

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/20/2025
NAME OF PROVIDER OR SUPPLIER TERRABELLA LINCOLNTON		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SALEM CHURCH ROAD LINCOLNTON, NC 28092		
(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 Lincoln County Department of Social Services (DSS) conducted a follow-up and complaint survey on March 18, 2025 through March 20, 2025.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.	5/23/25
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunization 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have an FL2 completed annually for 1 of 5 sampled residents (#2).	D 235		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

JGTM11

If continuation sheet 1 of 41

Reviewed & Acknowledged by Sam Melton, RN 5/19/25

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STREET ADDRESS, CITY, STATE, ZIP CODE

TERRABELLA LINCOLNTON

440 SALEM CHURCH ROAD
LINCOLNTON, NC 28092

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D 235	Continued From page 1 Review of Resident #2's current FL2 dated 02/21/24 revealed diagnoses included Alzheimer's Disease, major neurocognitive disease, hypertension, and gastric esophageal reflux disease. Review of Resident #2's resident register revealed an admission date of 04/11/23. Interview with the Special Care Unit Coordinator (SCC) on 03/20/25 at 12:16pm revealed: -She did not have an updated FL2 for Resident #2. -She thought the Health and Wellness Director (HWD) was responsible for the FL2s being completed because she was responsible for all clinical areas. -She was responsible for monthly audits on the charts and weekly audits on the medication carts and did not know why Resident #2 was not caught. Interview with the HWD on 03/20/25 at 1:50pm revealed: -She was responsible for Resident #2s FL2 being completed yearly. -She and the SCC were responsible for doing monthly audits on the charts but did not know how Resident #2 slipped through the cracks. -The facility had a change of ownership around the first of the year and it could have happened then. Interview with the Administrator on 03/20/25 at 2:48pm revealed: -She was not aware Resident #2 did not have a current FL2, and her last one was dated 02/21/24. -The HWD and SCC were responsible for doing monthly audits on all resident records.	D 235	<u>Rule: 10A NCAC 13F.0703 (b&c)</u> <u>Tuberculosis Test</u> A. Resident #2 FL2 has been updated and signed on 3/19/25 by the physician extender. B. Each admission into the community will be reviewed prior to each resident's admission. The admission documents will be reviewed by the DHW or designee. The provider will complete a FL2 annually. This to be audited by the DHW or designee for weekly compliance. C. On 3/26/25 DHW educated resident care staff on the importance of the FL2 being updated/signed by the (PCP) primary care provider. D. Beginning 4/1/25, The DHW or designee will audit weekly x 8 weeks to ensure FL2s are completed annually. Any identified concerns will be corrected. Any discrepancy will be discussed during the risk/quality assurance meeting.	5/23/25

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D 235	Continued From page 2 -A new FL2 was completed and signed by the PCP on 03/19/25. Attempted telephone interview with Resident #2's primary care provider (PCP) on 03/20/25 at 10:55am was unsuccessful.	D 235			
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.	D 254	<u>Rule: 10A NCAC 13F.801 (b)</u> <u>Resident Assessment</u> A. Resident #3 is no longer in the community. B. The DHW or designee will complete admission assessments within 30 days of admission. Each chart to be reviewed and compliant by 4/30/2025. C. The ED educated the clinical staff completing resident assessments that assessments are to be completed within 30 days of admission. D. The DHW or designee will randomly audit 3 resident charts weekly to ensure the resident assessments were completed within 30 days of admission x 8 weeks. The ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25	

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D 254	Continued From page 3 This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 5 sampled residents had an assessment and care plan completed within 30 days following admission (#3). The findings are: Review of Resident #3's current FL2 date 04/12/24 revealed: -Diagnoses included Alzheimer's disease and dementia. -Resident #3's level of care was Special Care Unit (SCU). -She was constantly disoriented. -She was semi-ambulatory. -She was incontinent of bladder and bowel. Review of Resident #3's Resident Register revealed she was admitted to the facility on 04/18/24. Review of Resident #3's Care Plan dated 04/16/24 revealed: -Resident #3 exhibited wandering and disruptive behaviors and resisted care. -Resident #3 was totally dependent with toileting, bathing, dressing and grooming. -The care plan was signed by Resident #3's Primary Care Provider (PCP) on 10/30/24. Interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm revealed: -She started working at the facility approximately three weeks ago. -She did not know why Resident #3's care plan was dated prior to her admission date.	D 254			

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D 254	Continued From page 4 Based on observations, record reviews and interviews it was determined Resident #3 was not interviewable. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The HWD was responsible for completing residents' care plans. -She did not know why Resident #3's care plan was dated prior to her admission date. Attempted telephone interview with Resident #3's PCP on 03/20/25 at 10:35am was unsuccessful.	D 254		
D 262	10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents had a care plan that was signed by the assessor upon completion (#3). The findings are: Review of Resident #3's current FL2 date 04/12/24 revealed: -Diagnoses included Alzheimer's disease and dementia. -Resident #3's level of care was Special Care Unit (SCU). -She was constantly disoriented. -She was semi-ambulatory.	D 262	<u>Rule: 10A NCAC 13F.0802 (d)</u> <u>Resident Care Plan</u> A. Resident #3 is no longer in the community. B. Resident care plans are reviewed and have been updated on 3/26/25 with the assessor's signature upon completion. C. Beginning 4/30/25, the DHW, or designee will discuss resident assessments to ensure care plans have been signed by the assessor during the stand-up meeting. D. The DHW or designee will randomly audit 3 resident charts weekly to ensure the resident care plans have been signed by the assessor x 8 weeks. The ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25

