STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036039	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA CRAMER MOUNTAIN	500 CRAMER MOUNTAIN ROAD CRAMERTON, NC 28032

(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 and follow-up survey from 03/24/26 to 03/25/26.	D 000		
D 254	10A NCAC 13F .0801 (c) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (c) When a facility identifies a change in a resident's baseline condition based upon the factors listed in Parts (1)(A) through (M) of this Paragraph, the facility shall monitor the resident's condition for no more than 10 days to determine if a significant change in the resident's condition has occurred. The facility shall conduct an assessment of a resident within three days after the facility identifies that a significant change in the resident's baseline condition has occurred. The facility shall use the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living including bathing, dressing, personal hygiene, toileting, or eating; (B) change in ability to walk or transfer, including falls if the resident experiences repeated falls, meaning more than one, on the same day, or multiple falls that occur over several days to weeks, new onset of falls not attributed to an identifiable cause, a fall with consequent change in neurological status, or physical injury; (C) pain worsening in severity, intensity, or duration, occurring in a new location, or new onset of pain associated with trauma;	D 254		

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D 254	Continued From page 1 (D) change in the pattern of usual behavior, new onset of resistance to care, abrupt onset or progression of agitation or combative behavior, deterioration in affect or mood, or violent or destructive behaviors directed at self or others; (E) no response by the resident to the intervention for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) when a resident has been enrolled in hospice; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or any pressure ulcer determined to be greater than Stage II; (I) a new diagnosis of a condition which affects the resident's physical, mental, or psychosocial well-being; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer meets the resident's needs; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint in accordance with Rule .1501 of this Subchapter and there is no current restraint order for the resident. (2) Significant change does not include the following: (A) changes that resolve with or without intervention; (B) an acute illness or episodic event. For the purposes of this Rule "acute illness" means symptoms or a condition that develops quickly and is not a part of the resident's baseline	D 254		

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D 254	Continued From page 2	D 254		

physical health or mental health status;
(C) an established, predictable cyclical pattern; or
(D) steady improvement under the current course of care.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a significant change care plan was completed for 1 or 1 resident who was admitted to hospice (#5).

The findings are:

Review of Resident #5's current FL2 dated 06/12/26 revealed:
-Diagnoses included chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, hypertension and ventricular arrhythmia.
-Resident #5 current level of care was hospital and recommended level of care was assisted living.
-Resident #5 was ambulatory.
-Resident #5 was continent of bowel.

Review of Resident #5's Resident Register revealed an admission date of 02/01/25.

Review of Resident #5's care plan dated 08/11/25

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D 254	Continued From page 3 revealed: -Resident #5 was independent with bathing, dressing, grooming, mobility, toileting, dining and ambulation. -Resident #5 used oxygen. Review of Resident #5's hospice certification revealed a start of hospice care date of 10/20/25. Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 1:22pm revealed: -She and the Health and Wellness Director (HWD) were responsible for completing change of condition care plans. -The previous HWD asked her to complete Resident #5's change of condition care plan when he was enrolled in hospice. -She completed Resident #5's change of condition care plan in the electronic system but did not print it or get it signed by Resident #5 Primary Care Provider (PCP). Interview with the Administrator on 03/25/26 at 1:54pm revealed: -The RCC and HWD were responsible for completing change of condition care plans when needed. -The person completing the care plan was responsible for getting it signed by the PCP. -There were no schedule audits of resident charts for care plans being completed.	D 254		
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	D 358		

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D 358	Continued From page 4	D 358		

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 observations, record review and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#5) related to oxygen.

The findings are:

Review of Resident #5's current FL2 dated 06/12/26 revealed:
-Diagnoses included chronic diastolic congestive heart failure, chronic obstructive pulmonary disease, atrial fibrillation, hypertension and ventricular arrhythmia.
-Resident #5 current level of care was hospital and recommended level of care was assisted living.
-Resident #5 was ambulatory.

Review of Resident #5's Resident Register revealed an admission date of 02/01/25.

Review of Resident #5 hospice certification orders dated 10/20/25 revealed there was an order for oxygen, 2 liters as needed for shortness of breath.

Review of Resident #5's January 2026, February 2026 and March 2026 electronic medication administration records (eMAR) revealed there was no entry for oxygen, 2 liters as needed.

Observation of Resident #5 on 03/25/26 at 12:55pm revealed:

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-He was sitting in his room.
-He was not using oxygen at the time of the observation.

Interview with Resident #5 on 03/25/26 12:55pm revealed:
-He thought he had been on oxygen for the past four to six months.
-He used oxygen at 2 liters when he needed it and put it on without staff assistance.
-He wore oxygen most of the time when he was in bed, overnight and when napping, and when he was sitting at his desk.
-Staff did not usually check on his oxygen.

Interview with a medication aide (MA) on 03/25/26 at 12:22pm and 1:16pm revealed:
-She was aware Resident #5 was on oxygen.
-Resident #5 was on oxygen for about a year.
-Resident #5 used oxygen 2 liters, when he needed it for shortness of breath.
-She had not seen oxygen 2 liters as needed on Resident #5's eMAR prior to today (03/25/26).
-The MAs did not document Resident 5's oxygen on his eMAR.

Interview with the Resident Care Coordinator (RCC) on 03/25/26 at 1:22pm revealed:
-She knew Resident #5 had oxygen in his room.
-She did not know when, but was told by the hospice Registered Nurse (RN) that Resident #5 did not want to use the oxygen.
-The hospice RN trained Resident #5 on the use of the oxygen equipment in case he needed it.
-Resident orders were to be faxed to the pharmacy and pharmacy staff entered the orders into the eMAR system.
-Resident #5's hospice certification orders were not faxed to the pharmacy because the facility did not have the orders until the surveyors requested

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D 358	Continued From page 6 them. -She was not notified by any MAs that Resident #5 used his oxygen and she had not seen him using it. Interview with the Administrator on 03/25/26 at 1:54pm revealed: -All resident medication orders, even self-administration orders, were to be on the resident's eMAR. -The RCC, Health and Wellness Director (HWD) and the Special Care Coordinator (SCC) were responsible for faxing all orders to the pharmacy. -After the pharmacy entered medication orders into the eMAR system, the RCC, HWD or the SCC needed to approve the order before it would show on the resident's eMAR. -Resident #5's oxygen order was not faxed to the pharmacy because the facility did not have the order until they received it yesterday (03/24/26).	D 358		