Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060156	A. BUILDING: _____ B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LITTLE AVENUE	7745 LITTLE AVENUE CHARLOTTE, NC 28226

(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 and the Mecklenburg County Department of Social Services conducted an annual survey from 01/28/25 to 01/29/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine healthcare needs for 1 of 5 sampled residents (#2) related to notifying the Primary Care Provider (PCP) for finger stick blood sugar (FSBS) of 401 or greater. The findings are: Review of Resident #2's current FL2 dated 08/22/24 revealed diagnoses included diabetes mellitus type 2 and hypertension. Review of Resident #2's Primary Care Provider's (PCP) order dated 09/24/24 revealed: -There was an order to check Resident #2's fingerstick blood sugar (FSBS) before each meal and at bedtime. -There was an order to notify Resident #2's PCP if his FSBS was 401 or greater. Review of Resident #2's November 2024 electronic Medication Administration Record (eMAR) revealed:	D 273	10A NCAC 13F .0902(b) Health Care Referral and Follow Up All resident orders will be audited to identify any/all orders with notification or other parameters. DHW/RCC/designee will maintain an ongoing list of residents with parameters and review documentation weekly to ensure compliance and prompt follow-up. All med aides will be retrained regarding med order parameters and MD notification parameters. DHW or designee will report review results weekly at morning management meeting to ensure ongoing compliance and prompt follow-up. ED will maintain overall responsibility for ensuring compliance.	3/15/2025

Reviewed and Ascknowledged by ELR on 03/06/25 Elizabeth Record

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D 273	Continued From page 1 -There was one instance his FSBS was greater than 401 and no documentation Resident #2's PCP was notified. -On 11/13/24 at 4:30pm his FSBS was 426. Review of Resident #2's December 2024 eMAR revealed: -There were four instance his FSBS was greater than 401 and no documentation Resident #2's PCP was notified. -On 12/01/24 at 11:30am his FSBS was 493. -On 12/07/24 at 8:00pm his FSBS was 552. -On 12/31/24 at 4:30pm his FSBS was 417. -On 12/31/24 at 8:00pm his FSBS was 466. Review of Resident #2's January 2025 eMAR revealed: -There was one instance his FSBS was greater than 401 and no documentation Resident #2's PCP was notified. -On 01/07/25 at 11:30am his FSBS was 423. Review of Resident #2's record revealed there was no documentation his PCP was notified of FSBS greater than 401 on 11/13/24 at 4:30pm, 12/01/24 at 11:30am, 12/07/24 at 8:00pm, 12/31/24 at 4:30pm and 8:00pm and on 01/07/25 at 11:30am. Interview with a medication aide (MA) on 01/29/25 at 12:13pm revealed: -She thought she reported Resident #2's FSBS results to his PCP each time the order indicated. -She thought she documented in Resident #2's progress notes each time she reported to his PCP. -She thought she reported Resident #2's FSBS reading of 423 on 01/07/25 at 11:30am to his PCP and though she just forgot to document it.	D 273		

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D 273	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 01/29/25 at 12:50pm revealed: -The MAs were responsible to contact Resident #2's PCP when his FSBS were outside of parameters. -During business hours, the MAs should contact the PCP and get directions from her. -After business hours, the MAs should contact the on-call provider for further directions. -The MAs were responsible for documenting all contact with the PCP or on-call providers in Resident #2's progress notes. Interview with Resident #2's PCP on 01/29/25 at 11:30am revealed facility staff usually notified the on-call providers of his high FSBS, but she was not usually notified directly. Interview with the Health and Wellness Director (HWD) on 01/29/25 at 12:33pm revealed: -The MAs were responsible to contact Resident #2's PCP for FSBS outside of parameters and documenting it in the resident's progress notes. -She did audits periodically to ensure documentation was being completed when Resident #2's PCP was notified for FSBS outside of parameters. -There was no set schedule for documentation audits, and she was unsure when her last audit was completed. Interview with the Administrator on 01/29/25 at 1:29pm revealed: -The MAs were responsible for documenting all PCP notifications in the resident's eMAR, the 24-hour report and in the resident's progress notes. -There was no regular schedule for audits of residents' progress notes.	D 273		