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D 262	Continued From page 5 -She was incontinent of bladder and bowel. Review of Resident #3's Resident Register revealed she was admitted to the facility on 04/18/24. Review of Resident #3's Care Plan dated 04/16/24 revealed: -Resident #3 exhibited wandering and disruptive behaviors and resisted care. -Resident #3 was totally dependent with toileting, bathing, dressing and grooming. -The care plan was not signed by the assessor. Interview with the Special Care Unit Coordinator (SCC) on 03/20/25 at 12:15pm revealed: -She began working at the facility approximately 2.5 months ago. -She received training on day to day running of the unit when she started her position at the facility. -She was informed of her clinical duties the previous week. -She was informed the previous week that completing care plans for the residents in the SCU was her responsibility when the Regional Registered Nurse (RN) discovered some care plans were overdue. Interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm revealed. -She started working at the facility approximately three weeks ago. -The SCC was responsible for completing the care plans in the SCU. -The SCC was responsible for signing the care plan upon completion. -She was not aware when hired the SCC did not know how to complete care plans for the residents in the SCU.	D 262			

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D 262	Continued From page 6 Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The HWD was responsible for completing and signing resident care plans. -The HWD could ask the SCC to assist with care plans of residents in the SCU. -She was not aware Resident #3's care plan was not signed by the assessor.	D 262		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents had a care plan that was signed by a provider within 15 days of the residents' being assessed (#3). The findings are: Review of Resident #3's current FL2 date 04/12/24 revealed: -Diagnoses included Alzheimer's disease and dementia.	D 263	<u>Rule: 10A NCAC 13F.0802 (e)</u> <u>Resident Care Plan</u> A. Resident #3 is no longer in the community. B. On 3/26/25, the DHW/designee audited all resident charts in memory care to ensure all care plans were signed by the provider within 15 days of completion. Resident files to be reviewed and compliant by 4/30/25. C. On 3/21/25, the ED educated the DHW and memory care director (MCD) on ensuring care plans are signed by the provider within 15 days of completion. D. DHW/ED or designee will audit 3 random care plans weekly x 8 weeks to ensure care plans are signed by the provider within 15 days. The ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25

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D 263	Continued From page 7 -Resident #3's level of care was Special Care Unit (SCU). -She was constantly disoriented. -She was semi-ambulatory. -She was incontinent of bladder and bowel. Review of Resident #3's Resident Register revealed she was admitted to the facility on 04/18/24. Review of Resident #3's Care Plan dated 04/16/24 revealed: -Resident #3 exhibited wandering and disruptive behaviors and resisted care. -Resident #3 was totally dependent with toileting, bathing, dressing and grooming. -The care plan was signed by Resident #3's Primary Care Provider (PCP) on 10/30/24. Interview with the Special Care Unit Coordinator (SCC) on 03/20/25 at 12:15pm revealed: -She began working at the facility approximately 2.5 months ago. -She received training on just day to day running of the unit when she started her position at the facility. -She was informed of her clinical duties the previous week. -She found out the previous week that completing care plans for the residents in the SCU was her responsibility when the Regional Registered Nurse (RN) discovered some care plans were overdue. Interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm revealed. -She started working at the facility approximately three weeks ago. -The SCC was responsible for completing the care plans in the SCU.	D 263			

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D 263	Continued From page 8 -The SCC was responsible for getting the care plan signed by the PCP within 15 days of completion. -She was not aware when hired the SCC did not know how to complete care plans for the residents in the SCU. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The HWD was responsible for having residents' care plans signed by the PCP within 15 days of completion. -The HWD could ask the SCC to assist with care plans of residents in the SCU. -She was not aware Resident #3's care plan was not signed within 15 days by the PCP. Attempted telephone interview with Resident #3's PCP on 03/20/25 at 10:35am was unsuccessful.	D 263		
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 (#4) related to a rejected pharmacy order for a medication to treat hypothyroidism (underactive thyroid gland). The findings are:	D 273		

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D 273	Continued From page 9 Review of Resident #4's current FL2 dated 09/04/24 revealed: -Diagnoses included hypothyroidism. -There was an order for levothyroxine (a medication to treat hypothyroidism) 175mcg daily. Review of Resident #4's Primary Care Provider's (PCP) orders dated 12/18/24 revealed an order for levothyroxine 175mcg, one tablet daily at 7:00am. Review of Resident #4's handwritten February 2025 Medication Administration Record (MAR) revealed: -There was an entry for levothyroxine 175mcg, one tablet daily at 7:00am. -There was documentation levothyroxine 175mcg, one tablet was administered daily at 7:00am from 02/01/25 through 02/20/25. -Levothyroxine 175mcg, one tablet was documented not administered from 02/21/25 through 02/23/25 due to Resident #1 being out of the facility. Review of Resident #4's February 2025 electronic MAR (eMAR) revealed: -The documented administration of medications on the eMAR began on 02/24/25. -There was no entry for levothyroxine 175mcg, one tablet daily. Review of Resident #4's March 2025 eMAR revealed there was no entry for levothyroxine 175mcg, one tablet daily. Review of a report titled "Rejected Orders" from 02/11/25 through 02/19/25 revealed Resident #4's levothyroxine order was rejected by the pharmacy on 02/19/25 for clarification and required a new order.	D 273	<u>Rule: 10A NCAC 13F. 0902 (b) Health Care</u> A. Resident #4 is no longer in the community. B. On 3/25/25, the director of health and wellness (DHW) or designee reviewed current resident orders that require referrals and follow-up to ensure medications orders are clarified as needed. C. The ED educated the clinical staff that all medications are clarified with the physician as needed. D. DHW or designee will do random audits three times weekly x 8 weeks for residents who have change in medication orders and those orders are communicated to the pharmacy and placed on MAR's. Any discrepancies will be reviewed in the stand up meeting. The need for continued monitoring will be discussed in the risk/quality assurance meeting.	5/23/25

