am. -Ten Fentanyl patches were documented as received on 10/27/20 at 4:47pm. -Ten Fentanyl patches were documented as wasted on 10/28/20 at 1:39pm by the MCM. -Ten Fentanyl patches were documented as received on 10/28/20 at 1:38pm by the MCM. -One Fentanyl patch was documented as administered on 10/28/20 at 2:04pm. -One Fentanyl patch was documented as administered on 10/29/20 at 8:01am. -One Fentanyl patch was documented as administered on 10/30/20 at 7:55am. -One Fentanyl patch was documented as administered on 10/31/20 at 9:20am. -Resident #6 went without a Fentanyl patch from 10/26/20 through 10/28/20 at 1:39pm. Review of Resident #6's electronic medication administration records (eMAR) for 11/01/2020 through 11/19/20 revealed: -There was an entry for Fentanyl 50 MCG/hour remove old patch and apply one patch every 72 hours. -One Fentanyl patch was documented as administered on 11/01/20. -One Fentanyl patch was documented as administered on 11/02/20. -One Fentanyl patch was documented as administered on 11/03/20. -One Fentanyl patch was documented as administered on 11/05/20. -Fentanyl should have been administered only on 11/01/20 and 11/04/20. Review of Resident #6's control substance log for 11/01/20 through 11/19/20 revealed: -One Fentanyl patch was documented as administered on 11/01/20 at 9:39pm. -One Fentanyl patch was documented as	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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	Continued From page 45 administered on 11/02/20 at 8:05am. -One Fentanyl patch was documented as administered on 11/03/20 at 7:48am. -One Fentanyl patch was documented as administered on 11/05/20 at 9:18am. Telephone Interview with the Memory Care Manager (MCM) on 11/24/20 at 1:21pm revealed: -She was responsible for entering the orders into the system. -There was a medication error when the order changed. -A new order was put in the system when the last patch was applied. -The new order caused a medication error for 10/29/30, 10/31/20 and 11/01/20. -Resident #6's Fentanyl patches should have been changed every 3 days. -Resident #6's Fentanyl patches should not have given on consecutive days. -She was informed by a MA that the medication was showing on the eMAR to be administered daily instead of every 72 hours as ordered on 11/06/20. -She tried to fix the order in the system. -She did not know the Fentanyl patches had been given on consecutive days prior to 11/06/20. Telephone interview with the current Administrator on 11/25/20 at 3:25pm revealed: -She did not know Resident #6 had received 11 doses on consecutive days of Fentanyl. -She did not know Resident #6 had missed a dose of the medication due the medication not being in the facility on 10/26/20. -Refusal of the medication that was documented on 10/26/20 should not have been entered because the medication was not available in the facility, "that is false documentation". -The MCM was responsible for entering orders	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1088002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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	Continued From page 46 into the system. Telephone interview with the previous Administrator on 11/24/20 at 10:22am revealed: -He was the Administrator when Resident #6 was admitted to the facility. -He lasted worked at the facility as the Administrator on 11/06/20. -He expected the MAs to administer all medication as the indicated by the order. -He did not know Resident #6's Fentanyl patches had not been administered as ordered. -He did not know Resident #6 had received the Fentanyl patches on consecutive days in October 2020 and November 2020. -He did not know the MCM had documented that Resident #6 has refused the medication when the medication was not in the facility on 10/26/20. -The MCM informed him the morning of 11/24/20. -The MCM was responsible for accurately entering the orders into the system. -The MCM was responsible for contacting the PCP and requesting refills for narcotics. -He expected the MCM to not document Resident #6 had refused the Fentanyl patch when the medication was not available in the facility.	D 367		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.	D 378	10A NCAC 13F .1006(b) Medication Storage Facility has implemented actions to assure that medications are maintained in a safe manner under locked security when not under the immediate or direct physical supervision of staff who are in charge of medications administration.	1/14/2021

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
--	---	--	--

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925
---	--

(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 378	Continued From page 47 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were under locked security when two medications aides left a medication cart unlocked, in the special care unit (SCU). The findings are: Review of the facility's medication policy and procedure manual revealed all medications administered by facility staff would be securely stored in a locked cabinet/cart, inaccessible by residents. Observation of the SCU on 11/19/20 from 10:17am to 10:32am revealed: -At 10:17 am, there was a medication cart left unattended and unlocked behind the nurse's station with the nurse's station half door left unlatched and left open to hallway. -There were no staff in the hallway near or around the medication cart. -There was one resident in a wheelchair attempting to enter the nurse's station by self-propelling herself through the opened, unlatched half door. -At 10:23am, two personal care aides entered the nurse's station, did not lock the medication cart and walked back out of the unlatched nurses station door and did not close the half door behind them. -At 10:25am, another resident walked passed the nurse's station with the open half door and unlocked medication cart eight times.	D 378	continued from page 47 Facility ED, MCM and/or designee will make rounds throughout facility daily. During rounds all medication areas and/or carts will be checked to assure they are locked and secure. Facility ED and MCM will review daily rounds results during daily stand up. ADO, DDCS and/or DVPO will complete no less than 2 rounds of facility during on site visits to assure all medication areas and/or carts are locked and secured. Facility has implemented Medication Storage Audit tool/form. Medication Storage audit tool will be completed weekly by ED, MCM and/or designee. Medication Storage Audit forms will be reviewed in Daily Stand up Meetings no less than weekly. ADO, DDCS and/or DVPO will review Medication Storage audit tool/form during each site visit. Training/In-Service completed with all Medication staff on duty 11/19/2020. Training conducted by DDCS, RN All staff have received training on the importance of medication storage. Medication Staff received training on Medication Storage audit forms. Training conducted by LHPS RN	12/30/2020 12/30/2020 1/14/2021 1/14/2021 1/14/2021 1/14/2021 11/19/2020 12/2/2020

