Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	R 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 11/19/25 to 11/20/25.	{D 000}	Community will ensure the preparation of & administration of medications, prescription & non-prescription, & treatments by staff are in accordance with orders by licensed prescribing practitioner which are maintained in resident's record, rules in section .1004 Med Admin & company policy. Specifically orders that have parameters will administered or held accordingly to physician orders. Med Aide team members re-educated on greater than/less than in reading orders & verifying to administer/hold based on prescriber order. Immediate action: 1.Nurse practitioner educated Med Aides on 11/20 regarding medication administration and the specifics of administering/ holding medication based on prescriber's order "greater than/less than." 2.Pharmacy has updated system & orders for the use of "greater than" or "less than" to support in reducing the margin of med administration error when reading the "<" or ">" for verifying orders. 11/20/25 Follow up: 1.ED, RCC, MCC or designee will audit MARs to verify any orders with parameters. ED, RCC, or designee review medication administration of orders w/ parameters daily for 2 weeks (non-business days will be reviewed following business day or Monday), then 2x/ week for 2 weeks. 2.Med aide, RCC, MCC, re-educated by RDRC (RN) or LPN designee for medication administration rights, medication administration orders. 11/26/25	12/26/25
{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: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents in the Special Care Unit (SCU) including errors for a medication used to treat low blood pressure (#2). The findings are: Review of Resident #2's current FL2 dated 09/03/25 revealed: -Diagnoses included unspecified mild dementia, unspecified transient cerebral ischemic attack, other specified anxiety disorders, Parkinson's Disease, hyperlipidemia, personal history of transient ischemic attack, orthostatic hypotension, and hypokalemia.	{D 358}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tori Darling-Behrendt, Executive Director 11/26/25

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{D 358}	Continued From page 1 -She was intermittently disoriented. -There was an order for midodrine (used to treat hypotension) 5mg take one tablet once daily, give for systolic blood pressure (BP) less than 100. Review of Resident #2's signed physician order dated 09/04/25 revealed an order for midodrine 5mg 1 tablet once a day, give for systolic BP less than 103. Review of Resident #2's September 2025 electronic medication administration record (eMAR) from 09/04/25 to 09/30/25 revealed: -There was an entry for midodrine 5mg tablet take one tablet once daily, check blood pressure in the left arm seated and standing, systolic BP less than 103, give midodrine. -There was documentation midodrine was administered when it should have been held, with examples as follows: -On 09/05/25 Resident #2's BP value was documented as 145/81. -On 09/06/25 Resident #2's BP value was documented as 132/62. -On 09/07/25 Resident #2's BP value was documented as 120/78. -On 09/09/25 Resident #2's BP value was documented as 105/73. -On 09/11/25 Resident #2's BP value was documented as 106/51. -On 09/13/25 Resident #2's BP value was documented as 140/82. -On 09/20/25 Resident #2's BP value was documented as 122/62. -On 09/29/25 Resident #2's BP value was documented as 104/70. -On 09/30/25 Resident #2's BP value was documented as 118/70. -There was documentation midodrine was held when it should have been administered, with	{D 358}		

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{D 358}	Continued From page 2 examples as follows: -On 09/14/25 and Resident #2's BP value was documented as 102/62. -On 09/28/25 and Resident #2's BP value was documented as 92/54. Review of Resident #2's signed physician order dated 10/16/25 revealed an order for midodrine 5mg 1 tablet every morning, hold for systolic BP >(greater than) 110. Review of Resident #2's October 2025 eMAR from revealed: -There was an entry for midodrine 5mg tablet take one tablet once daily, check blood pressure in the left arm seated and standing, systolic BP less than 103, give midodrine at 8:00am from 10/01/25 through 10/15/25. -There was a second entry for midodrine 5mg tablet take one tablet every morning, hold for systolic BP >(greater than) 110 from 10/17/25 through 10/31/25. -There was documentation midodrine was administered when it should have been held, with examples as follows: -On 10/01/25 and Resident #2's BP value was documented as 112/78. -On 10/04/25 and Resident #2's BP value was documented as 150/56. -On 10/06/25 and Resident #2's BP value was documented as 119/78. -On 10/10/25 and Resident #2's BP value was documented as 155/73. -On 10/15/25 and Resident #2's BP value was documented as 135/72. -On 10/18/25 and Resident #2's BP value was documented as 111/76. -On 10/30/25 and Resident #2's BP value was documented as 182/71. -On 10/31/25 and Resident #2's BP value was	{D 358}		