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D 273	Continued From page 10 Interview with the Regional Registered Nurse (RN) on 03/20/25 at 3:56pm revealed: -The facility had switched pharmacy providers recently and Resident #4's levothyroxine order was rejected at that time. -The previous HWD was responsible for following up on Resident #4's rejected levothyroxine order. -She was not aware Resident #4's levothyroxine order was not on February 2025 and March 2025 eMARs. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The previous HWD was responsible to follow up on the "Rejected Orders" report. -She was not aware the previous HWD had not followed up on Resident #4's levothyroxine order. -She was not aware Resident #4's levothyroxine 125mcg was not on her February 2025 and March 2025 eMARs. Attempted telephone interview with Resident #4's PCP on 03/20/25 at 10:55am was unsuccessful.	D 273			
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 5 sampled residents (#5) rights were not maintained related to a resident not having facetime calls with her family.	D 338			

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D 338	Continued From page 11 The findings are: Review of Resident #5's current FL2 dated 06/18/24 revealed: -Diagnoses included dementia, hypertension, osteoarthritis and degenerative joint disease. -She was semi ambulatory with a rollator. -She was intermittently disoriented. Interview with Resident #5's Healthcare Power of Attorney (POA) on 03/19/25 at 3:01pm revealed: -Before the facility took new ownership, she was able to have facetime calls weekly. -The facetime calls were on an IPAD, and she was able to see her mother and talk to her. -She was not sure how much her mother understood what she said but they were able to see each other and talk. -After the facility went under new ownership, she had not had a facetime call since mid January 2025 due to the equipment being taken with the previous owners. -She talked with the Special Care Unit Coordinator (SCC) about two months ago and the SCC was working on facetime calls, but they had never taken place. -She and the SCC had some words and the POA felt this was the reason it was taking so long. Interview with a medication aide (MA) on 03/18/25 at 11:31am revealed: -She was aware Resident #5 would have a facetime call with her daughter but did not know the calls had stopped. -Resident #5 was not able to say anything about the calls but when she saw her daughter on facetime she thought she may have recognized her.	D 338	<u>10A NCAC 13F.0909 Resident Rights</u> A. Resident # 5 spoke with POA via FaceTime. B. MCD/designee will ensure a device is available for residents to communicate with POA/family members by 4/30/25. C. ED educated the DHW and memory care director (MCD) that we need to ensure the rights of all residents are guaranteed and maintained without hinderance. Community has iPhone to assist with communication D. Ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25

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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 338	Continued From page 12 Interview with the SCC on 03/19/25 at 9:30am revealed: -The POA had called her and asked for her to set up facetime on Monday, Wednesday and Friday the first week in March 2025 with Resident #5. -The facetime calls had to be made on her phone, and she scheduled the calls with the POA and Resident #5 for the first week in March 2025. -She did not work the first week in March and the facetime calls never took place. Interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm revealed: -She was not aware of the facetime calls that were to take place and never received a call from Resident #5's POA. -She would have placed the facetime calls for Resident #5 and the POA if she had known about them. Interview with the Administrator on 03/20/25 at 2:48pm revealed: -She was made aware during the survey the facetime calls did not happen for Resident #5 and was aware the POA did not return a call to schedule another time. -She would discuss this with the SCC and get it scheduled.	D 338			
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	D 358			

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D 358	Continued From page 13 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 sampled residents (#1 and #4) related to a medication to treat pain (#1) and a medication to treat hypothyroidism (underactive thyroid gland). The findings are: 1. Review of Resident #1's current FL2 dated 05/29/24 revealed diagnoses included Alzheimer's disease, hypertension and depression. Review of Resident #1's Emergency Department (ED) after visit summary dated 02/13/25 revealed: -Resident #1 was seen in the ED for flank (the side of the body between the ribs and hip) pain. -Resident #1 was diagnosed with a closed fracture (a broken bone that does not break the skin) of one rib on the left side. Review of Resident #1 Primary Care Provider's (PCP) visit note dated 02/19/25 revealed there was an order to start tramadol (a medication to treat pain) 50mg, one tablet twice daily scheduled and one tablet daily as needed for pain. Review of Resident #1's handwritten February 2025 Medication Administration Record (MAR) revealed: -There was an entry dated 02/20/25 for tramadol two tablets twice daily at 8:00am and 8:00pm. -There was no dosage indicated for the tramadol	D 358	<u>Rule: 10A NCAC 13F.1004 (a)</u> <u>Medication Administration</u> A. Resident #1 did receive medication. Resident # 4 is no longer in the community. B. DHW/designee to review all discharge documents upon readmission from the hospital/ rehab. Documentation will be sent to the pharmacy. DHW or designee will review and approve the order once the correct medication has been delivered into the community. DHW or designee will review EMAR for ongoing compliance. C. DHW or designee to educate staff on correct process for reviewing and approving orders. Staff education to be completed by 4/30 D. The DHW or designee will randomly audit 3 resident charts weekly to ensure the resident medication is administered as ordered by the physician. The ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TERRABELLA LINCOLNTON

