STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045130	A. BUILDING: _____ B. WING _____	07/16/2026

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TERRABELLA OF HENDERSONVILLE	3851 HOWARD GAP ROAD HENDERSONVILLE, NC 28792

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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation on 07/14/26 to 07/16/26.	D 000		
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: TYPE A2 VIOLATION The facility failed to ensure medications were administered as ordered for 4 of 8 sampled residents (Resident #1, #2, #7, and #8) related to medications used to treat pain (#1), eye pressure and enlarged prostate (#2), bone disease (#7), and heart rate (#8). The findings are: Review of the facility's Medication Services Policy and Procedure dated 06/11/24 revealed: -The Executive Director ensured medication related services required for or requested by each resident would be provided. -The residents' medication administration record would be accurate. -The facility ensured that medications were administered to the residents. -All medications would be administered per	D 358		

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D 358	Continued From page 1 physician orders. 1. Review of Resident #8's current FL2 dated 06/29/26 revealed: -Diagnoses included essential primary hypertension and chronic kidney disease stage III. -Resident #8 was constantly disoriented. -There was an order for metoprolol succinate ER (used to reduce heart rate, cardiac workload, and blood pressure) 50mg twice daily. Review of Resident #8's current Resident Register revealed an admission date of 01/13/26. Review of a Cardiology Office Note dated 07/06/26 revealed: -Resident #8 was previously seen at the cardiology office on 06/17/26. -Resident #8's metoprolol succinate ER was increased to 50mg twice daily on 06/17/26 from 50mg every morning and 25mg in the evening. -Resident #8's coordinated care was made between the Health and Wellness Director (HWD) and the Primary Care Provider (PCP). -She was seen on 07/06/26 for a follow-up appointment from her 06/17/26 visit. -The Cardiologist determined Resident #8 had received the incorrect metoprolol succinate ER dose of 75mg of metoprolol nightly according to the documentation on the electronic medication administration record (eMAR). -The Cardiologist noted there was concern for bradycardia (low heart rate) and hypotension (low blood pressure). Review of Resident #8's PCP progress note dated 07/08/26 revealed: -Resident #8 was seen by the PCP on 07/08/26 as a follow up regarding lab values and atrial	D 358		

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fibrillation with rapid ventricular response (irregular heart rhythm that impairs effective blood flow).
-According to Resident #8's June 2026 eMAR she had possibly been receiving metoprolol succinate ER 75mg at night.
-Home Health Nursing confirmed there were only 25mg and 100mg tablets of metoprolol succinate ER available for admission 07/06/26.
-The medication aides (MAs) were uncertain about the correct dosing instructions.
-Facility staff attributed the error to the written order, which stated to increase metoprolol succinate ER to 50mg twice daily.
-The metoprolol succinate ER 25mg tablets nightly continued to be given resulting in a facility and pharmacy error.
-It was very unclear what dosage of metoprolol succinate ER Resident #8 had actually been receiving.
-Medication errors for Resident #8 remained a significant concern.

Review of Resident #8's June 2026 eMAR revealed:
-There was documentation of metoprolol succinate ER 50mg was administered at 9:00am daily from June 1 - June 30.
-There was documentation of metoprolol succinate ER 50mg was administered 50mg at 9:00pm nightly from June 1 - June 30.
-There was documentation of metoprolol succinate ER 50mg was administered at 9:00pm nightly from June 1 - June 30.

Review of Resident #8's July 2026 eMAR revealed:
-There was documentation of metoprolol succinate ER 50mg was administered at 9:00am daily from July 1 - July 15.

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D 358	Continued From page 3 -There was documentation of metoprolol succinate ER 50mg was administered at 9:00pm nightly from July 1 - July 15. Observation of Resident #8's medications on hand on 07/15/26 at 10:40am revealed there were 28 tablets of metoprolol succinate ER 50mg available for administration. Telephone interview with Resident #8's PCP on 07/15/26 at 9:25am revealed: -Resident #8 had a cardiology appointment in June 2026. -The cardiologist changed Resident #8's metoprolol from 50mg every morning and 25mg every evening to metoprolol 50mg twice daily. -Resident #8 was at high risk for being hypotensive, possibly having a stroke or having a malignant arrhythmia because she was receiving an improper dosage of metoprolol. Interview with Resident #8's family member on 07/15/26 at 11:20am revealed: -She was informed by another family member that Resident #8's PCP called and was concerned about her metoprolol dosage. -She called Resident #8's PCP and was informed there had been issues with facility staff failing to administer her metoprolol according to the medication order. -The PCP indicated that the medications were changed but it was not implemented by the facility staff as it should have been. -Resident #8 was diagnosed with atrial fibrillation in April 2026 during a hospitalization after a fall. -While she was hospitalized, Resident #8 was very hypotensive (low blood pressure) and had bradycardia (slow heart rate). -The family member was concerned that Resident #8 did not receive her medication	D 358		

