STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 the Iredell County Department of Social Services conducted an annual survey, follow-up survey and complaint investigation from October 15, 2025 to October 17, 2025.	D 000		
D 172	10A NCAC 13F .0512 Documentation Of Training And Competency Vali 10A NCAC 13F .0512 Documentation Of Training And Competency Validation An adult care home shall maintain documentation of the training and competency validation of staff required by the rules of this Section in the facility and available for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled staff records (A, B and C) had documentation of training and competency validation on the staff Licensed Health Professional Support (LHPS) for colostomy care. The findings are: 1.Review of Staff A's employee record revealed: -She was hired as a Medication Aide (MA) on 11/13/23. -There was no documentation on her staff LHPS that she completed the skills/competency evaluation on the care of the well established colostomy or ileostomy. Interview with Staff A on 10/16/25 at 08:30am revealed she completed both the 07/31/25 and 10/13/25 inservices on colostomy care but did not know if it had been documented in her employee	D 172	In reference to rule area 10A NCAC 13F .0512: Staff A, B, C have been trained and received competency validation on the staff LHPS for colostomy management. DHW, BOD and/or designee will perform a complete audit of care staff files and update, as necessary, all LHPS checkoffs to ensure all current LHPS tasks are included. DHW, BOD and/or designee will continue regular audits of files for care staff to ensure proper compliance of LHPS checkoffs.	12/10/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Dee Medlin, Area Executive Director | (X6) DATE: 11/21/2025

Reviewed and acknowledged 11/25/25 Faheemah Jones

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 172	Continued From page 1 record. Refer to interview with the Health and Wellness Director on 10/16/25 at 3:05pm. Refer to interview with the Administrator on 10/16/2025 at 3:07p.m. 2.Review of Staff B's employee record revealed: -She was hired as a Care Manager on 08/18/22. -There was no documentation on her staff LHPS that she completed the skills/competency evaluation on the care of the well established colostomy or ileostomy. Interview with Staff B on 10/16/25 at 10:45am revealed she completed both the 07/31/25 and 10/13/25 inservices on colostomy care but did not know if it had been documented in her employee record. Refer to interview with the Health and Wellness Director on 10/16/25 at 3:05pm. Refer to interview with the Administrator on 10/16/2025 at 3:07pm. 3. Review of Staff C's employee record revealed: -She was hired as a MA on 06/12/24. -There was no documentation on her staff LHPS that she completed the skills/competency evaluation on the care of the well-established colostomy or ileostomy. Interview with Staff C on 10/17/25 at 08:10am revealed she completed the training on colostomy care on 10/13/25 but did not know if it had been documented in her employee record. Refer to interview with the Health and Wellness	D 172		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 172	Continued From page 2 Director on 10/16/25 at 3:05pm. Refer to interview with the Administrator on 10/16/2025 at 3:07pm. _____ Interview with the Health and Wellness Director on 10/16/25 at 3:05pm revealed: -Employees that provided direct resident care received in-person training from a Home Health Registered Nurse on the care of a colostomy on 07/31/25 and 10/13/25. -The HWD was responsible to update each employee's LHPS skill/competency evaluation forms when new competencies were completed. -She did not remember to update the staff LHPS skill/competency evaluations after the 07/31/25 and 10/13/25 trainings. Interview with Administrator on 10/16/25 at 3:07pm revealed: -The HWD or the Regional Nurse were responsible to document the staff Licensed Health Professional Support (LHPS) competencies. -All staff would be checked off on colostomy care education when completed "going forward" and documentation would be completed in each staff's employee record. -Neither the HWD or herself remembered to document on employees' LHPS following colostomy care training completed July 31, 2025 and October 13, 2025.	D 172		