**440 SALEM CHURCH ROAD
LINCOLNTON, NC 28092**

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D 358	Continued From page 14 two tablets twice daily entry. -It appeared a "2" may have been written over a "4" for the number of tramadol tablets to administer twice daily. -There was documentation tramadol, one or two tablets was administered at 8:00am and 8:00pm from 02/20/25 through 2/23/25 and on 02/25/25 at 8:00pm. Review of Resident #1's February 2025 electronic MAR (eMAR) revealed: -The documented administration of medications on the eMAR began on 02/24/25. -There was an entry dated 02/19/25 for tramadol 50mg, two tablets twice daily at 8:00am and 8:00pm. -There was documentation tramadol 50mg was administered at 8:00am and 8:00pm from 02/24/25 through 02/28/25. Review of Resident #1's March 2025 eMAR revealed: -There was entry for tramadol 50mg, two tablets twice daily at 8:00am and 8:00pm. -There was documentation tramadol 50mg, two tablets was administered at 8:00am and 8:00pm from 03/01/25 through 03/17/25 and at 8:00am on 03/18/25 except at 8:00pm on 03/04/25 and 03/06/25 because the resident was out of the facility and at 8:00pm on 03/17/25 due to the medication was not available. Review of a controlled substance count sheets (CSCS) for Resident #1 revealed: -The label indicated the CSCS was for tramadol 50mg, two tablets twice daily for pain and one tablet daily for breakthrough pain. -There was a hand-drawn circle around the area of the label that indicated "Take 2 tablets". -There were 19 instances when tramadol 50mg	D 358		

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D 358	Continued From page 15 one tablet was removed from the bubble pack when the order was tramadol 50mg, two tablets. -On 02/22/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/22/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/23/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/23/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/24/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/24/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/25/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/26/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/26/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/27/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/27/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/03/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/09/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the	D 358			

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D 358	Continued From page 16 bubble pack. -On 03/09/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/10/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/10/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/11/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/15/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/15/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. Review of a second CSCI for Resident #1 revealed: -The label indicated the CSCI was for tramadol 50mg, two tablets twice daily for pain and one tablet daily for breakthrough pain. -On 03/19/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. Observation on 03/18/25 at 2:00pm of medications on hand for Resident #1 revealed: -There was a bubble pack of tramadol 50mg with 73 tablets remaining. -The label indicated 75 tablets of tramadol 50mg were dispensed on 03/17/25. -The directions were to administer two tablets by mouth twice daily for pain and one tablet by mouth daily as needed for breakthrough pain. Telephone interview on 03/18/25 at 1:43pm with a	D 358			

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D 358	Continued From page 17 representative from the facility's contracted pharmacy revealed: -The pharmacy entered medication orders on the residents' eMARs. -Resident #1's current tramadol order was tramadol 50mg, two tablets twice daily and tramadol 50mg one tablet daily as needed. -Resident #1's tramadol order was electronically sent to the pharmacy on 02/19/25 directly from the provider. -The pharmacy did not receive a faxed order from the facility for Resident #1's tramadol 50mg. Telephone Interview with Resident #1's PCP on 03/18/25 at 2:50pm revealed: -If she wrote a new medication order for a resident, she left a handwritten order at the facility in addition to electronically sending the order to the pharmacy. -The medical assistant or triage team in her organization inadvertently entered "2" instead of "1" when sending Resident #1's tramadol 50mg order to the pharmacy. -She expected facility staff to review the written order with what was entered into the resident's eMAR and to notify her if the orders did not match. Interview with a medication aide (MA) on 03/20/25 at 11:05am revealed: -When she administered medications to a resident she compared the order in the computer with the label on the medication. -If a medication order on the MAR/eMAR did not match the order on the medication label, her process was to call the pharmacy and the resident's PCP for clarification. -She was unsure why she administered tramadol 50mg, one tablet to Resident #1 on 02/24/25 at 8:00am as documented on Resident #1's	D 358			

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D 358	Continued From page 18 tramadol 50mg CSCI. Interview with the Special Care Unit Coordinator (SCC) on 03/20/25 at 12:15pm revealed: -The MAs were responsible to compare medication orders on the MAR/eMAR with the order on the medication label prior to administering a resident's medication. -If a medication order on the MAR/eMAR did not match the order on the medication label, the MAs were responsible to call the pharmacy for clarification. -She started at the facility approximately 2.5 months ago and was unsure if the MAs were trained to reach out to the pharmacy if a medication order on the MAR/eMAR did not match the order on the medication label. -The 19 instances when tramadol 50mg one tablet was removed from the bubble pack instead of two tablets were medication errors and were to be reported to the HWD. Interview with the Health and Wellness Director on 03/20/25 at 1:50pm revealed: -She began working at the facility approximately three weeks ago, around the time of the facility changed to a new eMAR system. -The pharmacy entered medication orders into the eMAR system. -If a resident's PCP wrote an order at the facility, the order should be faxed to the pharmacy even if the PCP electronically sent the order to the pharmacy. -The MA receiving the medication from the pharmacy was responsible to compare the medication label with the medication order on the MAR/eMAR before placing the medication in the medication cart. -If a medication label did not match the medication order, the MAs were responsible to	D 358		

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D 358	Continued From page 19 reach out to the PCP and the pharmacy for clarification. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The facility changed pharmacy providers recently and the Regional Registered Nurse (RN) coordinated the pharmacy transfer. -She was unsure who was responsible for placing orders on the MAR/the eMAR. -The MAs were responsible to compare the medication label with the order on the MAR/eMAR and to notify the HWD if there were any discrepancies. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #4's current FL2 dated 09/04/24 revealed: -Diagnoses included hypothyroidism. -There was an order for levothyroxine (a medication to treat hypothyroidism) 175mcg daily. Review of Resident #4's Primary Care Provider's (PCP) orders dated 12/18/24 revealed an order for levothyroxine 175mcg, one tablet daily at 7:00am. Review of Resident #4's handwritten February 2025 Medication Administration Record (MAR) revealed: -There was an entry for levothyroxine 175mcg, one tablet daily at 7:00am. -There was documentation levothyroxine 175mcg, one tablet was administered daily at 7:00am from 02/01/25 through 02/20/25. -Levothyroxine 175mcg, one tablet was documented not administered from 02/21/25	D 358			