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D 358	Continued From page 3 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 interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2) related to a medication to decrease blood sugar levels. The findings are: Review of Resident #2's current FL2 dated 08/22/24 revealed diagnoses included diabetes mellitus type 2 and hypertension. Review of Resident #2's Primary Care Provider's (PCP) order dated 09/24/24 revealed: -There was an order to check Resident #2's fingerstick blood sugar (FSBS) before each meal and at bedtime. -There was an order to inject aspart insulin (a medication to lower blood sugar levels) per sliding scale three times daily with meals: FSBS less than 120=0 units, 120-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=9 units, 301-350=10 units, 351-400=11 units, and notify Resident #2's PCP if FSBS was 401 or	D 358 D 358	10A NCAC 13F .1004(a) Med Admin All med aides will be re-trained regarding sliding scale insulin administration and following order parameters. ED/DHW/RCC or designee will review daily sliding scale insulin documentation for 3 weeks and then weekly thereafter. DHW or designee will report daily/weekly review results at morning management meeting to ensure ongoing compliance and prompt follow-up. ED will maintain overall responsibility for ensuring ongoing compliance.	3/15/2025

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D 358	Continued From page 4 greater. Review of Resident #2's PCP order dated 01/21/25 revealed: -There was an order to check Resident #2's FSBS before meals and at bedtime. -There was an order to inject aspart insulin 5 units at lunch and dinner. -There was an order to inject aspart insulin per sliding scale before meals and at bedtime: FSBS less than 120=0 units, 121-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=9 units, 301-350=10 units, 351-400=11 units, 401-450=12 units and notify Resident #2's PCP if FSBS was 451 or greater. Review of Resident #2's November 2024 electronic Medication Administration Record (eMAR) revealed: -There was an entry to check FSBS before meals and at bedtime, at 6:30am, 11:30am, 4:30pm, and 8:00pm.; inject apart insulin per sliding scale; FSBS less than 120=0 units, 120-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=9 units, 301-350=10 units, 351-400=11 units, and notify Resident #2's PCP if FSBS was 401 or greater. -There was no order on the eMAR for aspart insulin per sliding scale three times daily with meals. -There was documentation his FSBS on 11/01/24 at 8:00pm was 280 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/02/24 at 8:00pm was 180 and he received 6 units of aspart insulin. -There was documentation his FSBS on 11/03/24 at 8:00pm was 328 and he received 10 units of aspart insulin. -There was documentation his FSBS on 11/04/24	D 358		

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D 358	Continued From page 5 at 6:30am was 170 and he received 0 units of aspart insulin, when he should have received 6 units. -There was documentation his FSBS on 11/04/24 at 8:00pm was 377 and he received 11 units of aspart insulin. -There was documentation his FSBS on 11/05/24 at 8:00pm was 328 and he received 10 units of aspart insulin. -There was documentation his FSBS on 11/06/24 at 8:00pm was 227 and he received 8 units of aspart insulin. -There was documentation his FSBS on 11/07/24 at 8:00pm was 288 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/08/24 at 8:00pm was 194 and he received 6 units of aspart insulin. -There was documentation his FSBS on 11/09/24 at 8:00pm was 292 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/10/24 at 8:00pm was 198 and he received 6 units of aspart insulin. -There was documentation his FSBS on 11/11/24 at 8:00pm was 327 and he received 10 units of aspart insulin. -There was documentation his FSBS on 11/12/24 at 8:00pm was 395 and he received 11 units of aspart insulin. -There was documentation his FSBS on 11/13/24 at 8:00pm was 220 and he received 8 units of aspart insulin. -There was documentation his FSBS on 11/14/24 at 8:00pm was 221 and he received 8 units of aspart insulin. -There was documentation his FSBS on 11/15/24 at 8:00pm was 283 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/16/24	D 358		

