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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 a follow-up survey, annual survey, and complaint investigation on 08/24/24-08/29/24.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the main entrance door had a sounding device engaged that was audible throughout the facility when the door was opened which was accessible to residents who were identified as disoriented or had wandering behaviors and a Resident (#2) who had a diagnosis of dementia. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 94	D 067		

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D 067	Continued From page 1 beds. Review of the facility's census on 08/28/24 revealed there were 69 residents residing in the assisted living facility. Observation of the facility's main entrance door on 08/28/24 at 8:15am revealed the door was unlocked and did not alarm when the survey team entered the facility. Observation of the main entrance door on 08/29/24 at 7:30am revealed the door was unlocked and did not alarm when the survey team entered the facility. 1.a. Review of Resident #4's FL-2 dated 10/08/23 revealed: -Diagnoses included Alzheimer's Disease. -His level of care was assisted living facility (AL). -He was intermittently disoriented and verbally abusive. Review of staff notes dated 06/26/24 revealed that the Resident #4 refused his shower and was having increased confusion. b. Review of Resident #5's FL-2 dated 08/01/24 revealed: -Diagnoses included Escherichia coli, atrial fibrillation, pulmonary embolus, long term use of anticoagulants, hypertension, congestive heart failure, and cardiomyopathy. -Her level of care was AL. -She was intermittently disoriented. Review of Resident #5's care plan dated 07/23/24 revealed she had occasional confusion and some difficulty recalling details and needed occasional prompting or orientation.	D 067		

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D 067	Continued From page 2 c. Review of a fourth resident's FL-2 dated 11/15/23 revealed: -Diagnoses included unspecified dementia. -His level of care was AL. -He was intermittently disoriented. -He was taking two medications used to treat Alzheimer's Disease, Aricept and Namenda. Review of the fourth residents Resident Register dated 06/20/24 revealed he needed orientation to time and place. Interview with a MA on 08/29/24 at 10:58am revealed: -The fourth resident was unable to locate his room once he had left the room. -He would place a trash can outside his door so that he would be able to find his room. -She had not notified the PCP. Interview with the fourth resident on 08/29/24 at 7:05pm revealed: -He had to place a trash can outside his door to locate his room. -He had been getting lost in the building. d. Review of a fifth resident's FL-2 dated 05/22/24 revealed: -Diagnoses of dementia and memory loss and depression and anxiety. -Her level of care was AL. -There was no documentation in regard to orientation. Review of the fifth resident's physician notification fax sheet dated 07/01/24 from facility staff to the resident's PCP revealed: -The resident was more confused than usual wandering halls looking for small children.	D 067		

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D 067	Continued From page 3 -The resident said she felt like she was losing her mind. Review of the fifth resident's PCP acute visit dated 07/04/24 revealed: -The chief complaint was vascular dementia moderate with other behavioral disturbance, and adjustment disorder, adjustment disorder with mixed anxiety and depressed mood, frontotemporal neurocognitive disorder, restlessness and agitation, and anxiety disorder due to known physiological condition. -The resident had some exit seeking behaviors and they remained concerned about possible elopement. -She was having some adjustment disorder in trying to get used to the facility. Interview with the Senior Resident Care Coordinator (SRCD) on 08/29/24 at 10:50am revealed: -The fifth resident was confused, packed up her belongings and had wandering behaviors. -She was unable to locate her room every day. -She had declined since June 2024. -She spoke with the resident's PCP and she recommended a mental health evaluation and mental health evaluated her on 08/28/24. Observation of the fifth resident on 08/29/24 at 7:25pm revealed: -She was wandering the halls eating chocolate chip cookies and said she was unable to locate her room without help. -She walked past her room and down to the exit door on her hall and pushed on the door three times but the door did not open and when she turned around, she was tangled in the blind on the door. -She then walked down the hall and was able to	D 067		

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find her room.

e. Review of a sixth resident's FL-2 dated 06/20/24 revealed:
-Diagnosis included Alzheimer's Disease.
-Her level of care was AL.
-She was intermittently disoriented.