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	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 259	Continued From page 3 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 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.	D 259	In reference to rule area 10A NCAC 13F .0802 (a) and (c): Care plans of residents #1, 2, 3, 5, 6 have been reviewed and completed to reflect their personal care needs and also now have a certifying signature by PCP. DHW, RCC and/or designee will perform an audit of all current care plans to ensure each are signed by their physician. DHW, RCC and/or designee will randomly audit a sample of resident charts weekly to ensure there are current resident care plans which reflect their personal care needs and are signed by the PCP within 15 calendar days of completion of the assessment.	12/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 259	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 5 of 7 sampled residents had an accurate care plan that was signed by a provider within 15 days of the residents being assessed (#1, #2, #3, #5 and #6), and 2 of 7 residents had a care plan that was signed by the assessor (#1 and #6). The findings are: 1. Review of Resident #1's current FL2 dated 07/10/25 revealed diagnoses included encephalopathy, hyperlipidemia, and heart disease. Review of Resident #1's Resident Register revealed an admission date of 04/25/25. Review of Resident #1's care plan dated 07/11/25 revealed: -Resident #1 was resistant to assistance with dressing and grooming. -Resident #1 required stand-by assistance with dressing and grooming. -Resident #1 required assistance with bathing, toileting, and ambulation. -Resident #1 was independent with eating. -Resident #1's care plan dated 07/11/25 was not signed by the assessor. -The care plan was not signed by Resident #1's Primary Care Physician (PCP). Refer to interview with the Health and Wellness Director on 10/17/25 at 3:55pm.	D 259	Care plans of residents #1 and #6 have been reviewed and updated to reflect their personal care needs and now also have a certifying signature by their assessor. DHW, RCC and/or designee will perform an audit of all current care plans to ensure each are signed by their assessor. DHW, RCC and/or designee will randomly audit a sample of resident charts weekly to ensure there are current resident care plans which reflect their personal care needs and are signed by the assessor upon completion of the assessment.	12/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 259	Continued From page 5 Refer to interview with the Administrator on 10/17/25 at 4:00pm. 2. Review of Resident #3's current FL2 dated 04/14/25 revealed diagnoses included diabetes mellitus Type 2 (high blood sugar), hypertension (high blood pressure), history of pancreatic cancer, heart failure, and a history of transient ischemic attacks (temporary interruption of blood flow to the brain). Review of Resident #3's Resident Register revealed an admission date of 10/31/21. Review of Resident #3's care plan dated 01/20/25 revealed: -Resident #3 required limited assistance with toileting, ambulation and bathing. -Resident #3 was independent with eating, dressing, grooming and transfer. -The care plan was not signed by Resident #3's Primary Care Physician (PCP). Refer to interview with the Health and Wellness Director on 10/17/25 at 3:55pm. Refer to interview with the Administrator on 10/17/25 at 4:00pm 3.Review of Resident #5's current FL2 dated 8/13/25 revealed: -Diagnoses included dementia, hyperlipidemia, and chronic kidney disease. -Resident #5's recommended level of care was Special Care Unit (SCU). Review of Resident #5's Resident Register revealed an admission date of 08/14/25. Review of Resident #5's care plan dated 08/22/25 revealed:	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 259	Continued From page 6	D 259		

