STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036023	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACE RIDGE ASSISTED LIVING	1251 E HUDSON BLVD GASTONIA, NC 28054

(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 Gaston County Department of Social Services conducted an annual survey from 10/14/25 to 10/15/25.	D 000	**Disclaimer** The provider submits this Plan of Action (POA) in accordance with specific regulatory requirements. The Provider does not denote agreement with the Statement of Deficiencies, nor does it constitute an admission that the stated deficiencies are accurate. The Provider submits this POA with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings if at any time the Provider determines that the findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure physician's orders were implemented for 2 of 5 sampled residents related to discontinuing a medication to treat memory loss (#1) and discontinuing a medication to reduce excess fluid (#2). . The findings are: 1. Review of Resident #1's current FL2 dated 07/02/25 revealed a diagnosis of dementia. Review of Resident #1's signed Nurse Practitioner's (NP) orders dated 07/15/25 and 09/09/25 revealed there was an order for memantine ER (extended release) (a medication to treat memory loss) 28mg one capsule once daily. Review of a Resident #1's Mental Health Provider's (MHP) order dated 07/23/25 revealed	D 276	**Action Plan** To minimize the incidence of administering discontinued medications through proactive measures and efforts among staff and partnering pharmacy. **Corrective Measures** • An audit was completed of all current residents MAR's to ensure MAR accuracy. • Facility RCD, RCDA and SCU SIC will review all return orders from hospital visits and/or PCP visits with 72 hours of the residents return to the facility to ensure accuracy of residents' MAR.	11-30-25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Reviewed and Acknowledged by SSD on 11/25/25
Sharon Dunton RN

Andrew T Martin 11/17/25
Andrew Martin

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D 276	Continued From page 1 an order to discontinue memantine ER 28mg one capsule once daily. Review of Resident #1's August 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for memantine ER 28mg one capsule daily at 8:00am. -Memantine ER 28mg one capsule daily capsules was documented administered to Resident #1 daily at 8:00am from 08/01/25 to 08/31/25. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for memantine ER 28mg one capsule daily at 8:00am. -Memantine ER 28mg one capsule daily capsules was documented administered to Resident #1 daily at 8:00am from 09/01/25 to 09/30/25 except from 09/03/25 to 09/07/25 because the medication was on order from the pharmacy. Review of Resident #1's October 2025 eMAR revealed: -There was an entry for memantine ER 28mg one capsule daily at 8:00am. -Memantine ER 28mg one capsule daily capsules was documented administered to Resident #1 daily at 8:00am from 10/01/25 to 10/14/25. Observation of medications on hand for Resident #1 on 10/15/25 at 11:30am revealed: -There was a bubble pack containing memantine ER 28mg capsules with 22 capsules remaining. -The label indicated memantine ER 28mg 30 capsules were dispensed for Resident #1 on 10/03/25. Interview with a medication aide (MA) on 10/15/25 at 11:30am revealed:	D 276	• If the resident does not utilize the facilities pharmacy provider, the RCD, RCDA, and/or the SCU SIC will follow up with the residents RP within 3 days of residents return to ensure any new orders have been sent to residents' pharmacy provider for fulfillment. • Facility met with our pharmacy provider to format a more accurate review of hospital discharge paperwork to minimize the chance of missing discontinued medication. **Preventative Measures** • Facility has enhanced their nursing meetings to include any possible medication changes. This includes discussing residents who are out or have recently returned from a hospital stay and/or PCP visit that may have resulted in medication changes. • Facility and pharmacy will add reviewing recent hospital D/C paperwork to pharmacy's monthly review to ensure MAR accuracy. **Monitoring/Frequency** • The RCD, RCDA and/or the SCU SIC will conduct 5 random chart audits each month for the next quarter to ensure MAR accuracy.	11-30-25 2-15-26

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D 276	Continued From page 2 -He administered residents' medications according to the orders in the eMAR system. -Resident #1's orders in the eMAR system included memantine ER 28mg one capsule daily. -He administered memantine ER 28mg one capsule to Resident #1 that morning (10/15/25). Interview with the Special Care Coordinator (SCC) on 10/15/25 at 11:37am revealed: -Resident #1's MHP sent any medication orders directly to pharmacy. -She did not review Resident #1's MHP orders and notes to ensure pharmacy had transcribed them accurately. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 10/15/25 at 11:58am revealed: -The pharmacy did not receive an order from Resident #1's MHP to discontinue memantine ER 28mg one capsule daily. -He did not know why Resident #1's MHP discontinued memantine ER 28mg one capsule daily. Refer to the interview with the Administrator on 10/15/25 at 2:21pm. Attempted telephone interview with Resident #1's MHP on 10/15/25 at 1:58pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 05/01/25 revealed a diagnosis of dementia. Review of Resident #2's signed Nurse Practitioner (NP) orders dated 09/16/25 revealed there was an order for furosemide (a medication to treat swelling and fluid retention) 40mg one tablet twice daily at 8:00am and 2:00pm.	D 276		