Review of the sixth resident's progress note dated 07/11/24 revealed:
-The resident was disoriented.
-She had moderate cognitive impairment unable to state month, year, or season, and unable to recall the name of facility.

Interview with the sixth resident on 08/29/24 at 7:35pm revealed:
-She had been able to get around the building, but it all looked the same.
-She had been unable to locate her room, and staff had helped her get back to her room.

Interview with a MA on 08/29/24 at 10:58am revealed the sixth resident had been forgetting where she was going and then was not able to find her room.

2. Review of Resident #2's FL-2 dated 07/15/24 revealed:
-Diagnoses included subarachnoid hemorrhage, multiple rib fractures, laceration to scalp, falls, mood disorder, hypertension dysphagia, and benign prostatic hyperplasia.
-There was no documentation in regard to orientation.

Review of Resident #2's Resident Record revealed his admission date was 07/13/24.

Review of Resident #2's physician order sheet

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dated 07/15/24 revealed diagnoses included dementia with behavioral disturbances.

Review of Resident #2's hospital encounter dated 07/02/24 revealed:
-Resident #2 was sent to the hospital for suicidal ideations.
-Resident #2's chief complaint was dementia, with past medical history significant for advanced stage Alzheimer's dementia.
-His current living facility refused to take him back.

Review of Resident #2's hospital discharge summary dated 07/13/24 at 11:25am revealed:
-Resident #2's chief complaint was dementia, with past medical history was significant for advanced stage Alzheimer's dementia.
-Resident #2 also had a similar admission on 06/15/24.

Review of Resident # 2's initial incident report dated 08/15/24 at 7:15pm revealed:
-Resident # 2 was outside in his wheelchair trying to cross the street.
-Resident #2 resided in the assisted living building.
-Resident #2 started to hit and kick the staff when they tried to bring him back into the building.
-Resident #2 was sent to the hospital for mental status change.
-Resident #2's power of attorney was notified on 08/15/24 at 7:15pm.

Review of Resident #2's staff notes dated 07/22/24 at 10:47pm revealed:
-Resident #2 was rolling around in his wheelchair for an hour and a half (90 minutes) yelling and disturbing other residents.
-Resident #2 went from hall to hall knocking on

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other resident's doors.
-Resident #2 was also yelling at the staff.
-Staff was unable to determine what was wrong with Resident #2 or what he needed.

Review of Resident #2's incident report dated 08/15/24 at 7:15pm revealed:
-Resident #2 came down the hall calling for help.
-Resident #2 stated a male was soliciting him.
-Two staff members tried to help him due to an odor they smelled, and he refused.
-Resident #2 went to his room and called 911 stating he had been solicited.
-Resident #2 then went to front of the building and tried to call 911 again and staff tried to redirect him.
-A visitor came into the building to notify staff that a resident was at the road.
-Staff attempted to bring Resident #2 back into the building and the resident was swinging and kicking the staff.
-Staff called 911, the Executive Director (ED), and the power of attorney who was going to meet him at the hospital.

Observation on 08/29/24 of the area where Resident #2 was located when found on 08/15/24 revealed:
-He was located on a sidewalk directly beside a 4-lane highway.
-Directly across the 4-lane highway was a movie theater and shopping area.
-The speed limit on the 4-lane highway was 35.
-The facility was approximately 35 steps from the 4-lane highway and approximately 67 steps from the main entrance.
-This 4-lane highway was slopping downward and lead to an intersection with another 4-lane highway.

