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TYRRELL HOUSE	950 HWY 64 EAST COLUMBIA, NC 27925

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D 000	Initial Comments The Adult Care Licensure Section and the Tyrrell County Department of Social Services conducted a follow-up survey and complaint investigations on December 7, 2022 to December 8, 2022. The complaint investigations were initiated by the Tyrrell County Department of Social Services on November 8, 2022.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 2 of 6 sampled staff (Staff B and Staff E) were verified and had no findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: 1. Review of Staff B, medication aide (MA) personnel file on 12/08/22 revealed: -Staff B was hired 05/24/22. -There was no documentation of a Health Care Personnel Registry (HCPR) check upon hire. -Staff B had a HCPR check on 09/01/22 with no findings. Refer to the interview with the Business Office Manager (BOM) on 12/08/22 at 1:45pm.	D 137		

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D 137	Continued From page 1 Refer to the telephone interview with the previous Administrator on 12/08/22 at 11:50am. Refer to the interview with the Administrator on 12/08/22 at 2:30pm. 2. Review of Staff E, medication aide (MA) personnel file on 12/08/22 revealed: -Staff E was hired 03/29/19. -There was no documentation of a Health Care Personnel Registry (HCPR) check upon hire. -Staff E had a HCPR check on 04/09/19 with no findings. Refer to the interview with the Business Office Manager (BOM) on 12/08/22 at 1:45pm. Refer to the telephone interview with the previous Administrator on 12/08/22 at 11:50am. Refer to the interview with the Administrator on 12/08/22 at 2:30pm. _____ Interview with the Business Office Manager (BOM) on 12/08/22 at 1:45pm revealed: -She was the BOM for the facility for approximately two years. -She was responsible for running Health Care Personnel Registry (HCPR) checks on staff members upon hire. -She was not aware that Staff B and Staff E did not have a HCPR check upon hire. Telephone interview with the previous Administrator on 12/08/22 at 11:50am revealed" -She was the Administrator for the facility until 11/10/22. -The BOM was responsible for running HCPR check for staff upon hire. -She was not aware that Staff B and Staff E did	D 137		

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D 137	Continued From page 2 not have a HCPR check upon hire. Interview with the Administrator on 12/08/22 at 2:30pm revealed it was his expectation that the BOM run HCPR checks upon hire for all staff members.	D 137		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 6 sampled residents (#8) who was vomiting for 3 days. The findings are: Review of Resident #8's current FL-2 dated 09/14/22 revealed diagnoses included dementia, diabetes, and chronic kidney disease. Review of Resident #8's Resident Register revealed she was admitted to the facility on 09/26/22. Review of Resident #8's October 2022 facility progress notes revealed: -The primary care provider (PCP) was notified on 10/03/22 that Resident #8 was sent to the emergency department (ED) via Emergency Management Services (EMS) due to vomiting.	D 273		

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-There was no documentation that Resident #8's PCP had been notified of her vomiting before the resident was sent to the ED on 10/03/22.

Review of Resident #8's ED to hospital admission revealed:
-Resident #8 was brought into the ED due to vomiting.
-The facility stated that Resident #8 had been vomiting for 3 days.
-Resident #8 was dehydrated.
-Resident #8 was admitted to the hospital on 10/03/22 with a diagnosis of small bowel obstruction (a blockage in the small intestine).

Interview with Resident #8's family member on 12/08/22 at 11:38am revealed:
-When he visited Resident #8 on 10/03/22 she was vomiting what looked like bile.
-The last time he had visited Resident #8 prior to 10/03/22 was 09/30/22.
-On 10/03/22 he was told by a facility staff member that Resident #8 had been vomiting since 10/01/22 and that every time she ate or drank anything she vomited.
-Prior to his visit on 10/03/22 he had not been notified by facility staff that Resident #8 had been vomiting.
-He asked a facility staff member to call EMS for Resident #8.
-He did not know the name of the staff member, but the staff member told him she was not going to call EMS because she had just arrived at work and did not know what was going on with Resident #8.
-He contacted Resident #8's Power of Attorney (POA) and had him call EMS to the facility to transport the resident to the ED.

Interview with a personal care aide (PCA) on

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12/08/22 at 2:08pm revealed:
-She was working with Resident #8 on 10/01/22.
-Resident #8 did not look well and was vomiting.
-She posted in a facility phone application that Resident #8 was not looking well and was vomiting.
-The facility phone application was a way for facility staff to communicate with each other and the posts went to all staff in the facility.
-The facility phone application was only accessed by facility staff and not by PCPs.
-The PCA who was working the shift before her reported to her that Resident #8 had been vomiting every time she ate.
-The PCA that reported Resident #8's vomiting to her no longer worked at the facility.
-She did not remember a medication aide (MA) or any other staff checking on Resident #8 after she posted the notification of her vomiting in the facility phone application.
-She did not work at the facility on 10/02/22 or 10/03/22.