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 378	Continued From page 48 -At 10:32am, the SCU medication aide (MA) entered the nurse's station and walked passed the medication cart and upon exiting the nurse's station she pulled the controlled substance draw open and then locked the medication cart. -The MA exited the nurse's station and did not close the half door behind her. -The medication cart was left unlocked and unattended for approximately 15 minutes before the MA locked the medication cart. Observation of the SCU on 11/19/20 at 10:16am revealed the MA for the SCU was sitting in the dining room not with in view of the nurse's station or medication cart. Interview with a MA on 11/19/20 at 10:34am revealed: -She was the MA on the SCU and had passed medication that morning. -She did not know the medication cart was unlocked. -She did not know how long the medication cart had been left unlocked. -She was sitting in the dining room prior to entering the nurses' station and noticing the medication cart was unlocked. -She did not know why she had left the medication cart unlocked. -She last used the medication cart during her last morning medication pass at around 8:30 am. Second interview with a MA on 11/19/20 at 11:39am revealed: -She had worked at the facility as a MA for a year. -The medication cart was supposed to be locked at all times when it was not in sight of the MA. -When the medication cart was left unlocked the residents could have opened the medication cart and got a medication that could have "taken them	D 378			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925			
(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 378	Continued From page 49 out of here". -There were blood pressure medications, blood thinners, behavioral health medication, pain medication, including narcotic and prefilled syringes of morphine in the medication cart. -She had not noticed she had left the medication cart unlocked and unattended behind the nurse's station with the half door to the nurses' station left open. -"It was a careless mistake" to walk away from the medication cart and not lock it. -She knew there were residents that walked the hallway back and forth all day that could have opened the medication cart. -The medication cart was stored behind the nurses' station with the half door to the nurses' station closed to keep the residents from taking things from the medication cart. -There was a resident that would take spoons and cups off the medication cart. -The nurses station half door was supposed to be kept closed at all times. -There were residents that would enter the nurses' station and mess with things if the half door was left open. -She was last trained on medication storage last month by the facility's nurse. Interview with the Memory Care Manager (MCM) on 11/19/20 at 11:23am revealed: -The medication carts should be locked at all times when not supervised by the MAs. -If a MA could not see the cart, the medication cart should be locked. -There were at least 2 confused residents that wandered up and down the hallways. -One of the confused resident's that was a known wander would take cups and spoons off the medication cart and put them under her shirt. -The other confused resident that wandered	D 378			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 378	Continued From page 50 would grab whatever she saw at the moment from the medication cart. -She expected the MA to lock the medication cart when not in use. -She expected the nurses' station half door to remain closed at all times to prevent the wandering residents from entering the nurses' station. -The MAs had received training on securing the medication cart when training for the MA position and annually. Interview with the current Administrator on 11/19/20 at 12:37pm revealed: -The medication carts should be locked at all times when not supervised by the MAs. -There were confused residents that wandered up and down the hallways in the SCU. -One of the confused residents that wandered would grab whatever she saw from the medication cart. -She expected the MA to lock the medication cart when not in use. -She expected the nurses' station half door to remain closed at all times to prevent the wandering residents from entering the nurses' station. -The MAs had been trained how to properly secure the medication carts. -She had spoken to the same MA before (time unspecified) about leaving the medication cart unlocked in the SCU. The facility failed to ensure medications were maintained under locked security or under direct supervision of staff in charge of medication administration by leaving a medication cart unlocked and unattended on the SCU for approximately 15 minutes with wandering and confused residents with one of the residents	D 378			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 378	Continued From page 51 attempting to access the medication cart. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection on 11/19/20 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2021.	D 378			
D 801	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 801	10A NCAC 13F .1801(a)(b) Infection Prevention and Control Program Facility has procedures in place to assure Infection Control policies and procedures are in place. Staff member who screened herself was immediately counseled regarding proper screening process for COVID-19. On 11/20/2020, all staff present were re-in-serviced regarding COVID-19 and Infection Prevention and Control Program. The Executive Director and Care Managers will provide the training. The community will ensure all employees are screened upon entry into the community for signs and symptoms of COVID-19 (e.g., temperature checks and symptom questions) using the electronic Coronavirus Visitor Screening tool during an	12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/30/2020	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal088002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 601	Continued From page 54 Observation of the facility's personal protective equipment (PPE) on hand on 11/18/20 at 12:09pm revealed: -There were 7 boxes and 6 cases of vinyl exam gloves. -There were 15 boxes of face mask. -There were 3 cases of disposable gowns. -There were one and a half cases of face shields. -There were 70 KN95 mask. 1. Review of Resident #6's current FL-2 dated 10/13/20 revealed: -Diagnoses included Alzheimer's disease and dementia, hypertension, osteoarthritis and displaced fracture left femur. -Resident #6's recommended level of care was Special Care Unit (SCU). Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 10/12/20. Review of Resident #6's hospital discharge dated 11/19/20 revealed Resident #6 was seen at the emergency room (ER) on 11/19/20. Review of Resident #6's progress notes revealed: -On 11/19/20 at 3:10pm, the Memory Care Manager (MCM) documented Resident #6 was transported by emergency management services (EMS) to the local hospital. -On 11/19/20 at 11:17pm, Resident #6 had returned from the hospital and was placed in her room. Observation of the SCU on 11/20/20 at 2:10pm through 2:12pm revealed: -Resident #6 was in her semi-private room with no mask on with the room door and the suit door	D 601	Noncompliance with social distancing and mask wearing will be reviewed daily during standup, weekly during at Risk and Monthly during QA. The ED, RCC and MCD are present during these meetings. RCC and MCD are responsible for physician and family notification of non-compliance with facility policy in their respective areas, and the ED is responsible for day to day compliance. Residents/staff identified not to be compliant with infection control regulation and facility policy and procedures will be re-educated on policy by their respective care managers and/or the Executive Directors. The Care Managers/Executive Directors are responsible for notifying families and physicians of non-compliance with infection control. Documentation of notifications will be made on Infection Control Event Report. Care plans will be updated as needed. Signs and symptoms of Coronavirus that develop in any caregiver during a working shift shall be reported by the caregiver to their immediate supervisor as soon as possible. The caregiver's supervisor requests the caregiver to go home and then reports the event to the Executive Director.	12/30/2020	12/30/2020

