

PRINTED: 06/16/2025
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL023048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2025
NAME OF PROVIDER OR SUPPLIER TERRABELLA SHELBY		STREET ADDRESS, CITY, STATE, ZIP CODE 1550 CHARLES ROAD SHELBY, NC 28162		
(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 and Cleveland County Department of Social Services conducted an annual survey June 4, 2025 through June 5, 2025.	D 000	Identification labels indicating a change in direction were placed on-bottles in question during survey to correct this issue 6/6/25.	6/6/25
D 354	10A NCAC 13F .1003 (c) Medication Labels 10A NCAC 13F .1003 Medication Labels (c) The facility shall assure the container is relabeled by a licensed pharmacist or a dispensing practitioner at the refilling of the medication when there is a change in the directions by the prescriber. The facility shall have a procedure for identifying direction changes until the container is correctly labeled. No person other than a licensed pharmacist or dispensing practitioner shall alter a prescription label. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure medication containers had correct labels for 1 of 5 sampled residents (Resident #2) for medications used to treat fluid overload and high blood pressure. The findings are: Review of Resident #2's current FL2 dated 05/19/25 revealed diagnoses included heart disease, hypertension, hyperlipidemia and urinary	D 354	A correct physician order and labeled prescription bottle of medication was supplied on 6/7/25 and delivered by the POA of Resident #2 to correct this violation. DHW or designee shall assure all containers are the correct medication, dosage, and route as per the physician's order. Any discrepancy will be sent to the pharmacy for review, and a correctly labeled Medication package will be sent to the community. A "change" label will be placed on the incorrect package until the new correctly labeled package is received. When received, the DHW, RCC, MA or designee will review the medication to ensure the packaging matches the physician's order.	6/7/25

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

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WTS711

If continuation sheet 1 of 11

Reviewed and acknowledged by *Melissa J. Jones*, 7/11/25.

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D 354	Continued From page 1 tract infection. a. Review of Resident #2's physician's order dated 04/03/25 revealed an order for furosemide 40mg, one tablet once daily. Review of Resident #2's electronic medication administration records (eMAR) for April, May, and June 2025 revealed furosemide 40mg one tablet was administered once daily. Observation of Resident #2's medication on hand on 06/05/25 revealed: -There was a bottle of furosemide 20mg tablets, take two tablets on Monday, Wednesday and Friday and one tablet on all other days. -The bottle of furosemide 20mg was labeled with the resident's name and a dispense date of 05/01/25. -The bottle of furosemide 20mg label displayed a quantity of 45 that was crossed out and a quantity of 90 that was written in. -The bottle of furosemide 20mg had a remaining count of 19 tablets. -The bottle of furosemide 20mg did not have a "change" medication label that matched the active order for 40mg tablets, one tablet once daily. Refer to telephone interview with Resident #2's family member on 06/05/25 at 1:23pm. Refer to interview with a medication aide (MA) on 06/05/25 at 3:25pm. Refer to interview with a pharmacist at Resident #2's pharmacy on 06/05/25 at 11:29am. Refer to interview with the HWD on 06/05/25 at 1:10pm.	D 354	MA training completed on 6/26/25 8:26/25. MA will review labels of medication to insure they match the MAR. If not, it will be brought to the attention of the supervisor and an identifying sticker placed on the medication container until a container with a corrected label arrives.	6/26/25

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TERRABELLA SHELBY

**1550 CHARLES ROAD
SHELBY, NC 28152**

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D 354	Continued From page 2 Refer to interview with the Administrator on 06/05/25 at 2:57pm. b) Review of Resident #2's physician's order dated 12/19/24 revealed an order to decrease spironolactone 25mg, take one tablet once daily. Review of Resident #2's physician's order dated 05/19/25 revealed an order for spironolactone 25mg, take one tablet once daily. Review of Resident #2's e-MAR for April, May, and June 2025 revealed spironolactone 40mg, one tablet once daily was administered. Observation of Resident #2's medication on hand on 06/05/25 revealed: -There was a labeled bottle of spironolactone 25mg tablets, take 1 tablet by mouth two times daily. -The bottle of spironolactone 25mg had a dispense date of 04/01/25 with a quantity of 120 tablets. -The bottle of spironolactone 25mg had a remaining count of 56 tablets. -The bottle of spironolactone 25mg did not have a "change" in medication label that matched the active order for 25mg tablets, one tablet once daily. Refer to telephone interview with Resident #2's family member on 06/05/25 at 1:23pm. Refer to interview with a medication aide (MA) on 06/05/25 at 3:25pm. Refer to interview with a pharmacist at Resident #2's pharmacy on 06/05/25 at 11:29am.	D 354		