Telephone interview with a second PCA on 12/08/22 at 2:14pm revealed:
-She worked with Resident #8 the weekend of 10/01/22.
-Resident #8 told her that she felt sick, so she helped lay her in bed and then the resident vomited.
-She was not sure if the incident of vomiting occurred on 10/01/22 or 10/02/22.
-She helped Resident #8 up into a chair so she could clean her bed and the resident continued to vomit.
-She reported to a MA that Resident #8 was vomiting.
-The MA that she reported the vomiting to no longer worked at the facility.
-She reported the vomiting to the MA towards the

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end of her shift, so she was not sure what was done for Resident #8 after that.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:26pm revealed:
-She was working at the facility as a MA in the beginning of October 2022.
-She was not working on 10/03/22 but she knew Resident #8 was vomiting because she was notified via the facility phone application that Resident #8 had been sent out to the ED for vomiting.
-She was unaware that Resident #8 had been vomiting prior to 10/03/22.
-She contacted Resident #8's PCP from home on 10/03/22 to make her aware that Resident #8 had been sent out to the ED due to vomiting.
-She had not contacted the PCP about Resident #8's vomiting prior to the resident being sent to the ED.
-She was not sure if anyone else had contacted Resident #8's PCP about her vomiting prior to her being sent to the ED.
-Any PCP notification should be documented in the resident's progress notes.
-The lead MA at the time told her he had asked Resident #8's family member to bring her omeprazole (an over-the-counter medication used to treat too much acid in the stomach) from home for her to take to help with her vomiting.
-The lead MA no longer worked at the facility.
-She did not know if Resident #8 received any medication to help with her vomiting but if she did it should be recorded on her electronic medication administration record (eMAR).

Telephone interview with the facility's previous Administrator on 12/08/22 at 11:50am revealed:
-She was the facility's Administrator on 10/03/22.
-Her last day as the facility's Administrator was

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11/10/22.
-She was not on duty at the facility 10/01/22 to 10/03/22 but had been notified by facility staff that Resident #8 was vomiting on 10/01/22.
-She was not sure if facility staff notified her that Resident #8 was vomiting on 10/02/22 or not.
-She thought that facility staff had given Resident #8 some over the counter medication to help with her vomiting.
-She was not sure if Resident #8's PCP had been notified that she was vomiting.

Review of Resident #8's record revealed there were no orders for medications to relieve vomiting.

Review of Resident #8's October 2022 electronic medication administration record (eMAR) revealed there were no entries for medications for nausea or vomiting.

Interview with the facility's current Administrator on 12/08/22 at 2:25pm revealed he expected a resident's PCP to be notified if a resident had been vomiting longer than 24 hours.

Interview with Resident #8's PCP on 12/08/22 at 11:17am revealed:
-Since Resident #8 was a new admission to the facility she had not seen the resident prior to her being sent to the ED on 10/03/22.
-She was not notified by facility staff that Resident #8 had been vomiting for 3 days.
-She was notified by facility staff that Resident #8 was sent to the ED due to vomiting but expected to be notified by facility staff if a resident was having continuous vomiting.
-She was not sure if Resident #8 had an order for medications for nausea and vomiting, but if she had been notified by facility staff that Resident #8

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D 273	Continued From page 7 was vomiting, she could have ordered medication for her vomiting. -If the medications did not work, she would have had staff send Resident #8 to the hospital for evaluation. Based on observations, interviews, and record reviews it was determined that Resident #8 was not interviewable. _____ The facility failed to notify a resident's (#8) primary care provider of vomiting that had been ongoing for 3 days including after the resident ate food or drank liquids. The resident was admitted to the hospital with a diagnoses of small bowel obstruction. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	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: (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.	D 276		

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This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to ensure implementation of an order for 1 of 5 sampled residents (#4) related to a dressing change.

The findings are:

Review of Resident #4's current FL-2 dated 06/28/22 revealed diagnoses included Type 2 diabetes.

Review of Resident #4's physician order sheet dated 10/03/22 revealed:
-Resident #4 had a squamous cell carcinoma removed from his back (Squamous cell carcinoma is a type of skin cancer).
-There was an order for vaseline and band aid to back daily until healed.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed there was no entry for vaseline and band aid to back daily.

Review of Resident #4's record revealed there was no documentation that vaseline and band aid had been applied to Resident #4's back daily in October 2022.

Interview with Resident #4 on 12/07/22 at 2:35pm revealed:
-He had a skin cancer removed from his back in October 2022.
-A band aid was placed on his back by the dermatologist office when he had the skin cancer removed, and it was supposed to be changed daily.
-Facility staff never changed the band aid to his back, and the band aid eventually fell off.