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D 067	Continued From page 7 Observation of traffic on the 4-lane highway on 08/29/24 from 4:11pm to 4:17pm revealed there was a total of 48 vehicles that drove by the facility in a 6-minute timeframe. Interview with SRCD on 08/29/24 at 9:25am and 9:51am revealed: -On 08/15/24 after 5:00pm Resident #2 came down the hall pushing his wheelchair calling "help, help". -She and a medication aide (MA) checked on him and he said a man was trying to solicit him. -They tried to redirect Resident #2 but was unsuccessful. -Resident #2 said he was going to call 911 from his phone around 6:00pm. -He gave the SRCD his phone after he told 911, he had been solicited and she spoke with 911 and explained that she was his caregiver trying to take him to the restroom and then they hung up. -She went to Resident #2's room on 08/15/24 around 6:30pm to check on him and see if he needed incontinent care and he told her to leave. -Staff did not return to check on him after that. -Resident #2 exited the facility around 6:45pm through the front door on 08/15/24. -He went down the sidewalk to the 4-lane highway. -A person from the community came into the building at 7:00pm and talked with a MA and told her that a resident was at the highway. -He was in his wheelchair and was swinging his arms and legs. -She and another a MA went to the highway and brought him back into the facility. -Three staff members found Resident #2 sitting in his wheelchair at the highway. -Resident #2 was swinging his arms and legs cursing at the staff as he had a grip on the wheels of is wheelchair and staff was unable to push him.	D 067		

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-One MA picked up the resident's feet and he released his hands, and staff rolled him backwards into the facility.
-Staff parked him inside the facility, and he started kicking the front door.
-The facility called 911 and his family member for his change in condition at 7:15pm and he was sent to the hospital.
-Resident #2 was able to get out the main entrance again while she was calling the family member.
-Staff found him on the porch and they waited with him until the ambulance arrived.
-The main entrance was not alarmed on 08/15/24 when Resident #2 exited the facility twice.
-She thought that the main entrance was on a timer and locked at 8:00pm but was not sure.

Interview with the Maintenance Director (MD) on 08/29/24 at 9:38am, 12:10pm, and 1:41pm revealed:
-The alarm system was only a few years old.
-The main entrance door was locked by one of the MAs.
-The main entrance door did not lock automatically.
-The main entrance only alarmed when the door was locked.
-He checked the alarm system, and he could make the main entrance doors alarm to staff beepers and portable phone when the door was unlocked 24 hours a day and 7 days a week.
-He was instructed by a previous Administrator not to activate the door to alarm because it would alarm every time the main entrance was opened.

Interview with Resident #2's primary care provider (PCP) on 08/29/24 at 2:25pm revealed:
-She was new to the facility.
-She was unsure if Resident #2 was appropriate

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for assisted living but she had only visited him one time.
-Because she had only had one visit, she was unable to speak to his baseline orientation.

Interview with Resident #2's power of attorney (POA) on 08/29/24 revealed:
-He was seen by Neurology in 2020 and diagnosed with dementia.
-The SRCD had called her and informed her that Resident #2 had a mental breakdown and that he left the facility on 08/15/24.
-He was seen by Psychiatrist in the hospital July 2024, and she was told that he had dementia with behaviors and that he could not control his behaviors.
-She had been informed by a Neurologist during his hospital admission in June 2024 that he was not able to control his behaviors and he was placed on medications.
-She was informed during his July 2024 hospital admission by the attending provider and Psychiatrist that he would need to be in a memory care unit.

Interview with the facility's Licensed Practical Nurse (LPN) on 08/29/24 at 11:10am revealed:
-There were three staff, herself, the Memory Care Director (MCD), and the SRCD that would go to the hospitals or other facilities to evaluate potential residents.
-She and the SRCD went to a facility to evaluate Resident #2 before accepting him (not sure of the date).
-They were not provided any paperwork to review but did interview him and he could answer their questions and walk.
-His previous facility told them that he would get agitated when he wanted to visit his family member in their memory care unit.

