Adult Care Home Corrective Action Report (CAR)

I. Facility Name: TerraBella Durham
Address:4713 Garrett Rd
Durham, NC

County: Durham
License Number: HAL-032-133

II. Date(s) of Visit(s): 07/11/25, 07/14/25, 07/15/25, 07/18/25, 07/29/25, 08/21/25, 08/29/25

Purpose of Visit(s): Complaint Investigation NC00232181
Exit/Report Date: 08/29/2025

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .1004	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: 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.**		
Level of Non-Compliance: Type A2 Violation		
Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 6 sampled residents (Resident #1 and #4) received medications as ordered by the licensed prescribing practitioner, for a medication used to treat severe pain (Resident #1), and a medication used to treat anxiety (Resident #4). The findings are: Review of the facility's Medication Policy for Receiving Medications dated 06/11/24 revealed: -Community Med Techs would follow a consistent workflow to		

ensure medications received by the Community were properly logged and stored.
-This policy outlined the medication workflow for processing medications received by the Community that would be followed by all medication staff.
-The term Medication Administration Report (MAR) will be used to refer to both the paper MAR and the EMAR.
-As soon as medications arrived at the Community they were noted as received on the Medication Refill-New Order Roster.
-New medications the Community was not expecting (e.g., family took the resident to a physician and came back with a new medication and new order) did not need to be placed on the Medication Refill-New Order Roster.
-All medications, including over the counter medications, must be verified for accuracy and labeling.
-Verify the label on each medication contains all the required information.
-Enter medication information on the Centrally Stored Medication Record.
-A log or bound book provided by the pharmacy, or pharmacy record of medication delivery may be used in lieu of the Centrally Stored Medication Record.
-The pharmacy log, book, or record of delivery must include the same information as contained on the Centrally Stored Medication Record and account for every medication in central storage.
-Verify the physician's order has been transcribed on the MAR accurately.
-If individual medications were packaged within the labeled box, such as transdermal patches verify the medication packages contained in the box.

1. Review of Resident #1's current FL-2 dated 04/01/25 revealed:
-Diagnoses included primary hypertension (inactive), femur fracture, and acute peptic ulcer.
-Resident #1 was non-ambulatory and used a wheelchair.
-Resident #1 was intermittently disoriented.
-There was an order for fentanyl 50mcg/hr applied (order apply one patch topically every 3 days after removing old patch contact MD when 2 patches remain).
-There was an order for oxycodone (a medication used to treat moderate to server pain) 5mg take 1 tablet by mouth every 4 hours as needed for pain.

Review of a Physician order for Resident #1 dated 06/11/25 revealed:
-The order for fentanyl (a medication used for anxiety and seizures) 50mcg/hr was discontinued on 06/11/2025.
-There was an order for fentanyl 75mcg/hr, apply 1 patch to skin every three days and remove after 3 days.
-There were instructions to contact the provider when 2 patches remained and to note the increased dose.

Review of Resident #1's June 2025 revealed:

-There was an entry for fentanyl 50mcg/hr, apply 1 patch every 3 days at 8:00am.
-Fentanyl 50mcg/hr was documented as administered on 06/03/25, 06/06/25, and 06/09/25.
-Fentanyl 50mcg/hr was discontinued on 06/11/25.
-There was an entry for fentanyl 75mcg/hr, apply 1 patch every 3 days at 8:00am.
-Fentanyl 75mcg/hr was documented as administered on 06/13/25, 06/15/25, 06/17/25, 06/19/25, and 06/21/25.
-Fentanyl 75mcg/hr was documented as not administered on 06/28/25 at 8:00am, due to medication unavailable.
-There was no documented administration of fentanyl 75mcg/hr from 06/22/25 to 06/30/25.
-There was an entry for oxycodone 5mg take 1 tablet by mouth every 4 hours as needed for pain.
-Oxycodone was documented as administered on 06/28/25 at 7:47am.