-She was disoriented.
-She had a history of wandering behaviors.
-She was ambulatory and required assistance with bathing and grooming.
-Resident #5's care plan was not signed by the Primary Care Physician (PCP).

Interview with the Special Care Coordinator (SCC) on 10/17/25 at 11:44am revealed:
-She was not working during the time when Resident #5 moved to the SCU.
-She was aware the care plan needed to be signed within 15 days by the primary care provider (PCP).
-The SCU director was responsible for faxing the care plan to the primary care provider (PCP).
-She was not sure why the care plan was not signed by the PCP.

Refer to interview with the Health and Wellness Director (HWD) on 10/17/25 at 3:55pm.

Refer to interview with the Administrator on 10/17/25 at 4:00pm.
4.Review of Resident #6's current FL2 dated 6/11/25 revealed:
-Diagnoses included dementia, cerebral infraction anorexia, hypertension, hyperlipidemia, and atrial fibrillation.
-Resident #6's recommended level of care was Special Care Unit (SCU).

Review of #6's Resident register revealed an admission date of 3/28/25.

Review of Resident #6's care plan dated 3/24/25 revealed:
-She was intermittently disoriented.
-She was non-ambulatory and used a wheelchair for mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 259	Continued From page 7 -She required total assistance with dressing, grooming, bathing and transfers. -Resident #6's care plan was not signed by the assessor or the Primary Care Physician (PCP). Interview with the Special Care Coordinator on 10/17/25 at 1:20pm revealed: -Resident #6 moved from another state and she had faxed her care plan multiple times to her PCP and never received a response. -She was aware the care plan needed to be signed within 15 days by the primary care provider (PCP). -The SCU director was responsible for faxing the care plan to the primary care provider (PCP). -She was not sure why the care plan was not signed by the assessor, but it must have been overlooked with the multiple faxes that were being sent to her PCP. Refer to interview with the Health and Wellness Director (HWD) on 10/17/25 at 3:55pm. Refer to interview with the Administrator on 10/17/25 at 4:00pm. _____ Interview with the HWD on 10/17/2025 at 3:55pm revealed: -She was responsible along with the SCC to ensure the care plans were signed by the assessor and PCP. -We had merged three electronic medical records systems in July which caused signatures to be missed beginning in July 2025. Interview with the Administrator on 10/17/2025 at 4:00pm revealed: -The SCC and the HWD were responsible for making sure the care plans were signed by the assessor and the PCP.	D 259		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 259	Continued From page 8 -She expected that all care plans were signed on a timely basis by both the assessor and PCP.	D 259		
D 263	10A NCAC 13F .0802 (f) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (f) The care plan shall be revised as needed based on the results of a significant change assessment completed in accordance with Rule .0801 of this Section. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 6 sampled residents (#1) had a care plan assessment completed within 10 days of a significant change when the resident was admitted to hospice care. The findings are: Review of Resident #1's current FL2 dated 07/10/25 revealed diagnoses included encephalopathy, hyperlipidemia, and heart disease. Review of Resident #1's Resident Register revealed an admission date of 04/25/25. Review of Resident #1's care plan dated 07/11/25 revealed: -Resident #1 required stand-by assistance with dressing and grooming. -Resident #1 required assistance with bathing, toileting, and ambulation.	D 263	In reference to rule area 10A NCAC 13F .0802(f): Care plan of Resident #1 has been reviewed and updated to reflect hospice care. DHW, RCC, and MCD will be re-educated on when a COC assessment is required. DHW or designee will complete a timely assessment when a change in condition is identified. DHW, RCC and/or designee will audit a sample of resident charts weekly to ensure any resident with a change of condition has a significant change assessment completed within 10 days.	12/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 263	Continued From page 9	D 263		

-Resident #1 was independent with eating.
-There was no significant change noted on the care plan before or after Resident #1 was admitted to hospice care on 07/25/25.

Review of Resident #1's hospice progress report dated 08/05/25 revealed there was documentation Resident #1 was admitted to hospice services on 07/25/25.

Interview with the Resident Care Coordinator (RCC) on 10/17/25 at 1:45pm revealed:
-She and/or the HWD were responsible for updating the care plan if there was a change in condition for any resident.
-After it was determined Resident #1 had a change in condition, her Primary Care Provider should have been notified, and her care plan should have been updated.

Interview with the Health and Wellness Director (HWD) on 10/17/25 at 3:00pm revealed:
-Resident medical records were merged between four different systems between 07/15/25 and 10/01/25.
-She and the RCC were responsible for conducting resident assessments and updating care plans when there was a change in condition.
-Resident #1's change in condition should have been documented within ten days of when it was decided she was to start with hospice services, and it was missed.

Interview with the Administrator on 10/17/25 at 4:05pm revealed:
-She was not aware Resident #1's change in condition was not documented on her medical record within 10 days of the change.
-There were changes in the manner resident records were kept over the past few months and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 263	Continued From page 10 the newest record keeping process is improved. -She expected the RCC, Special Care Coordinator (SCC), or HWD to contact the provider and update care plans after a change in condition was determined.	D 263		
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 reviews, and interviews, the facility failed to ensure medications were administered as ordered for 1 of 6 sampled residents (#1) related to medications to treat high cholesterol, lung disease, loosen mucus, and dementia. The findings are: Review of Resident #1's current FL2 dated 07/10/25 revealed diagnoses included encephalopathy, hyperlipidemia, coronary artery disease and heart disease. Review of Resident #1's Resident Register revealed an admission date of 04/25/25. a. Review of Resident #1's hospice physician orders dated 08/29/25 revealed Resident #1 had	D 358	In reference to rule area 10 NCAC 13F .1004(a): DHW, RCC and/or designee will re-educate all MAs of the importance of administering medications as ordered. DHW, RCC and/or designee will audit medication cart(s) weekly to ensure medications are administered as ordered. DHW, RCC and/or designee will review missed medication report on a daily basis and provide follow up to any concerns identified.	12/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 11	D 358		

an order for simvastatin (medication used to lower cholesterol), 40mg one tablet by mouth at bedtime.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for simvastatin 40mg take one tablet by mouth at bedtime.
-There were entries simvastatin was documented "other" (as not given) on 09/03/25, 09/05/25 to 09/06/25, 09/08/25, and 09/13/25 to 09/14/25, "refused" on 09/10/25 to 09/12/25 and "with family/pharmacy" on 09/07/25.
-There was documentation an explanation for "other" simvastatin was "not given due to medication on order", "not on cart", or "faxed the pharmacy to deliver."
-There was no documentation indicating the physician or provider was contacted after Resident #1 repeatedly refused simvastatin.

