STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036039	A. BUILDING: _____ B. WING _____	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA CRAMER MOUNTAIN	500 CRAMER MOUNTAIN ROAD CRAMERTON, NC 28032

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D 000	Initial Comments The Adult Care Licensure Section and the Gaston County Department of Social Services conducted an annual survey from 06/25/24 to 06/26/24.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as prescribed for 3 of 5 sampled residents (Resident #1, #3, #4) related to a medication used to control elevated blood sugar, a medication used to treat depression and a medication to treat COPD. The findings are: Review of Resident #1's current FL2 dated 03/12/24 revealed diagnoses included congestive obstructive pulmonary disease (COPD) arthritis, hypertension, atrial fibrillation (a-fib) and diabetes. Review of Resident #1's signed Physician orders dated 06/04/24 revealed: -There was an order to check finger stick blood sugar (FSBS) three times daily at 7:30am, 12pm and 5:00pm. -There was an order for Novolog insulin Flexpen	D 358		

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D 358	Continued From page 1 100 units, (a rapid acting insulin used to lower elevated blood sugar levels), inject per sliding scale: FSBS: 0-150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, greater than 400 = 6 units. Review of Resident #1's April 2024 electronic medication administration Record (eMAR) revealed: -There was an entry for Novolog insulin Flexpen 100 units, inject per sliding scale insulin at 7:30am, 12pm and 5:00pm. -On 04/30/24 at 12pm, the resident's FSBS was 154 and she received no Novolog insulin when the order stated she should have received one unit. Review of Resident #1's May 2024 eMAR revealed: -There was an entry for Novolog insulin Flexpen 100 units, inject per sliding scale at 7:30am, 12pm and 5:00pm. -On 05/07/24 at 12pm, the resident's FSBS was 180 and she received no Novolog insulin when the order stated she should have received one unit. -On 05/12/24 at 12pm, the resident's FSBS was 189 and she received no Novolog insulin when the order stated she should have received one unit. Review of Resident #1's June 2024 eMAR revealed: -There was an entry for Novolog insulin Flexpen 100 units, inject per sliding scale at 7:30am, 12pm and 5:00pm. -On 06/04/24 at 12pm, the resident's FSBS was 190 and she received no Novolog insulin when the order stated she should have received one	D 358		

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D 358	Continued From page 2 unit. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/26/24 at 11:10 revealed: -Resident #1 had an order for Novolog insulin Flexpen 100 units, inject per sliding scale: FSBS: 0-150 = 0 units, 151-200 = 1 unit, 201-250 = 2 units, 251-300 = 3 units, 301-350 = 4 units, 351-400 = 5 units, greater than 400 = 6 units. -On 05/02/24, two pens of Novolog insulin Flexpen 100 units, 6 milliliters each, was dispensed to Resident #1. -"When the resident received too much Novolog insulin it could lead to elevated blood sugars resulting in the resident experiencing dizziness, possible weakness, and passing out." -"If the resident had high blood sugar levels it could cause thirst and dry mouth." Interview with a medication aide (MA) on 06/26/24 at 10:20am revealed: -She was not aware she gave the wrong sliding scale insulin on 04/30/24, 05/07/24, 5/12/24 and 06/04/24. -The system gave the amount of sliding scale insulin to give when the FSBS was put on the MAR. -Resident #1 started getting sliding scale insulin on 04/12/24 and she had coaching by the Health and Wellness Director (HWD) in April 2024 because she was documenting incorrectly. -She thought she was giving the right dose but not putting it on the eMAR correctly. -She thought she had been doing it correctly because insulin was a very important medication. -She had no excuse because she saw where she had made the errors. -She was oriented to diabetes and insulin by a Registered Nurse (RN) who came to the facility	D 358		

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before she started giving medication.
-She was not sure who audited the charts to catch any errors when the incorrect dose was administered but knew the HWD had done audits depending on the situation.