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D 358	Continued From page 20 through 02/23/25 due to Resident #1 being out of the facility. Review of Resident #4's February 2025 electronic MAR (eMAR) revealed: -The documented administration of medications on the eMAR began on 02/24/25. -There was no entry for levothyroxine 175mcg, one tablet daily. Review of Resident #4's March 2025 eMAR revealed there was no entry for levothyroxine 175mcg, one tablet daily. Review of a report titled "Rejected Orders" from 02/11/25 through 02/19/25 revealed Resident #4's levothyroxine order was rejected by the pharmacy on 02/19/25 for clarification and required a new order. Telephone interview on 03/20/25 at 1:12pm with a representative from the facility's contracted pharmacy revealed: -Resident #4 had an order dated 02/19/25 for levothyroxine 125mcg, one tablet daily. -Resident #4's medications were profiled only and the pharmacy had never dispensed levothyroxine 125mcg for the resident. -If Resident #4 did not receive her levothyroxine as ordered she should have her thyroid levels tested prior to restarting her levothyroxine. Interview with the Regional Registered Nurse (RN) on 03/20/25 at 3:56pm revealed: -The previous HWD was responsible for following up on Resident #4's rejected levothyroxine order. -She was not aware Resident #4 did not receive her levothyroxine 125mcg, one tablet daily as ordered.	D 358		

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D 358	Continued From page 21 Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The previous HWD was responsible to follow up on the "Rejected Orders" report. -She was not aware Resident #4 had not received her levothyroxine 125mcg, one tablet daily as ordered. Attempted telephone interview with Resident #4's PCP on 03/20/25 at 10:55am was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) Instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367	<u>Rule: 10A NCAC 13F .1004 (i) Medication Administration</u> A. Resident #1 MAR has been updated. B. DHW/designee to review all discharge documents upon readmission from the hospital/ rehab. Documentation will be sent to the pharmacy. DHW or designee will review and approve the order for accuracy once the correct medication has been delivered into the community.	5/23/25

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D 367	Continued From page 22 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of Medication Administration Records (MARs) and electronic Medication Administration Record (eMAR) for 1 of 5 sampled residents (#1) related to a medication to treat pain. The findings are: Review of Resident #1's current FL2 dated 05/29/24 revealed diagnoses included Alzheimer's disease, hypertension and depression. Review of Resident #1 Primary Care Provider's (PCP) visit note dated 02/19/25 revealed there was an order to start tramadol (a medication to treat pain) 50mg, one tablet twice daily scheduled and one tablet daily as needed for pain. Review of a controlled substance count sheets (CSCS) for Resident #1 revealed: -There were 75 tramadol 50mg tablets dispensed on 02/19/25 along with a CSCS. -The label indicated the CSCS was for tramadol 50mg, two tablets twice daily for pain and one tablet daily for breakthrough pain. -There was a hand-drawn circle around the area of the label that indicated "Take 2 tablets". -On 02/22/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/22/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/23/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack.	D 367	C. DHW or designee to educate staff on correct process for reviewing and approving orders and ensure documentation on the CSCS (controlled substance count sheet) matches the order in the electronic medication administration record. Staff education to be completed by 4/30 D. The DHW or designee will randomly audit 3 resident charts weekly to ensure the MARs (Medication Administration Records) are accurate. The ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25

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D 367	Continued From page 23 -On 02/23/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/24/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/24/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/25/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/26/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/26/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/27/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 02/27/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/03/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/09/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/09/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/10/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/10/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/11/25 at 8:00pm one tablet of tramadol	D 367			

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D 367	Continued From page 24 50mg was documented as removed from the bubble pack. -On 03/15/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. -On 03/15/25 at 8:00pm one tablet of tramadol 50mg was documented as removed from the bubble pack. Review of a second CSCS for Resident #1 revealed: -There were 75 tramadol 50mg tablets dispensed on 03/17/25 along with a CSCS. -The label indicated the CSCS was for tramadol 50mg, two tablets twice daily for pain and one tablet daily for breakthrough pain. -On 03/19/25 at 8:00am one tablet of tramadol 50mg was documented as removed from the bubble pack. Review of Resident #1's handwritten February 2025 MAR revealed: -There was an entry dated 02/20/25 for tramadol two tablets twice daily at 8:00am and 8:00pm. -There was no dosage indicated for the tramadol two tablets twice daily entry. -It appeared a "2" was written over a "1" for the number of tramadol tablets to administer twice daily. -There was documentation tramadol, two tablets were administered at 8:00am and 8:00pm from 02/20/25 through 2/23/25 and on 02/25/25 at 8:00pm. Review of Resident #1's February 2025 eMAR revealed: -The documented administration of medications on the eMAR began on 02/24/25. -There was an entry dated 02/19/25 for tramadol 50mg, two tablets twice daily at 8:00am and	D 367			

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D 367	Continued From page 25 8:00pm. -There was documentation tramadol 50mg, two tablets were administered at 8:00am and 8:00pm from 02/24/25 through 02/28/25. Review of Resident #1's March 2025 eMAR revealed: -There was entry for tramadol 50mg, two tablets twice daily at 8:00am and 8:00pm. -There was documentation tramadol 50mg, two tablets were administered at 8:00am and 8:00pm from 03/01/25 through 03/17/25 and at 8:00am on 03/18/25 except on 03/04/25 and 03/06/25 at 8:00pm because the resident was out of the facility and on 03/17/25 at 8:00pm due to the medication was not available. Observation on 03/18/25 at 2:00pm of medications on hand for Resident #1 revealed: -There was a bubble pack of tramadol 50mg with 73 tablets remaining. -The label indicated 75 tablets were dispensed on 03/17/25. -The directions on the label were to administer two tablets by mouth twice daily for pain and one tablet by mouth daily as needed for breakthrough pain. Interview with a medication aide (MA) on 03/20/25 at 11:05am revealed: -The MAs were responsible to accurately document medications administered on the residents' MAR/eMARs. -She thought Resident #1's tramadol 50mg was increased from one tablet to two tablets because the resident continued to have pain. -When she administered medications to a resident she compared the order in the computer with the label on the medication. -She was unsure why she documented she	D 367		