Refer to interview with a pharmacist at the facility's contracted pharmacy on 10/17/25 at 2:20pm.

Refer to interview with a medication aide (MA) on 10/17/25 at 1:45pm.

Refer to interview with the RCC on 10/17/25 at 1:45pm.

Refer to interview with the HWD on 10/17/25 at 3:00pm.

Refer to interview with the Administrator on 10/17/25 at 4:05pm.

b. Review of Resident #1's hospice physician orders dated 08/29/25 revealed Resident #1 had an order for Trelegy Ellipta (a medication used to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 12	D 358		

treat lung disease), 100-62.5-25 mcg powder take one blister with device by inhalation once daily.

Review of Resident #1's August 2025 eMAR revealed:
-There was an entry for Trelegy Ellipta 100-62.5-25 mcg powder take one blister with device by inhalation once daily.
-There were entries Trelegy Ellipta was documented as "other" on 08/06/25, 08/09/25, 08/10/25, 08/25/25, and 08/29/25.
-There was no entry documented on 08/19/25 that Resident #1 was administered Trelegy Ellipta.
- There was documentation an explanation for "other" Trelegy Ellipta was "not given due to awaiting delivery", "not available", or "will order from pharmacy".
-There was no documentation staff followed up on the status of Resident #1's Trelegy Ellipta.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Trelegy Ellipta 100-62.5-25 mcg powder take one blister with device by inhalation once daily.
-There were entries Trelegy Ellipta was documented as not given "other" on 09/06/25, 09/07/25, 09/17/25, 09/20/25, 09/21/25, and 09/26/25.
- There was documentation an explanation for "other" Trelegy Ellipta was "ordering from pharmacy", "not given due to awaiting delivery", "not available", or "will order from pharmacy".
-There was no documentation staff followed up on the status of Resident #1's Trelegy Ellipta.

Review of Resident #1's October 2025 eMAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 13	D 358		

-There was an entry for Trelegy Ellipta 100-62.5-25 mcg powder take one blister with device by inhalation once daily.
-There were entries Trelegy Ellipta was documented as not given "other" on 10/04/25, 10/10/25, and 10/15/25.
- There was documentation an explanation for "other" Trelegy Ellipta was "not given due to awaiting delivery", "not available", or "will order from pharmacy".
-There was no documentation staff followed up on the status of Resident #1's Trelegy Ellipta.

Refer to interview with a pharmacist at the facility's contracted pharmacy on 10/17/25 at 2:20pm.

Refer to interview with a medication aide (MA) on 10/17/25 at 1:45pm.

Refer to interview with the RCC on 10/17/25 at 1:45pm.

Refer to interview with the HWD on 10/17/25 at 3:00pm.

Refer to interview with the Administrator on 10/17/25 at 4:05pm.

c. Review of Resident #1's hospice physician orders dated 08/29/25 revealed:
-Resident #1 had an order for sodium chloride (a medication used to loosen mucus in the lungs), 3% solution for nebulization, by inhalation two times daily.
-Resident #1 had no current order for sodium chloride three times per day "as needed" for shortness of breath/ wheezing.