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D 276	Continued From page 3 Review of Resident #2's signed hospital discharge orders dated 10/01/25 revealed there was an order to discontinue furosemide 40mg one tablet by mouth twice daily. Review of Resident's September 2025 electronic Medication Administration Record (eMAR) revealed: -There was an entry for furosemide 40mg one table twice a day at 8:00am and 2:00pm. - Furosemide 40mg one tablet twice daily was administered to Resident #2 at 8:00am and 2:00pm from 09/17/25 to 09/26/25. -Resident #2 was hospitalized from 09/27/25 to 10/01/25. Review of Resident #2's signed hospital discharge orders dated 10/01/25 revealed there was an order to stop furosemide 40mg one tablet by mouth twice daily. Review of Resident #2's October 2025 eMAR revealed: -There was an entry for furosemide 40mg one table twice a day at 8:00am and 2:00pm. -Furosemide 40mg one tablet twice daily was administered to Resident #2 at 8:00am and 2:00pm from 10/02/25 to 10/15/25. Observation of medications on hand for Resident #2 on 10/15/25 at 10:10am revealed: -There was a bubble pack containing furosemide 40mg with 43 tablets remaining. -The label indicated furosemide 40mg 60 tablets were dispensed for Resident #2 on 09/16/25. Interview with a medication aide (MA) on 10/15/25 at 10:15am revealed: -He administered residents' medications according to the orders in the eMAR system.	D 276		

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D 276	Continued From page 4 -Resident #2's order in the eMAR system included furosemide 40mg one tablet twice daily. -He administered furosemide 40mg one tablet to Resident #2 that morning (10/15/25). Interview with the Special Care Coordinator (SCC) on 10/15/25 at 9:45am revealed: -She was responsible to review the hospital discharge documents for residents returning from the hospital. -She did not review hospital discharge documents for residents returning from the hospital. -She put the hospital discharge documents in the tray for the NP to review on her next visit. -She did not know of medication changes until the pharmacy documented the changes on the eMAR. -The hospital on 10/01/25 sent the hospital discharge documents to the pharmacy for any medication's changes. - She did not know of the medication change for the furosemide until this interview. -She was aware of other medications for Resident #2 that was discontinued because the medications were noted by the pharmacy to be discontinued on the October 2025 eMAR. -The medication orders changes were completed by the pharmacy but not the furosemide 40mg. -Furosemide 40mg twice a day was administered to Resident #2 on 10/15/25 at 8:00am. Telephone interview with a representative with the facility's contracted pharmacy on 10/15/25 at 9:40am revealed: -On the hospital discharge documents dated 10/01/25, Resident #2's furosemide 40mg twice a day was discontinued. -The pharmacy missed the order, and the furosemide continued to be on the October 2025 eMAR.	D 276		

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D 276	Continued From page 5 Telephone interview with a Pharmacist with the facility's contracted pharmacy on 10/15/25 at 12:15pm revealed: -The pharmacy missed the discontinue order from the hospital discharge documents dated 10/01/25. -The order was to discontinue furosemide 40mg one table twice daily at 8:00am and 2:00pm. -The pharmacy missed the order, and the furosemide continued to be on the October 2025 eMAR. -The negative side effect from being administered the furosemide 40mg twice daily could be dehydration and /or low blood pressure. Refer to the interview with the Administrator on 10/15/25 at 2:21pm. Interview with the Administrator on 10/15/25 at 2:21pm revealed: -The SCC or the medication aide (MA) was responsible to look at medication orders for changes. -The SCC or MA was responsible to ensure the pharmacy knew of the medication changes or discontinuation of a medication. -The SCC or MA was responsible to ensure all other MA's knew of any medication changes. -Daily, any medication changes were sent to the pharmacy and then all orders were to be placed in a basket for the Resident Care Director (RCD). -The RCD was responsible to review the orders and ensure the changes were entered in the computer system. -Medication orders for the Special Care Unit (SCU) would be given to the SCC and the SCC would file in the correct resident's record. -Medication orders for the assisted living area would be filed by the RCD in the correct	D 276		

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D 276	Continued From page 6 resident's record. -If the RCD was not available the Assistant Resident Care Director (ARCD) would be responsible to remove the medication changes from the basket and be placed on the RCD's desk for review. -It is the responsibility of the RCD to ensure all the orders were followed through prior to being filed.	D 276		