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D 367	Continued From page 26 administered tramadol 50mg, two tablets to Resident #1 on 02/24/25 at 8:00am when she documented removing tramadol 50mg one tablet on Resident #1's tramadol 50mg CSCI. -She was unsure if there were any audits completed of residents' MARs/eMARs for accuracy. Interview with the Special Care Unit Coordinator (SCC) on 03/20/25 at 12:15pm revealed: -The MAs were responsible to accurately document medications administered on the MAR/eMAR. -She started at the facility approximately 2.5 months ago. -The MAs were trained by "seasoned" MAs on documentation when hired. -She was unsure if the MAs were trained on documentation by the nurse. -She was unsure if there were any audits completed of residents' MARs/eMARs for accuracy. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The MAs were responsible for accurate documentation of medications administered. -She was unsure if audits were completed of residents' MARs/eMARs for accuracy.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate	D 392		

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D 392	Continued From page 27 reconciliation of controlled substances. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 1 of 5 sampled residents (#1) related to a medication to controlled pain. The findings are: Review of Resident #1's current FL2 dated 05/29/24 revealed diagnoses included Alzheimer's disease, hypertension and depression. Review of Resident #1 Primary Care Provider's (PCP) visit note dated 02/19/25 revealed there was an order to start tramadol (a medication to treat pain) 50mg, one tablet twice daily scheduled and one tablet daily as needed for pain. Review of a controlled substance count sheets (CSCS) for Resident #1 revealed: -The label indicated the CSCS was for tramadol 50mg, two tablets twice daily for pain and one tablet daily for breakthrough pain. -On 02/27/25 at 8:00am the CSCS indicated there were 64 tablets of tramadol 50mg tablets remaining for Resident #1 prior to signing out the 8:00am dose on 02/27/25. -On 02/27/25 at 8:00am, one tablet of tramadol 50mg was signed out and the amount remaining was 62 tablets of tramadol 50mg. -On 03/02/25 at 8:00pm the CSCS indicated there were 51 tablets of tramadol 50mg tablets remaining for Resident #1 prior to signing out the 8:00pm dose on 03/02/25. -On 03/02/25 at 8:00pm, two tablets of tramadol	D 392	<u>Rule: 10A NCAC 13F. .1008 (a)</u> <u>Controlled Substance</u> A. Resident #1 MAR has been updated. B. DHW/designee reviewed all controlled substance count sheets (CSCS) for accuracy on 3/26/25. C. DHW or designee to educate staff on accurate documentation on the CSCS. Staff training to be completed by 4/30. D. The DHW or designee will randomly audit 3 resident CSCSs x 8 weeks to ensure accuracy. The ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.		5/23/25

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D 392	Continued From page 28 50mg was signed out and the amount remaining was 50 tablets of Tramadol 50mg. -On 03/09/25 at 8:00am the CSCS indicated there were 29 tablets of tramadol 50mg tablets remaining for Resident #1 prior to signing out the 8:00am dose on 03/09/25. -On 03/09/25 at 8:00am, one tablet of tramadol 50mg was signed out and the amount remaining was 27 tablets of Tramadol 50mg. -The entry for 03/12/25 at 8:00pm appeared the original documentation of amount remaining was "17" tablets with "16" handwritten over the "17". -The entry for 03/13/25 at 5:00am appeared the original documentation of amount remaining was "16" tablets with "15" handwritten over the "16". -The entry for 03/13/25 at 8:00am appeared the original documentation of "amount given" was "1" tablet with "2" handwritten over the "1". -The entry for 03/13/25 at 8:00am appeared the original documentation of amount remaining was handwritten over and "13" tablets remained. -The entry for 03/13/25 at 8:00pm revealed the "amount given" was marked over and was illegible. -The entry for 03/13/25 at 8:00pm revealed the "amount remaining" was marked over, illegible and "11" was written next to it. Interview with a medication aide (MA) on 03/20/25 at 11:05am revealed: -When she administered controlled substances she compared the order in the computer with the label on the medication. -She signed out the controlled substance on the CSCS after she placed the medication in the medication cup. -If the resident refused the medication, she "wasted" it with another MA or the nurse and documented the waste on the CSCS and on the resident's eMAR.	D 392			

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D 392	Continued From page 29 -If she incorrectly documented on a resident's CSCS, she would draw a single line through it, place her initials by it and place correct documentation after it. -When MAs started a shift and took over responsibility of a medication cart, the on-coming MA was responsible to confirm the count of controlled substances and the CSCSs were accurate with the off-going MA. -She always completed the counting of controlled substances when she began her shift and when she ended her shift but could not answer for all MAs. -While working at the facility, there had been one instance the controlled substance count did not match the CSCS and she immediately notified the nurse in the facility. Interview with the Special Care Unit Coordinator (SCC) on 03/20/25 at 12:15pm revealed: -The MAs were responsible to accurately document controlled substances on the CSCS. -The MAs were responsible to ensure the count of controlled substances match the documentation on the CSCSs when coming on shift and when going off shift by reviewing the controlled substance count and count sheet with the MA taking over responsibility of the medication cart. -The MAs were responsible to draw a single line through any documentation changes, initial the change, and then write the correct documentation. -She started as the SCC approximately 2.5 months ago and was unsure who trained the MAs on proper documentation. -She had not seen any documentation "written over" on CSCSs but she had seen "written over" documentation on a MAR and brought it to the Administrator's attention.	D 392			