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D 276	Continued From page 9 -When he returned to the dermatologist's office to have his sutures removed from his back the nurse told him it appeared that the band aid had not been changed as it should have been. -The area where the skin cancer was removed was now healed and had not caused him any problems. Interview with a medication aide (MA) on 12/08/22 at 9:04am revealed: -She thought she remembered changing the band aid to Resident #4's back in October 2022. -When she changed the band aid, she removed the band aid to Resident #4's back, cleaned the area, and applied a cream to it. -She thought she remembered the orders to change the band aid being on Resident #4's October 2022 eMAR. -The eMAR was where staff documented any treatments including dressing changes. -The MAs would know to perform dressing changes on a resident because it would be listed on the resident's eMAR. Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:26pm revealed: -She was not aware of Resident #4 having dressing changes ordered to his back in October 2022. -It was the care manager or the lead MA's responsibility to enter dressing change orders on the eMAR for residents. -The facility did not have a care manager or lead MA at the beginning of October 2022 so she was not sure who would have been responsible for entering orders on the eMAR during that time. -MAs would not know to perform a dressing change on a resident unless it was entered on the eMAR.	D 276		

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D 276	Continued From page 10 Interview with the Administrator on 12/08/22 at 2:25pm revealed: -He expected resident's dressing changes to be performed as ordered. -Resident dressing change orders should be entered on the eMAR so MAs knew to perform the dressing change. Telephone interview with a nurse at the dermatologist's office on 12/08/22 at 12:54pm revealed: -Resident #4 had a carcinoma removed from his back in October 2022. -When Resident #4 returned to the office to have his sutures removed from the area there was no band aid on the area where the carcinoma had been removed. -Normally, when dressing changes were performed as ordered the area was not scabbed over and the sutures were soft. -When Resident #4 returned to have his sutures removed the area where the carcinoma was removed was scabbed over and the sutures were not soft but crusty instead. -At the time Resident #4 told her that facility staff had not been changing the band aid on his back. Telephone interview Resident #4's primary care provider (PCP) on 12/08/22 at 11:17am revealed she expected resident dressings to be performed as ordered.	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	D 358		

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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 ensure medications were administered as ordered for 3 of 7 residents sampled (#2, #4, and #9) including medications for pain management and treatment of glaucoma (#9) and reflux (#2), a resident that was not started on medications immediately following two hospital stays (#2) and a resident that had an ordered anti-anxiety medication discontinued but continued to receive that medication (#4).

The findings are:

1. Review of Resident #2's current FL-2 dated 10/18/22 revealed diagnoses included hypertension, acute respiratory failure, and muscle weakness.

a. Review of Resident #2's hospital discharge summary dated 12/04/22 revealed:
-Resident #2 was hospitalized from 11/26/22 to 12/04/22.
-While hospitalized Resident #2 complained of abdominal pain and it was discovered that she had an ileus (intestinal blockage).
-There was an order for Lactulose 20gm daily as needed for constipation for up to 15 days (Lactulose is a medication used to treat constipation).

Interview with Resident #2 on 12/07/22 at 8:03am

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revealed:
-She returned to the facility from the hospital on 12/04/22.
-She had not yet received her medications that were ordered to help her have a bowel movement.

Observations of Resident #2's medications on hand on 12/07/22 at 2:10pm revealed there was no Lactulose available for administration.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 8:35am revealed Resident #2 told her that she did not want to fill her Lactulose when she got back from the hospital on 12/04/22.

A second interview with Resident #2 on 12/08/22 at 9:35am revealed:
-She had not had a bowel movement in 6 days and felt like she was "about to bust".
-She requested the Lactulose that was ordered for constipation but was told by the SCC that the medication was not available from the pharmacy yet.

Telephone interview with a pharmacist at Resident #2's pharmacy revealed:
-The pharmacy received the order for Lactulose on 12/07/22 and dispensed the order on 12/07/22.
-The facility had not picked up the Lactulose as of 12/08/22.

Observation of Resident #2's medications on hand on 12/08/22 at 10:15am revealed there was no Lactulose available for administration.

Telephone interview with Resident #2's PCP on 12/08/22 at 11:15pm revealed:

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-She was not aware that Resident #2 had not had a bowel movement in 6 days.
-She expected Resident #2 to receive the as needed Lactulose medication to ensure that she did not become constipated.

b. Review of Resident #2's hospital discharge summary dated 12/04/22 revealed:
-Resident #2 was hospitalized from 11/26/22 to 12/04/22 with Acute Respiratory Failure and Chronic Obstructive Pulmonary Disease (COPD) exacerbation.
-She was treated with high dose steroids and nebulizer treatments while at the hospital.
-There was an order to start a Prednisone taper with instructions to begin on 12/05/22 (Prednisone is an oral steroid used to treat inflammation and should not be stopped abruptly without tapering).
-There was an order for Prednisone 10mg with instructions to take 2 tablets with breakfast for 2 days, then 1 tablet with breakfast for 2 days, then ½ tablet with breakfast for 2 days, to start on 12/05/22.

Interview with Resident #2 on 12/07/22 at 8:03am revealed:
-She returned to the facility from the hospital on 12/04/22.
-She had not yet received her medications that were ordered to help her breathing.
-She was having difficulty breathing.

Observations of Resident #2's medications on hand on 12/07/22 at 2:10pm revealed there was no Prednisone available for administration.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 8:35am revealed:
-Resident #2 told her that she did not want to fill

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her Prednisone when she got back from the hospital on 12/04/22.
-Resident #2 was seen by the facility's primary care provider on 12/06/22 and the PCP convinced Resident #2 to take the Prednisone.
-The prednisone was delivered yesterday evening and would start today (12/08/22).