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D 358	Continued From page 6 at 8:00pm was 315 and he received 10 units of aspart insulin. -There was documentation his FSBS on 11/18/24 at 8:00pm was 272 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/19/24 at 8:00pm was 271 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/20/24 at 8:00pm was 376 and he received 11 units of aspart insulin. -There was documentation his FSBS on 11/21/24 at 8:00pm was 357 and he received 11 units of aspart insulin. -There was documentation his FSBS on 11/22/24 at 8:00pm was 134 and he received 4 units of aspart insulin. -There was documentation his FSBS on 11/23/24 at 8:00pm was 289 and he received 9 units of aspart insulin. -There was documentation his FSBS on 11/24/24 at 8:00pm was 249 and he received 8 units of aspart insulin. -There was documentation his FSBS on 11/25/24 at 8:00pm was 177 and he received 6 units of aspart insulin. -There was documentation his FSBS on 11/26/24 at 8:00pm was 177 and he received 6 units of aspart insulin. -There was documentation his FSBS on 11/27/24 at 8:00pm was 309 and he received 10 units of aspart insulin. -There was documentation his FSBS on 11/28/24 at 8:00pm was 313 and he received 10 units of aspart insulin. -There was documentation his FSBS on 11/29/24 at 4:30pm was 376 and he received 10 units of aspart insulin, when he should have received 11 units. -There was documentation his FSBS on 11/29/24	D 358		

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D 358	Continued From page 7 at 8:00pm was 199 and he received 6 units of aspart insulin. -There was documentation his FSBS on 11/30/24 at 8:00pm was 149 and he received 4 units of aspart insulin. Review of Resident #2's December 2024 eMAR revealed: -There was an entry to check FSBS before meals and at bedtime, at 6:30am, 11:30am, 4:30pm, and 8:00pm.; inject apart insulin per sliding scale; FSBS less than 120=0 units, 120-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=9 units, 301-350=10 units, 351-400=11 units, and notify Resident #2's PCP if FSBS was 401 or greater. -There was no order on the eMAR for aspart insulin per sliding scale three times daily with meals. -There was documentation his FSBS on 12/01/24 at 8:00pm was 329 and he received 10 units of aspart insulin. -There was documentation his FSBS on 12/02/24 at 8:00pm was 399 and he received 11 units of aspart insulin. -There was documentation his FSBS on 12/03/24 at 8:00pm was 180 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/04/24 at 8:00pm was 220 and he received 8 units of aspart insulin. -There was documentation his FSBS on 12/05/24 at 6:30am was 120 and he received 0 units of aspart insulin, when Resident #2 should have received 4 units. -There was documentation his FSBS on 12/06/24 at 8:00pm was 284 and he received 9 units of aspart insulin. -There was documentation his FSBS on 12/07/24 at 6:30am was 120 and he received 0 units of	D 358		

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D 358	Continued From page 8 aspart insulin, when Resident #2 should have received 4 units. -There was documentation his FSBS on 12/07/24 at 8:00pm was 552 and he received 12 units of aspart insulin. -There was documentation his FSBS on 12/08/24 at 8:00pm was 255 and he received 9 units of aspart insulin. -There was documentation his FSBS on 12/09/24 at 8:00pm was 192 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/10/24 at 8:00pm was 205 and he received 8 units of aspart insulin. -There was documentation his FSBS on 12/11/24 at 8:00pm was 477 and he received 11 units of aspart insulin. -There was documentation his FSBS on 12/12/24 at 8:00pm was 294 and he received 9 units of aspart insulin. -There was documentation his FSBS on 12/13/24 at 8:00pm was 181 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/14/24 at 8:00pm was 194 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/15/24 at 8:00pm was 164 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/16/24 at 8:00pm was 209 and he received 8 units of aspart insulin. -There was documentation his FSBS on 12/17/24 at 8:00pm was 360 and he received 11 units of aspart insulin. -There was documentation his FSBS on 12/18/24 at 8:00pm was 213 and he received 8 units of aspart insulin. -There was documentation his FSBS on 12/19/24 at 4:30pm was 251 and he received 8 units of	D 358		