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D 392	Continued From page 30 Interview with the Health and Wellness Director on 03/20/25 at 1:50pm revealed: -The MAs were responsible to accurately document controlled substances removed and administered on the CSCS. -Two MAs were to confirm the number of controlled substances remaining and the count documented on the CSCS each time the medication cart responsibility changed from one MA to another. -If there were any discrepancies during the controlled substance count, the MAs were to notify her or the administrator and were not to leave the facility until the count was investigated. -If staff were to change written documentation, they were to draw a single line through the inaccurate documentation, initial the entry and then write the correct documentation next to it. -She started working as the HWD three weeks ago and was unsure if there were any audits of controlled substances and CSCS for accuracy and proper documentation. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The MAs were responsible to ensure the controlled substance on hand were accurately documented on the CSCS. -Two MAs were responsible to verify the controlled substances and the CSCS were accurate each time the responsibility of the medication cart changed hands. -If there were any discrepancies with the controlled substances on hand or the CSCS, the MAs were to notify the HWD and an investigation would be started immediately. -She was unsure if there were any audits of controlled substances and CSCS completed.	D 392		

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D 419	Continued From page 31	D 419		
D 419	10A NCAC 13F .1104 (a) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident. If the statement is marked by the resident, there shall be one witness signature. For residents who have been adjudicated incompetent, the signature of the resident's authorized representative shall be required. Witnesses cannot include the staff handling the residents' personal funds transactions. The statement shall be maintained in the facility. This Rule is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure all Medicaid residents (Resident #2) were shown an accurate accounting of monies received and disbursed and the balance on hand was available upon request. The findings are: Review of Resident #2's current FL2 dated 02/24/24 revealed: - Diagnoses including Alzheimer's Disease, hypertension, major neurocognitive disease and	D 419	<u>Rule: 10A NCAC 13F. 1104 (a)</u> <u>Accounting for Resident's</u> <u>Personal Funds</u> A. Resident #2 has been provided with an updated statement of funds in account. B. BOM/designee will provide those residents on State-County Special Assistance with their personal funds transactions when requested. C. Executive Director/Designee will randomly audit resident trust funds weekly x 8 weeks. Any identified concerns will be corrected. Any discrepancy will be discussed during the risk/quality assurance meeting.	5/23/25

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D 419	Continued From page 32 gastroesophageal reflux disease. -Her responsible person was a family member. Observation of Resident #2's Resident Trust Transaction for October 2024, November 2024 and December 2024 was correct but there were no other transactions after December 2024. Telephone interview with the Corporate Business Office Manager on 03/18/25 at 2:18pm revealed: -The facility was under new management since the end of January 2025, and they were working on getting all Medicaid accounts up to date. -Since January 2025, she was staying at the facility free until the account was reconciled around the end of March 2025. Interview with Resident #2's responsible person on 03/18/25 at 11:06am revealed: -She was concerned about Resident #2's money because she had not received any bills in several months. -She was told since the new management came in, the business office had been working on the issues and would have it straightened out by the end of March 2025. -The business office manager gave me a \$1500 food stamp card sometime in January 2025 before she left, and I am not sure what to do with it. Interview with the Administrator on 03/20/25 at 2:48pm revealed: -She was aware of the resident funds issue with Medicaid residents. -This had been going on since new management came in around the end of January 2025 and was supposed to be resolved by the end of March 2025. -Residents could continue to receive their	D 419		

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D 419	Continued From page 33 monthly allowance but bills have not been taken out of the Resident Trust Transaction. -The Resident Trust Transaction did not show the correct monthly amount.	D 419			
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) for incidents involving 2 of 5 sampled residents (Resident #1 and #4) who required emergency medical treatment. The findings are: Review of the facility's Incident Reports policy dated 06/11/24 revealed injuries and unusual incidents would be reported in compliance with state regulatory requirements. 1. Review of Resident #1's current FL2 dated 05/29/24 revealed: -Diagnoses included Alzheimer's disease, hypertension and depression.	D 451	<u>Rule: 10A NCAC 13F. 1212 (a)</u> <u>Reporting of Accidents and</u> <u>Incidents</u> A. Resident #1 & #4 incident reports have been submitted to the county monitor. B. Director of Health and Wellness/Designee will review/discuss incidents during daily standup meetings and email reporting form to county monitor. C. Executive Director/designee will randomly audit incident reporting binder weekly to ensure any resident with incidents which requires transfer to the ED, will have a form sent to the county monitor. Ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.		5/23/25

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D 451	Continued From page 34 -Resident # was constantly disoriented. -The recommended level of care was documented as Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 11/29/21. a. Review of Resident #1's staff progress note dated 02/13/25 at 10:15pm revealed Resident #1 had pain in her lower right back and was sent out for observation. Review of Resident #1's Emergency Department (ED) after visit summary dated 02/13/25 revealed: -Resident #1 was seen in the ED for flank (the side of the body between the ribs and hip) pain. -Resident #1 was diagnosed with a closed fracture (a broken bone that does not break the skin) of one rib on the left side. Interview with the local county DSS Adult Services Supervisor on 03/19/25 at 2:56pm revealed DSS was not notified of Resident #1's incident on 02/13/25 that required emergency treatment at the local hospital. Refer to the interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm. Refer to the interview with the Administrator on 03/20/25 at 2:44pm. Based on observations, interviews and record review, it was determined that Resident #1 was not interviewable. b. Review of Resident #1's staff progress note dated 02/18/25 at 9:00pm revealed Resident #1 was found on the floor, complained of pain in her back, was holding her side and was sent to the	D 451		