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{D 358}	Continued From page 3 documented as 129/71. -There was documentation midodrine was held when it should have been administered, with examples as follows: -On 10/05/25 and Resident #2's BP value was documented as 84/55. -On 10/19/25 and Resident #2's BP value was documented as 108/81. Review of Resident #2's November 2025 eMAR from 11/01/25 to 11/18/25 revealed: -There was an entry for midodrine 5mg tablet take one tablet every morning, hold for systolic BP > 110. -There was documentation midodrine was administered when it should have been held, with examples as follows: -On 11/02/25 and Resident #2's BP value was documented as 130/72. -On 11/03/25 and Resident #2's BP value was documented as 122/63. -On 11/07/25 and Resident #2's BP value was documented as 119/63. -On 11/14/25 and Resident #2's BP value was documented as 126/70. -On 11/15/25 and Resident #2's BP value was documented as 128/68. -On 11/16/25 and Resident #2's BP value was documented as 133/70. Observation of the medications on hand for Resident #2 on 11/19/25 at 3:30pm revealed: -There were 21 tablets remaining of 28 tablets dispensed on 11/03/25 in a bubble pack labeled as midodrine one tablet every morning, hold for systolic BP >(greater than) 110. -There was no bubble pack labeled as midodrine 5mg one tablet once daily, check blood pressure in the left arm seated and standing, systolic BP less than 103, give midodrine available for	{D 358}		

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{D 358}	Continued From page 4 administration. Review of Resident #2's blood pressure values revealed the facility documented a blood pressure value of 100/50 on 11/19/25 at 8:10am. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/19/25 at 2:30pm revealed: -Resident #2 had a previous order on file for midodrine 5mg take 1 tablet once daily, check blood pressure in the left arm seated and standing, systolic BP less than 103, give midodrine. -Midodrine 5mg under the previous parameters was dispensed for Resident #2 on 09/04/25 for 25 tablets and on 09/29/25 for 28 tablets. -Resident #2 had a current order on file for midodrine 5mg take one tablet every morning, hold for systolic BP greater than 110. -Midodrine 5mg under the current parameters was dispensed of Resident #2 on 10/27/25 for 28 tablets. Telephone interview with Resident #2's primary care provider (PCP) on 11/19/25 at 2:10pm revealed: -She knew about some of the medication errors for Resident #2's midodrine from September 2025 and she changed the order in October 2025 for Resident #2's midodrine. -She was not aware of the total amount of the medication errors in October 2025 November 2025 related to Resident #2's midodrine. -Resident #2's BP could be high if midodrine was administered above the parameter and she expected possible outcomes of extreme hypertension and severe strokes. -She expected the facility to hold Resident #2's midodrine when it should be held according to the	{D 358}		

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{D 358}	Continued From page 5 order parameter. Interview with a medication aide (MA) on 11/19/25 at 3:42pm revealed: -She administered medications to Resident #2 but usually in the evening. -She followed the medication orders in the eMAR system when administering medications to residents. -She knew there was a parameter to hold Resident #2's midodrine if her systolic BP was above 110. -She was not aware Resident #2's midodrine had been documented as administered when it should have been held according to Resident #2's ordered parameters. -The Resident Care Coordinator (RCC) was responsible for reviewing the eMAR audits but she had not been informed of any medication errors until yesterday (11/19/25). Interview with a second MA on 11/20/25 at 8:45am revealed: -She followed the medication orders in the eMAR system when administering medications to residents. -She knew Resident #2 had a hold parameter for midodrine but she was not sure how to read the greater than or less than sign in the eMAR. -She did not know there were times in September 2025, October 2025, and November 2025 when she administered Resident #2's midodrine when it should have been held. -The RCC was responsible for reviewing the eMAR audits but she had not been informed of any medication errors until the RCC told her yesterday (11/19/25). Interview with the Special Care Unit Coordinator (SCUC) on 11/20/25 at 9:40am revealed:	{D 358}		

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{D 358}	Continued From page 6 -She knew Resident #2 had a hold parameter for midodrine because she administered medications for residents when she assisted as a MA on the work schedule. -She did not know Resident #2's midodrine was administered when it should have been held from September through November 2025 until the RCC told her on 11/19/25. -The MA administering medications would be responsible to hold Resident #2's midodrine if it should be held. -The RCC was responsible for reviewing the eMAR audits as part managing the residents clinical needs. Interview with the RCC on 11/20/25 at 8:55am revealed: -She was responsible for completing medication cart audits monthly and the third shift MAs were responsible for completing weekly medication cart audits. -She was not aware of a facility process for eMARs to be audited related to medication errors and she thought she would be responsible for reviewing the eMAR audits if the process existed. Interview with the Administrator on 11/20/25 at 9:50am revealed: -She did not know Resident #2's midodrine was administered when it should have been held from September through November 2025 until the RCC told her on 11/19/25. -The RCC was responsible for completing medication cart audits monthly and the third shift MAs were responsible for completing weekly medication cart audits. -She expected the MAs to follow provider orders and MAs were responsible to hold Resident #2's midodrine if it should be held. -She expected the RCC to review the eMAR	{D 358}		

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{D 358}	Continued From page 7 audits at least monthly and the third shift MAs to complete medication cart audits once a week. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. The facility failed to ensure medications were administered as ordered for 1 of 5 residents (#2), who was administered a medication ordered to treat low blood pressure and should have been held according to systolic blood pressure parameters ordered by the resident's physician placing the resident at risk for extreme hypertension and severe strokes. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/20/25 for this violation.	{D 358}		