A second interview with Resident #2 on 12/08/22 at 9:35am revealed:
-The first day that she returned to the facility from the hospital, she did not think that she needed the Prednisone because she was feeling good.
-When she woke up the next day on 12/05/22 she had difficulty breathing and told the SCC that she needed the Prednisone.
-She was seen by the PCP on 12/06/22 and the PCP said she needed to start the Prednisone as soon as possible in order to help her breathing.
-The SCC told her that she would get her the Prednisone 12/07/22 but it was not picked up until the evening of 12/07/22 so she could not start it until 12/08/22 because it was ordered with breakfast.

Telephone interview with a pharmacist at Resident #2's pharmacy revealed:
-The pharmacy received the order for the Prednisone taper on 12/07/22.
-The Prednisone taper was dispensed and picked up on 12/07/22.

Observation of Resident #2's medications on hand on 12/08/22 at 10:15am revealed Prednisone was available for administration.

Telephone interview with Resident #2's PCP on 12/08/22 at 11:15pm revealed:
-She was notified by the SCC that Resident #2 was having difficulty breathing when she saw the

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resident on 12/06/22.
-She instructed the resident that it was important for her to take the Prednisone taper as ordered.
-She expected the Prednisone to be started on 12/06/22 after she spoke with the resident.

c. Review of Resident #2's hospital discharge summary dated 11/03/22 revealed:
-Resident #2 was sent to the emergency department due to slurred speech.
-Resident #2 was discharged from the emergency department on 11/03/22 with acute bronchitis.
-There was an order to start Mucinex DM, 1 tablet twice a day for 7 days (Mucinex is a medication used to treat chest congestion and loosen mucus).

Review of Resident #2's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Mucinex DM, with instructions to administer 2 tablets by mouth twice a day, scheduled for administration at 8:00am and 8:00pm.
-Mucinex DM 2 tablets were documented as administered 11/08/22 to 11/13/22 at 8:00am and 8:00pm.
-Mucinex DM 2 tablets were documented as administered on 11/14/22 to 11/15/22 at 8:00pm.

Interview with Resident #2 on 12/08/22 at 8:35am revealed:
-When she returned to the hospital on 11/03/22 there was a delay in the facility picking up her medication from the local pharmacy.
-She continued with chest congestion and a cough until she started the medication that was ordered on discharge.

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Interview with the Special Care Coordinator (SCC) on 12/08/22 at 10:05am revealed:
-The hospital called Resident #2's Mucinex DM to a pharmacy that was not her normal pharmacy.
-She was not in the role of SCC at the time and there was no lead medication aide (MA) so she was not sure who put the order on the eMAR and why it was two tablets.
-She did not recall Resident #2 complaining of chest congestion when she returned from the hospital on 11/03/22.

Interview with the Administrator on 12/08/22 at 2:25pm revealed:
-He expected medication orders to be implemented upon returning to the facility from the hospital including Resident #2's Mucinex DM.
-He expected medications to be administered as ordered including Resident #2's Mucinex DM.

Telephone interview with Resident #2's primary care provider (PCP) on 12/08/22 at 11:15pm revealed she expected Resident #2 to receive her Mucinex DM within 24 to 48 hours of being discharged to ensure that the resident's acute bronchitis was improved.

d. Review of Resident #2's current FL-2 dated 10/18/22 revealed there was an order for Omeprazole 40mg twice a day (Omeprazole is a medication used to treat gastric reflux).

Review of Resident #2's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Omeprazole 40mg, with instructions to administer 1 capsule twice a day, scheduled for administration at 8:00am and 4:30pm.
-Omeprazole 40mg was documented as

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administered twice a day from 10/01/22 to 10/25/22.
-There was a second entry for Omeprazole 40mg daily, with instructions to take 1 capsule daily, scheduled for administration at 8:00am.
-Omeprazole 40mg was documented as administered daily at 8:00am from 10/26/22 to 10/31/22.

Review of Resident #2's November 2022 eMAR revealed:
-There was an entry for Omeprazole 40mg daily, with instructions to take 1 capsule daily, scheduled for administration at 8:00am.
-Omeprazole 40mg was documented as administered daily at 8:00am from 11/01/22 to 11/26/22. (The resident was hospitalized from 11/26/22 to 12/04/22)

Review of Resident #2's December 2022 eMAR revealed:
-There was an entry for Omeprazole 40mg daily, with instructions to take 1 capsule daily, scheduled for administration at 8:00am.
-Omeprazole 40mg was documented as administered daily from 12/04/22 to 12/07/22

Review of Resident #2's facility record revealed there was no order to change Omeprazole 40mg to daily.

Observation of Resident #2's medications on hand on 12/08/22 at 10:00am revealed Omeprazole 40mg was available for administration.