Review of Resident #1's July 2025 eMAR from 07/01/25 to 07/11/25 revealed:
-There was an entry for fentanyl 75mcg/hr, apply 1 patch every 3 days at 8:00am.
-There was no documented administration of fentanyl 75mcg/hr from 07/01/25 to 07/03/25.
-Fentanyl 75mcg was documented as administered on 07/04/25, 07/07/25, and 07/10/25.
-There was an entry for oxycodone 5mg take 1 tablet by mouth every 4 hours as needed for pain.
-Oxycodone was documented as administered on 07/04/25 at 5:07pm.

Review of the facility's contracted pharmacy packing slip dated 06/12/25 revealed the facility received two boxes of fentanyl 75mcg/hr, containing 5 patches each for Resident #1 on 06/12/25.

Review of Resident #1's Pharmacy Controlled Drug Record dated 01/12/25 revealed:
-There was a medication label for fentanyl 75mcg/hr, apply one patch every 3 days, remove after 3 days, contact the provider when 2 patches remain and to note the increased dose.
-The date on the form (01/12/25) was handwritten by the medication aide (MA) who received the medication from the pharmacy.
-The quantity was documented as 5 of 10.
-Fentanyl 75mcg/hr, apply 1 patch was documented as administered on 06/13/25 at 8:00am, with 4 remaining; on 06/15/25 at 8:00am, with 3 remaining; on 06/17/25 at 8:00am, with 2 remaining; on 06/19/25 at 8:00am, with 1 remaining; and on 06/21/25 at 8:00am, with zero remaining.

Review of Resident #1's Pharmacy Controlled Drug Record dated 06/12/25 revealed:
-There was a medication label for fentanyl 75mcg/hr, apply one patch every 3 days, remove after 3 days, contact the provider when 2

patches remain and to note the increased dose.
-The quantity was documented as 5 of 10.
-There was no documentation of fentanyl 75mcg/hr being administered to Resident #1.

Observation of Resident #1's medication available for administration on 07/28/25 at 2:00pm revealed:
-There was a box labeled fentanyl 75mcg/hr, apply one patch topically every 3 days after removing the old patch, with a dispense date of 06/11/25.
There was one patch left to administer.
-The quantity was documented as 10 of 10.

Interview with an MA on 07/11/25 at 12:49pm revealed:
-On 06/21/25 she was working from 7am to 7pm as the MA.
-She discovered Resident #1 was missing one box of fentanyl 75mcg/hr.
-Each box of fentanyl 75mcg/hr had 5 patches.
-She administered the last patch that morning to Resident #1.
-She informed the Resident Care Coordinator (RCC) that same morning and the RCC responded she would look into it.
-On 06/23/25 she was called into the Executive Director's (ED) office where she had to explain to both the ED and the Director of Health and Wellness (DHW) there was one missing box of fentanyl 75mcg/hr for Resident #1.
-There was a medication count sheet dated 06/12/25 for fentanyl 75mcg/hr, but there was no medication to go with the sheet.
-Each narcotic had a medication count sheet to go with it.
-The medication count sheet dated 01/12/25 had fentanyl 75mcg/hr documented as given every two days instead of every three days, as the prescription order.
-She stated staff were not reading the prescription.

Interview with Resident #1's Primary Care Provider (PCP) on 07/11/25 at 1:42pm revealed:
-The facility notified her of the missing fentanyl 75mcg/hr on 06/25/25 when she was making her rounds with the residents.
-She had to order two new boxes, count of 10 patches of fentanyl 75mcg/hr for the resident on 06/25/25.
-She did not look at the narcotic sheets when she did her rounds with the residents.
-She only reviewed the controlled drug record when staff informed her a resident was running low on a medication.

Interview with a representative from facility's contracted pharmacy on 07/14/25 at 4:05pm revealed:
-Resident #1's fentanyl 50mcg/hr was ordered on 05/22/25 and was put on hold until 06/08/25 then dispensed to the facility on 06/08/25 with a quantity of 2 boxes of 5, to equal 10 patches and then it was discontinued on 06/11/25.
-Resident #1's fentanyl 75mcg/hr was ordered on 06/11/25 and dispensed on 06/11/25; there were 2 boxes of 5, to equal 10 patches.
-Resident #1's fentanyl 75mcg/hr was reordered on 06/25/25 but was

put on hold until 07/03/25 then it was dispensed on 07/03/25, with 2 boxes of 5 to equal 10 patches.
-The resident could have slurred speech, stomach pains, unresponsiveness, and loss of consciousness if fentanyl was not administered as ordered.

