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TERRABELLA SALISBURY	1915 MOORESVILLE ROAD SALISBURY, NC 28147

(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 an annual and a follow-up survey from 02/11/25 to 02/13/25.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a resident room and bathroom on the D Hall was kept clean. The findings are: Observation of a resident's room on the D hall on 02/11/25 at 8:50am revealed: -There was scattered paper debris on the carpet in the living area. -There were two brownish stains on the floor in the living area in front of the bed. -There was a pile of crumbs on the bottom and in front of a small side table next to a chair. -There was a brown substance on the floor of the shower. -There were several brown spots in the toilet bowl.	D 074		

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D 074	Continued From page 1 A second observation of the resident's room on the D Hall on 02/12/25 at 8:45am revealed: -There was scattered paper debris on the carpet in the living area. -There were two brownish stains on the floor in the living area in front of the bed. -There was a pile of crumbs on the bottom and in front of a small side table next to a chair. -There was a brown substance on the floor of the shower. -There were several brown spots in the toilet bowl. A third observation of the resident's room on the D Hall on 02/13/25 at 8:30am revealed: -There was more scattered paper debris on the carpet in the living area. -There were two brownish stains on the floor in the living area in front of the bed. -There was a pile of crumbs on the bottom and in front of a small side table next to a chair. -There was a brown substance on the floor of the shower. -There were several brown spots in the toilet bowl. Interview with a resident that resided on the D Hall on 02/11/25 at 9:10am revealed: -The housekeeper quit last week. -Her room was not being cleaned. -Some of the managers cleaned the common areas over the weekend but did not clean her room. -She would like her room to be cleaned. Second interview with a resident that resided on the D Hall on 02/13/25 at 9:45am: -Her room had been dirty for several days. -There were stains on the carpet, trash on the floor, and the shower and toilet were dirty.	D 074		

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D 074	Continued From page 2 -She had not seen a housekeeper in a few days. -She did not like her room to be dirty and wanted it to be cleaned. Interview with a personal care aide (PCA) on 02/13/25 at 9:00am revealed: -She changed the linen on residents' beds when she gave showers. -She removed the trash from the trash can at the end of her shift. -She did not clean the resident rooms or bathrooms but if she saw something that needed attention, she would clean it. -She tried to get the stains out of the carpet at the beginning of the week in the resident room on D Hall. -The housekeeper that worked at the facility quit last week. Interview with the Maintenance/Housekeeping Director on 02/13/25 at 9:20am revealed: -The Administrator took over the cleaning of the rooms from him. -He was not aware the resident room on the D Hall was dirty and needed to be cleaned. Interview with the Resident Care Coordinator (RCC) on 02/13/25 at 9:50am revealed: -She knew there were stains on the carpet in a room on D Hall and the staff tried to clean it up. -She did not know the floor, toilet and shower floor were still dirty. -She was supposed to do rounds on the rooms and check for cleanliness. Interview with the Administrator on 02/13/25 at 9:25am revealed: -The housekeeper quit abruptly, and she had taken over the housekeeping responsibilities. -She started cleaning the facility over the	D 074		

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D 074	Continued From page 3 weekend but had not yet gotten to each resident room. -She did not know the resident room on D Hall was dirty. -The floor staff should have cleaned the stains on the floor, vacuumed the floor, and cleaned the toilet and shower. -If the floor staff did not know what to use to clean the resident room, they should have asked the RCC or other managers. -The RCC was expected to go room to room each day and check for cleanliness. -She expected the resident rooms to be kept clean.	D 074		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at each meal for 25 of 30 assisted living (AL) residents in addition to other beverages. The findings are: Observation of the lunch meal service on	D 306		

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D 306	Continued From page 4 02/11/25 for the AL dining room between 12:00pm and 1:00pm revealed: -There were 25 residents present for the lunch meal service. -The beverages were served by the personal care aides (PCA) from a beverage cart. -Beverages included lemonade, milk, tea, coffee, and water. -The PCAs poured lemonade and tea for all the residents and offered water or milk to each resident. -Five residents were served water and all the other residents were served other beverages. -No other residents were served water. Observation of the breakfast meal service on 02/12/25 for the AL dining room between 8:00am and 8:45am revealed: -There were 30 residents present for the breakfast meal service. -The beverages were served by the PCAs from a beverage cart. -Beverages included juice, milk, tea, coffee, and water. -The PCAs poured juice and tea for all the residents and offered water or milk to each resident. -Five residents were served water and all the other residents were served other beverages. -No other residents were served water. Interview with a resident on 02/12/25 at 8:20am: -Beverages served with meals usually included coffee, juice, and tea. -If he wanted water with his meals, he had to ask for it. -He would drink water with every meal if it was served to him with each meal. Interview with a second resident on 02/12/25 at	D 306		

