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
	HAL018036	A. BUILDING: _____ B. WING _____	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

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D 000	Initial Comments The Adult Care Licensure Section and Catawba County Department of Social Services conducted an annual survey on May 13, 2026 through May 14, 2026.	D 000		7/15/26
D 259	10A NCAC 13F .0802 (a) (c) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan. (c) The care plan shall include the following: (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Subchapter; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with	D 259	**D 259** **10A NCAC 13F 0802 (a) (c) Resident Care Plans** The Community will develop and implement care plans for each resident based on their assessment that is resident centered to include resident's preferences related to care and services. All resident care plans will be reviewed for accuracy of ADL's, diagnoses and orientation status. Signatures will be obtained within 15 days from family and physician provider on completed. Families will be notified and sent a copy of the care plan once completed by email or USPS. If a response is not given within 7 days Director of Health and	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark Mitchell TITLE: Executive Director (X6) DATE: 6/12/26

Reviewed and acknowledged by Melissa J. Jones, 6/12/26

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D 259	Continued From page 1 associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 2 of 5 sampled residents (#1 and #4) had a care plan that was signed by the provider within 15 days of the residents being assessed. The findings are: 1. Review of Resident #1's current FL-2 dated 10/27/25 revealed: -Diagnoses included hypothyroidism, hyperparathyroidism, Vitamin D deficiency, hypercholesterolemia, hypercalcemia, anxiety disorder, insomnia and chronic pain syndrome. -Resident #1 was semi-ambulatory. -There was no information related to orientation status. -Resident #1 received continuous oxygen. Review of Resident #1's Resident Register revealed an admission date of 12/13/23.	D 259	Wellness (DHW), Resident Care Coordinator (RCC), and Memory Care Director (MCD) will follow up with the family for signature and care plan. Physician signature will be obtained upon next weekly visit by the DHW, RCC and/or MCD. An audit will be completed on all care plans to ensure completion and accuracy to regulations. The DHW, Assistant Executive Director (AED), and Executive Director (ED) will monitor each Wednesday that the signatures are being obtained.	

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D 259	Continued From page 2 Review of Resident #1's care plan dated 11/25/25 revealed: -Resident #1 required supervision for bathing -Resident #1 was independent with ambulation, toileting, eating, transfers, dressing, and grooming. -Resident #1 utilized a rollator and a wheelchair. -Resident #1 utilized continuous oxygen. -The care plan was not signed by Resident #1's Primary Care Provider (PCP). Refer to the telephone interview with the PCP on 05/13/26 at 3:40pm. Refer to the telephone interview with the former RCC on 05/14/26 at 11:21am. Refer to the interview with the RCC on 05/14/26 at 11:41am. Refer to the interview with the Administrator on 05/14/26 ay 11:51am. 2. Review of Resident #4's current FL2 dated 04/09/26 revealed: -Diagnoses included hypertension, hyperlipidemia, anxiety disorder, depressive disorder, chronic obstructive pulmonary disease, gastroesophageal reflux disease, osteoarthritis, hyperthyroidism, and insomnia. -Resident #4 was semi-ambulatory -There was no information related to orientation status. Review of Resident #4's Resident Register revealed an admission date of 09/17/25. Review of Resident #4's Care Plan dated 01/24/26 revealed:	D 259		

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D 259	Continued From page 3 -Resident #4 required limited assistance with bathing, dressing, and grooming. -Resident #4 was independent with ambulation, toileting, eating, and transfers. -Resident #4 utilized a rollator and a wheelchair. -The care plan was not signed by Resident #4's Primary Care Provider (PCP). Refer to the telephone interview with the PCP on 05/13/26 at 3:40pm. Refer to the telephone interview with the former RCC on 05/14/26 at 11:21am. Refer to the interview with the RCC on 05/14/26 at 11:41am. Refer to the interview with the Administrator on 05/14/26 ay 11:51am. Telephone interview with the PCP on 05/13/26 at 3:40pm revealed: -She did not know the resident's care plans had not been completed. -The former RCC would leave resident care plans for her to sign in a notebook. -She would sign the care plans and place them in the same notebook. -The last time she signed resident care plans was in April. Telephone interview with the former RCC on 05/14/26 11:21am revealed: -She left the facility on 04/21/26. -She was responsible for completing care plans on all residents and making sure the primary care physician (PCP) signed them. -She completed each care plan, printed them, and placed them in a notebook for the physician to sign.	D 259		

