STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 04/11/23 - 04/13/23.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#6, #7) observed during the medication pass including errors with a medication used to lower blood sugar and provide cardiovascular benefits (#6) and a medication used to treat dementia associated with Alzheimer's disease (#7); and for 1 of 5 sampled residents (#1) for errors with long-acting insulin used to lower blood sugar. The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 27 opportunities during the 8:00am medication pass on 04/12/23. a. Review of Resident #6's current FL-2 dated 01/06/23 revealed: -Diagnoses included vascular dementia, type 2 diabetes, and chronic kidney disease.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 1	D 358		

-There was an order for "may crush appropriate meds".
-There was an order for Jardiance 10mg 1 tablet daily. (Jardiance is used to lower blood sugar and may be used for benefits in treating cardiovascular disease. Jardiance is a once-a-day film coated medication and should not be crushed or divided according to the manufacturer.)

Observation of the 8:00am medication pass on 04/12/23 revealed:
-The medication aide (MA) prepared morning medications for Resident #6, including one Jardiance 10mg tablet.
-The MA crushed all of Resident #6's oral medications, including the Jardiance tablet, mixed them in applesauce and administered the medications to the resident at 7:43am.

Observation of Resident #6's medications on hand on 04/12/23 at 11:28am revealed:
-There was a supply of Jardiance 10mg tablets on hand dispensed on 03/21/23.
-There were no instructions on the medication label indicating Jardiance should not be crushed.

Review of Resident #6's April 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Jardiance 10mg take 1 tablet once daily scheduled for 8:00am.
-Jardiance 10mg was documented as administered daily from 04/01/23 - 04/12/23.
-There was no information noted on the eMAR to indicate the medication should not be crushed.

Interview with the MA on 04/12/23 at 11:28am revealed:
-She usually crushed all of Resident #6's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 2	D 358		

medications because the resident would not take the medications if they were not crushed.
-There was usually a "Do Not Crush" sticker on the medication label if a medication could not be crushed.
-She was not aware of the facility having a Do Not Crush (DNC) list.

Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable.

Interview with the Director of Health and Wellness (DHW) on 04/12/23 at 11:47am revealed:
-The MAs should not crush medications that should not be crushed.
-There were usually instructions on the eMARs indicating if a medication should not be crushed.
-The facility did not have a DNC list to her knowledge, but she could get one from the pharmacy.
-If a medication could not be crushed, she or the MAs could check with the provider to get the medication order changed if needed.

Interview with Resident #6's primary care provider (PCP) on 04/13/23 at 1:33pm revealed:
-Jardiance would not be released properly if crushed and should be taken whole.
-Jardiance was also being used for cardiovascular benefits for Resident #6.
-She would continue to monitor Resident #6's labs to determine her glycemic control.

b. Review of Resident #7's current FL-2 dated 01/06/23 revealed:
-Diagnoses included Alzheimer's dementia with early onset.
-There was an order for Memantine 10mg take 1 tablet twice a day at 8:00am and 6:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 3 (Memantine is used for the treatment of moderate to severe dementia of the Alzheimer's type.) Interview with a medication aide (MA) on 04/12/23 at 7:51am revealed: -She could not find Resident #7's Memantine in the medication cart or in the back-up medication supply in the facility. -Memantine should be a monthly cycle filled medication and should be in the medication cart. -The monthly cycle fill usually came from the pharmacy on the 23rd or 24th of each month. -She was not sure why Resident #7's Memantine was not in the medication cart because there should still be some left in the monthly cycle fill. Observation of Resident #7's medications on hand on 04/12/23 at 7:51am revealed there was no Memantine in the medication cart or back-up medication storage supply for Resident #7. Observation of the 8:00am medication pass on 04/12/23 revealed: -The MA prepared and administered medications scheduled for 8:00am to Resident #7 at 7:55am. -No Memantine 10mg was prepared and administered to Resident #7 when she received her other 8:00am medications at 7:55am. Review of Resident #7's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Memantine 10mg take 1 tablet twice a day at 8:00am and 8:00pm. -Memantine 10mg was documented as administered at 8:00am and 8:00pm from 04/01/23 - 04/11/23. -Memantine was documented as not administered at 8:00am on 04/12/23 due to the medication being "ordered".	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 4 Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable. A second interview with the MA on 04/12/23 at 11:32am revealed: -She notified the Director of Heath and Wellness (DHW) that Resident #7's Memantine could not be located during the medication pass that morning, 04/12/23. -Resident #7's Memantine should have been on hand unless there were no refills, then the MAs were responsible for contacting the provider for a new prescription. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 04/13/23 at 1:03pm revealed: -Resident #7's Memantine 10mg tablets were included in monthly cycle fills. -Resident #7's Memantine was last dispensed on 03/21/23 with 60 tablets, which was a 30-day supply. -There should have been some Memantine 10mg tablets on hand on 04/12/23 for administration since a 30-day supply was dispensed on 03/21/23. Interview with the DHW on 04/12/23 at 11:47am revealed: -Some medications came in monthly cycle fills from the pharmacy and some did not. -If a medication was not in the cycle fill, the MAs were responsible for reordering when there was a 7-day supply remaining. -If a medication was in the cycle fill and the supply was getting down to a 2-day supply and it was not the end of the cycle, the MAs should call the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 5	D 358		

-If a monthly cycle filled medication was out of refills, the MAs were responsible for contacting the provider for more refills.
-Resident #7's Memantine should have been available for administration.