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D 451	Continued From page 35 ED. Review of Resident #1's ED after visit summary dated 02/18/25 revealed Resident #1 was seen for a fall. Interview with the local county DSS Adult Services Supervisor on 03/19/25 at 2:56pm revealed DSS was not notified of Resident #1's incident on 02/18/25 that required emergency treatment at the local hospital. Refer to the interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm. Refer to the interview with the Administrator on 03/20/25 at 2:44pm. Based on observations, interviews and record review, it was determined that Resident #1 was not interviewable. 2. Review of Resident #4's current FL2 dated 09/04/24 revealed diagnoses included type 2 diabetes mellitus, hypertension and muscle weakness. Review of Resident #4's Resident Register revealed an admission date of 08/01/22. Review of Resident #4's staff progress note dated 02/20/25 at 8:30pm revealed Resident #4's caregiver requested Resident #4 be sent to the ED for change of condition. Review of Resident #4's hospital discharge summary dated 02/24/25 revealed Resident #4 was hospitalized from 02/20/25 through 02/24/25 for generalized weakness.	D 451			

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D 451	Continued From page 36 Interview with the local county DSS Adult Services Supervisor on 03/19/25 at 2:56pm revealed DSS was not notified of Resident #4's incident on 02/20/25 that required emergency treatment at the local hospital. Refer to the interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm. Refer to the interview with the Administrator on 03/20/25 at 2:44pm. Interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm revealed: -She began working at the facility approximately three weeks ago. -The medication aide (MA) on duty was responsible for completing accident or incident reports when necessary. -The HWD was responsible for sending resident accident and incident reports to the county DSS office. -She was not aware DSS was to be notified every time a resident was sent to the ED until it was clarified recently. Interview with the Administrator on 03/20/25 at 2:44pm revealed: -The HWD or herself were responsible to send accident and incident reports to the county DSS office. -She was not aware that all accidents and incidents that required a resident being sent to the hospital were to be sent to the county DSS office until recently, when the DSS office clarified the rule.	D 451		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan	D 464		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 03/20/2025
NAME OF PROVIDER OR SUPPLIER TERRABELLA LINCOLNTON		STREET ADDRESS, CITY, STATE, ZIP CODE 440 SALEM CHURCH ROAD LINCOLNTON, NC 28092		
(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 464	Continued From page 37 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (Resident #3 and Resident #5) had Special Care Unit (SCU) resident profiles completed with 30 days of admission and quarterly thereafter. The findings are: 1. Review of Resident #3's current FL2 date 04/12/24 revealed: -Diagnoses included Alzheimer's disease and dementia. -Resident #3's level of care was Special Care Unit (SCU). -She was constantly disoriented.	D 464	<u>Rule: 10A NCAC 13F. 1307 Special Care Unit and Resident Profile & Care Plan</u> A. Resident #3 & #5 Care plan has been updated. B. On 3/26/25, the DHW/designee audited all resident charts in memory care to ensure all assessments were completed within 30 days of admission and quarterly thereafter. Any updates to the care plans were completed at this time. C. On 3/21/25, the ED educated the DHW and memory care director (MCD) on completing written resident profiles/assessments within 30days of admission and quarterly thereafter. Any updates to the care plans will be completed annually and as needed based on the assessment. D. DHW or designee will audit 3 resident profile/assessments weekly x 8 weeks. Ongoing need for continued monitoring will be discussed during the risk/quality assurance meeting.	5/23/25

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D 464	Continued From page 38 -She was semi-ambulatory. -She was incontinent of bladder and bowel. Review of Resident #3's Resident Register revealed she was admitted to the facility on 04/18/24. Review of Resident #3's Care Plan dated 04/16/24 revealed: -Resident #3 exhibited wandering and disruptive behaviors and resisted care. -Resident #3 was totally dependent with toileting, bathing, dressing and grooming. -The care plan was signed by Resident #3's Primary Care Provider (PCP) on 10/30/24. Refer to the interview with the Special Care Unit Coordinator (SCC) on 03/19/25 at 9:30am. Refer to the interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm. Refer to the interview with the Administrator on 03/20/25 at 2:48pm. 2. Review of Resident #5's current FL2 dated 06/18/24 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia and degenerative joint disease. -Resident #5 was intermittently disoriented -Resident #5 was semi ambulatory with a rollator. -The recommended level of was the SCU. Review of Resident #5's resident register revealed she was admitted 07/17/23. Telephone interview with Resident #5's Healthcare Power of Attorney (POA) on 03/19/25 at 2:02pm revealed: -She was the POA for all of Resident #5's	D 464			

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D 464	Continued From page 39 healthcare needs and signed all of the paperwork when she was admitted but did not remember the names of the forms. Refer to the interview with the Special Care Unit Coordinator (SCC) on 03/19/25 at 9:30am. Refer to the interview with the Health and Wellness Director (HWD) on 03/20/25 at 1:50pm. Refer to the interview with the Administrator on 03/20/25 at 2:48pm Interview with the Special Care Unit Coordinator (SCC) on 03/19/25 at 9:30am revealed: -She would assist with the Care Plans sometimes, but they were the responsibility of the Health and Wellness Director (HWD). -She did not know the SCU profile was late in being completed. -She was supposed to audit the residents' records monthly. Interview with the HWD on 03/20/25 at 1:50pm revealed: -She was not responsible for completing the SCU profile for Resident #5 and thought the SCC was responsible. -She did not make the SCC aware she was responsible for the SCU profiles because she thought she knew. -The SCC was responsible for auditing the SCU resident records monthly. Interview with the Administrator on 03/20/25 at 2:48pm revealed: -She was not aware Resident #5 did not have a SCU profile completed quarterly. -SCU profiles were to be completed quarterly, and the SCC was responsible for the SCU	D 464			

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D 464	Continued From page 40 profiles in the SCU. -Chart audits were done monthly by the SCC.	D 464			