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D 354	Continued From page 3 Refer to interview with the HWD on 06/05/25 at 1:10pm. Refer to interview with the Administrator on 06/05/25 at 2:57pm. Telephone interview with Resident #2's family member on 06/05/25 at 1:23pm revealed: -Resident #2's uses an outside pharmacy and does not use the facility's pharmacy. -She picked up Resident #2's furosemide and spironolactone refills on 05/29/25, when the pharmacy contacted her that the refills were available for pick up. -She does not deliver the refills to the facility until the facility contacts her when Resident #2's medications were running out and refills were needed. -She informed the facility on multiple occasions of the dosage changes for Resident #2's furosemide and spironolactone but the pharmacy was never notified. Interview with a MA on 06/05/25 at 3:25pm revealed: -She administered medications by reviewing the eMAR and did not review the label on the medication container. -She did not realize Resident #2's furosemide and spironolactone medication bottles had not been relabeled to show change in directions according to the order, and she should have matched the medication bottle directions to the eMAR directions. -All MAs were responsible for placing labels on resident medications if there was a change in directions and communicating with the Health and Wellness Director (HWD) if there was a need for clarification.	D 354			

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D 354	Continued From page 4 Interview with a pharmacist at Resident #2's pharmacy on 06/05/25 at 11:29am revealed: -Resident #2 had an active order for furosemide 20mg, take 2 tablets Monday, Wednesday and Friday then 1 tablet on all other days. -They did not receive an order change for Resident #2 for furosemide 40mg, one tablet once daily or an order to change spironolactone 25mg, one tablet once daily. -Resident #2's family member picked up a refill for furosemide 20mg on 04/01/25, 05/02/25 and 05/29/25 (45 tablets dispensed per refill) and spironolactone 25mg on 04/01/25 and 05/29/25 (120 tablets dispensed per refill). -All orders from providers were received via fax communication. Interview with the HWD on 06/05/25 at 1:10pm revealed: -Resident #2 did not utilize the facility's contracted pharmacy and her outside Primary Care Physician (PCP) was responsible for notifying the pharmacy of orders and medication changes. -Resident #2's family member was responsible for delivering the refills from the pharmacy to the facility, once the facility informed her of the need for refills. -She was responsible for conducting or overseeing medication cart audits assigned to MAs monthly. -Since the physician orders for Resident #2's furosemide 40mg, 1 tablet daily and spironolactone 25mg 1 tablet once daily matched the eMAR, she expected the NAs to place a label on the medication bottles to match the current order and eMARs. Interview with the Administrator on 06/05/25 at 2:57pm revealed: -The HWD was responsible for sending orders to	D 354			

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D 354	Continued From page 5 the facility's contracted pharmacy. -If a resident uses an outside pharmacy, their PCP was responsible for communicating medication changes to that pharmacy. -Resident #2's furosemide and spironolactone medication changes should have been caught and relabeled during monthly or weekly medication cart audits. -She did not know why Resident #2's furosemide medication label change went unnoticed from April 2025 to June 2025. -She did not know why Resident #2's spironolactone medication label change went unnoticed from December 2024 to June 2025. -She expected the labels would have been changed before the medications were placed on the cart and MAs should have matched Resident#2's medication labels to the eMAR orders.	D 354		
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	D 367		

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D 367	Continued From page 6 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 the electronic Medication Administration Record (eMAR) was accurate for 2 of 5 sampled residents related to oxygen administration (#1 & #3). The findings are: 1. Review of Resident #1's current FL2 dated 07/19/25 revealed diagnoses included chronic kidney disease, hypertension, heart failure, chronic obstructive pulmonary disease and dysphasia following cerebral infarction. Review of Resident #1's signed physician orders dated 05/08/25 revealed there was an order for oxygen 2 liters per minute (LPM) as needed for shortness of breath, may increase by oxygen one LPM every 15 minutes for comfort, to a max of oxygen 5 LPM. Review of Resident #1's April 2025, May 2025 and June eMAR revealed there was no entry for O2. Observation of Resident #1's room on 06/05/25 at 9:50am revealed an oxygen concentrator with oxygen tubing not in in her room. Interview with Resident #1 on 06/05/25 at 9:45am	D 367	Oxygen orders were verified and added to the eMar on 6/7/25 during the survey. Med Tech in-service on 6/26/25 included checking eMar for oxygen usage. The DHW or designee will review and verify orders for oxygen as they are received and enter in eMar.	6/7/25