Telephone interview with Resident #2's pharmacy on 12/08/22 at 9:30am revealed:
-The most recent order that they have on file for Resident #2's Omeprazole 40mg is for twice a

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day.
-The pharmacy dispensed 60 pills on 10/24/22 (a 30-day supply).
-The pharmacy had Omeprazole ready to be picked up because it was on automatic refill; but the facility had not picked up the medication yet as of 12/08/22.

Interview with Resident #2 on 10/24/22 at 8:35am revealed she did not know how often she was taking Omeprazole, but she was not having any reflux issues.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:25pm revealed:
-The pharmacy, the lead medication aide (MA) or the care managers could make changes to the eMAR.
-She was not able to locate an order for Omeprazole 40mg changing from twice a day to once a day but someone had changed it on the MAR.
-She was not in the SCC role when the medication was changed.

Interview with the Administrator on 12/08/22 at 2:30pm revealed he expected residents to receive medications as ordered including Resident #2's Omeprazole.

Telephone interview with Resident #2's primary care provider (PCP) on 12/08/22 at 11:15am revealed:
-Resident #2 was ordered Omeprazole for treatment of gastric reflux.
-Resident #2 was to receive Omeprazole 40mg twice a day.
-She was not sure why Resident #2 was administered Omeprazole once a day, instead of twice as ordered.

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-It was important for Resident #2 to receive Omeprazole as ordered twice a day to prevent gastric reflux and stomach discomfort.

2. Review of Resident #9's current FL-2 dated 06/21/22 revealed diagnoses included dementia, hyperlipidemia, primary open angle glaucoma, peripheral vascular disease, and coronary artery disease.

a. Review of Resident #9's physician's orders dated 10/04/22 revealed there was an order for Neurontin 300mg three times a day (Neurontin is a medication used to treat nerve pain).

Review of Resident #9's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Neurontin 300mg with instructions to give 1 capsule three times a day, scheduled for administration at 8:00am, 12:00pm, and 8:00pm.
-Neurontin 300mg was not documented as administered from 10/03/22 at 8:00pm to 10/15/22 at 8:00pm (37 consecutive doses).
-Neurontin 300mg was not documented as administered from 10/19/22 at 8:00am to 10/20/22 to 8:00pm (9 consecutive doses).

Interview with Resident #9 on 12/08/22 at 9:05am revealed:
-The medication aides (MA) administered her medications to her.
-She was not aware of a time that she missed any oral medications during October of 2022 including her Neurontin.
-She was not having any increased pain that she could recall in October of 2022.

Observation of Resident #9's medications on

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hand on 12/08/22 at 8:54am revealed there was Neurontin 300mg available for administration.

Telephone interview with a pharmacist at Resident #9's current pharmacy on 12/08/22 at 9:07am revealed:
-The pharmacy received an order for Resident #9's Neurontin 300mg three times a day on 10/18/22.
-The pharmacy dispensed 90 capsules of Neurontin 300mg (30-day supply) to the facility on 10/19/22.
-Neurontin should not be stopped suddenly without consulting a physician because it could cause side effects including increased nerve pain.

Telephone interview with a pharmacist at Resident #9's previous pharmacy on 12/08/22 at 9:16am revealed they last dispensed 63 capsules (21-day supply) to the facility on 09/16/22.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:25pm revealed:
-The facility changed pharmacies in October 2022.
-The new pharmacy required a physical prescription to fill Resident #9's Neurontin.
-The lead MA or Care Managers were responsible for ensuring that prescriptions for medications were sent to the pharmacy.
-The facility was without a Care Manager during the pharmacy transition in October of 2022 and the previous Administrator was acting as the Care Manager during that time.

Telephone interview with the previous Administrator on 12/08/22 at 11:50am revealed she was not aware that Resident #9 was without Neurontin during October 2022.

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Interview with the Administrator on 12/08/22 at 2:25pm revealed he expected medications to be available for administration including Resident #9's Neurontin.

Telephone interview with Resident #9's primary care provider on 12/08/22 at 11:15pm revealed:
-Resident #9 was ordered Neurontin for management of chronic pain.
-She was not aware that Resident #9 missed 37 consecutive doses and 9 consecutive doses in October of 2022 of Neurontin.
-She expected Resident #9 to have Neurontin available for administration.
-Resident #9 was on Neurontin for a long time so she did not think that it would cause her withdraws from the medication for going without it for that amount of time.

b. Review of Resident #9's physician's orders dated 10/04/22 revealed there was an order for Lantanoprost 0.005%, instill 1 drop in each eye at bedtime. (Lantanoprost is a medication solution used to treat increased pressure inside the eye caused by glaucoma).

Interview with Resident #9 on 12/08/22 at 9:02am revealed:
-She was on two different eye drops, one for dry eyes and one for glaucoma.
-There were times when she did not get her eye drops as ordered and the medication aides (MA) would say that she was only ordered one eye drop.
-She could not remember the last time that she received both of her eye drops correctly because staff informed her that they were waiting on the eye drops from the pharmacy.

Observation of Resident #9's medications on

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hand on 12/08/22 at 8:54am revealed there was no Lantanoprost available for administration.