Review of Resident #1's August 2025 eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 14 revealed: -There was an entry for sodium chloride 3% 4ml vial nebulizer, inhale one vial via nebulizer twice a day. -There was an entry for sodium chloride 3% 4ml vial nebulizer, inhale one vial via nebulizer three times daily as needed for shortness of breath/ wheezing. -There was an entry on 08/04/25 (8:30pm) sodium chloride was documented as "other" (machine not working). -There were entries sodium chloride was documented as "refused" on 08/11/25, 08/14/25, 08/25/25 and 08/31/25. -There was no documentation indicating the physician or provider was contacted after Resident #1 repeatedly refused sodium chloride nebulizer treatment. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for sodium chloride 3% 4ml vial nebulizer, inhale one vial via nebulizer twice a day. -There was an entry for sodium chloride 3% 4ml vial nebulizer, inhale one vial via nebulizer three times daily as needed for shortness of breath/ wheezing. -There was documentation Resident #1 refused sodium chloride on fourteen occasions (09/06/25 to 09/07/25, 09/11/25 to 09/15/25, 09/19/25 to 09/20/25, 09/24/25, 09/26/25 to 09/27/25. -Entries for "other" were documented as "not given due to awaiting delivery", "not available", or "will order from pharmacy". -There was no documentation indicating the physician or provider was contacted after Resident #1 repeatedly refused sodium chloride nebulizer treatment.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 15 Review of Resident #1's October 2025 eMAR revealed: -There was an entry for sodium chloride 3% solution for nebulization, by inhalation two times daily. -There was an entry for sodium chloride 3% solution for nebulization, by inhalation three times daily "as needed." -There was documentation Resident #1 refused sodium chloride on six occasions 10/01/25 8:30am to 10/02/25 8:30am and 8:30pm, 10/04/25 8:30pm to 10/11/25 8:30pm, 10/15/25 8:30am, 10/15/25 (no documentation for 8:30pm dose). -There was no documentation indicating the physician or provider was contacted after Resident #1 repeatedly refused sodium chloride nebulizer treatment. Refer to interview with a pharmacist at the facility's contracted pharmacy on 10/17/25 at 2:20pm. Refer to interview with a medication aide (MA) on 10/17/25 at 1:45pm. Refer to interview with the RCC on 10/17/25 at 1:45pm. Refer to interview with the HWD on 10/17/25 at 3:00pm. Refer to interview with the Administrator on 10/17/25 at 4:05pm. d. Review of Resident #1's hospice physician orders dated 08/29/25 revealed: -Resident #1 had an order for donepezil (a medication used to treat dementia), 5mg one tablet by mouth at bedtime.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 16 Review of Resident #1's August 2025 eMAR revealed: -There was an entry for donepezil 5mg take one tablet by mouth at bedtime. -There were entries donepezil was documented as "refused" on 08/01/25 and "other" (on 08/02/25 to 08/06/25, 08/08/25, 08/10/25 to 08/14/25, 08/13/25 to 08/14/25, 08/16/25 to 08/17/25, 08/19/25, and 08/25/25. -Entries for "other" were documented as not given due to awaiting delivery, not available, not on cart, or will order from pharmacy, machine not working. -There was no documentation staff followed up on the status of Resident #1's donepezil. Refer to interview with a pharmacist at the facility's contracted pharmacy on 10/17/25 at 2:20pm. Refer to interview with a medication aide (MA) on 10/17/25 at 1:45pm. Refer to interview with the RCC on 10/17/25 at 1:45pm. Refer to interview with the HWD on 10/17/25 at 3:00pm. Refer to interview with the Administrator on 10/17/25 at 4:05pm. _____ Interview with a pharmacist at the facility's contracted pharmacy on 10/17/25 at 2:20pm revealed: -Resident #1's Trelegy Ellipta (inhaler) was last dispensed in April 2025. -Resident #1's sodium chloride was last dispensed in April 2025 for 60 vials.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 17	D 358		

-Resident #1's donepezil was dispensed on 08/25/25 for 30 tablets and on 09/30/25 for 30 tablets.

Interview with a medication aide (MA) on 10/17/25 at 1:45pm revealed:
-She always checked the order against the medication on hand before administering and documenting as given or refused.
-If she documented a medication on the eMAR as "other", she always documented appropriately and informed the Resident Care Coordinator (RCC), contacted the pharmacy and/ or the resident's provider about the need for a refill or resident refusals.
-All NAs were responsible for auditing the MAR against the cart for at least two residents two to three times per week.
-She was not sure if NAs were auditing as required.

Interview with the RCC on 10/17/25 at 1:45pm revealed:
-She along with the Special Care Coordinator (SCC) and the Health and Wellness Director (HWD) was responsible for completing monthly medication cart audits via a check off list kept in binder.
-She expected MAs to perform medication cart audits weekly and notify the RCC, SCC, HWD, and physician or primary care provider if residents refuse medication, or if the pharmacy needs refills.
-She expected MAs to document against the eMAR truthfully and appropriately.