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D 358	Continued From page 9 aspart insulin, when Resident #2 should have received 9 units. -There was documentation his FSBS on 12/19/24 at 8:00pm was 144 and he received 4 units of aspart insulin. -There was documentation his FSBS on 12/20/24 at 8:00pm was 186 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/21/24 at 8:00pm was 300 and he received 9 units of aspart insulin. -There was documentation his FSBS on 12/22/24 at 8:00pm was 188 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/23/24 at 8:00pm was 221 and he received 8 units of aspart insulin. -There was documentation his FSBS on 12/24/24 at 8:00pm was 196 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/25/24 at 4:30pm was 187 and he received 5 units of aspart insulin, when Resident #2 should have received 6 units. -There was documentation his FSBS on 12/25/24 at 8:00pm was 495 and he received 11 units of aspart insulin. -There was documentation his FSBS on 12/26/24 at 8:00pm was 170 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/27/24 at 8:00pm was 306 and he received 10 units of aspart insulin. -There was documentation his FSBS on 12/28/24 at 11:30am was 122 and he received 0 units of aspart insulin, when Resident #2 should have received 4 units: -There was documentation his FSBS on 12/28/24 at 8:00pm was 221 and he received 8 units of aspart insulin.	D 358		

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D 358	Continued From page 10 -There was documentation his FSBS on 12/29/24 at 8:00pm was 154 and he received 6 units of aspart insulin. -There was documentation his FSBS on 12/31/24 at 8:00pm was 466 and he received 11 units of aspart insulin. Review of Resident #2's January 2025 eMAR revealed: -There was an entry dated 12/24/24 to check FSBS before meals and at bedtime, at 6:30am, 11:30am, 4:30pm, and 8:00pm.; inject apart insulin per sliding scale; FSBS less than 120=0 units, 120-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=9 units, 301-350=10 units, 351-400=11 units, and notify Resident #2's PCP if FSBS was 401 or greater. -The entry dated 12/24/24 did not indicate aspart insulin per sliding scale three times daily with meals. -The entry dated 12/24/24 was discontinued on 01/21/25. -There was an entry dated 01/21/25 to check FSBS before meals and at bedtime, at 7:30am, 11:30am, 4:30pm, and 8:00pm.; inject apart insulin per sliding scale; FSBS less than 120=0 units, 121-150=4 units, 151-200=6 units, 201-250=8 units, 251-300=9 units, 301-350=10 units, 351-400=11 units, 401-450=12 units and notify Resident #2's PCP if FSBS was 451 or greater. -There was documentation his FSBS on 01/01/25 at 8:00pm was 353 and he received 11 units of aspart insulin. -There was documentation his FSBS on 01/02/25 at 8:00pm was 353 and he received 10 units of aspart insulin. -There was documentation his FSBS on 01/04/25 at 8:00pm was 264 and he received 9 units of aspart insulin.	D 358		

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D 358	Continued From page 11 -There was documentation his FSBS on 01/05/25 at 8:00pm was 385 and he received 11 units of aspart insulin. -There was documentation his FSBS on 01/06/25 at 6:30am was 120 and he received 0 units of aspart insulin, when Resident #2 should have received 4 units. -There was documentation his FSBS on 01/06/25 at 8:00pm was 178 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/07/25 at 8:00pm was 200 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/08/25 at 6:30am was 142 and he received 6 units of aspart insulin, when Resident #2 should have received 4 units. -There was documentation his FSBS on 01/08/25 at 8:00pm was 248 and he received 8 units of aspart insulin. -There was documentation his FSBS on 01/09/25 at 11:30am was 281 and he received 8 units of aspart insulin, when Resident #2 should have received 9 units. -There was documentation his FSBS on 01/09/25 at 8:00pm was 294 and he received 9 units of aspart insulin. -There was documentation his FSBS on 01/10/25 at 8:00pm was 392 and he received 11 units of aspart insulin. -There was documentation his FSBS on 01/11/25 at 8:00pm was 241 and he received 8 units of aspart insulin. -There was documentation his FSBS on 01/12/25 at 8:00pm was 162 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/13/25 at 8:00pm was 273 and he received 9 units of aspart insulin. -There was documentation his FSBS on 01/14/25	D 358		