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D 259	Continued From page 4 -She was not sure why some of the care plans did not get signed by the PCP. Interview with the RCC on 05/14/26 at 11:41am revealed: -She started working as the RCC at the end of April 2026. -She was aware care plans had to be signed by the PCP within 15 days of the assessment. -She was responsible for completing care plans and making sure the PCP signed them. -She printed the care plans and placed them in a folder for the PCP to sign. -She placed care plans in each resident's record after the PCP signed them. -She had recently started auditing charts on 05/07/26 but did not realize some of the residents did not have signed care plans by the PCP. Interview with the Administrator on 05/14/26 at 11:51am revealed: -The RCC was responsible for completing care plans and making sure the PCP signed the care plans. -They had an online tracking system in place to make sure they met deadlines, but there was no way to check online if the PCP had signed care plans. -He thought chart audits would be the only way to check if the PCP had signed care plans. -He thought the staff were doing chart audits. -He was not sure why some of the residents did not have signed care plans by the PCP.	D 259		
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	D 273		

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D 273	Continued From page 5 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 for 1 of 4 sampled residents (#5) related to an order to notify the Primary Care Provider (PCP) of blood sugar readings less than 70. The findings are: Review of Resident #5's current FL2 dated 04/06/26 revealed: -Diagnoses included Alzheimer's disease and diabetes mellitus type II. -He was constantly disorientated. -His level of care was for special care unit (SCU). Review or Resident #5's Resident Register revealed an admission date of 04/15/25. Review of Resident #5's signed physician's order dated 10/24/25 revealed there was an order for finger stick blood sugar (FSBS) before each meal and at bedtime and to notify the PCP if FSBS was less than 70 or greater than 400. Review of Resident #5's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry to monitor Resident #5's FSBS before each meal and at bedtime and to notify the PCP if FSBS was less than 70 or greater than 400. -On 03/23/26 at 7:59am Resident #5's FSBS was 62. -On 03/26/26 at 8:36am Resident #5's FSBS was 66. -There were 2 of 120 opportunities when	D 273	**D 273** **10A NCAC 13F. .0902(b)** **Health Care** The community will ensure referral and follow-up related to orders requiring notification of the Primary Care Provider (PCP) as ordered. Med Tech's are to assure that Blood Sugars below 70 or Blood Sugars over 400 will be reported to the physician/provider for further instructions. Also, documentation will be made in Extended Care Professionals (ECP), (which is our Emar) concerning the contact and any orders given to the Med Tech. The DHW, RCC, and MCD will monitor Monday to Friday and on Monday for the weekend in ECP that these procedures are followed by the Med Tech for compliance. Reports are available in ECP to enable the DHW, RCC, and MCD to quickly evaluate compliance.	7/15/26

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D 273	Continued From page 6 Resident #5's FSBS was less than 70. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's April 2026 eMAR revealed: -There was an entry to monitor Resident #5's FSBS before each meal and at bedtime and to notify the PCP if FSBS was less than 70 or greater than 400. -On 04/01/26 at 8:12am Resident #5's FSBS was 68. -On 04/02/26 at 7:59am Resident #5's FSBS was 64. -On 04/04/26 at 9:01am Resident #5's FSBS was 64. -On 04/05/26 at 8:44am Resident #5's FSBS was 60. -On 04/07/26 at 8:04am Resident #5's FSBS was 65. -On 04/13/26 at 7:01am Resident #5's FSBS was 56. -On 04/17/26 at 9:18am Resident #5's FSBS was 54. -On 04/18/26 at 7:30am Resident #5's FSBS was 47. -On 04/19/26 at 9:49am Resident #5's FSBS was 48. -On 04/20/26 at 8:15am Resident #5's FSBS was 55. -On 04/21/26 at 8:16am Resident #5's FSBS was 65. -On 04/27/26 at 7:23am Resident #5's FSBS was 66. -There were 12 of 120 opportunities when Resident #5's FSBS was less than 70. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's May 2026 eMAR	D 273	Med Tech's will receive an in-service by July 15th concerning Diabetes, reporting, and documentation by the DHW or other qualified Registered Nurse.	