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D 067	Continued From page 10 -She spoke with his PCP, and they decided he would be acceptable for the assisted living facility even with his behaviors. -The facility admitted residents to assisted living if dementia was not their first diagnoses. -She was not sure who determined what the primary diagnoses was. -She was not sure if the main entrance to the facility had an alarm. -She did not know where Resident #2's paperwork was from the assessment. Interview with the Administrator on 08/29/24 at 1:45pm revealed: -She was not sure if there was an alarm on the main entrance door. -The facility did not have any residents that had wandering behaviors. -The facility locked the main entrance door at a specific time in the evening and unlocked them in the morning, not sure of the times. Interview with the Area Regional Nurse on 08/29/24 at 2:00pm revealed: -She was new to her role. -She was not sure if the main entrance door had an alarm. -The facility was not required to have the main entrance door alarm every time it was opened. -The residents and staff would be overwhelmed with the alarm going off all day. -The main entrance door was locked in the evening and unlocked in the morning, not sure what the times were. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. The facility failed to ensure the main entrance	D 067		

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D 067	Continued From page 11 door was alarmed with an audible sounding device when the doors were opened to prevent residents who were identified as disoriented or having wandering behaviors and a resident who was diagnosed with advanced stage Alzheimer's dementia from exiting the facility without the staff's knowledge. The facility's failure was 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 08/29/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 13, 2024	D 067		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff C) completed their 5, 10, or 15 hour training and clinical skills.	D 125		

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D 125	Continued From page 12 The findings are: Review of Staff C's personnel record revealed: -Staff C was hired on 08/07/23 as a medication aide (MA). -There was no documentation the 5-, 10-, or 15-hour training was completed. -There was a medication clinical skills checklist that was not completed and signed by a Registered Nurse. Interview with the Business Office Manager (BOM) on 08/29/24 at 5:02pm revealed: -She received the medication aide trainings and checklist from the nurse. -She was responsible for ensuring staff had their trainings in their personnel files. -She had not audited any personnel files since she was hired April 2024. Interview with the Administrator on 08/29/24 at 6:08pm revealed: -She was in the facility periodically since May 2024. -She knew MAs had to complete their trainings and clinical skills checklist before administering medications. -The Resident Care Coordinator (RCC) and BOM were responsible to ensure the 5-, 10-, or 15-hour training and clinical skills checklist for the MAs were done. -She was not aware Staff C was missing training and clinical skills checklist documentation.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

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to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure health care was coordinated as ordered for 2 of 6 sampled residents (#2, #3) related to failing to obtain labwork to check three blood tests and a urinalysis test (#3) and a delay in collecting and testing a urinalysis test (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 04/09/24 revealed diagnoses included dementia, chronic kidney disease, acute respiratory failure with hypoxia, and fracture of pelvis without disruption of pelvic ring.

a. Review of Resident #3's primary care provider (PCP) visit note dated 06/20/24 revealed:
-The resident was significantly hypotensive (low blood pressure), had dizziness, increased pallor (pale skin), and appeared to be volume contracted (dehydrated).
-There was potential need for emergency room evaluation, but the resident's power of attorney opted not to send the resident to the hospital.
-Facility staff was to monitor the resident's blood pressure and push fluids.
-There was an order for the following labwork: complete blood count (CBC), comprehensive metabolic panel (CMP), and thyroid stimulating hormone (TSH). (CBC measures the number and types of cells in your blood to provide information about overall health. CMP measures substances in the blood to evaluate the body's chemical balance and metabolism. TSH measures the amount of thyroid hormones in the

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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 273	Continued From page 14 blood to determine if the thyroid is functioning properly). Review of Resident #3's lab results revealed there was no documentation of a CBC, CMP, or TSH blood test being done as ordered on 06/20/24. Interview with the Memory Care Director (MCD) on 08/29/24 at 5:52pm revealed: -The medication aide (MA) on duty at the time an order was received was responsible for ensuring orders for labwork were completed. -The MAs were responsible for sending orders for labwork to the lab company used by the facility. -If Resident #3's labwork was not in the record, it was not done. -She was responsible for checking behind the MAs to make sure labs were completed. -She had not seen Resident #3's orders for labwork on 06/20/24. Interview with the Administrator on 08/29/24 at 7:00pm revealed the MCD or Resident Care Coordinator (RCC) were responsible for checking to make sure lab orders were completed. Interviews with the Area Regional Nurse (ARN) on 08/29/24 at 2:42pm and 7:05pm revealed: -If the lab results were not in Resident #3's record, the labs were not done. -She spoke with a representative at the lab company used by the facility today, 08/29/24, and there were no records of Resident #3's labs ordered on 06/20/24. -Staff on duty when an order was received was responsible for sending lab orders to the lab used by the facility. -Staff on duty could be a MA, the MCD, or the RCC.	D 273		