Telephone interview with a pharmacist at the facility's previous pharmacy on 11/08/22 at 9:16am revealed:
-The pharmacy dispensed Lantanoprost 0.005% on 10/30/22 and the bottle would have 25 doses.
-The Lantanoprost that was dispensed on 10/30/22 should last the resident until 11/24/22.

Telephone interview with a pharmacist at Resident #9's current pharmacy on 11/08/22 at 9:07am revealed they have an order for Lantanoprost 0.005%, instill one drop in each eye at bedside on the resident's profile but they have never received a request to dispense the medication to the resident.

Review of Resident #9's November 2022 electronic medication administration (eMAR) revealed:
-There was an entry for Lantanoprost 0.005%, with instructions to instill 1 drop in each eye at bedtime, scheduled for administration at 8:00pm.
-Lantanoprost was documented as administered from 11/01/22 to 11/30/22 at 8:00pm.

Review of Resident #9's December 2022 eMAR from 120/01/22 to 12/06/22 revealed:
-There was an entry for Lantanoprost 0.05%, with instructions to instill 1 drop in each eye at bedtime, scheduled for administration at 8:00pm.
-Lantanoprost 0.005% was documented as administered from 12/01/22 to 12/06/22.

Interview with a medication aide (MA) on 12/08/22 at 9:25am revealed:
-The last of the Lantanoprost solution for Resident #9 was administered last night.

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-It was the Special Care Coordinator's (SCC) responsibility to order medications since there was not a lead MA.
-She was told by the SCC that Resident #9's Lantanoprost eye drops had been ordered at the pharmacy and would arrive tonight (12/08/22).

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12/08/22 at 12:25pm revealed:
-She was not aware that Resident #9's Lantanoprost had not been filled since 10/24/22.
-The facility changed pharmacies in October of 2022, and she could not recall if Resident #9 received any Lantanoprost from the new pharmacy.
-It was the lead MA's responsibility to ensure that residents had their medications available for administration and they just hired a lead MA yesterday (12/07/22).
-She was not aware of any medication cart audits to ensure that medications were available for administration.

Interview with the Administrator on 12/08/22 at 2:25pm revealed he expected medications to be available for administration including Resident #9's Lantanoprost.

Telephone interview with Resident #9's primary care provider (PCP) on 12/08/22 at 11:15am revealed:
-Resident #9 was ordered Lantanoprost 0.005% for her glaucoma.
-She expected Resident #9 to have Lantanoprost available for administration.

3. Review of Resident #4's current FL-2 dated 06/28/22 revealed:
-Diagnoses included vascular dementia and

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major depressive disorder.
-There was an order for alprazolam 0.5mg (used to treat anxiety) on Tuesday, Thursday, and Saturday 30 minutes prior to shower, on shower days.

Review of Resident #4's physician order sheet dated 11/18/22 revealed there was an order to discontinue alprazolam 0.5mg on shower days.

Review of Resident #4's record revealed there was no order to discontinue Resident #4's alprazolam prior to 11/18/22.

Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for alprazolam 0.5mg on Tuesday, Thursday, and Saturday 30 minutes prior to shower, on shower days scheduled for administration at 3:00pm to 11:00pm.
-Alprazolam 0.5mg was documented as administered at 3:00pm to 11:00pm on 10/04/22, 10/06/22, 10/08/22, 10/11/22, and 10/13/22.
-Alprazolam 0.5mg was documented as discontinued at 3:00pm to 11:00pm on 10/15/22, 10/18/22, 10/20/22, 10/25/22, 10/27/22, and 10/29/22.
-Alprazolam 0.5mg was documented as refused at 3:00pm to 11:00pm on 10/22/22.

Review of Resident #4's November 2022 eMAR revealed:
-There was an entry for alprazolam 0.5mg on Tuesday, Thursday, and Saturday 30 minutes prior to shower, on shower days scheduled for administration at 3:00pm to 11:00pm.
-Alprazolam 0.5mg was documented as administered at 3:00pm to 11:00pm 11/12/22, 11/15/22, and 11/17/22.

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-Alprazolam 0.5mg was documented as discontinued at 3:00pm to 11:00pm on 11/01/22, 11/03/22, 11/05/22, 11/08/22, and 11/10/22.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/22 at 9:39am revealed alprazolam 0.5mg on Tuesday, Thursday, and Saturday 30 minutes prior to shower was last dispensed for Resident #4 on 10/28/22.

Interview with Resident #4 on 12/07/22 at 2:35pm revealed:
-He no longer received a shower but bathed himself in his room.
-He was unsure of the last time he received a shower.
-When he was receiving showers he did not recall receiving any medication before his showers.