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D 273	Continued From page 7 revealed: -There was an entry to monitor Resident #5's FSBS before each meal and at bedtime and to notify the PCP if FSBS was less than 70 or greater than 400. -On 05/01/26 at 7:41am Resident #5's FSBS was 68. -There was 1 of 120 opportunities when Resident #5's FSBS was less than 70. -There was no documentation Resident #5's PCP was notified. Review of Resident #5's record revealed there was no documentation his PCP was notified when his FSBS was less than 70. Interview with Resident #5's PCP on 05/13/26 at 3:40pm revealed: -She knew Resident #5's FSBS readings had been low and had been monitoring them. -She had adjusted his insulin in April due to low FSBS. -The facility only notified her of Resident #5's low FSBS in person while visiting the facility. -She had not received any other notification of Resident #5's low FSBS readings. -When in the facility, she reviewed Resident #5's eMAR for low FSBS readings. -She expected the facility to follow physician orders and notify her of FSBS readings less than 70. -Resident #5 could experience hypoglycemia (low blood sugar), become unresponsive or unconscious. Interview with a medication aide (MA) on 05/13/26 at 2:16pm revealed: -The MAs were responsible for checking Resident #5's FSBS and notify his PCP if his FSBS was outside of parameters.	D 273		

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D 273	Continued From page 8 -The MAs were responsible for documenting all PCP notifications in the resident's progress notes. -The MAs were to notify the Special Care Coordinator (SCC), Resident Care Coordinator (RCC) or the Health and Well Director (HWD). -She was unable to find any documentation or notification to Resident #5's PCP office in the eMAR system. Interview with the previous RCC on 05/14/26 at 11:38am revealed: -Her last day at the facility was 04/21/26. -The MAs were responsible for notifying the HWD and contacting the PCP when Resident #5's FSBS was outside of parameters. -The MAs were responsible for documenting PCP notification in the resident's progress note and in the eMAR system. Interview with the SCC on 04/14/26 at 3:10pm revealed: -She started working as the SCC in early April. -The MAs were responsible for calling the PCP if Resident #5's FSBS was less than 70. -The MAs were to report low FSBS readings to the HWD. -She did not know Resident #5's FSBS had been less than 70. -She believed the HWD completed eMAR audits but did not know what exactly was reviewed. Interview the HWD on 05/14/26 at 3:29pm revealed: -He did not know Resident #5 had low FSBS readings. -The MAs were to call the PCP if Resident #5's FSBS was less than 70 but may have forgotten to document PCP notification. -The MAs were to report low FSBS readings to the RCC, SCC and/or HWD.	D 273		

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D 273	Continued From page 9 -The MAs were responsible for documenting PCP notification in the eMAR system and/or a progress note. -The MAs were responsible for documenting the date, time, and who they spoke with at the PCP office. -He did not know there was no documentation of PCP notification for Resident #5 having low FSBS readings. Interview with the Administrator on 05/14/26 at 3:49pm revealed: -He did not know Resident #5's FSBS readings were less than 70. -The MAs were responsible for contacting the PCP when Resident #5's FSBS was less than 70. -The MAs were responsible for reporting low FSBS readings to the on-call person which were the HWD, RCC and/or the SCC. -The HWD was responsible for completing an eMAR audit daily and presenting any issues including FSBS readings out of parameters in the daily stand-up meetings which, "Obviously had not happened." -The HWD was responsible for investigating and following up on any issues identified on the eMAR audits. -The MAs were responsible for documenting PCP notification. -He expected the MAs to follow all physician orders. Attempted telephone interview with a second MA on 05/13/26 at 3:35pm was unsuccessful.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 283		