Interview with the HWD on 10/17/25 at 3:00pm revealed:
-All staff were responsible for auditing the medication carts at least two times per week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 358	Continued From page 18 -She expected medications to be administered as ordered. -Due to four different merged systems, she was responsible for manually adding medications to the new system and there may have been errors along the way. -All "administered", "refused" and "other" eMAR codes should be documented on the eMAR appropriately. -She expected NAs to contact the primary care physician or provider after three refused medication doses. Interview with the Administrator on 10/17/25 at 4:05pm revealed: -One of the MAs who documented Resident #1's medications from August 2025 to October 2025, no longer worked at the facility. -She did not know why MAs documented some of Resident #1's medications as "other" on certain days and administered on other days if medications were on hand. -She expected MAs to contact the pharmacy or provider and notify the RCC or HWD if a resident's active medication was not on the cart or needed a refill. -She believed there was lack of communication between the facility and hospice related to reconciling Resident #1's medications.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 464	Continued From page 19 care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 residents (#2 & #6) had a Special Care Unit (SCU) resident profile updated on a quarterly basis. The findings are: 1. Review of Resident 2's current FL2 dated 03/27/25 revealed: -Diagnoses included dementia, hypertension, atrial fibrillation and type 2 diabetes. -He was intermittently disoriented. -He moved from the Assisted Living (AL) to the Special Care Unit (SCU) on 04/09/25. Review of Resident #2's record revealed: -A SCU resident profile was completed on 04/14/25 and 10/16/25. -There was no SCU resident profile completed in July 2025. Interview with the Administrator on 10/17/25 at	D 464	In reference to rule area 10A NCAC 13F .1307: Charts of residents #2 and #6 have been reviewed and updated to reflect current Special Care Unit (SCU) resident profile. All SCU resident charts will be audited by DHW, SCC, and/or designee for current SCU resident profiles. DHW, SCC and/or designee will audit a sample of resident charts weekly to ensure all new residents have a Special Care Unit (SCU) resident profile within 30 days and quarterly thereafter.	12/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 464	Continued From page 20 5:00pm revealed Resident #2 was an internal transfer and moved from the AL to SCU, and the electronic records system would not alert us that his SCU profile was due. Refer to interview with the Special Care Coordinator (SCC) on 10/17/2025 at 11:44am. Refer to interview with the Health and Wellness Director (HWD) on 10/17/25 at 3:55pm. Refer to interview with the Administrator on 10/17/2025 at 4:00pm. 2. Review Resident #6's current FL2 dated 6/11/25 revealed: -Diagnoses included dementia, cerebral infraction anorexia, hypertension, hyperlipidemia, and atrial fibrillation. -She was intermittently disoriented. -She was non-ambulatory and used a wheelchair for mobility. Review of Resident #6's record revealed: -A SCU resident profile was completed on 3/28/25 and 10/4/25. -There was no SCU resident profile completed in June 2025. Refer to interview with the Special Care Coordinator (SCC)on 10/17/25 at 11:44am. Refer to interview with the Health and Wellness Director (HWD) on 10/17/25 at 3:55pm. Refer to interview with the Administrator on 10/17/2025 at 4:00pm. _____ Interview with the Special Care Coordinator (SCC) on 10/17/25 at 11:44am revealed:	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049035	A. BUILDING: _____ B. WING _____	R-C 10/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA LAKE NORMAN	140 CARRIAGE CLUB DRIVE MOORESVILLE, NC 28117

(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 464	Continued From page 21 -The resident profiles were to be completed within 30 days of admission and quarterly thereafter. -The SCC was responsible for completing the resident's quarterly profiles and reviews with the family. -She could see there was an alert in the electronic record system for Resident #2 and Resident #6 SCU profiles to be done in June and July of 2025. -She was not sure why Resident #2's and Resident #6's SCU profile were missing because she was not working at the facility during that time. Interview with the Health and Wellness Director (HWD) on 10/17/25 at 3:55pm revealed: -She or the SCC were responsible for completing the SCU resident profiles. -During that time in July of 2025 was when the facility's electronic records system was being merged with a new electronic records system and may have been the reason the SCU profiles were missing. Interview with the Administrator on 10/17/2025 at 4:00pm revealed: -The SCC or HWD were responsible for ensuring the SCU resident profile was completed on a quarterly basis. -It was her expectation that all SCU resident profiles are completed quarterly.	D 464		

Dee Medlin, Area Executive Director 11/21/2025