Interview with a medication aide (MA) on 12/08/22 at 9:04am revealed:
-Resident #8's alprazolam 0.5mg on shower days had been discontinued but she was not sure what day it was discontinued.
-MAs were expected to administer medications as ordered.
-She was not sure why Resident #4's alprazolam 0.5mg was marked as discontinued on the eMAR before a discontinue order was received from his primary care provider (PCP).
-If there was a current order for Resident #8's alprazolam he should have received it as ordered.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:26pm revealed:
-She expected residents to receive all medications as ordered.
-She was not sure why Resident #4's alprazolam

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	Hal089002	A. BUILDING: _____ B. WING _____	R 12/08/2022

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 26 0.5mg on shower days was marked as discontinued when there was still a current order for it. Interview with the Administrator on 12/08/22 at 2:25pm revealed he expected resident medications to be administered as ordered. Interview with Resident #4's primary care provider (PCP) on 12/08/22 at 11:17am revealed: -Alprazolam 0.5mg was ordered for Resident #4 prior to showers because he was having anxiety when he had to get a shower. -She discontinued Resident #4's alprazolam prior to his showers because staff communicated to her that the resident no longer needed it. -She expected Resident #4 to receive all medications as ordered. _____ The facility failed to ensure medications were administered as ordered by running out of medications including a medication used to treat nerve pain and eye drops used to manage glaucoma (#9). There was a delay in implementing a tapered steroid medication for a resident that returned from the hospital with an acute respiratory failure resulting in increased shortness of breath for the resident (#2) and there was a delay in starting medications for chest congestion ordered upon discharge for a resident (#2). The facility did not start medication ordered for constipation after a resident was hospitalized and that did not have a bowel movement in 6 days (#2). The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/08/22 for this violation.	D 358		

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D 358	Continued From page 27 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 22, 2023.	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). This Rule is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure that medication administration records (MAR) were complete and accurate for 2 of 7 residents sampled (#4, #9). The findings are:	D 367		

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D 367	Continued From page 28 1. Review of Resident #9's current FL-2 dated 06/21/22 revealed diagnoses included Dementia, primary open angle glaucoma, peripheral vascular disease, and coronary artery disease. Review of Resident #9's physician's orders dated 10/04/22 revealed: -There was an order for Cyclosporine 0.05%, instill one drop in each eye twice a day (Cyclosporine is a medication solution used to treat dry eyes). -There was an order for Lantanoprost 0.005%, instill one drop in each eye at bedtime (Lantanoprost is a medication solution used to treat increased pressure inside the eye. Review of Resident #9's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Cyclosporine 0.05%, with instructions to instill 1 drop in each eye twice a day, scheduled for administration at 8:00am and 8:00pm. -Cyclosporine 0.05% was documented as not administered on 11/03/22 at 8:00am, with reason stating "duplicate". -There was an entry for Lantanoprost 0.005%, with instructions to instill 1 drop in each eye at bedtime, scheduled for administration at 8:00pm. Review of Resident #9's December 2022 eMAR revealed: -There was an entry for Cyclosporine 0.05%, with instructions to instill 1 drop in each eye twice a day, scheduled for administration at 8:00am and 8:00pm. -Cyclosporine 0.05% was documented as not administered on 12/03/22 at 8:00pm, with reason stating "duplicate".	D 367		

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-There was an entry for Lantanoprost 0.05%, with instructions to instill 1 drop in each eye at bedtime, scheduled for administration at 8:00pm.
-Lantanoprost 0.05% was documented as administered on 12/03/22 at 8:00pm.

Interview with Resident #9 on 12/8/22 at 9:02am revealed:
-She was on two different eye drops, one for dry eyes and one for glaucoma.
-There were times when she did not get her eye drops as ordered and the medication aides (MA) would say that she was only ordered one eye drop.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:25pm revealed:
-Resident #9 was ordered two types of eye drops.
-The MA should not have documented duplicate for one of the eye drops because the resident is ordered two different eye drops.
-The MA documented "duplicate" because she thought the eye drops were the same medication.

Refer to the interview with the Administrator on 12/08/22 at 2:25pm.

Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 12/08/22 at 11:15am.

2. Review of Resident #4's current FL-2 dated 06/28/22 revealed:
-Diagnoses included type 2 diabetes.
-There was an order for glipizide (used to treat diabetes) 5mg every morning with breakfast.
-There was an order for metformin (used to treat diabetes) 1000mg twice daily with meals.

a. Review of Resident #4's October 2022

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electronic medication administration record (eMAR) revealed:
-There was an entry for glipizide 5mg scheduled for administration at 8:00am.
-Glipizide 5mg was documented as administered 10/01/22 to 10/04/22 and 10/13/22 to 10/31/22.
-Glipizide 5mg was documented as "x" 10/05/22 to 10/12/22 with no notation as to why.

Interview with Resident #4 on 12/07/22 at 2:35pm revealed he did not remember ever going without his diabetes medication.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/22 at 9:39am revealed a 30-day supply of glipizide 5mg was dispensed for Resident #4 on 09/28/22.