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D 283	Continued From page 10 (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure food stored and served to all residents was protected from contamination related to foods stored that were not labeled, dated, spoiled or had expiration date and the cleaning of the floors in the walk-in cooler, walk-in freezer, main kitchen area and dry storage room. The findings are: Review of the facility's Food Establishment Inspection Report dated 04/24/26 revealed: -The facility received a sanitation score of 98 percent. -Corrective Actions included cleaning frequency	D 283	**D 283** **10A NCAC 13F. 0904(a)(2)** **Nutrition and Food Service** The community will ensure that all food is stored, labeled dated and disposed of in accordance with proper Serve Safe Standards. The community will maintain a daily sanitary environment in the kitchen through assigned cleaning schedules by the Culinary Service Supervisor (CSS). Monitoring will be conducted daily by the CSS and the AED. In-Services will be conducted for all dietary employees concerning proper storage, labeling/dating, and disposal of foods. We will request the local Health Inspector to conduct the in-service if available or conduct it by a qualified Food Service Director in TerraBella.	7/15/26

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D 283	Continued From page 11 and restrictions related to cleaning / repairing floors, and walls throughout the kitchen, dry storage and trash can. Observation of the kitchen on 05/13/26 at 11:25am revealed: -There was visible signage posted on the walk-in cooler/ freezer that directed kitchen staff to label and date all foods stored in the cooler. -There was an unlabeled and opened container of whipped cream, an unlabeled and open container of sour cream (5 liters), an unlabeled plastic container of wilted brownish and green colored salad leaves, two large clear bags of frozen sausages unlabeled and removed from original packaging, a large container of vegetable soup dated 04/22/26, five unlabeled plastic bags of shredded carrots and cabbage, six containers of large unlabeled and opened salad dressing, a large container of half covered cooked rice with a date of 05/02/26 in the walk-in cooler. -There was loose food debris, trash debris, a frozen packaged pork roast, on the heavily soiled floor, in the walk-in cooler and walk-in freezer. -There was loose food debris and trash debris under the steam table, and a heavily soiled floor, throughout the main kitchen area. -There was grease build up and french fries on the floor between the stove and grease fryer. Interview with the Dietary Manager (DM) on 05/13/26 at 3:15pm revealed: -All kitchen staff were responsible for labeling open containers of food stored in the refrigerator and discarding them within 5-7 days after the labeled date. -She did not have a chance to move the grease fryer to clean between the stove and fryer to remove grease debris/ build-up and loose food particles.	D 283		

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D 283	Continued From page 12 -She had not created a kitchen cleaning log and expected all staff to clean the kitchen. -The walk-in cooler and walk-in freezer floors could not be cleaned with water because they would freeze. -She was ultimately responsible for ensuring food stored for resident consumption was properly labeled and oversight of kitchen sanitation. Observation of the kitchen on 05/14/26 at 9:21am revealed: -The walk-in cooler and walk-in freezer floors were still heavily soiled with debris. -There was continued grease buildup and food debris between the grease fryer and the stove that had not been cleaned after the first observation on 05/13/26. Interview with the DM on 05/14/26 revealed she did not have a chance to clean under the debris from the floor of the walk-in cooler and walk-in freezer floor after it was observed by the State Surveyor on 05/13/26, due to a food delivery that was received on 05/14/26. Interview with the Administrator on 05/14/26 at 2:45pm revealed: -He knew about the Food Establishment Inspection Report dated 04/24/26 that indicated corrective actions that included cleaning frequency and restrictions related to cleaning / repairing floors, and walls throughout the kitchen, dry storage and trash can. -The DM was responsible for ensuring opened foods stored in the kitchen were properly labeled, and oversight of kitchen staff to assure regular sanitation tasks were performed. -He was informed of the issues with the kitchen on 05/13/26 but did not know the sanitation of the cooler and freezer floors was not done on	D 283		

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D 283	Continued From page 13 05/14/26. -His expectation was for all foods served to residents to be prepared and stored in a sanitary environment.	D 283		
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 record review and interviews the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#3) related to a medication used to treat dementia behaviors. The findings are: Review of Resident #3's current FL2 dated 04/09/26 revealed: -Diagnoses included dementia, respiratory failure, chronic kidney failure, dysphagia, and anemia. -Resident #3 was constantly disoriented. -Resident #3's level of care was special care unit (SCU). Review of Resident #3's resident register revealed an admission date of 04/21/23. Review of Resident #3's record revealed a	D 358	**D 358** **10A NCAC 13F .1004 (a) Medication Administration** The community will prepare and administer medications, prescriptions, non-prescription and treatments in accordance with prescribing practitioner's orders. Orders are received by the community/pharmacy to be filled. The pharmacy enters the orders into ECP and then they fill it to be delivered to the community. It is then the responsibility of the RCC, or MCD to review the received prescription against the original order and to ensure that it was entered into ECP correctly before being approved and placed on the med cart for distribution. The DHW is then responsible for reviewing all new medication orders M-F and on Monday for the weekend	7/15/26