Division of Health Service Regulation

PRINTED: 12/21/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 980 HWY 64 EAST COLUMBIA, NC 27925			
(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 801	Continued From page 55 open. -Resident #6's suite mate was in their room with room door half way opened. -Resident #6 was in her semi-private room with no mask on. -The MCM entered Resident #6's room with a mask on and no face shield, no gloves, no gown and was talking to the resident standing less than four feet apart. -The MCM did not wash her hands nor did she use hand sanitizer to clean her hands after she exited Resident #6's room. -The MCM did not close Resident #6's room door nor the suite door when exited. -The MCM left Resident #6's room and walked down the hallway talk to staff. Observation on the SCU on 11/20/20 at 2:14pm revealed: -The MCM entered Resident #6's room with a mask on and no face shield, no gloves and no gown. -The MCM did not wash her hands nor did she use hand sanitizer to clean her hands after exiting Resident #6's room. -The MCM did not close Resident #6's room door nor the suite door when she exited. -The MCM left Resident #6's room and walked down the hallway to her office. Observation on the SCU on 11/20/20 at 2:14pm revealed: -There were three staff that entered Resident #6's room. -The three staff wore a mask, a face shield and gloves. -The three staff did not wear gowns. Observation on the SCU on 11/20/20 at 2:20pm to 2:42pm revealed:	D 801	All staff at the Community were advised that a caregiver with Coronavirus symptoms has been identified, and they are to be asked to report any Coronavirus signs and symptoms that they might develop to their immediate supervisor as soon as possible and not to come to work until the symptoms resolve. Staff with Coronavirus diagnosis will be excluded from work for 10 days and at least 24 hours after they are no longer symptomatic and no longer have a fever (off fever reducing medications). The Executive Director is responsible for assuring compliance with Infection Control Policy. (Ongoing)	12/30/2020	12/30/2020

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	---	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST

COLUMBIA, NC 27925

(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 601	Continued From page 56 -There were three staff that entered Resident #6's room, a personal care aide (PCA), a medication aide (MA) and a housekeeper. -There was a resident in a wheelchair that entered Resident #6's room behind the staff with no mask on and was removed by staff. -The PCA wore a mask and face shield, no gloves and no gown. -The MA wore a mask and face shield, no gloves and no gown. -The housekeeper wore a mask, gloves and face shield and no gown. -The MA washed her hands after she exited Resident #6's room. -The housekeeper removed her gloves but did not wash her hands nor hand sanitize after she exited Resident #6's room. -The housekeeper entered another resident's room. -The PCA, who did not wear her gloves did not wash her hands nor hand sanitize after she exited Resident #6's room. -The PCA walked down the hallway entered the passcode to the SCU door and exited the SCU to the assisted living unit (AL). Observation on the SCU on 11/20/20 at 4:50pm to 5:02pm revealed: -There were two PCAs and a MA that entered Resident #6's room with mask, gloves and face shield on, no gown. -The three staff did not remove PPE, did not wash their hands not use hand sanitizer upon exiting Resident #6's room. -One of the staff rolled Resident #6 in her wheelchair out of her room, down the hallway, through the TV room and into the dining room for dinner. -The staff then assisted Resident #6 out of her wheelchair and into a chair in the TV room to wait	D 601		