Interview with the Administrator on 04/12/23 at 12:19pm revealed:
-The facility had a back-up pharmacy that could be utilized by the MAs.
-Medication could be obtained from the back-up pharmacy in a couple of hours or sooner.

Interview with Resident #7's primary care provider (PCP) on 04/13/23 at 1:33pm revealed:
-Resident #7's Memantine should be administered as ordered.
-She was not concerned of any effects to the resident for missing one dose of Memantine.

2. Review of Resident #1's current FL-2 dated 04/03/23 revealed:
-Diagnoses included dementia and type 2 diabetes.
-There was an order for Lantus Solostar insulin inject 22 units nightly. (Lantus is long-acting insulin used to lower blood sugar.)

Review of Resident #1's previous FL-2 dated 02/08/23 revealed an order for Levemir Flextouch insulin inject 18 units at bedtime. (Levemir is long-acting insulin used to lower blood sugar. Levemir and Lantus are similar but not the same medication.)

Review of Resident #1's after-visit summary dated 04/04/23 revealed:
-There was an order to discontinue Levemir FlexTouch insulin daily at 8:00pm.
-There was an order to begin Lantus Solostar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 6	D 358		

insulin 22 units daily at 8:00pm.

Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Levemir FlexPen insulin inject 18 units subcutaneously every evening at 8:00pm.
- Levemir FlexPen insulin was documented as administered at 8:00pm from 03/01/23 - 03/31/23, with no exceptions documented.

Review of Resident #1's April 2023 (eMAR) revealed:
-There was an entry dated 04/04/23 for Lantus Solostar insulin inject 22 units daily at 8:00pm.
- Lantus Solostar insulin 22 units was documented as administered at 8:00pm from 04/04/23 - 04/10/23, with no exceptions documented.

Observation of Resident #1's medications on hand on 04/13/23 at 12:45pm revealed:
-There was a supply of Levemir FlexPen insulin dispensed on 02/23/23 labeled with Resident #1's name.
-There was no Lantus Solostar insulin on hand.

Interview with a medication aide (MA) on 04/13/23 at 3:10pm revealed:
-She did not receive a fax from the pharmacy about Resident #1's Lantus Solostar insulin not being sent to the facility.
-She made a mistake and administered Levemir insulin to Resident #1 because the resident previously received Levemir insulin.
-She documented Lantus Solostar insulin administered at 8:00pm from 04/04/23 - 04/10/23, when she actually administered Levemir.
-She did not match the medication being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 7	D 358		

administered to the medication listed on the eMAR.

Interview with a second MA on 04/13/23 at 3:20pm revealed:
-She did not receive a fax from the pharmacy about Resident #1's Lantus Solostar insulin not being sent to the facility.
-She administered Levemir insulin to Resident #1 because she was used to documenting for that medication.
-She documented Resident #1 received Lantus Solostar insulin on the eMAR at 8:00pm from 04/04/23 - 04/10/23, when she actually administered Levemir Flextouch insulin.
-She did not match the medication being administered to the eMAR unless something looked different or did not look right.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 04/13/23 at 1:05pm revealed:
-On 04/04/23, Resident #1's Lantus Solostar insulin was not sent to the facility because it was not covered by the resident's insurance.
-There was a fax sent to the facility on 04/04/23 stating Lantus insulin would need to be paid for out of pocket.
-There was no order on file at the pharmacy to discontinue Lantus insulin or to restart Levemir insulin.

Interview with the Director of Health and Wellness (DHW) on 04/13/23 at 1:20pm revealed:
-Cart audits should be done at least weekly by the MAs to ensure residents had the correct medications on hand.
-She did not receive a fax from the pharmacy regarding Resident #1's Lantus insulin not being covered by the resident's insurance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(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 8 -She was not notified by the MAs that Resident #1 was administered Levemir insulin instead of Lantus insulin. Interview with Resident #1's PCP on 04/13/23 at 1:45pm revealed: -She was not concerned Resident #1 received Levemir insulin instead of Lantus insulin since they were both long-acting insulins. -The MAs should match the eMARs and medication labels. -If the MAs had administered Resident #1's rapid-acting insulin when long-acting insulin was ordered, it could have caused low blood sugar. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection control measures were implemented during the medication pass on 04/12/23 by 2 of 2 medication aides observed who failed to wash or sanitize their hands prior to preparing and after administering a topical medicated cream, eye drops, and multiple oral medications to residents,	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 9	D 371		

including feeding crushed medications in applesauce to residents.