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D 358	Continued From page 14 hospice admission date 12/06/24. Review of Resident #3's physician order summary dated 04/06/26 revealed an order for quetiapine (medication used to treat dementia behaviors) 25mg tablet, one tablet by mouth at bedtime at 8:00pm. Review of Resident #3's March 2026 and April 2026 electronic medication administration records (eMAR) revealed: -There was an entry for quetiapine 25mg tablets, one tablet by mouth at bedtime at 8:00pm. -There was documentation Resident #3's quetiapine 25 mg, one tablet by mouth at bedtime at 8:00pm, was administered from 03/01/26 to 04/29/26. -There was no documentation 25mg, one tablet by mouth at bedtime at 8:00pm was administered on 04/30/26, as ordered. Review of a verbal physician's order dated 04/30/26 revealed Resident #3 had an order to discontinue quetiapine 25mg at bedtime, start quetiapine 50mg, one tablet at bedtime, and quetiapine 25mg, one tablet by mouth in the morning for agitation. Review of Resident #3's record revealed a physician's order change dated 05/02/26 to discontinue quetiapine 50mg at bedtime and start quetiapine 25mg twice daily. Review of Resident #3's May 2026 eMAR revealed: -There was an entry for quetiapine 25mg tablets, one tablet by mouth every morning at 8:00am. -There was no documentation quetiapine 25mg tablets, one tablet by mouth every morning at 8:00am, was administered on 05/01/26, 05/04/26,	D 358	against meds received and approved by the RCC or MCD as a final quality check. A daily report at Standup is to be given to the AED that this procedure has taken place and in compliance. An in-service will be conducted with the Med Techs on medication administration and following physician orders by the DHW. An audit will be conducted on all current residents. Weekly auditing will be conducted by the DHW, RCC, MCD, and AED to ensure orders are followed as prescribed moving forward.	

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D 358	Continued From page 15 05/05/26 and 05/06/26, as ordered. -There was documentation quetiapine 25mg tablets, one tablet by mouth every morning at 8:00am, was administered on 05/02/26 and 05/03/26. -There was an entry for quetiapine 50mg tablets, one tablet by mouth at bedtime at 8:00pm. -There was documentation quetiapine 50mg tablets, one tablet by mouth at bedtime was administered at 8:00pm on 05/01/26 and 05/03/26 and was refused on 05/02/26. -There was an entry for quetiapine 25mg tablets one tablet by mouth twice daily at 8:00am and 8:00pm. -There was documentation Resident #3 was administered 25mg tablets one tablet by mouth twice daily at 8:00am on 05/07/26 to 05/13/26 and at 8:00pm from 05/06/26 to 05/12/26. -There was no documentation Resident #3 was administered 25mg tablets one tablet by mouth twice daily at 8:00am on 05/06/26, as ordered. Observation of medications available for administration on 05/13/26 revealed Resident #3 had quetiapine 25mg tablets, one tablet by mouth twice daily, 30 tablets dispensed on 05/04/26, and 18 tablets were available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/14/26 at 9:00am revealed: -Resident #3 had an active order dated 04/30/26 for quetiapine 25mg one tablet every morning and 50mg, one tablet at bedtime. - Resident #3's quetiapine 25mg tablets, 15 tablets and 50mg 15 tablets were dispensed to the facility on 04/30/26. -They received an order on 05/04/26 from Resident #3's Primary Care Physician (PCP) for quetiapine 25mg tablet, one tablet in the morning	D 358		