Division of Health Service Regulation

STATE FORM

0000

NSWN11

If continuation sheet 57 of 70

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 601	Continued From page 57 until dinner was brought to the dining room. -Resident #6 was less than two feet away from staff and less than three feet away from 2 other residents. -Staff did not encourage or redirect the residents including Resident #6 to put on a mask nor to social distance. Based on observations, interviews, and record reviews it was determined Resident #6 was not interviewable. Telephone interview with Resident #6's family member on 11/23/20 at 1:09pm revealed: -Resident #6 was admitted to the facility on 10/12/20. -She requested that Resident #6 be sent to the ER on 11/19/20. -The facility notified her late on 11/20/20 that the resident was going to be placed in quarantine and could not leave her room. -The facility had never told her anything about Resident #6 having to be put in quarantine. -Resident #6 had never been in quarantine before even when she was admitted. -If she had known Resident #6 was going to be quarantined, she would not have requested to send the resident to the ER. -Resident #6 did not get a COVID-19 test before returning to the facility on 11/19/20. -Resident #6 was not put in quarantine when she was admitted to the facility on 10/12/20. Interview with a MA on 11/20/20 at 2:16pm revealed Resident #6 was in her semi-private room with her roommate. Interview with a PCA on 11/20/20 at 2:17pm revealed: -She worked with Resident #6 that morning.	D 601		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27926
---	--

(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 601	Continued From page 58 -She performed activities of daily living (ADLs) this morning. -She dressed Resident #6 this morning. -She helped Resident #6 put her dentures her mouth this morning. -She had taken Resident #6 to the dining room for breakfast this morning -No one at the facility had informed her Resident #6 was supposed to be on COVID-19 quarantine. Interview with a housekeeper on 11/20/20 at 2:36pm revealed: -She had entered Resident #6's suite several times today including to clean. -She wore her mask, face shield and gloves on. -She did not wear a gown. -She did not know Resident #6 had been out of the facility and had returned. -No one at the facility had told her about Resident #6 being on any kind of COVID-19 quarantine or precautions. Interview with a PCA on 11/20/20 at 2:42pm revealed: -She worked as a PCA on the SCU. -Residents that left the facility had to quarantine for 7 days when they returned to the facility. -Currently there were no residents in the facility on COVID-19 quarantine. Interview with a MA on 11/20/20 at 2:43pm revealed: -Resident #6 returned from the ER on 11/19/20 around 6:30pm. -She had given Resident #6 medications in her room today. -She had assisted Resident #6 to the bathroom today and applied cream to her bottom. -She wore her mask, face shield and gloves each time she had to enter Resident #6's room to help	D 601		

Division of Health Service Regulation

PRINTED: 12/21/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 960 HWY 64 EAST COLUMBIA, NC 27925			
(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 801	Continued From page 59 her. -She did not wear a gown while performing the task because no one had told her she needed to wear a gown. Confidential Interview with a staff revealed: -They knew from working at another job that staff was supposed to wear full PPE including gloves, gowns, mask and face shield when staff entered Resident #6's room because she had returned from the ER. -They knew from working at another job that Resident #6 was supposed to be on COVID-19 quarantine for 14 days and placed in a private room. -They knew that a PPE station was supposed to be set up outside of Resident #6's room so that staff could apply the proper PPE before they entered the room, along with a trash container inside the resident's room to put the gowns and PPE in prior to exiting the resident's room. -The facility did not tell the staff what to do when a resident was on COVID-19 quarantine. -The MCM only told staff to monitor and administer medications to Resident #6 today. -The MCM had not informed the staff Resident #6 was supposed to be on COVID-19 quarantine. -The ER had not informed staff Resident #6 was supposed to be on COVID-19 quarantine. -They did not know why the facility did not use COVID-19 precautions when the residents returned to the facility or for new admissions. -The previous Administrator nor the current Administrator nor the MCM had given any instruction or training related to COVID-19 precautions. -They were not aware of any residents on the SCU or the AL unit ever being on and kind of quarantine for COVID-19 precaution.	D 801			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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)	(X6) COMPLETE DATE	
D 601	Continued From page 60 Interview with a second PCA on 11/20/20 at 4:51pm revealed: -She worked on the SCU as a PCA. -She did not know what to do with a resident that had returned from outside the facility related to COVID-19 quarantine. -No one at the facility had told her what to do related to quarantine and isolating the residents. -No one at the facility told her Resident #8 was supposed to be in quarantine. -She worked with Resident #6 and wore a mask and a face shield only. Confidential interview with a third staff revealed: -The facility did not quarantine any of the residents when they returned to the facility or if they were a new admission. -The staff just started wearing PPE (gowns, mask and face shields) for Resident #6 since the state left the facility. -Resident #6 was the only resident that staff had ever used full PPE for. Confidential interview with a fourth staff revealed: -The facility did not implement any COVID-19 precautions, no COVID-19 quarantine for any of the residents that entered the facility. -There were new admissions and residents that left the facility and returned recently on both the SCU and the AL unit that were not put on any kind of COVID-19 quarantine or precautions. -Staff did not have to use any other PPE other than the face shields and mask. -The facility had not provided any COVID-19 training related to COVID-19 quarantine. -Management had never told staff to place Resident #6 on COVID-19 quarantine. -Management had only told staff to wear a mask and face shield when caring for Resident #6. -Two other residents were sent to the ER and	D 601			