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D 306	Continued From page 5 8:30am revealed: -Residents were offered water with each meal. -He would drink water with his meals if it was served to him. -He drank what was served to him and did not ask for water. Interview with a PCA on 02/12/25 at 8:45am revealed: -She assisted in the AL dining room during meals. -She relied on dietary staff to provide beverages for residents at mealtimes. -Water was offered to all residents. -A few residents were served water, but the other residents were served a mixture of other beverages. -She was aware water should have been served to all residents with each meal, but she offered water because some of the AL residents refused to drink the water. Interview with a second PCA on 02/12/25 at 8:55am revealed: -She assisted in the AL dining room during meals. -Beverages were prepared by the dietary staff on beverage carts. -The PCA served the residents beverages from the beverage cart. -A few residents were served water, but the other residents were served tea and juice. -She did not know water should have been served to all residents with each meal. Interview with a dietary staff on 02/12/25 at 9:05am revealed: -Beverages were prepared and placed on a beverage cart by the dietary staff before mealtimes. -Water was always available as a beverage for the AL residents.	D 306		

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-The PCAs were responsible for serving beverages to the AL residents from the beverage cart.
-She was not aware water was not served with the lunch meal service on 02/11/25 for 20 residents or with the lunch meal service on 02/12/25 for 25 residents.
-She was aware water should have been served to all residents with each meal.

Interview with the acting Dietary Manager (DM) on 02/12/25 at 9:15am revealed:
-She was aware water should have been served daily to all AL residents with each meal.
-Beverages were prepared by the dietary staff on beverage trays and served by the PCAs at every meal.
-Water was always available as a beverage for the AL residents.
-She was not aware water was not served with the lunch meal service on 02/11/25 for 20 residents or with the breakfast meal service on 02/12/25 for 25 residents.
-She expected water to be served to the AL residents during every meal according to nutritional requirements.

Interview with the Resident Care Coordinator (RCC) on 02/12/25 at 9:30am revealed:
-She was not aware residents should have been served water daily with each meal.
-The PCAs relied on dietary staff to provide beverages for residents at mealtimes.
-The PCAs were responsible for serving beverages to the residents from the beverage cart.
-She was aware AL residents had not been served water with each meal because she thought water was optional for the residents.

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D 306	Continued From page 7 Interview with the Health and Wellness Director (HWD) on 02/12/25 at 9:20am revealed: -She was aware water should have been served daily to all residents with each meal. -Beverages were prepared by the dietary staff on beverage trays and then served by the PCAs with each meal. -Water was always available as a beverage for all residents. -She was not aware water was not served with the lunch meal service on 02/11/25 for 20 residents or with the lunch meal service on 02/12/25 for 25 residents. -She expected water to be served to all residents during every meal. Interview with the Administrator on 02/12/25 at 9:45am revealed: -She did not know the AL residents were not served water with each meal. -She knew residents were to be served water daily with each meal. -There should be no issues for AL residents to be served water during each meal. -She expected water to be served to all residents during every meal according to nutritional requirements and regulations.	D 306		
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	D 358		

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D 358	Continued From page 8 and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review, the facility failed to administer medications as ordered for 1 of 6 sampled residents including a medication to lower blood sugar (#2). The findings are: Review of Resident #2's current FL-2 dated 12/31/24 revealed: -Diagnoses included diabetes mellitus type 2 and dementia. -There was an order for finger stick blood sugar (FSBS) checks before meals. -There was an order for lispro (a rapid acting insulin) 10 units with meals if FSBS was above 200 and to hold if Resident #2 did not eat or if the FSBS result was below 200. Review of Resident #2's December 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lispro kwikpen 100units/ml inject 10 units with meals if FSBS greater than 200 (hold if resident does not eat/has no plans to eat or FSBS less than 200 with scheduled administration times of 8:00am, 12:00pm, and 5:00pm. -The FSBS results from 12/01/24 to 12/31/24 ranged from 64 to 469. -There were 6 doses of lispro 10 units documented as administered when Resident #2's FSBS result was below 200. -On 12/11/24 at 5:00pm, the FSBS was 193; 10	D 358		

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units of lispro were documented as administered.
-On 12/14/24 at 5:00pm, the FSBS was 138; 10 units of lispro were documented as administered.
-On 12/24/24 at 12:00pm, the FSBS was 188; 10 units of lispro were documented as administered.
-On 12/27/24 at 12:00pm, the FSBS was 129; 10 units of lispro were documented as administered.
-On 12/27/24 at 5:00pm, the FSBS was 123; 10 units of lispro were documented as administered.
-On 12/28/24 at 5:00pm, the FSBS was 135; 10 units of lispro were documented as administered.