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D 358	Continued From page 16 and one tablet at bedtime. -Although they did not receive a discontinued order for quetiapine 50mg, one tablet at bedtime, the 50mg at bedtime was replaced by 25mg does twice daily. -Quetiapine 25mg, one tablet twice daily, 56 tablets were to be dispensed with the next cycle fill on 05/15/26. -The facility would have had enough quetiapine 25mg tablets to administer to Resident #3 on the days that were missed on 04/30/26 (8:00am dose), 05/01/26 (8:00am dose), 05/04/26 (8:00am and 8:00pm doses), 05/05/26 (8:00am and 8:00pm doses), and the 8:00am dose on 05/06/26. Interview with the Special Care Coordinator (SCC) on 05/14/26 at 10:48am revealed: -The former Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for handling the orders prior to her being assigned one week ago. -She had not started auditing eMARs and running missed medication reports. -She knew Resident #3's quetiapine was changed a few times because it was mentioned in the stand-up meeting. -The MAs were responsible for documenting the eMAR as they administered medications. -She did not know why there was no documentation or explanation showing Resident #3 was administered quetiapine on 04/30/26 (8:00am dose), 05/01/26 (8:00am dose), 05/04/26 (8:00am and 8:00pm doses), 05/05/26 (8:00am and 8:00pm doses), and the 8:00am dose on 05/06/26. -She could only assume Resident #3 did not receive those doses of quetiapine on those days, as ordered because there was no documentation.	D 358		

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D 358	Continued From page 17 Interview with the HWD on 05/14/26 at 11:15am revealed: -The former RCC was responsible for overseeing medication audits and running missed dose reports for the assisted living (AL) unit and the SCU. -Since the RCC position became vacant in the middle of April 2026, the missed medication dose report was not generated and Resident #3's missed doses of quetiapine were not flagged for further investigation. -He was in the process of contacting MAs who worked on the shifts when the holes in the eMAR occurred. -He expected all medications to be administered as ordered and documented on the eMAR accurately. Interview with the Administrator on 05/14/26 at 3:55pm revealed: -The MAs were responsible for documenting if a medication was administered or not administered. -If a medication was not administered, the MA was to provide a reason why the medication was not administered. -The former RCC was responsible for weekly eMAR audits. -The HWD took over and became responsible for running missed medication reports after the RCC position was vacated. -Resident #3 could have missed five doses of quetiapine since there was always quetiapine available for administration. -He expected MAs to administer medications as ordered, document the eMAR accurately and notify the SCC, RCC or HWD if there was any issue with medications.	D 358		

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D 367	Continued From page 18	D 367		
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). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure electronic Medication Administration Records (eMARs) were accurate for 2 of 5 residents (#2 and #3) related to documentation of medications to lower risks of blood clots (#2) and a medication medication used to treat dementia behaviors (#3). The findings are:	D 367	**D 367** **10A NCAC 13F 01004 (j) Medication Administration** The community is responsible for ensuring that the Emar (ECP) is accurate related to documentation of medications which are administered to the residents. Proper medication management will be met as follows. Orders are received by the community/pharmacy to be filled. The pharmacy enters the orders into ECP and then they fill it to be delivered to the community. It is then the responsibility of the RCC, or MCD to review the received prescription against the original order and to ensure that it was entered into ECP correctly before being approved and placed on the med cart for distribution. The DHW is then responsible for reviewing all new medication orders M-F and	7/15/26

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D 367	Continued From page 19 1. Review of Resident #2's current FL2 dated 04/09/26 revealed diagnoses included atrial fibrillation (irregular heart rhythm), atrial flutter (irregular heart rhythm) and history of a cerebral infarct (stroke). Review of Resident #2's Nurse Practitioner's (NP) note dated 04/10/26 revealed there was an order for warfarin (a medication to decrease the risk of blood clots) 5mg, one tablet daily on Mondays, Wednesday, Fridays, Saturdays and Sundays. Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There were two entries for warfarin 5mg, one tablet on Mondays, Wednesdays, Fridays, Saturdays, and Sundays. -There was documentation on the first entry that warfarin 5mg, one tablet was administered on Mondays, Wednesdays, Fridays, Saturdays and Sundays from 04/03/26 to 04/29/26 at 5:00pm except on 04/22/26 because there were duplicate orders. -There was documentation on the second entry that warfarin 5mg, one tablet was administered on Wednesday (04/22/26), Friday (04/24/26), Saturday (04/25/26), Sunday (04/26/26), and Monday (04/27/26). -The second entry had documentation on Wednesday (04/29/26) warfarin 5mg, one tablet was not administered as it was a duplicate order. Review of Resident #2's controlled substance count sheets (CSCS) for warfarin 5mg revealed warfarin 5mg, one tablet was signed out on 04/24/26, 04/25/26, 04/26/26 and 04/27/26 at 5:00pm when the eMAR indicated warfarin 5mg, one tablet was administered on two different entries at 5:00pm.	D 367	on Monday for the weekend against meds received and approved by the RCC or MCD as a final quality check. A daily report at Standup is to be given to the AED that this procedure has taken place and in compliance. An in-service will be conducted with the Med Techs on medication administration and following physician orders by the DHW. An audit will be conducted on all current residents. Weekly auditing will be conducted by the DHW, RCC, MCD, and AED to ensure orders are followed as prescribed moving forward.	