Division of Health Service Regulation

STATE FORM

0099

NSWN11

If continuation sheet 61 of 78

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27928			
(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 601	Continued From page 61 were not put on any kind of quarantine upon returning to the facility. -They had never witnessed any residents at the facility placed on any kind of quarantine. Interview with a third PCA on 11/20/20 at 4:52pm revealed: -She worked on the SCU and the assisted living unit (AL) as a PCA. -She worked on the SCU the night of 11/19/20, when Resident #6 returned from the ER. -She did not know Resident #6 was supposed to be in quarantine. -No one at the facility had told her about isolating residents for COVID-19 precautions. -The MCM and the MA had told staff to wear a mask, a face shield and gloves. -She had never used a gown while at the facility for any reason. -No one at the facility had ever told the staff they had to wear gowns for any reason. -None of the residents on the SCU or the AL side had ever been on quarantine. -Resident #6 was admitted about 3 weeks ago and she was not put on any kind of quarantine. Interview with the MCM on 11/20/20 at 2:53pm revealed: -Resident #6 was discharged from the ER on 11/19/20 around 6:30 pm and returned to the facility around 7:00pm -7:30pm. -She did not know if the facility had a policy for COVID-19 quarantine. -She had not seen any documentation or COVID-19 quarantine policy for the facility. -The staff tried to keep the residents in their room and out of other residents' rooms. -She expected staff to wear proper PPE which was gloves, mask and face shields. -She did not know if the staff needed to wear	D 601			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27926

(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 601	Continued From page 62 gowns when entering a COVID-19 quarantine room. -The current Administrator had not told her Resident #6 needed to be on COVID-19 quarantine upon returning to the facility on 11/19/20. Telephone interview with the county health department communicable disease nurse on 11/24/20 at 9:51am revealed: -She had not provided any guidance to the facility regarding quarantine for residents following emergency room visits or hospitalizations. -The facility was not on the contact list to provide receive from the health department. -The facility should follow the guidelines provided by the CDC and NC DHHS. Interview with the current Administrator on 11/20/20 at 11:44am revealed: -Resident #6 had been sent out to the ER on 11/19/20. -Resident #6 returned to the facility from the ER on 11/19/20. -She did not know if Resident #6 had been placed on COVID-19 quarantine. -She did not know if Resident #6 was put on COVID-19 quarantine when she returned to the facility from the ER on 11/19/20. -She had not received any direction or training from Corporate related to COVID-19 precautions for new admissions or residents returning to the facility. -She did not know if new admissions or if returning residents needed to be quarantined as a COVID-19 precaution. -The facility did not have any policies related to COVID-19 precautions for new admission or residents returning to the facility that she was aware of.	D 601		

Division of Health Service Regulation

PRINTED: 12/21/2020
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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 601	Continued From page 63 -She expected returning residents to be in quarantine for at least three days upon entering the facility. -She expected new admissions to be quarantined for fourteen days upon entering the facility. -She had not heard anything from corporate about the COVID-19 precautions, but she expected the residents returning to the facility to be quarantined and kept separate from other residents for three days. -She expected staff to wear proper personal protective equipment (PPE) including gowns, mask, face shield and gloves when entering Resident #6's room. -If Resident #6 was on COVID-19 quarantine she would be in a private room, she would have to eat in her room, and staff would have to use proper PPE which when entering Resident #6's room for any reason. -She or the MCM were responsible for informing the staff to quarantine Resident #6 as a COVID precaution upon Resident #6's return to the facility on 11/19/20. -She nor the MCM had informed the staff to place Resident #6 on COVID-19 quarantine from her 11/19/20 ER visit. -If Resident #6 had COVID-19 and not immediately put on COVID-19 quarantine upon returning to the facility, the COVID-19 could spread to the other residents and to the staff. 2. A personal care aide (PCA) was observed on 11/18/20 at 10:10am on the assisted living unit walking down the hallway towards the Administrator's office with her mask under her chin. Observation of the special care unit (SCU) dining area on 11/19/20 at 10:16am revealed there was a medication aide (MA) sitting at a table with her	D 601		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal088002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 801	Continued From page 64 mask under her chin singing to three residents located approximately 5 feet away. Telephone interview with the MA (observed in the SCU dining room on 11/19/20) on 11/30/20 at 4:46pm revealed: -She really did not remember the observation on 11/19/20 while wearing her mask under her chin. -If she was wearing her mask under her chin then she was probably eating or talking during the observation. -Her mask was under her chin because she was sitting away from the residents and sometimes, she pulled her mask under chin at work because she "had to get some fresh air". A PCA was observed on 11/19/20 at 1:15pm on the assisted living unit walking up the hallway with her mask under her chin. Confidential interview with a staff revealed: -Staff were supposed to wear a mask as soon as they entered the building and the entire time that they were in the building whether they were working with the residents or not. -There were some staff that did not wear their masks at all. Confidential interview with a second staff revealed: -Staff wore their masks under their chins. -The issues with staff not wearing their masks properly had been reported to management. -The management at the facility told the staff to wear their mask appropriately and some staff had been written up; but staff continued to not wear their masks appropriately over their mouths and noses. Telephone interview with the county health	D 801		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 601	Continued From page 65 department communicable disease nurse on 11/24/20 at 9:51am revealed: -All staff should wear masks while working at the facility, practice social distancing, and avoid contact greater than fifteen minutes. -She had not provided any guidance to the facility regarding staff wearing masks because the facility was not on the contact list to receive guidance from the health department. -The facility should follow the guidelines provided by the CDC and NC DHHS. Telephone interview with a community partner on 11/26/20 at 2:05pm revealed: -There was a problem at the facility with the PCAs and MAs wearing their masks below their noses and under their chins when working at the facility. -There was no enforcement of the care staff to wear their masks appropriately at the facility by management. -The front office staff wore their masks appropriately over their noses and mouths, but there was it was not emphasized for the PCAs and MAs to wear their masks appropriately. Interview with the previous Administrator on 11/20/20 at 11:01am revealed: -He last worked as the Administrator at the facility on 11/06/20. -He always expected all staff to wear a mask and to follow the proper guidelines while in the facility to protect the health of the residents. Interview with the current Administrator on 11/20/20 at 11:44am revealed her first day as the Administrator at the facility was 11/09/20 and she always expected all staff to wear their masks when they are working at the facility.	D 601		