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D 273	Continued From page 15 Attempted telephone interviews with Resident #3's PCP on 08/29/24 at 4:34pm and 4:50pm were unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #3 was not interviewable. b. Review of Resident #3's primary care provider (PCP) visit note dated 06/20/24 revealed: -The was significantly hypotensive (low blood pressure), had dizziness, increased pallor (pale skin), and appeared to be volume contracted (dehydrated). -There was potential need for emergency room evaluation, but the resident's power of attorney opted not to send the resident to the hospital. -Facility staff was to monitor the resident's blood pressure and push fluids. -There was an order for urinalysis (UA) with culture and sensitivity (used to check for urinary tract infections). Review of Resident #3's lab result records revealed there was no documentation of UA with culture and sensitivity being done as ordered on 06/20/24. Review of Resident #3's facility notes revealed no documentation to indicate the resident's urine was collected by staff to send to the lab for UA with culture and sensitivity as ordered on 06/20/24. Interview with the Memory Care Director (MCD) on 08/29/24 at 5:52pm revealed: -The medication aide (MA) on duty at the time an order was received was responsible for ensuring orders for UAs were completed.	D 273		

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-The MAs or personal care aides (PCAs) were responsible for collecting a urine sample and calling the lab used by the facility to come pick up the urine sample.
-If Resident #3's UA results were not in the record, it was not done.
-She was responsible for checking behind the MAs to make sure UAs were completed.
-She had not seen Resident #3's order for UA with culture and sensitivity on 06/20/24.
-The resident was not currently having symptoms of a urinary tract infection to her knowledge.

Interview with the Administrator on 08/29/24 at 7:00pm revealed the MCD or Resident Care Coordinator (RCC) were responsible for checking to make sure UA orders were completed.

Interviews with the Area Regional Nurse (ARN) on 08/29/24 at 2:42pm and 7:05pm revealed:
-If the UA results were not in Resident #3's record, the UA was not done.
-She spoke with a representative at lab company used by the facility today, 08/29/24, and there was no record of Resident #3's UA being done as ordered on 06/20/24.
-Staff on duty when an order was received was responsible for sending lab orders to the lab used by the facility.
-Staff on duty could be a MA, the MCD, or the RCC.

Attempted telephone interviews with Resident #3's PCP on 08/29/24 at 4:34pm and 4:50pm were unsuccessful.

Based on observations, interviews, and record review, it was determined that Resident #3 was not interviewable.

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D 273	Continued From page 17 2. Review of Resident # 2's FL-2 dated 07/15/2024 revealed diagnoses included subarachnoid hemorrhage, multiple rib fractures, laceration to scalp, falls, mood disorder, hypertension dysphagia, and benign prostatic hyperplasia. Review of Resident #2's Resident Record revealed his admission date was 07/13/24. Review of Resident #2's physician notification fax sheet dated 08/12/24 revealed an order for a urinalysis (UA) and culture and sensitivity. Review of Resident #2's UA report revealed: -The UA was collected on 08/15/24. -The lab received the UA to process on 08/16/24. -The initial report date was 08/16/24. -The final report date was 08/18/24 and it was positive for a urinary tract infection (UTI). Interview with a medication aide (MA) on 08/29/24 at 1:30pm revealed: -The provider handed their orders to the MA. -Urine would have been collected and the lab service notified to pick up the specimen from the facility. -A note would have been placed on the 24-hour report and a verbal report would have been provided to next shift. -A note would have been placed in the resident's record that a UA was collected and sent to the lab. -There was documentation in the 24-hour report that a UA was collected on Resident #2. -Documentation that the UA was collected and sent to the lab on 08/12/24 should have been in the facility's lab computer system. -There was not any documentation that a UA for Resident #2 was sent to the lab from	D 273		