Interview with a medication aide (MA) on 12/08/22 at 9:04am revealed:
-Resident #4's glipizide was on "sync fill" which meant it was automatically refilled by the pharmacy every month.
-She did not remember Resident #4 ever being out of glipizide.
-She did not know why there was an "x" on the eMAR for some days in October 2022 for Resident #4's glipizide.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:26pm revealed:
-All of Resident #4's medications except for his narcotics were on "sync fill".
-She did not know of a time that Resident #4 was out of glipizide.
-The pharmacy put medications and administration times on the eMAR for residents, but the care manager or lead MA could also put medications on the MAR.
-She did not know why there was an "x" on

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Resident #4's eMAR for glipizide some days in October 2022.

Refer to the interview with the Administrator on 12/08/22 at 2:25pm.

Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 12/08/22 at 11:15am.

b. Review of Resident #4's October 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for metformin 1000mg scheduled for administration at 8:00am and 5:00pm.
-Metformin 1000mg was documented as administered at 8:00am and 5:00pm 10/01/22 to 10/03/22 and 10/13/22 to 10/31/22.
-Metformin 1000mg was documented as administered at 8:00am 10/04/22.
-Metformin 1000mg was documented as "x" at 5:00pm on 10/04/22 with no explanation.
-Metformin 1000mg was documented as "x" at 8:00am and 5:00pm on 10/05/22 to 10/12/22 with no explanation.

Interview with Resident #4 on 12/07/22 at 2:35pm revealed he did not remember ever going without his diabetes medication.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/08/22 at 9:39am revealed a 30-day supply of metformin 1000mg was dispensed for Resident #4 on 09/28/22.

Interview with a medication aide (MA) on 12/08/22 at 9:04am revealed:
-Resident #4's metformin was on "sync fill" which

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meant it was automatically refilled by the pharmacy every month.
-She did not remember Resident #4 ever being out of metformin.
-She did not know why there was an "x" on the eMAR some days in October 2022 for Resident #4's metformin.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:26pm revealed:
-All of Resident #4's medications except for his narcotics were on "sync fill".
-She did not know of a time that Resident #4 was out of metformin.
-The pharmacy put medications and administration times on the eMAR for residents, but the care manager or lead MA could also put medications on the MAR.
-She did not know why there was an "x" on Resident #4's eMAR for metformin some days in October 2022.

Refer to the interview with the Administrator on 12/08/22 at 2:25pm.

Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 12/08/22 at 11:15am.

Interview with the Administrator on 12/08/22 at 2:25pm revealed resident eMARs should be complete and accurate.

Telephone interview with the facility's contracted primary care provider (PCP) on 12/08/22 at 11:15am revealed she expected resident's eMARS to be accurate.

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D 451	Continued From page 33	D 451		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the notification of the local county Department of Social Services (DSS) for 1 of 3 sampled residents (#7) who had a fall with injury that required treatment at the hospital. The findings are: Review of Resident #7's FL-2 dated 03/15/22 revealed: -Diagnoses included intervertebral disc degeneration, spondylosis, atrial fibrillation (irregular heartbeat), hypertension, hypercholesterolemia, and thyroid disorder. -She was semi-ambulatory and intermittently confused. -She was continent of bladder and bowel. Review of Resident #7's Incident Report dated 10/18/22 revealed: -Resident #7 fell in her room on 10/18/22 at 3:45pm. -The fall was not witnessed. -Resident #7 stated " she was trying to pick something up and slipped". -Resident #7 was complaining of right leg pain.	D 451		

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-Resident #7 was transported to the emergency room by Emergency Medical Services transport.
-Resident #7's responsible party was notified of the resident's fall and being sent to the hospital.
-Resident #7's physician was notified of the resident's fall and being sent to the hospital.
-On the form section that stated if the county was notified there was a name of a facility staff member.
-The Incident Report was completed by the previous Administrator.

Interview with a medication aide (MA) on 12/07/22 at 2:10pm revealed:
-She was working when Resident #7 fell on 10/18/22.
-She notified Resident #7's family and her primary care provider (PCP).
-She was not sure who was responsible for notifying the local county Department of Social Services (DSS) of the resident's fall.
-She did not know if the county DSS was aware of Resident #7's fall on 10/18/22.

Interview with the Special Care Coordinator (SCC) on 12/08/22 at 12:25pm revealed:
-She was working as the lead MA when Resident #7 fell on 10/18/22.
-It was the responsibility of the Administrator to send the Incident Report to the county DSS.
-She was not sure how to send the Incident Report to the county DSS because she was taught that it was the Administrator's responsibility.
-She did not know if the county DSS was aware of Resident #7's fall on 10/18/22.

Telephone interview with the previous Administrator on 12/08/22 at 11:50am revealed:
-It was her responsibility, as the Administrator to

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D 451	Continued From page 35 ensure that the Incident Reports were sent to the county DSS. -It was an oversight that Resident #7's Incident Report for her fall on 10/18/22 was not sent to the county DSS. -She was without a Care Manager during that time and sometimes her previous Care Manager sent the incident reports to the county DSS. -She was the Administrator of the facility during the time of Resident #7's fall on 10/18/22. Interview with the Administrator on 12/08/22 at 2:30pm revealed it was the responsibility of the Administrator to ensure that Incident Reports were sent to the county DSS.	D 451		