Division of Health Service Regulation

STATE FORM

6808

N5WN11

If continuation sheet 66 of 76

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1009002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925
---	--

(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 601	Continued From page 66 3. Interview with the current Administrator on 11/18/20 at 10:00am revealed: -There were no COVID-19 positive residents at the facility. -There were no COVID-19 positive staff at the facility. Review of the facility's COVID-19 infection control training meeting sign-in sheet dated 10/22/20 compared with the facility's COVID-19 Screening Log revealed, there were 20 out of 37 staff who signed in for the COVID-19 training with no documentation of COVID-19 screenings. Interview with the previous Administrator on 11/20/20 at 11:01am revealed: -He presided over the staff's COVID-19 training on 10/22/20. -He thought all staff had been screened for COVID-19 prior to coming into the facility for the training. -It was his expectation that all staff and visitors be screened for COVID-19 prior to being allowed entrance to the facility whether for work or for training. -He did not know that some staff did not screen for COVID-19 and still entered the facility for the training on 10/22/20. -Staff were supposed to be screened by the lead MA, Business Office Manager, or another staff member when they entered the facility. Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 10/23/20 on the 11:00pm to 7:00am shift, there were 2 out of 4 staff clocked in for duty with no documentation of COVID-19 screenings.	D 601		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 601	Continued From page 67 Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 10/24/20, there were 7 out of 19 staff clocked in for duty with no documentation of COVID-19 screenings. Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 10/25/20, there were 6 out of 10 staff clocked in for duty with no documentation of COVID-19 screenings. Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 10/30/20 from 7:00pm to 11:00pm, there was 1 staff who clocked in at 7:00pm but there was no documentation of a COVID-19 screening for this staff member until 9:29pm per the facility's screening log. Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 10/30/20 on the 11:00pm to 7:00 shift, there was 1 of 4 staff clocked in for duty with no documentation of a COVID-19 screening. Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 10/31/20, there were 5 out of 13 staff clocked in for duty with no documentation of COVID-19 screenings. Review of the facility's time card report for facility staff compared with the facility's COVID-19 Screening Log revealed on 11/01/20, there were 5 out of 13 staff clocked in for duty with no documentation of COVID-19 screenings.	D 601			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 601	Continued From page 68 Observation and review of staff who worked on 11/18/20 during the 7:00am to 7:00pm shift compared with the facility's COVID-19 Screening Log revealed there were 3 out of 9 staff worked with no documentation of COVID-19 screenings. Telephone interview with the county health department communicable disease nurse on 11/24/20 at 9:51am revealed: -Most facilities had COVID-19 screenings in place for all staff and visitors for entrance in their facilities. -She had not provided any guidance to the facility regarding COVID-19 entrance screenings because the facility was not on the contact list to receive guidance from the health department. -The facility should follow the guidelines provided by the CDC and NC DHHS. Interview with a medication aide (MA) on 11/19/20 at 3:32pm revealed: -All staff was supposed to screen every time they entered the building. -Staff was supposed to rescreen when they left for lunch and returned to the building. Telephone interview with a MA on 11/30/20 at 11:24am revealed: -Staff were supposed to screen for COVID-19 every time they entered the facility. -She worked at the facility on 10/25/20, 10/31/20, and 11/01/20. -She reported to work late 11/01/20 and she took her temperature, but she forgot to get someone else to log in her COVID-19 screening in the electronic device after she got to work. -Staff screenings were supposed to be completed by the lead medication aide (MA), the Business Office Manager (BOM), or the Administrator. -Staff were not supposed to screen themselves	D 601			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAI089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 84 EAST COLUMBIA, NC 27925			
(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 601	Continued From page 69 for COVID-19, but sometimes she screened herself. -She did not know what happened to her COVID-19 screenings for 10/25/20 and 10/31/20. Confidential interview with a staff revealed: -Staff were supposed to screen by another staff member for COVID-19 symptoms and have their temperature checked before clocking in for work and documented their results electronically. -Sometimes staff did not perform the COVID-19 screenings because the electronic device did not work, or the Internet was not working. -There was no alternate system in place if the electronic device did not work, so the employees did not do the COVID-19 screenings when the device did not work. -Staff would take only take their temperature and not do the screening questions when the electronic device did not work because there was no paper form for the screenings. Telephone interview with the Memory Care Manager (MCM) on 11/30/20 at 1:35pm revealed: -Staff were supposed to be screened for COVID-19 when they first arrived for their shift at the facility using the electronic device to document their screenings. -If staff did not screen for COVID-19 when they reported to work, it was because the staff chose to walk passed the electronic device and not do the screenings. -Staff were not allowed to do their own COVID-19 screenings. -She could not explain why she did not have a COVID-19 screening for 10/30/20 when comparing her timesheet against the facility's COVID-19 screening logs. Interview with the previous Administrator on	D 601			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27926			
(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 601	Continued From page 70 11/20/20 at 11:01am revealed: -He last worked as the Administrator at the facility on 11/06/20. -Training was provided on screening staff and visitors for COVID-19 upon entrance to the facility on 06/22/20 and 10/22/20. -He expected staff and visitors to be screened as soon as they arrived at the facility. -He expected staff to screen when they returned to the facility after they left for their lunch breaks. -Staff did their COVID-19 screenings electronically prior to the start of their shift. -Staff were not supposed to do their own COVID-19 screenings. -The BOM, Administrator, or the lead MA did the COVID-19 screenings when for staff and visitors when they entered the facility. -Staff's COVID-19 screenings were compiled and reviewed by their corporate office. -No one at the facility reviewed the staff COVID-19 screenings to ensure all staff who were working were screened for COVID-19 prior to the start of their shift. Interview with the current Administrator on 11/20/20 at 11:44am revealed: -All staff had been trained to perform the COVID-19 screening for visitors and staff by the previous Administrator (date not specified). -She expected all visitors and staff to be screened for COVID-19 upon entry to the facility. -She expected staff to screen when they returned to the facility from lunch breaks if the left the facility. -She expected staff to do the COVID-19 screening upon each entry to the facility whether staff was on the schedule to work or not which including trainings and visitations at the facility. -Their corporate office was responsible for ensuring staff screened for COVID-19 when	D 601			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1009002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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 601	Continued From page 71 entering the facility by ensuring the schedule and the screening matched and she would be alerted by the corporate office. -She was not sure how soon the corporate office would alert her if staff failed to screen for COVID-19 prior to working at the facility. -She did not know how she would be notified by corporate if staff who were not scheduled to work, failed to screen for COVID-19 prior to the start of their shift. Telephone interview with the current Administrator on 11/30/20 at 2:05pm revealed: -The timesheets provided for review represents the staff who worked in facility and these staff should have been screened for COVID-19 prior to the start of their work shift. -Staff were not allowed to do their own COVID-19 screenings. -COVID-19 screenings should be observed and documented by another staff member on the electronic device. -If the electronic device was not working, staff should document their COVID-19 screenings on the paper response forms that were kept by the electronic device. -She had reinforced to the staff on 11/27/20 about the need to ensure all staff completed their COVID-19 screenings upon entrance to the facility. -If the internet was not working, then staff may not be completing their COVID-19 screenings electronically, but they should be completing the paper screenings for COVID-19. -The BOM kept the copies of the paper screenings for COVID-19. Telephone interview with the BOM on 11/30/20 at 3:06pm revealed she was not able to locate any paper COVID-19 screenings for staff.	D 601		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
---	--	--	---