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D 273	Continued From page 18 08/12/24-08/15/24. Interview with the Senior Resident Care Director (SRCD) on 08/29/24 at 1:19pm revealed: -The provider would have written the orders for Resident #2's urinalysis and then placed them in the folder to be processed. -The SRCD, Resident Care Coordinator (RCC), and MA checked the folder daily. -When a specimen was collected and sent to the lab the person that collected the order documented it in a book. -The lab was notified to pick up the specimen after it was collected. -She was unable to locate documentation that the UA had been sent for Resident #2 on 08/12/24. -A copy of the order should have been made and the original placed in the resident's record. -The copied order was placed in the red folder until it was completed and then placed in the green folder. -She was not sure what happened related to the UA for Resident #2. Review of the 24-hour shift report dated 08/12/24 first shift revealed there was an entry that a UA was collected on Resident #2. Interview with the Administrator on 08/29/24 at 1:45pm revealed: -She did not know the process for orders at the facility. -She did not know that Resident #2's UA was not collected when it was ordered. -She expected orders to be completed when they were ordered. Interview with the Area Regional Nurse on 08/29/24 at 1:51pm revealed: -She was new in her role.	D 273		

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D 273	Continued From page 19 -She did not know what the facility process was for completing orders. -Orders should have been completed when they were ordered. Interview with Resident #2's primary care provider (PCP) on 08/29/24 at 2:25pm revealed: -She was new to the facility and had only seen Resident #2 once. -She had requested a UA and culture on 08/12/24. -She was concerned that it had taken 3 days to obtain the urine specimen.	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. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation and implementation for 1 of 5 residents (#3) sampled who had an order for heart rate to be checked twice daily and was receiving medication that could lower heart rate. The findings are: Review of Resident #3's current FL-2 dated 06/29/18 revealed diagnoses included dementia, chronic kidney disease, acute respiratory failure	D 276		

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D 276	Continued From page 20 with hypoxia, and fracture of pelvis without disruption of pelvic ring. Review of Resident #3's physician's order dated 06/20/24 revealed an order to check and record heart rate (HR) and blood pressure (BP) twice a day - hold Metoprolol if systolic blood pressure (SBP) less than (<) 110, call provider if SBP greater than (>) 180 or heart rate > 110. (Metoprolol is used to lower blood pressure and heart rate.) Review of Resident #3's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 25mg 1 tablet twice a day, hold for SBP < 110; call if SBP is >180 or HR > 110. -Metoprolol and BP were scheduled at 8:00am and 8:00pm. -Metoprolol was documented as administered twice a day from 06/21/24 - 06/30/24. -The resident's BP ranged from 114/70 - 149/75 from 06/21/24 - 06/30/24. -There was no entry on the eMAR to document HR. -There was no documentation of the resident's HR being checked twice a day as ordered. Review of Resident #3's July 2024 eMAR revealed: -There was an entry for Metoprolol Tartrate 25mg 1 tablet twice a day, hold for SBP < 110; call if SBP is >180 or HR > 110. -Metoprolol and BP were scheduled at 8:00am and 8:00pm. -Metoprolol was documented as administered twice a day from 07/01/24 - 07/31/24 except at 8:00am on 07/24/24 when it was held for SBP of 105.	D 276		

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-The resident's BP ranged from 114/65 - 160/76 from 07/01/24 - 07/31/24.
-There was no entry on the eMAR to document HR.
-There was no documentation of the resident's HR being checked twice a day as ordered.