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D 367	Continued From page 7 revealed: -She did not know when oxygen had been ordered. -She did not use oxygen on a regular basis and did not know when she last used oxygen. Interview with a medication aide (MA) on 06/05/25 at 10:40am revealed: -She knew Resident #1 had an oxygen concentrator in her room for use. -Resident #1 did not have oxygen as needed listed on the eMAR prior to 06/05/25. -She did not recall Resident #1 using oxygen. -Orders for as needed oxygen had always been listed on the eMAR to document when oxygen was required and/or administered. -She did not check to see if Resident #1 had an entry for oxygen as needed on the eMAR. Interview with the Hospice Registered Nurse (RN) on 06/05/25 at 11:46am revealed: -She had faxed Resident #1's oxygen order to the facility on 05/8/25. -She knew Resident #1 had not been using oxygen. -She administered oxygen to Resident #1 on 05/21/25 due to shortness of breath. Interview with the Health and Wellness Director (HWD) on 06/05/25 at 12:25pm and 1:05pm revealed: -She first received Resident #1's oxygen order on 06/04/25 but she knew Resident #1 had an oxygen concentrator prior to receiving the 06/04/25 order. -She did not know why Resident #1's oxygen orders had not been entered into the eMAR. -She was responsible for ensuring all orders and treatments were entered into the eMAR.	D 367			

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D 367	Continued From page 8 Refer to interview with the Administrator on 06/05/25 at 2:54pm. 2. Review of Resident #3's current FL2 dated 9/11/24 revealed: -Diagnoses included chronic obstructive pulmonary disease and diabetes mellitus, type 2. -There was an order for oxygen 2 liters LPM, continuous. Observation during the initial tour on 06/04/25 at 10:25am revealed Resident #3 was wearing O2 via nasal cannula and there was an O2 concentrator and portable O2 tanks in Resident #3's room. Review of Resident #3's April 2025, May 2025 and June 2025 eMAR revealed there was no entry for oxygen 2 LPM of continuous. Interview with Resident #3 on 06/05/25 at 9:30am revealed: -She had been using and wore oxygen continuously for several years. -The facility staff did not assist her with oxygen administration or provide maintenance on her tubing or oxygen concentrator. Interview with a MA on 06/05/25 at 3:23pm revealed: -She knew Resident #3 wore oxygen continuously. -Oxygen orders and/or treatments were supposed to be placed on the eMAR for MAs to ensure residents were wearing their oxygen as order. -MAs were responsible for documenting oxygen administration the eMAR. -She did not know Resident #3 did not have oxygen orders on the eMAR. Interview with the HWD on 06/05/25 at 12:25 and	D 367		

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D 367	Continued From page 9 1:05pm revealed: -She knew Resident #3 was on continuous oxygen. -She did not know Resident #3's O2 was not listed on the eMAR. -O2 orders and/treatments were always placed on the eMAR. -It was her responsibility to ensure all orders or treatments were entered correctly onto the eMAR. Refer to the interview with the Administrator on 06/05/25 at 1:09pm and 2:54pm. Interview with the Administrator on 6/5/25 at 1:09pm and 2:54pm revealed: -She did not know Resident #1 and #3's O2 orders were not on their eMAR. -The HWD was responsible for ensuring all orders were sent to the facilities contracted pharmacy and entered correctly onto the eMAR. -MAs were responsible for notifying the Resident Care Coordinator (RCC), Special Care Coordinator (SCC) or the HWD for any orders missing from a residents eMAR. -The HWD was responsible for ensuring all orders and treatments were entered correctly on the eMAR. -She believed it was the Primary Care Provider's (PCP) responsibility to make sure orders were sent to the pharmacy. -The Administrator and HWD were ultimately responsible for following up on orders. -The HWD was responsible for ensuring all orders and treatments were entered correctly on the eMAR. -She believed it was the Primary Care Provider's (PCP) responsibility to make sure orders were sent to the pharmacy. -The Administrator and HWD were ultimately	D 367		

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D 367	Continued From page 10 responsible for following up on orders.	D 367		