STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092220	A. BUILDING: _____ B. WING _____	R 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA KNIGHTDALE	2408 HODGE ROAD KNIGHTDALE, NC 27545

(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 on July 15, 2026 through July 16, 2026.	{D 000}		
D 386	10A NCAC 13F .1007 (a) Medication Disposition 10A NCAC 13F .1007 Medication Dispositiona (a) Medications shall be released to or with a resident upon discharge if the resident has a physician's order to continue the medication. Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents according to Rule .1004(o) of this Subchapter. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure prescribed medication of a resident was not given to another resident upon discharge for 1 of 1 sampled resident (#4). The findings are: Review of the facility's medication handling upon the discharge or death of a resident dated 06/11/24 revealed: -Upon resident discharge, all medications should go with the resident. -The Director of Health and Wellness (HWD) or Medication Aide (MA) would create a list and count all medications. -The resident and/ or responsible party would sign the list, indication agreement with the quantity of each medication being transferred with the resident out of the community. -The signed list would be placed in the resident's record.	D 386		

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D 386	Continued From page 1 Review of Resident #4's current FL-2 dated 04/30/26 revealed diagnoses included Alzheimer's with agitation, hypertension, chronic bilateral knee pain and hypothyroidism. Review of Resident #4's physician's order dated 06/16/26 revealed an order for Tramadol Hcl tablet 50mg, take 1 tablet every 12 hours as needed (PRN) for pain. (Tramadol Hcl is used to treat pain). Observation of Resident #4's medications on hand on 07/16/26 at 10:06am revealed there were no Tramadol Hcl 50mg tablets in the medication cart. Review of Resident #4's controlled substance log for the Tramadol Hcl 50 mg on 07/16/26 at 10:06am revealed there were 24 tablets remaining in the facility. Interview with Resident #4 on 07/16/26 at 1:46pm revealed: -His side was hurting but he did not let anyone know. -He did not know if he took anything for pain. "I just take what they give me and not ask any questions." Interview with the Health and Wellness Director (HWD) on 07/16/26 at 10:54am revealed: -Resident #4's Tramadol Hcl 50mg tablets were not in the medication cart yesterday, 07/15/26, when the second shift medication aide (MA) came in. -The MA who was on duty on 07/15/26 told her on 07/16/26, she accidentally put Resident #4's Tramadol in a bag with another resident who was discharged on 07/15/26.	D 386		

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D 386	Continued From page 2 Interview with a MA on 07/16/26 at 12:00pm revealed Resident #4 did not need any Tramadol this morning because she asked him if he was in pain. Interview with a family member of the resident who was discharged from the facility on 07/16/26 at 2:11pm revealed: -The resident had discharged from the facility on 07/15/26. -There was Tramadol Hcl 50mg tablet for Resident #4 in the bag with the other resident's medication. -He would return the Tramadol to the facility on 07/17/26. Interview with a hospice nurse on 07/16/26 at 1:55pm revealed she received an alert from the facility that they needed another prescription for Resident #4's Tramadol because the current medication was mistakenly sent home with a resident who was discharged from the facility. Second interview with the HWD on 07/16/26 at 2:15pm revealed: -The facility reordered the Tramadol for Resident #4. -She would receive the medication from the family member but then would follow their company's policy to return the medication to the pharmacy or destroy it. Second interview with a MA on 07/16/26 at 3:15pm revealed when she packed the medication for the other resident on 07/15/26, she accidentally picked up Resident #4's Tramadol. -She never looked at the medication to verify what was in the bag. Third interview with the HWD on 07/16/26 at	D 386		

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D 386	Continued From page 3 3:19pm revealed: -The MA should have completed a medication log which would have included the medications and the amount that were being discharged to the other resident. -The MA and the family should have signed the log after verifying the medications that were being discharged with the resident. Interview with the Administrator on 07/16/26 at 3:59pm revealed: -The MA should have completed a delivery sheet. -The delivery sheet came from the pharmacy. -The delivery sheet included the list of all the medications the discharged resident was taking with them. -The MA should have compared the medications in the facility to the delivery sheet. -The MA and the family receiving the medications should have signed the delivery sheet.	D 386		