Review of Resident #2's January 2025 eMAR revealed:
-There was an entry for lispro kwikpen 100units/ml inject 10 units with meals if FSBS greater than 200 (hold if resident does not eat/has no plans to eat or FSBS less than 200 with scheduled administration times of 8:00am, 12:00pm, and 5:00pm.
-The FSBS results from 01/01/25 to 01/31/25 ranged from 47 to 309.
-There were 7 doses of lispro 10 units documented as administered when Resident #2's FSBS result was below 200.
-On 01/07/25 at 8:00am, the FSBS was 71; 10 units of lispro were documented as administered.
-On 01/12/25 at 5:00pm, the FSBS was 183; 10 units of lispro were documented as administered.
-On 01/15/25 at 5:00pm, the FSBS was 192; 10 units of lispro were documented as administered.
-On 01/22/25 at 5:00pm, the FSBS was 195; 10 units of lispro were documented as administered.
-On 01/26/25 at 5:00pm, the FSBS was 137; 10 units of lispro were documented as administered.
-On 01/28/25 at 8:00am, the FSBS was 57; 10 units of lispro were documented as administered.
-On 01/29/25 at 5:00pm, the FSBS was 198; 10 units of lispro were documented as administered.

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D 358	Continued From page 10 Review of Resident #2's February 2025 eMAR from 02/01/25 to 02/11/25 revealed: -There was an entry for lispro kwikpen 100units/ml inject 10 units with meals if FSBS greater than 200 (hold if resident does not eat/has no plans to eat or FSBS less than 200 with scheduled administration times of 8:00am, 12:00pm, and 5:00pm. -FSBS results from 02/01/25 to 02/11/25 ranged from 60 to 342. -There were 2 doses of lispro 10 units documented as administered when Resident #2's FSBS result was below 200. -On 02/05/25 at 5:00pm, the FSBS was 114; 10 units of lispro were documented as administered. -On 02/08/25 at 5:00pm, the FSBS was 146; 10 units of lispro were documented as administered. Review of Resident #2's laboratory results revealed a hemoglobin A1C (a test to measure the average blood sugar level over the past 3 months) result of 8.5 collected on 09/18/24. Observation of Resident #2's medications on hand on 02/13/25 at 9:30am revealed: -There were three lispro 3ml flexpens available for administration with a dispensed date of 10/11/24 with instructions to administer 10 units before each meal for FSBS greater than 200. -There were two lispro 3ml flexpens available for administration with instructions to administer 8 units before each meal for FSBS greater than 200. -There was one lispro 3ml flexpen available for administration that was not labeled with instructions to administer 8 units before each meal for FSBS greater than 200. Interview with Resident #2 on 02/13/25 at 9:30am revealed:	D 358		

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-She got her FSBS checked 3 times a day before she ate her meals.
-If her FSBS was below 200, she did not get insulin.
-The medication aides (MAs) usually told her what her FSBS result was.
-Her FSBS ran lower in the mornings.
-She did not think she got insulin when she should not have.

Telephone interview with a representative from the facility's contracted pharmacy on 02/12/25 at 2:23pm revealed:
-Resident #2 had an order dated 10/11/24 to administer 10 units lispro with meals if FSBS was greater than 200 (hold if resident does not eat or if FSBS below 200).
-Three 3ml lispro flexpens were dispensed on 10/11/24.
-An order was received on 10/22/24 to hold the lispro 10 units with meals.
-On 10/24/24, the order for lispro 10 units was restarted.
-The pharmacy requested clarification of the order and sent a request to the facility but did not receive a response.
-There were no dispense dates after 10/11/24 for lispro.

Telephone interview with Resident #2's primary care provider (PCP) on 02/13/25 at 3:02pm revealed:
-Resident #2 had an order to give lispro 10 units with each meal and hold if the FSBS was below 200 or the resident did not eat her meal.
-On 10/22/24, she held Resident #2's insulin and restarted it on 10/24/24.
-She had not received a request from the facility or the pharmacy to clarify the order.
-She thought the order was clear as it was

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written.
-Resident #2 was a fragile diabetic and had a history of becoming hypoglycemic.
-She was concerned Resident #2 would become hypoglycemic if she was given insulin when her FSBS was less than 200.