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(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 12 at 8:00pm was 160 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/15/25 at 8:00pm was 257 and he received 9 units of aspart insulin. -There was documentation his FSBS on 01/16/25 at 6:30am was 120 and he received 0 units of aspart insulin, when Resident #2 should have received 4 units. -There was documentation his FSBS on 01/16/25 at 8:00pm was 175 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/17/25 at 8:00pm was 163 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/18/25 at 8:00pm was 302 and he received 10 units of aspart insulin. -There was documentation his FSBS on 01/20/25 at 8:00pm was 177 and he received 6 units of aspart insulin. -There was documentation his FSBS on 01/21/25 at 6:30am was 270 and he received 8 units of aspart insulin, when Resident #2 should have received 9 units. -There was documentation his FSBS on 01/21/25 at 8:00pm was 293 and he received 8 units of aspart insulin, when Resident #2 should have received 9 units. Interview with Resident #2 on 01/28/25 at 11:32am revealed: -He did not know what insulin he received. -The MAs performed his FSBS and determined how much insulin he was to receive. Telephone interview with a representative from the facility's contracted pharmacy on 01/29/25 at 10:25am revealed: -There was an order for Resident #2, dated	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060156	A. BUILDING: _____ B. WING _____	01/29/2025

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D 358	Continued From page 13 09/24/24, for FSBS before meals and at bedtime and an order for sliding scale insulin three times daily with meals. -The order for Resident #2's sliding scale aspart insulin, dated 09/24/24, was placed into the eMAR system by pharmacy staff. -After an order was placed into the eMAR system by the pharmacy, facility staff were to review the order for accuracy and either accept or reject the order. -The sliding scale insulin order dated 09/24/24 for Resident #2 was entered incorrectly into the eMAR system as Resident #2 did not have an order for sliding scale insulin at bedtime. Interview with a medication aide (MA) on 01/29/25 at 12:13pm revealed: -When administering Resident #2's sliding scale insulin she first checked his FSBS. -She reviewed Resident #2's sliding scale insulin order to determine how much insulin to administer depending on his FSBS. -She thought she incorrectly documented she administered 10 units of aspart insulin on 11/29/24 at 4:30pm because Resident #2 should have received 11 units for a FSBS of 376. Interview with the facility's Health and Wellness Director (HWD) on 01/29/25 at 12:33pm revealed: -The pharmacy was responsible for entering resident medication orders into the eMAR system. -The MAs, the Resident Care Coordinator (RCC) and she were responsible for comparing resident medication orders with the orders entered into the eMAR system by pharmacy. -If the order was entered correctly into the eMAR system, the MA, RCC or she would approve the order.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060156	A. BUILDING: _____ B. WING _____	01/29/2025

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D 358	Continued From page 14 -In the instance of Resident #2's sliding scale insulin order dated 09/24/24, the staff member approving the order missed the sliding scale insulin was not to be administered at bedtime. -She did audits periodically of residents' eMARs to ensure sliding scale insulin was being administered according to PCP orders. -There was no set schedule for eMAR audits, and she was unsure when her last audit was completed. Interview with the Administrator on 01/29/25 at 1:29pm revealed: -The pharmacy was responsible for entering medication orders into the eMAR system. -The MAs, RCC, and HWD were responsible for comparing the order with what the pharmacy entered into the eMAR to ensure it was accurate. -The staff member accepting Resident #2's sliding scale insulin order dated 09/24/24 missed that he was not to receive insulin at bedtime. -There was not a process in place for a second staff member to review orders for accuracy.	D 358		