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TYRRELL HOUSE

950 HWY 64 EAST
COLUMBIA, NC 27925

(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)	(X6) COMPLETE DATE
D 601	Continued From page 72 4. Observation of the nurse's station on the assisted living unit on 11/18/20 at 10:08am revealed: -There was a resident in a wheelchair, who was not wearing a mask, who rolled down past the nurse's station where three staff were standing wearing mask. -There was another resident at the nurse's station using the telephone with his mask under his chin. -There was less than six feet distance between the resident without a mask, the resident with his mask under his chin and the 3 staff at the nurse's station. -None of the three staff at the nurse's station reminded either resident about correct mask usage or social distancing. Observation of the Special Care Unit (SCU) on 11/18/20 at 11:15am revealed: -There were two residents standing in another resident's room. -The three residents were not wearing masks and were standing less than two feet apart. Observation of the SCU dining room on 11/19/20 from 10:16am to 10:31am revealed there were three residents, who were not wearing masks, sitting together at a table less than two feet apart and the residents were singing. Telephone interview with the medication aide (MA) (observed with the residents in the SCU dining room on 11/19/20) on 11/30/20 at 4:46pm revealed: -She knew the residents at the table were not wearing masks and they were supposed to be sitting at least 6 feet apart. -Residents were supposed to wear masks, but it was hard to get the residents in the SCU to keep	D 601		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 980 HWY 64 EAST COLUMBIA, NC 27825		
(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 601	Continued From page 73 on a mask. -She did not encourage the residents to at least practice social distance even when they did not wear their masks because it was hard to explain about mask wearing and social distancing to the residents. -She should have separated the residents at individual tables in the dining room. Observation of the SCU on 11/18/20 at 11:48am revealed a male resident, who was not wearing a mask, entered a female resident's room who had an uncovered meal tray. Telephone interview with the county health department communicable disease nurse on 11/24/20 at 9:51am revealed: -All residents should wear masks and practice social distancing of at least six feet apart. -She had not provided any guidance to the facility regarding residents wearing masks because the facility was not on the contact list to receive guidance from the health department. -The facility should follow the guidelines provided by the CDC and NC DHHS. Interview with a personal care aide (PCA) on the SCU on 11/18/20 at 11:30am revealed: -The residents were supposed to wear masks because of the pandemic. -She tried to redirect residents to wear their masks and encouraged the residents to social distance by staying six feet apart. -Social distancing was difficult to maintain with the residents in the SCU because they did not understand. Telephone interview with a MA on 11/30/20 at 10:32am revealed: -Residents were supposed to wear masks when	D 601		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: #H1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 601	Continued From page 74 they were outside of their rooms. -Staff encouraged the residents to wear their masks and to social distance, but most of the residents at the facility did not understanding the precautions that needed to be taken because of the pandemic. Interview with the current Administrator on 11/20/20 at 11:44am revealed it was her expectation that all residents wear masks when they were outside of their rooms and staff should remind the residents to wear their masks and to social distance. The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic and to encourage residents to wear masks and ensure social distancing, failed to quarantine a resident (#6) who returned to the facility from an emergency room visit with COVID-19 status unknown, failed to ensure staff wore masks appropriately covering their noses and mouths, and failed to ensure staff were screened for signs and symptoms of COVID-19 prior to entrance to the facility. The facility's failure to practice infection control measures to reduce the risk of transmission and infection from COVID-19 resulted in substantial risk of serious physical harm and neglect to the residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/20/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER	D 601			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Hal089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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 601	Continued From page 75 30, 2020.	D 601			