The findings are:

Review of the facility's medication/treatment administration policy and procedure updated 08/27/20 revealed:
-Appropriate infection control practices would be followed during the administration process.
-Infection control practices for washing hands in between each resident during administration would be followed.
-This included washing hands with every third resident's medication administration, using hand sanitizer (if hands are not visibly dirty) in between each resident.
-This included wearing gloves with the administration of injectables, eye/ear drops, sprays, patches, inhalers, suppositories, etc., or whenever the possibility of having contact with bodily fluids was present.
-This included washing hands when gloves were removed.

Observation of a medication aide (MA) administering medications in the special care unit (SCU) during the 8:00am medication pass on 04/12/23 from 7:40am - 8:08am revealed:
-There was a bottle of hand sanitizer on both medication carts for the SCU.
-At 7:40am, the MA was administering medications to a resident in the television room then returned to the medication cart in the medication room.
-The MA did not sanitize or wash her hands prior to preparing medications for the next resident.
-The MA prepared and administered crushed oral medications in applesauce to a second resident at 7:43am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 10 -The MA fed the applesauce with crushed medications to the second resident with ungloved hands. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA prepared and administered oral medications to a third resident at 7:46am. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA prepared and administered oral medications to a fourth resident at 7:55am. -The MA put the medication cup to the resident's mouth and held the water cup to the resident's mouth with ungloved hands. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA prepared and administered oral medications to a fifth resident at 8:00am. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA prepared and administered crushed oral medications in applesauce to a sixth resident at 8:02am. -The MA fed the applesauce with crushed medications to the sixth resident with ungloved hands and placed her ungloved hand on the resident's back. -The MA held the water cup to the sixth resident's mouth with ungloved hands. -The MA returned to the medication cart and used her hands to enter documentation into the computer system.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 11 -The MA did not sanitize or wash her hands. -At 8:08am, the MA walked to the second medication cart in the medication room in the SCU and started preparing medications for another resident. -The MA did not sanitize or wash her hands prior to starting the administration of medications for the second medication cart. Interview with the MA in the SCU on 04/12/23 at 11:32am revealed: -The MAs were supposed to sanitize their hands between each resident when they administered medications. -She did not always use the hand sanitizer when administering medications because it burned her hands. -She did not usually use gloves when administering oral medications because the plastic cups were hard to grab with gloves on. -She had her own hand sanitizer that did not burn her hands as much as the facility's hand sanitizer. -Soap and water did not burn her hands and there were sinks with soap and water available to use in the SCU. -She had no explanation for not using her personal hand sanitizer or washing her hands with soap and water during the 8:00am medication pass on 04/12/23. Observation of a second MA administering medications in the assisted living (AL) during the 8:00am medication pass on 04/12/23 from 8:24am - 8:53am revealed: -There was no hand sanitizer on either of the two medication carts in the AL. -The MA had a lanyard around her neck with a small bottle of hand sanitizer. -At 8:24am, the MA was administering crushed	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 12	D 371		

medications in applesauce to a resident in a common sitting area then returned to the medication cart in the hallway.
-The MA did not sanitize or wash her hands prior to preparing medications for the next resident.
-The MA prepared and administered oral medications to a second resident at 8:29am.
-The MA also administered a topical medication cream to the second resident's fingernails and hands with gloved hands.
-The MA returned to the medication cart, removed the gloves, and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered oral medications to a third resident at 8:37am.
-The MA also administered an eye drop to the third resident with gloved hands at 8:39am.
-The MA returned to the medication cart, removed the gloves, and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered oral medications, including mixing a powdered medication into water, for a fourth resident at 8:47am.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-At 8:53am, the MA went down the hall and began preparing medications for a fifth resident without washing or sanitizing her hands.

Interview with the MA in the AL on 04/12/23 at 11:15am revealed:
-The MAs were supposed to sanitize their hands between each resident when they administered medications.
-There was usually hand sanitizer on both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063025	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA SOUTHERN PINES	101 BRUCEWOOD ROAD SOUTHERN PINES, NC 28387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 371	Continued From page 13	D 371		

medication carts in the AL.
-She had her own supply of hand sanitizer on her lanyard.
-She usually used hand sanitizer between each resident when she administered medications.
-She had no explanation for not sanitizing or washing her hands during the 8:00am medication pass on 04/12/23.

Interview with the Director of Health and Wellness (DHW) on 04/12/23 at 11:47am revealed:
-The MAs were trained to sanitize or wash their hands between each resident when administering medications.
-Hand sanitizer should be available and stored on each medication cart.
-The MAs should have sanitized or washed their hands between each resident when they administered medications that morning on 04/12/23.
-Not sanitizing or washing hands could transmit diseases.

Interview with the Administrator on 04/12/23 at 12:19pm revealed:
-The MAs were supposed to wash or sanitize their hands between each resident when administering medications.
-There was plenty of hand sanitizer in the facility and there were automatic hand sanitizer stations in the hallways.
-The MAs should wash or sanitize their hands between residents to prevent cross-contamination.