Review of Resident #3's August 2024 eMAR revealed:
-There was an entry for Metoprolol Tartrate 25mg 1 tablet twice a day, hold for SBP < 110; call if SBP is >180 or HR > 110.
-Metoprolol and BP were scheduled at 8:00am and 8:00pm.
-Metoprolol was documented as administered twice a day from 08/01/24 - 08/28/24 except at 8:00am on 08/01/24 when it was held for SBP of 103.
-The resident's BP ranged from 117/59 - 156/83 from 08/01/24 - 08/28/24.
-There was no entry on the eMAR to document HR.
-There was no documentation of the resident's HR being checked twice a day as ordered.

Observation of Resident #3's medications on hand on 08/29/24 at 1:21pm revealed:
-There was a supply of Metoprolol Tartrate 25mg with a start date of 08/19/24.
-The instructions were to take 1 tablet twice a day, hold for SBP <110; call if SBP >180 or HR >110.

Interview with a medication aide (MA) on 08/29/24 at 1:30pm revealed:
-The MAs did not enter orders into the eMAR system, so she was not sure why Resident #3's eMAR did not show the resident's HR checks.
-She used a BP machine to check Resident #3's BP before she administered the Metoprolol.

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D 276	Continued From page 22 -The BP machine also checked the HR when the BP was checked. -She usually wrote down the resident's BP and HR on her notebook paper so she could enter the numbers into the eMAR system later. -She documented the resident's HR in her notebook, and it was 71 that morning, 08/29/24. -She had not contacted the resident's primary care provider (PCP) because the resident's HR had not been >110. -The resident's HR was usually in the 70s or 80s. Telephone interview with the Quality Assurance Specialist at the facility 's contracted pharmacy on 08/29/24 at 4:53pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility staff was responsible for reviewing and approving the orders before they became active orders in the eMAR system. -The prompt for HR in the eMAR system was "pulse" so the eMAR system may not have read the prompt correctly if it was entered as HR. -The facility staff had access to and could have added pulse to the eMAR system and there would be an entry for documenting the resident's HR. Interview with the Memory Care Director (MCD) on 08/29/24 at 5:52pm revealed: -The facility's contracted pharmacy entered orders into the eMAR system. -She, the MAs, and the Resident Care Coordinator (RCC) were responsible for checking the orders in the eMAR system to make sure they were accurate prior to approving the orders. -She was not aware Resident #3's eMAR did not have an entry to document the resident's HR. -The resident's HR should be checked twice a day and documented on the eMAR.	D 276		

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D 276	Continued From page 23 Interview with the Administrator on 08/29/24 at 7:00pm revealed: -The facility's contracted pharmacy entered orders into the eMAR system. -The MAs, MCD, and RCC were responsible for checking the eMARs to make sure orders were entered accurately. Attempted telephone interviews with Resident #3's PCP on 08/29/24 at 4:34pm and 4:50pm were unsuccessful.	D 276		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication staff who administered medications actually observed 1 of 4 residents (#1) taking their medications during the morning medication pass observed in the special care unit (SCU) on 08/29/24. The findings are: Review of Resident #1's current FL-2 dated 03/15/24 revealed:	D 366		

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D 366	Continued From page 24 -Diagnoses included dementia, metabolic encephalopathy, myasthenia gravis, type 2 diabetes, hypertension, coronary artery disease, and gastroesophageal reflux disease. -The resident was documented as constantly disoriented. -The resident was documented as having wandering behaviors. Observation of the 8:00am medication pass in the special care unit (SCU) on 08/29/24 revealed: -Resident #1 was sitting at a table in the SCU dining room on the left with 2 other residents sitting at the table with him. -There were 7 other residents at other tables in the dining room with Resident #1. -There were 2 personal care aides (PCAs) in the dining room at another table providing feeding assistance to other residents. -Resident #1's back was to the PCAs and they could not see his plate from where they were sitting. -The medication aide (MA) prepared 5 medications to administer to Resident #1. -The MA put one Cephalexin 500mg capsule (an antibiotic for infection) and one Isosorbide Mononitrate 60mg ER tablet (for heart and blood pressure) in a medication cup. -The MA prepared and crushed one Metformin 1,000mg tablet, one Acetaminophen 500mg tablet (for pain or fever), and one Vitamin D3 50,000units tablet (for Vitamin D deficiency). -The MA then took the breakfast plate for Resident #1 from one of the dietary aides and took it to the medication room. -The MA sprinkled the crushed medications all over the resident's scrambled eggs on his plate and stirred it together. -The MA went into the dining room and sat the resident's plate with crushed medications mixed	D 366		

