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 06/19/2025

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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 a follow-up survey from 06/17/25 to 06/19/25.	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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) who had orders for a medication to treat an underactive thyroid and a medication to lower blood cholesterol levels. Review of Resident #1's current FL2 dated 02/19/25 revealed diagnoses included diabetes mellitus type II with chronic kidney disease, muscle weakness, pulmonary hypertension, heart disease, muscle weakness and non-rheumatic aortic stenosis. a. Review of Resident #1's signed physician's order dated 06/12/25 revealed there was an order for levothyroxine sodium 50 mcg (used to treat	D 358		

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D 358	Continued From page 1 hypothyroidism) once daily to start on 06/12/25. Review of Resident #1's June 2025 electronic medication record (eMAR) from 06/12/25 to 06/17/25 revealed: -There was no entry for levothyroxine sodium 50mcg once daily. -There was no documentation levothyroxine sodium 50mcg was administered daily from 06/12/25 to 06/17/25. Observation of medication on hand for Resident #1 on 06/18/25 at 12:15pm revealed there was no levothyroxine sodium available for administration. Interview with Resident #1 on 06/19/25 at 9:45am revealed: -Her previous primary care provider (PCP) had ordered 2 new medications on 06/12/25 but she was not aware of which medications. -She had not received any new medications from the medication aides (MA) recently since the visit with her PCP. -She had not experienced any recent issues with her thyroid. Interview with Resident #1's responsible party on 06/19/25 at 11:00am revealed: -He was aware the PCP had ordered levothyroxine for Resident #1 on 06/12/25. -He had stopped the PCP from sending the orders to Resident #1's previous pharmacy and had requested the PCP send the order to the facility on 06/12/25. -He was not aware Resident #1 had not received the levothyroxine and expected the facility to administer the medication properly to Resident #1. Telephone interview with a representative for the	D 358		

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D 358	Continued From page 2	D 358		

facility's contracted pharmacy on 06/19/25 at 9:00am revealed:
-The pharmacy received an order for levothyroxine sodium 50mcg once daily for Resident #1 on 06/12/25.
-The levothyroxine sodium was flagged as held in the pharmacy's system due to another pharmacy being scheduled to fill the order.
-The facility staff had not communicated with the pharmacy about Resident #1's levothyroxine sodium until yesterday (06/18/25).

Telephone interview with Resident #1's PCP on 06/19/25 at 12:40pm revealed:
-Resident #1 was ordered levothyroxine sodium 50mcg once daily to treat her low thyroid hormone levels from Resident #1's 06/11/25 laboratory results.
-He faxed the levothyroxine sodium order to the facility on 06/12/25 after Resident #1's responsible party requested he stop the fax transmission of the order to Resident #1's previous pharmacy.
-He was not aware Resident #1 had not received levothyroxine sodium as ordered.
-Resident #1 was not at significant risk if she had not received her levothyroxine sodium as ordered since 06/12/25 but the facility staff should start the administration for Resident #1's levothyroxine sodium immediately.
-He expected Resident #1 to be administered levothyroxine sodium once daily as ordered.

Interview with a MA on 06/18/25 at 12:20pm revealed:
-Resident #1 did not have an entry in the eMAR for levothyroxine sodium 50mcg daily.
-She only administered the medications that were entered into the eMAR.
-She did not know Resident #1 had an order for

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D 358	Continued From page 3 levothyroxine from her PCP on 06/12/25 that had not been entered into the eMAR or sent to the pharmacy. Interview with a second MA on 06/18/25 at 12:35pm revealed: -She did not know Resident #1 had an order for levothyroxine from her PCP on 06/12/25 that had not been entered into the eMAR or sent to the pharmacy. -The Resident Care Coordinator (RCC) and the Health and Wellness Director (HWD) were responsible for reviewing new orders, sending orders to the pharmacy, and updating the eMAR. Interview with the RCC on 06/18/25 at 3:30pm revealed: -She was new to her role as the RCC and was not aware the pharmacy had not received Resident #1's orders for levothyroxine from 06/12/25 until yesterday (06/17/25). -MAs should have reviewed the PCP's orders from 06/12/25 and faxed Resident #1's new orders for levothyroxine to the pharmacy. Interview with the HWD on 06/18/25 at 3:45pm revealed she was not aware the pharmacy had not received Resident #1's orders for levothyroxine from 06/12/25 until yesterday (06/17/25). Refer to the interview with the RCC on 06/18/25 at 3:30pm. Refer to the interview with the HWD on 06/18/25 at 3:45pm. Refer to the interview with the Administrator on 06/19/25 at 10:30am.	D 358		