Telephone interview with Resident #1's pharmacy provider on 08/20/25 at 4:21pm revealed Resident #1 could experience increased pain, and opioid withdrawal symptoms, since she abruptly stopped taking the medication.

Interview with the ED and the Special Care Unit (SCU) Director on 07/14/25 at 5:00pm revealed:
-She did not know staff were not administering medication to Resident #1 according to Resident #1's prescription.
-The pharmacy must have changed the time and date for staff to issue the medication every two days instead of every three days.
-The Quick MAR system prompted the date and time for the MA to administer individual medications to each resident.
-The MA could not see when the previous MA administered the resident's medication unless she printed the eMAR.
-The pharmacy entered the prescription into the database of the Quick MAR system not the facility.
-The physician sent the prescription to the pharmacy and not the facility, especially when it was a narcotic drug.
-When the facility needed a refill, they would contact the physician and not the pharmacy.
-She reviewed the camera of the delivery person of the facility's contracted pharmacy delivering the medication of Resident #1 to the building on 06/12/25, at 11:30pm.
-She interviewed both MAs that worked third shift; one MA received and signed for the medication from the delivery person, and the other MA took the medication and placed it in the SCU medication cart.
-The delivery person was a third-party company.

Interview with the RCC on 07/15/25 at 3:00pm revealed:
-On Saturday, 06/21/25, during the 1st shift between 10:00am and 10:30am, she was informed by a MA that a box of fentanyl 75mcg/hr for Resident #1 was missing.
-The MA informed her she gave Resident #1 her last patch out of the box of 5 patches.
-She thought the facility had received a partial amount of the medication and was waiting for the other amount to come in on Monday (06/23/25).

Interview with the SCU Director and the DHW on 07/15/25 at 4:30pm revealed:
-The DHW came into the facility on 06/22/25 between 1:00pm and 2:00pm and overheard the conversation of the MA and the RCC discussing the missing fentanyl 75mcg/hr.
-The DHW told the RCC to call the pharmacy and the provider.
-The next day the DHW followed up with the ED thinking she knew,

but she did not.
-The facility did inform Resident #1's PCP that fentanyl was missing on 06/21/25.
-The MA's, had administered resident #1 prescribed PRN oxycodone in place of the fentanyl 75mcg/hr.
-On 06/27/25, The DHW realized the issue with the fentanyl 75mcg/hr was that it was administered every two days instead of every third day.
-The DHW and the SCU Director stated any medication that was scheduled into the Quick MAR would not populate until their scheduled date and time.
-They did not know why the Quick MAR populated an early administration of the fentanyl 75mcg/hr during the week of 06/13/25 through 06/21/25.
-The SCU Director stated she reviewed the MARs and noticed when the prescription changed from 50mcg/hr of fentanyl to 75mcg/hr that was when it went from being administered three days to two days.

Interview with the Area ED on 07/17/25 at 12:35pm revealed:
-Staff clicked the wrong button on the Quick MAR.
-The Quick MAR prompted staff to approve the medication according to the prescription that was on the computer screen.
-Staff were given scheduled dates and times to click according to the prescription.
-Staff did not click on the correct dates according to the prescription.
-This was an error on the facility staff.

Interview with Resident #1's PCP on 07/17/25 at 3:29pm revealed:
-Resident #1 could have experienced sedation because of the fentanyl 75mcg/hr being administered every two days instead of every three days.
-She verbally told staff to give Resident #1 the as needed (PRN) oxycodone until she received the fentanyl 75mcg/hr patches.
-It was her fault she did not put it in a written order; she verbally told a staff member but did not remember the staff's name.
-She checked on Resident #1 on 07/25/25 when she completed her rounds in the facility.
-Resident #1 was not in any danger regarding being administered the fentanyl patch every 2 days.
-She saw Resident #1 two times a month for pain management.