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in the scrambled eggs on the table in front of the resident.
-At 8:10am, the MA administered the whole Cephalexin capsule and Isosorbide Mononitrate tablet with a spoon to the resident.
-The MA did not encourage or attempt to have the resident eat the scrambled eggs with the other crushed medications.
-The MA left the dining room and did not stay to observe the resident take the crushed medications mixed in the scrambled eggs.
-The MA went across the hall to the medication room and started preparing medications for another resident.
-The MA's back was to the dining room and she could not see Resident #1.
-At 8:20am, the MA came to the dining room door and asked another resident to go to the medication room and she left immediately and went back to the medication room.
-The MA did not check on Resident #1 to see if he had eaten the eggs mixed with the crushed medications.
-At 8:28am, the MA went back into the dining room, walked past Resident #1's table, and went to another table to administer medications to another resident.
-The MA did not look at or check Resident #1's plate when she walked past the resident at 8:28am and again at 8:29am when she exited the dining room.
-At 8:30am, the MA went back into the dining room and walked past Resident #1 to ask a question to one of the PCAs in the dining room.
-The MA did not look at or check Resident #1's plate when she walked past the resident at 8:30am and again at 8:31am when she exited the dining room.
-At 8:40am, the MA went back into the dining room, walked past Resident #1's table, and went

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to another table to administer medications to another resident.
-The MA did not look at or check Resident #1's plate when she walked past the resident at 8:40am and again at 8:45am when she exited the dining room.
-At 8:49am, the MA went back across the hall to the medication room with her back to the dining room as she prepared medications.
-At 9:09am, the resident finished eating and his plate was removed from the dining room by dietary staff.
-The resident had eaten all his scrambled eggs, with a few scattered tiny morsels on the plate.

Interview on 08/29/24 at 9:15am with one of the PCAs in the dining room with Resident #1 on 08/29/24 revealed:
-She was new at the facility, and she did not administer medications.
-She had not been asked to observe any residents take their medications.
-She was not aware of any residents who had medications mixed in with the food at mealtimes.

Interview on 08/29/24 at 9:24am with the second PCA in the dining room with Resident #1 on 08/29/24 revealed:
-She had worked at the facility for 5 years and she did not administer medications.
-No one had left medications in the dining room and asked her to observe a resident take their medications.
-She had "no clue" if medications were mixed in food during mealtimes for any of the residents.

Interview with the MA on 08/29/24 at 1:54pm revealed:
-She was aware she was supposed to observe residents take their medications.

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 _____	R-C 08/29/2024

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 366	Continued From page 27 -She usually crushed Resident #1's medications that could be crushed and put them in his food because the resident would sometimes not take the medications depending on his mood. -She usually went back to the dining room to check to see if the resident ate all his food mixed with medications or the PCAs would watch the resident. -She thought the resident ate all his eggs that morning, 08/26/24. Interview with the Memory Care Director (MCD) on 08/29/24 at 2:01pm revealed: -The MAs had been trained and knew they were supposed to observe all residents take all their medications. -If the MA did not observe the resident take his medication, another resident could unknowingly ingest the food with medication or the resident may not get the full amount of medication. Interview with the Administrator on 08/29/24 at 2:31pm revealed: -The MAs should observe residents while they take all their medications. -If Resident #1 was not observed to take his medication, the resident might not take all of it or another resident could take the medication. Based on observations, interviews, and record review, it was determined that Resident #1 was not interviewable.	D 366		