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related medication administration, medication storage, and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#1, #6) including one resident with a history of falls with injuries receiving inappropriate administration of an as needed (PRN) controlled substance used for pain management for behavioral issues for one resident (#1) and a second resident who missed at least one dose of a Fentanyl patch and had her Fentanyl patch administered more frequently than ordered (#6) [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].	D912	GS 131D-21(2) Declaration of Resident Rights Facility has implemented systems, procedures and processes to assure residents receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. Facility has implemented Daily Stand-Up Meeting, Weekly At Risk Meetings and Monthly QA meetings. Meetings will include all facility Management staff and outside providers when available. Resident personal care needs, all falls, changes in residents conditions, resident appointments, any compliance concerns with Medication administration and/or any needed follow-up on routine/acute care needs are discussed during these meetings. Facility has reimplemented "Bucket List" system to assure timely and proper follow-up on any written procedures, treatments, or orders prescribed by physician or licensed health professional. Facility ADO, DDCS, ED and MCM have completed an audit of resident records, medication administration records, and medication carts. Facility has contacted licensed prescribing practitioner of any missed or inappropriate medication administration.	1/14/2021 12/30/2020 1/14/2021 12/30/2020	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: Ha1089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925		
(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
D912	Continued From page 76 2. Based on observations, interviews, and record reviews, the facility failed to ensure medications were under locked security when two medications aides left a medication cart unlocked, in the special care unit (SCU) [Refer to Tag D378 10A NCAC 13F .1006(b) Medication Storage (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to ensure the implementation of physician's orders for 1 of 5 sampled residents related to a resident (#6) who had diarrhea and was ordered (#6) for obtaining a stool specimen for a lab as ordered on 4 separate occasions [Refer to Tag D278 10A NCAC 13F .0902(c) Health Care (Type B Violation)].	D912	Continued from page 76 Facility ED and/or MCM will pull/review Medication compliance reports daily to assure accuracy. Should medication error be noted facility MCM, ED and/or Medication Staff will immediately notify prescribing physician, complete medication error report, and notify ADO, DDCS. All staff have received training on resident rights and dignity. Training conducted by DVPO/NCALA,CDP Facility has requested first available resident rights training from Osbudman	1/14/2021 12/2/2020 1/14/2021
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on Interviews and record reviews, the facility failed to ensure residents were free neglect as related related to supervision and infection prevention and control. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and	D914	GS 131D-21 (4) Declaration of Residents' Rights Facility has implemented systems, procedures and processes to assure residents receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. Facility has implemented Daily Stand-Up Meeting, Weekly At Risk Meetings and Monthly QA meetings. Meetings will include all facility Management staff and outside providers when available. Residents assessed as Fall Risk or At Risk are discussed during daily stand up and/or weekly At Risk meetings Minutes for meetings are kept in binder in ED office. Facility Area Director of Operations (ADO) Divisional Director of Clinical Services (DDCS) and/or Divisional VP of Operations (DVPO) will review minutes from meetings during on site visits.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAI089002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 11/30/2020
NAME OF PROVIDER OR SUPPLIER TYRRELL HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 HWY 64 EAST COLUMBIA, NC 27925			
(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	
D914	Continued From page 77 maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and to reduce the risk of transmission and infection as related to the facility's failure to observe quarantine precautions for one resident (#6) after their return from an emergency room visit, staff failing to wear masks, staff failing to perform COVID-19 screenings when entering the facility, and residents not social distancing at least six feet [Refer to Tag D601 10A NCAC 13F .1801 Infection Prevention and Control (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 residents sampled (#1) who had at least ten falls resulting in five emergency room visits and injuries including a fractured right clavicle, a fractured sacrum, facial contusions, and multiple head injuries including a scalp laceration, subdural hematomas, and subarachnoid hemorrhage [Refer to Tag D270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].	D914	Continued from page 77 Facility ED, MCM and/or designee will make rounds throughout facility daily. During rounds employees will redirect any residents who do not have mask in place or to social distance. Facility ED and MCM will review daily rounds results during daily stand up. ADO, DDCS and/or DVPO will complete no less than 2 rounds of facility during on site visits to assure proper infection control measures are in place. Facility ED and Care Manager have reassessed all residents for Fall Risk. Facility Area Director of Operations (ADO), Divisional Director of Clinical Services (DDCS) and/or Divisional VP of Operations (DVPO) have reviewed fall assessments. All staff have received training on resident rights and dignity. Training conducted by DVPO/NCALA, CDP Facility has requested first available resident rights training from Osbudman	12/30/2020 12/30/2020 12/30/2020 12/30/2020 12/2/2020 1/14/2021	