Interview with a second MA on 07/16/25 at 11:12am revealed:
-She was working third shift, on the assisted living (AL) side on 06/12/25 at 11:12pm.
-The delivery person from the pharmacy came in after 11:00pm and she signed for the delivery.
-The delivery person did not scan the items in front of her; he handed her a red sealed disposal bag as usual.
-She reached inside the sealed red bag to pull out two papers to sign she saw two boxes of medication, but she did not know what they were.
-When she signed for the medications, there were medications in the red bag for both the AL side and SCU.

-She signed the two papers and slid under the door of the DHW office.
-She did not review the items in the delivery bag.

Telephone interview with Resident #1's family member on 07/18/25 at 5:04pm revealed:
-Resident #1 always had chronic health issues.
-Resident #1 always experienced pain.
-Resident #1 was unable to verbalize or indicate when she is in pain.

Based on observation, interviews and record reviews, Resident #1 was not interview able.

2. Review of Resident #4's current FL-2 dated 04/01/25 on revealed:
-Diagnoses include dementia, depression, hypertension, and osteoporosis.
-She was ambulatory.
-She was intermittently disoriented.
-She needed services from the facility's contracted Hospice agency.

Review of physician orders for Resident #4 dated 04/01/25 revealed:
-An order for lorazepam (a medication used for anxiety) 0.5mg, 1 tablet by mouth every 4 hours as needed for breakthrough anxiety/restlessness.
-An order for lorazepam (a medication used for anxiety) 0.5mg, take 1 tablet by mouth every 12 hours.

Review of physician orders for Resident #4 dated 04/17/25 revealed:
-An order for lorazepam 0.5mg, take 1 tablet by mouth every 12 hours.
-An order of lorazepam (a medication used for seizures) 2mg/ml oral concentrated solution, for seizure activity only.
-Take 1ml (2mg) orally every 15 minutes until seizure activity stops; maximum of 3 doses.

Review of Resident #4's July 2025 electronic medication administration record (eMAR) from 07/01/25 to 07/11/25 revealed:
-There was an entry for lorazepam 0.5mg, take 1 tablet by mouth every 12 hours, scheduled for 8:00am and 8:00pm.
-Lorazepam 0.5mg, take 1 tablet by mouth every 12 hours was documented as administered twice daily from 07/01/25 to 07/10/25, and on 07/11/25 at 8:00am.
-There was an entry for lorazepam 0.5mg, take 1 tablet by mouth every 4 hours as needed for breakthrough anxiety/restlessness.
-Lorazepam 0.5mg, take 1 tablet by mouth every 4 hours as needed for breakthrough anxiety/restlessness was documented as administered on 07/01/25 at 8:00pm.
-There was an entry for lorazepam SOLN 2mg/ml CONC take 1ml (2MG) by mouth every 15 minutes until seizure activity stops (max 3 doses) prefilled syringes.
-Lorazepam SOLN 2mg/ml CONC take 1ml (2mg), was documented as administered on 07/01/25 at 7:00pm and reason for administration

was agitation.
-Lorazepam SOLN 2mg/ml CONC take 1ml (2mg), was documented as administered on 07/06/25 at 7:00pm and reason for administration was agitation.

Review of Resident #4's July 2025 Pharmacy Controlled Drug Record revealed:
-There was a medication label for lorazepam SOLN 2mg/ml, take 1ml (2mg) by mouth every 15 minutes until seizure activity stops (max 3 doses) Prefilled Syringes.
-The quantity was documented as 1 of 1; 6 syringes = 6ML
-Lorazepam SOLN 2mg/ml, take 1ml (2mg) by mouth every 15 minutes until seizure activity stops (max 3 doses) was documented as administered on 07/01/25 at 7:00pm, with 5 prefilled syringes remaining.
-Lorazepam SOLN 2mg/ml, take 1ml (2mg) by mouth every 15 minutes until seizure activity stops (max 3 doses) was documented as administered on 07/06/25 at 7:00pm, with 4 prefilled syringes remaining.

Observation of medication on hand for Resident #4 on 07/11/25 12:30pm revealed:
-Lorazepam 0.5mg was available for administration.
-Lorazepam SOLN 2mg/ml, CONC (syringes) was available for administration.
-There was one black plastic bag, with 4 syringes, secured with a rubber band keeping the 4 syringes together.
-The prescription on the black bag read Lorazepam SOLN 2mg/ml, CONC (syringes), quantity 6 of 6.