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D 367	Continued From page 20 Observation of medications on hand for Resident #2 on 05/13/26 at 4:45pm revealed: -There were two bubble pack cards of warfarin 5mg labeled with Resident #2's name on them. -One bubble pack card had a dispense date of 04/02/26 and had warfarin 5mg, one tablet remaining in the card. -The second bubble pack card had a dispense date of 04/24/26 and contained 20 tablets. Interview with a medication aide (MA) on 05/13/26 at 4:54pm revealed: -Resident #2 had duplicate orders for warfarin 5mg in the eMAR in April 2026. -She thought she only marked one of the entries as administered and the other as not administered because of the duplicate order. -She only administered warfarin 5mg, one tablet on 04/24/26, 04/25/26, 04/26/26 and 04/27/26 as indicated on Resident #2's CSCS. -She did not know when, but she informed the Health and Wellness Director (HWD) that Resident #2 had duplicate warfarin 5mg entries on her eMAR. -She thought the previous Resident Care Coordinator (RCC) changed the order in the eMAR system. Telephone interview with the previous RCC on 05/14/26 at 11:21am revealed: -The facility had issues at times with duplicate orders entered by the pharmacy. -She did not know the date, but staff had brought it to her attention that Resident #2 had duplicate warfarin 5mg order in the eMAR system. -She removed Resident #2's duplicate warfarin 5mg order and reviewed the warfarin CSCS to ensure the correct dose had been signed out to administer to the resident.	D 367		

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D 367	Continued From page 21 Interview with the HWD on 05/14/26 at 3:30pm revealed: -The MAs were responsible to make him and the RCC aware of any duplicate orders in the eMAR system. -The MAs were able to document notes in the eMAR system if a resident had a duplicate order. -He was not aware Resident #2 had duplicate warfarin 5mg orders in the eMAR system. Interview with the Administrator on 04/14/26 at 3:50pm revealed: -The RCC or the HWD reviewed all medication orders in the eMAR system and had to approve the order before it showed on the resident's eMAR. -The MA should have questioned why there were duplicate warfarin 5mg orders for Resident #2 and called the pharmacy. -The MA should not have documented warfarin 5mg, one tablet was documented in both entries. 2. Review of Resident #3's current FL2 dated 04/09/26 revealed: -Diagnoses included dementia, respiratory failure, chronic kidney failure, dysphagia, and anemia. -Resident #3 was constantly disoriented. -Resident #3's level of care was special care unit (SCU). Review of Resident #3's resident register revealed an admission date of 04/21/23. Review of Resident #3's record revealed a hospice admission date 12/06/24. Review of Resident #3's physician order summary dated 04/06/26 revealed an order for quetiapine (medication used to treat dementia behaviors) 25mg tablet, one tablet by mouth at	D 367		