Interview with a MA on 02/12/25 at 10:50am revealed:
-Resident #2 had an order to hold her lispro insulin if her FSBS was below 200.
-She did not give Resident #2 insulin if her FSBS was below 200.
-She could have documented in error that she administered insulin when the FSBS was below 200 because Resident #2 received another insulin also.

Interview with a second MA on 02/12/25 at 12:43pm revealed:
-She checked Resident #2's FSBS before dinner when she worked.
-She thought the order for the lispro was confusing.
-She would give Resident #2 lispro if her FSBS was below 200 because she knew she was going to eat her meal.
-She should have asked for clarification if she was confused about the order.

Interview with the Resident Care Coordinator (RCC) on 02/12/25 at 1:04pm revealed:
-She thought the order for Resident #2's lispro was clear.
-The MAs had not asked for clarification of the order.
-She checked the eMARs for new medications, discontinued medications, missed medication, and late medications.
-She had not reviewed Resident #2's eMARs for

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D 358	Continued From page 13 errors in insulin administration but should be checking that also. -She was concerned the MAs were not following the orders. Interview with the Health and Wellness Director (HWD) on 02/13/25 at 1:13pm revealed: -She had been doing a lot of education with the MAs. -She created an audit for the eMARs but checking FSBS results and insulin administration was not part of the audit. -She was not aware insulin was being administered to Resident #2 when it should not be. -More education was needed. -She was concerned insulin was being administered when it should not be. -She expected the MAs to follow the physician's orders as written. Interview with the Administrator on 02/13/25 at 1:43pm revealed: -She did not know what kind of audits of eMARs were being done. -The RCC and HWD were responsible for checking eMARs and ensuring orders were being followed. -It was important to follow insulin orders with parameters closely. -She expected MAs to follow the physician's orders as written ask for clarification, if needed. _____ The facility failed to administer insulin as ordered to Resident #2 who had a history of being a fragile diabetic with episodes of hypoglycemia, placing her at risk for low blood sugar levels. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080030	A. BUILDING: _____ B. WING _____	R 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 14 The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/12/25. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 30, 2025.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all non-prescription medications stored by the facility were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration for 1 of 6 sampled residents including an over-the-counter medication for pain. The findings are: Review of the facility's policy titled "Medication Storage-Centrally Stored Medications" revealed all medications, including over-the-counter medications, were kept in locked storage at all times. Review of Resident #2's current FL-2 dated	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 378	Continued From page 15 01/11/24 revealed: -Diagnoses included altered mental status. -There was no order for extra strength acetaminophen. Observation of Resident #2's room on 02/12/25 at 9:45am revealed: -There was a bottle of extra strength acetaminophen on the night stand. -The bottle was not labeled to indicate who the medication was for or instructions for use. -The bottle was visible from the room's entrance. -The bottle was one-fourth full. A second observation of Resident #2's room on 02/12/25 at 2:15pm revealed: -There was a bottle of extra strength acetaminophen on the night stand. -The bottle was not labeled to indicate who the medication was for or instructions for use. -The bottle was visible from the room's entrance. -The bottle was one-fourth full. Observation of Resident #2's room at various times on 02/12/25 and 02/13/25 revealed Resident #2's room door was kept closed but unlocked throughout the day when she was not present in the room. Interview with Resident #2 on 02/12/25 at 9:45am revealed: -She got the extra strength acetaminophen from the drug store when she went out with her family. -She did not know if she had an order for it. -She took the extra strength acetaminophen for headaches. -She could not recall the last time she took the extra strength acetaminophen. Interview with the medication aide (MA) on	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080030	A. BUILDING: _____ B. WING _____	R 02/13/2025

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D 378	Continued From page 16 02/13/25 at 1:13pm revealed: -Resident #2 did not self-administer her medications. -She was unaware Resident #2 had extra strength acetaminophen in her room. -Resident #2 did not lock her door when she went out. -If there were medications in resident rooms, she was supposed to remove them and take them to the Resident Care Coordinator (RCC). Interview with the RCC on 02/13/25 at 9:50am revealed: -Resident #2 did not self-administer her medications. -She was not aware there was a bottle of extra strength acetaminophen in Resident #2's room. -All staff were expected to observe resident rooms for medications at the bedside and bring them to her attention. Interview with the Health and Wellness Director (HWD) on 02/13/25 at 9:53am revealed: -Resident #2 did not self-administer her medications. -She was not aware there was a bottle of extra strength acetaminophen in Resident #2's room. Interview with the Administrator on 02/13/25 at 9:55am revealed: -She expected floor staff and MAs to look around resident rooms when they provided care or administered medications. -Resident #2 should not have extra strength acetaminophen at her bedside. -The RCC was expected to go room to room each day and check for medications at the bedside.	D 378		