Interview with the Director of Health and Wellness (DHW) on 07/15/25 at 4:30pm revealed:
-Resident #4 last had a seizure 04/20/25 at 11:25am and the Primary Care Provider (PCP) was called.
-There was no documentation of a seizure on 07/01/25 and 07/06/25 in Resident #4's record.
-He did not know staff had given the wrong medication to Resident #4 for agitation.

Interview with Resident #4's Hospice Nurse on 07/16/25 at 8:55am revealed:
-She did not review Resident #4's controlled substances unless staff informed her about a particular medication.
-The facility had notified Hospice when Resident #4 had a seizure on 04/17/25 and 04/20/25.
-She was not notified by the facility that Resident #4 had a seizure on 07/01/25 and 07/06/25.
-Lorazepam SOLN 2mg/ml could make Resident #4 very sleepy.
-She was not aware of Resident #4 having side effects, this should not have happened.

Interview with the Area Executive Director (ED), the DHW and Special Care Unit (SCU) Director on 07/17/25 at 12:35pm revealed:

-After reviewing the Pharmacy Controlled Drug Record and eMAR for Resident #4, the MA should not have administered Resident #4's seizure medication for agitation on 07/01/25 and 07/06/25.
-The eMAR and Pharmacy Controlled Drug Record indicated Resident #4 had lorazepam tablets ordered for agitation.
-There was no documentation in the record of Resident #4 having seizure activity on date and 07/01/25 and 07/06/25.

-The eMAR and Pharmacy Controlled Substance Drug Record for Resident #4 showed she was given seizure medication for agitation on 07/01/25 and 07/06/25.
-There was no documentation from the facility or Hospice to support reason Resident #4 was given seizure medication on both days.

Interview with the MA on 07/17/25 at 12:57pm revealed:
-She was instructed by a Nurse from Hospice who came into the facility on 07/01/25 at 8:00pm to administer Lorazepam SOLN 2mg/ml CONC to Resident #4.
-She did not know the nurse's name from Hospice.
-She administered the lorazepam SOLN 2mg/ml CONC seizure medication for agitation to Resident #4 at 8:00pm on 07/01/25.
-Resident #4 was shaking badly on 07/01/25.
-She gave her some water and then sat with her until she calmed down.

Review of the MA's progress notes dated 07/02/25 revealed:
-The MA notes that were dated 07/02/25 at 6:50am, were a late entry for 07/01/25.
-Resident #4 had a nice evening and night after she had a fall.
-Her nurse from Hospice came to visit her around 8pm and he said that Resident #4's daughter was concerned about her fall.
-The family member suggested not to give Resident #4 the oxycodone, only Ativan PRN.
-She stated so, Ativan was administered and after that she did not have any complaints.

Attempted telephone interview with Resident #4's Hospice Nurse Practitioner (NP) on 08/21/25 at 1:34pm was unsuccessful.

Based on observations, interviews, and record reviews, Resident #4 was not interviewable.

The facility failed to administer medications as ordered by a licensed prescribing practitioner for Resident #1 and Resident #4. Resident #1's fentanyl 75mcg/hr transdermal patch was applied every second day instead of every third day from 06/13/25 to 06/21/25 and was unavailable for administration from 06/24/25 to 07/03/25. Receiving the fentanyl patch every 2 days instead of every 3 days could result in sedation, slurred speech, stomach pain, unresponsiveness, and loss of consciousness. Not having the medication available for administration could result in increased pain and opioid withdrawal symptoms, since she abruptly stopped taking the medication.

Resident #4 administered lorazepam solution 2mg/ml, on 07/01/25 and 07/06/25 for agitation. The lorazepam order was written to be administered for seizure activity only. Lorazepam could make Resident #4 very sleepy. The failure of the facility resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on July 17, 2025, for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 28, 2025		

IV. Delivered Via:	Hand Delivered/ Email	Date: 08/29/2025
DSS Signature:	Jo Ann Hooper	Return to DSS by: 09/18/25

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:	
Comments:			
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*			