Interview with the HWD on 06/26/24 11:10am revealed:
-She was not aware of the sliding scale insulin errors made on 04/30/24, 05/07/24, 05/12/24 and 06/04/24.
-All MA's had diabetic training which included education on how to administer sliding scale insulin prior to starting on the medication carts but the MA who made the errors had recently received more coaching in April 2024.

Interview with the Administrator on 06/26/24 at 3:30pm revealed she was not aware of the sliding scale insulin errors made on 04/30/24, 05/07/24, 05/12/24 and 06/04/24.

Attempted telephone interview with Resident #1's Primary Care Physician (PCP) on 06/26/24 at 11:04am was unsuccessful.

Refer to the interview with the HWD on 06/26/24 at 11:10am.

Refer to the interview with the Administrator on 06/26/24 at 3:30pm.

2. Review of Resident #3's current FL-2 dated 07/08/23 revealed diagnoses included hypertension, cardiomyopathy, depression and gastroesophageal reflux.

Review of Resident #3's signed Physician orders dated 02/27/2024 revealed an order for mirtazapine (a medication to treat depression,

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insomnia, mood, and poor appetite) 7.5mg tablet at bedtime.

Review of Resident #3's April 2024 eMAR revealed:
-There was an entry for mirtazapine 7.5mg one tablet daily scheduled for 8:00pm.
-The entry was circled with the MA's initials, indicating medication was not available on 04/01/24 to 04/14/24.
-On 04/02/24 mirtazapine 7.5mg tablet was not administered with an additional note which read; "follow up".
-On 04/06/24 mirtazapine 7.5mg tablet was not administered, with an additional note which read; "MA called daughter as she supplies the medication".
-On 04/08/24 mirtazapine 7.5mg tablet was not administered, with an additional note which read; "medication had been ordered from pharmacy".
-On 04/09/24 mirtazapine 7.5mg tablet was not administered, with an additional note; "waiting on refill from Physician".
-On 04/11/2024 mirtazapine 7.5mg tablet was not administered, with an additional note; "waiting on refill".

Review of Resident #3's nurses notes revealed no documentation of notification to Resident #3's physician regarding missed medications in April 2024.

Review of Resident #3's May 2024 eMAR revealed:
-There was an entry for mirtazapine 7.5mg one tablet scheduled for 8:00pm.
-The entry was circled with the MA's initials, indicating medication was not available on 05/02/24 to 05/11/24.
-On 05/10/24 mirtazapine 7.5mg tablet was not

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administered, with an additional note which read; "MA had asked pharmacy to refill multiple times".
-On 05/11/24 mirtazapine 7.5mg tablet was not administered, the note read; "pharmacy will not fill, MA will speak with staff nurse Monday".

Review of Resident #3's nurses notes revealed no documentation of notification to Resident #3's physician regarding missed medications in May 2024.

Telephone interview with a representative from the facilities contracted pharmacy on 06/26/24 at 10:40am revealed:
-Resident #3 had an order for mirtazapine 7.5mg one tablet at bedtime.
-There were 16 tablets of mirtazapine 7.5mg, delivered to the facility on 04/13/24.
-Resident #3's medications were dispensed only by this pharmacy when the medications were not delivered to the facility by Resident #3's responsible person.

Telephone interview with a representative from Resident #3's pharmacy on 06/26/24 at 11:55am revealed:
-Resident #3 had an order for mirtazapine 7.5mg one tablet at bedtime.
-There were 90 tablets of mirtazapine 7.5mg picked up by Resident #3's Responsible Party on 06/15/24 but in April and May of 2024 there was no record mirtazapine 7.5mg was dispensed.
-When Resident #3 did not receive her mirtazapine she could have mood instability, decreased appetite and sleep less.

Telephone interview with Resident #3's Responsible Party on 06/26/24 at 10:10am revealed:
-She was aware Resident #3 missed some

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medications in April and May 2024.
-The facility notified her they were obtaining medications from the contracted pharmacy in April and May 2024.
-The facility staff was responsible for making sure Resident #3 had medications at the facility.