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D 358	Continued From page 4 b. Review of Resident #1's signed physician's order dated 06/12/25 revealed there was an order for rosuvastatin calcium 40mg (used to treat high cholesterol) once daily to start on 06/12/25. Review of Resident #1's June 2025 eMAR from 06/12/25 to 06/17/25 revealed: -There was no entry for rosuvastatin calcium 40mg once daily. -There was no documentation rosuvastatin calcium 40mg was administered daily from 06/12/25 to 06/17/25. Observation of medication on hand for Resident #1 on 06/18/25 at 12:15pm revealed there was no rosuvastatin calcium available for administration. Interview with Resident #1 on 06/19/25 at 9:45am revealed: -Her previous PCP had ordered 2 new medications on 06/12/25 but she was not aware of which medications. -She had not received any new medications from the MAs recently since the visit with her PCP. -She had not experienced any recent issues with her cholesterol. Interview with Resident #1's responsible party on 06/19/25 at 11:00am revealed: -He was aware the PCP had ordered rosuvastatin for Resident #1 on 06/12/25. -He had stopped the PCP from sending the orders to Resident #1's previous pharmacy and had requested the PCP send the order to the facility on 06/12/25. -He was not aware Resident #1 had not received the rosuvastatin and expected the facility to administer the medication properly to Resident #1.	D 358		

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D 358	Continued From page 5 Telephone interview with a representative for the facility's contracted pharmacy on 06/19/25 at 9:00am revealed: -The pharmacy received an order for rosuvastatin calcium 40mg once daily for Resident #1 on 06/12/25. -The rosuvastatin calcium was flagged as held in the pharmacy's system due to another pharmacy being scheduled to fill the order. -The facility staff had not communicated with the pharmacy about Resident #1's rosuvastatin calcium until yesterday (06/18/25). Telephone interview with Resident #1's PCP on 06/19/25 at 12:40pm revealed: -Resident #1 was ordered rosuvastatin calcium 40mg once daily to treat her elevated cholesterol levels from Resident #1's 06/11/25 laboratory results. -He faxed the rosuvastatin calcium order to the facility on 06/12/25 after Resident #1's responsible party requested he stop the fax transmission of the order to Resident #1's previous pharmacy. -He was not aware Resident #1 had not received rosuvastatin calcium as ordered. -Resident #1 was not at significant risk if she had not received her rosuvastatin calcium as ordered since 06/12/25 but the facility staff should start the administration for Resident #1's rosuvastatin calcium immediately. -He expected Resident #1 to be administered rosuvastatin calcium once daily as ordered. Interview with a MA on 06/18/25 at 12:20pm revealed: -Resident #1 did not have an entry in the eMAR for rosuvastatin calcium 40mg daily. -She only administered the medications that were entered into the eMAR.	D 358		

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D 358	Continued From page 6 -She did not know Resident #1 had an order for rosuvastatin from her PCP on 06/12/25 that had not been entered into the eMAR or sent to the pharmacy. Interview with a second MA on 06/18/25 at 12:35pm revealed: -She did not know Resident #1 had an order for rosuvastatin from her PCP on 06/12/25 that had not been entered into the eMAR or sent to the pharmacy. -The RCC and the HWD were responsible for reviewing new orders, sending orders to the pharmacy, and updating the eMAR. Interview with the RCC on 06/18/25 at 3:30pm revealed: -She was new to her role as the RCC and was not aware the pharmacy had not received Resident #1's orders for rosuvastatin from 06/12/25 until yesterday (06/17/25). -MAs should have reviewed the PCP's orders from 06/12/25 and faxed Resident #1's new orders for rosuvastatin to the pharmacy. Interview with the HWD on 06/18/25 at 3:45pm revealed she was not aware the pharmacy had not received Resident #1's orders for rosuvastatin from 06/12/25 until yesterday (06/17/25). Refer to the interview with the RCC on 06/18/25 at 3:30pm. Refer to the interview with the HWD on 06/18/25 at 3:45pm. Refer to the interview with the Administrator on 06/19/25 at 10:30am. _____ Interview with the RCC on 06/18/25 at 3:30pm	D 358		

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D 358	Continued From page 7 revealed: -She, the HWD, and the MAs were responsible for reviewing new orders when residents returned from a PCP visit. -She, the HWD, and the MAs were responsible for faxing new orders from medical providers to the pharmacy. Interview with the HWD on 06/18/25 at 3:45pm revealed: -She, the RCC, and the MAs were responsible for reviewing new orders when residents returned from a PCP visit. -She, the RCC, and the MAs were responsible for faxing new orders from medical providers to the pharmacy. -She and the RCC were responsible for auditing the eMAR to ensure medications were administered as order by the physician. -She assumed the MAs had reviewed the PCP's orders from 06/12/25 and faxed Resident #1's new orders to the pharmacy. Interview with the Administrator on 06/19/25 at 10:30am revealed: -She did not know Resident #1 did not have some medications. -She expected the MAs, the RCC, and the HWD to review new orders when residents returned from a PCP visit. -She expected the RCC and the HWD to audit the eMARS on a weekly basis to avoid medications not being administered to the residents. -She expected MAs to administer Resident #1's medications as ordered by the physician.	D 358		