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D 367	Continued From page 22 bedtime at 8:00pm. Review of Resident #3's April 2026 eMAR revealed: -There was an entry for quetiapine 25mg tablets, one tablet by mouth at bedtime at 8:00pm. -There was documentation Resident #3's quetiapine 25 mg, one tablet by mouth at bedtime at 8:00pm, was administered from 04/01/26 to 04/29/26. -There was no documentation 25mg, one tablet by mouth at bedtime at 8:00pm was administered on 04/30/26. Review of a verbal physician's order dated 04/30/26 revealed Resident #3 had an order to discontinue quetiapine 25mg at bedtime, start quetiapine 50mg, one tablet at bedtime, and add quetiapine 25mg, one tablet by mouth in the morning for agitation. Review of Resident #3's record revealed a physician's order change dated 05/02/26 to discontinue quetiapine 50mg at bedtime and start quetiapine 25mg twice daily. Review of Resident #3's May 2026 eMAR revealed: -There was an entry for quetiapine 25mg tablets, one tablet by mouth every morning at 8:00am. -There was no documentation quetiapine 25mg tablets, one tablet by mouth every morning at 8:00am, was administered on 05/01/26, 05/04/26, 05/05/26 and 05/06/26. -There was documentation quetiapine 25mg tablets, one tablet by mouth every morning at 8:00am, was administered on 05/02/26 and 05/03/26. -There was an entry for quetiapine 50mg tablets, one tablet by mouth at bedtime at 8:00pm.	D 367		

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D 367	Continued From page 23 -There was documentation quetiapine 50mg tablets, one tablet by mouth at bedtime was administered at 8:00pm on 05/01/26 and 05/03/26 and was refused on 05/02/26. -There was an entry for quetiapine 25mg tablets one tablet by mouth twice daily at 8:00am and 8:00pm. -There was documentation Resident #3 was administered 25mg tablets one tablet by mouth twice daily at 8:00am on 05/07/26 to 05/13/26 and at 8:00pm from 05/06/26 to 05/12/26. Observation of medications available for administration on 05/13/26 revealed Resident #3 had quetiapine 25mg tablets, one tablet by mouth twice daily, 30 tablets dispensed on 05/04/26, and 18 tablets were available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/14/26 at 9:00am revealed: -Resident #3 had an active order dated 04/30/26 for quetiapine 25mg one tablet every morning and 50mg, one tablet at bedtime. -Resident #3's quetiapine 25mg tablets, 15 tablets and 50mg 15 tablets were dispensed to the facility on 04/30/26. -They received an order on 05/04/26 from Resident #3's Primary Care Physician (PCP) for quetiapine 25mg tablet, one tablet in the morning and one tablet at bedtime. -Although they did not receive a discontinued order for quetiapine 50mg, one tablet at bedtime, the 50mg at bedtime was replaced by 25mg doses twice daily. -Quetiapine 25mg, one tablet twice daily, 56 tablets was to be dispensed with the next cycle fill on 05/15/26. Interview with the Special Care Coordinator	D 367		

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D 367	Continued From page 24 (SCC) on 05/14/26 at 10:48am revealed: -The former RCC and the HWD were responsible for handling the orders prior to her being assigned one week ago. -She had not started auditing eMARs and running missed medication reports. -She knew Resident #3's quetiapine was changed a few times because it was mentioned in the stand-up meeting. -The MAs were responsible for documenting the eMAR as they administered medications. -She did not know why there was no documentation or explanation showing Resident #3 was administered quetiapine 04/30/26 (8:00am dose), 05/01/26 (8:00am dose), 05/04/26 (8:00am and 8:00pm doses), 05/05/26 (8:00am and 8:00pm doses), and the 8:00am dose on 05/06/26. -Resident #3 did not receive those doses of quetiapine on those days, as ordered because there was no documentation. Interview with the HWD on 05/14/26 at 11:15am revealed: -The former RCC was responsible for overseeing medication audits and ensuring medication orders matched the eMARs for residents residing on the assisted living (AL) unit and the SCU. -Since the RCC position became vacant in the middle of April, the oversight of medication audits was not performed, therefore the multiple order changes in Resident #3's doses of quetiapine within a few days, that delayed the start and stop of each order. -He expected all medications to be administered as ordered and documented on the eMAR accurately. Interview with the Administrator on 05/14/26 at 3:55pm revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL018036	A. BUILDING: _____ B. WING _____	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA NEWTON	1088 RADIO STATION ROAD NEWTON, NC 28658

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D 367	Continued From page 25 -The former RCC was responsible for weekly eMAR audits. -After the RCC position was vacated, the HWD took over and became responsible for medication audits and ensuring eMARs were accurate. -He expected MAs to administer medications as ordered, document the eMAR accurately and notify the SCC, RCC or HWD if there were any issues with medications.	D 367		