Interview with the HWD on 06/25/24 at 5:15pm revealed:
-When Resident #3 had seven tablets of mirtazapine 7.5mg remaining in the facility, the Responsible Party was to be notified the medication needed to be filled.
-The Responsible Party sometime would not answer the call.
-If the medication was not available after notifying the Responsible Party, the MA was responsible for ordering the medication through the facility's contracted pharmacy and the facility would bill the Responsible Party for the cost of the medication.
-The MA should have notified Resident #3's physician regarding the days Resident #3 did not receive the mirtazapine 7.5mg.
-She reported there was no documentation by the facility of the physician being notified.

Interview with the Administrator on 06/26/24 at 4:00pm revealed:
-When the Responsible Party did not supply Resident #3's medications the facility was responsible to ensure the medications were ordered from the facilities contracted pharmacy.
- The MA should notify the physician and document in the eMAR they had notified the physician.

Attempted telephone interview with Resident #3's Primary Care Physician (PCP) on 06/26/24 at 9:45am was unsuccessful.

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D 358	Continued From page 7 Refer to the interview with the HWD on 06/26/24 at 11:10am. Refer to the interview with the Administrator on 06/26/24 at 3:30pm. 3. Review of Resident #4's current FL-2 dated 6/26/2024 revealed: -Diagnoses of chronic obstructive pulmonary disease, hypertension, anxiety, chronic low back pain, and venous insufficiency. -An order for continuous oxygen 2 liters per minute via nasal canula. Review of Resident #4's hospital order requisition dated 6/10/2024 revealed an order for continuous oxygen at 2 liters per minute via nasal cannula. Review of Resident #4's June 2024 eMAR revealed: -There was an entry for oxygen 2L per minute via nasal cannula. -There was no documentation indicating the oxygen was administered from 06/10/24 - 06/23/24 An observation of Resident #4 on 06/25/24 at 9:30am revealed she was not wearing her oxygen. Interview with MA on 06/26/2024 at 3:11pm revealed: -Resident #4 was not on oxygen prior to her 6/2/2024-6/10/2024 hospitalization. -Resident #4 was not always compliant with her oxygen. -Medication Aides were responsible for documenting their initials indicating if oxygen was in use on the eMAR.	D 358		

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D 358	Continued From page 8 -She did not know how to enter the information from the computer to indicate if oxygen was in use or not in use on the eMAR. Interview with the HWD on 6/26/2024 at 3:43pm revealed: -Resident was admitted to the hospital on 06/02/24 to 06/10/24. -Resident #4 was not on oxygen prior to her hospital admission on June 2, 2024. -Resident #4 was discharged with a set of starter portable oxygen tanks and a concentrator. -The MAs were responsible for documenting on the eMAR that the oxygen was in use and at the proper dosage and turned on and off. Interview with Administrator on 6/26/2024 at 3:59pm revealed: -Resident #4 was not on oxygen prior to her hospitalization 6/02/2024-6/10/2024. -She did not know staff were not documenting on the eMAR when they were ensuring the oxygen was in use. -MAs were responsible for indicating if oxygen was in use on the eMAR. Refer to the interview with the HWD on 06/26/24 at 11:10am. Refer to the interview with the Administrator on 06/26/24 at 3:30pm. _____ Interview with the Health and Wellness Director (HWD) on 06/26/24 11:10am revealed she audits the charts for certain issues that happen, but medication errors have not been audited consistently.	D 358		

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D 358	Continued From page 9 Interview with the Administrator on 06/26/24 at 3:30pm revealed: -The facility should be doing audits but without a Residential Care Coordinator it was hard to make it happen. -Audits have not been done consistently and only for issues that have happened. -The contracted pharmacy and the corporate office did not do any audits. -The expectation was to have no errors in sliding scale insulin, oxygen, and medication errors.	D 358		