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D 358	Continued From page 4 correctly. Telephone interview with Resident #8's PCP on 07/15/26 at 1:59pm revealed: -She was notified by Resident #8's Cardiologist on 07/06/26 that some medication changes that were made on 06/17/26 with the metoprolol succinate ER had yet to be implemented by the facility staff. -It was evident based on the Cardiologists' review of the medication administration record for June 2026 that Resident #8's metoprolol had been administered at too high of a dose for several days. Interview with the Resident Care Coordinator (RCC) on 07/15/26 at 11:50am revealed: -She was not aware Resident #8's metoprolol succinate ER had not been given per the physician's order. -Any changes or questions about medications should always be directed to her or the HWD. -She did not see the cardiology report for Resident #8. Interview with the HWD on 07/15/26 at 3:14pm revealed: -She spoke with Resident #8's Cardiologist about the metoprolol succinate ER dosage. -The medication orders went directly from the cardiology office and the PCP to the pharmacy. -There was a communication breakdown between the Cardiologist and the PCP regarding who should actually have discontinued Resident #8's metoprolol succinate ER 25mg nightly dosage. -She did not call the Cardiologist of the PCP for a clarification of the order. Interview with the Administrator on 07/16/26 at	D 358		

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D 358	Continued From page 5 9:10am revealed: -She was unaware there had been a problem with the dosage of Resident #8's metoprolol until 07/15/26. -She came from a skilled nursing background and expected the PCP to place a stop order on a medication or a discontinue order on a medication when changes were made. -The metoprolol orders for Resident #8 were not clear enough and should have been clarified by the HWD or the RCC. -The staff needed to pay closer attention to medication orders for residents when multiple providers were writing medication orders for those residents. Attempted interview with Resident #8 on 07/15/26 at 2:40pm revealed she was not interviewable based on a diagnosis of constant disorientation. Attempted telephone interviews with Resident #8's Cardiologist on 07/15/26 at 2:27pm and 07/16/26 at 8:02am were unsuccessful. -The medication orders go directly from the cardiology office and the PCP to the pharmacy. -There was a communication breakdown between the cardiologist and the PCP regarding who should actually have discontinued Resident #8's metoprolol succinate ER 25mg nightly dosage. Interview with the Administrator on 07/16/26 at 9:10am revealed: -She had been unaware there had been a problem with the dosage of Resident #8's metoprolol until 07/15/26. -The Administrator came from a skilled nursing background and expected the PCP to place a stop order on a medication or a discontinue order on a medication when changes were made.	D 358		

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-The metoprolol orders for Resident #8 were not clear enough and should have been clarified by the Health and Wellness Director (HWD) or the Resident Care Coordinator (RCC).
-The staff needed to pay closer attention to medication orders for residents when multiple providers were writing medication orders for those residents.

Attempted interview with Resident #8 on 07/15/26 at 2:40pm revealed she was not interviewable.

Attempted telephone interviews with Resident #8's cardiologist on 07/15/26 at 2:27pm and 07/16/26 at 8:02am were unsuccessful.
2. Review of Resident #1's current FL2 dated 06/29/26 revealed:
-Diagnoses included dementia (a progressive decline in cognitive abilities affecting memory and reasoning) and high blood pressure.
-He was ambulatory and constantly disoriented.
-The recommended level of care was memory care.

Review of a physician's progress note for Resident #1 dated 06/03/26 revealed there was an order to change oxycodone (used to treat pain) 5mg to 2 times daily scheduled and every 4 hours as needed for pain/agitation.

Review of physician's orders for Resident #1 dated 06/29/26 revealed there was an electronic order for oxycodone 5mg 3 times daily, and 3 times daily was crossed out and two times daily was handwritten next to it.

Review of Resident #1's electronic medication administration record (eMAR) for June 2026 revealed:
-There was an entry for oxycodone 5mg take 1

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tablet 3 times daily with administration times of 08:00am, 12:00pm, and 8:00pm.
-There was documentation the oxycodone was administered on 06/01/26 - 06/06/26 at 8:00am, 12:00pm, and 8:00pm, 06/07/26 at 12:00pm, 06/08/26 at 12:00pm and 8:00pm, 06/09/26 at 12:00pm, 06/10/26 at 12:00pm, 06/11/26 at 12:00pm and 8:00pm, 06/12/26 at 12:00pm, 06/13/26 at 12:00pm and 8:00pm, 06/14/26 at 8:00am, 12:00pm, and 8:00pm, and 06/15/26 at 8:00am and 12:00pm.
-There was a second entry for oxycodone 5mg take 1 tablet 2 times daily with administration times of 8:00am and 8:00pm.
-There was documentation the oxycodone was administered on 06/07/26 at 8:00am and 8:00pm, 06/08/26 at 8:00am, 06/09/26 at 8:00am and 8:00pm, 06/10/26 - 06/13/26 at 8:00am, and 06/15/26 at 8:00pm.

Observation of Resident #1's medications on hand revealed there was one bubble pack labeled oxycodone 5mg, 30 tablets dispensed on 06/03/26 and 28 remained, a second bubble pack labeled oxycodone 5mg, 30 tablets dispensed on 07/01/26 and 30 remained, and a third bubble pack labeled oxycodone 5mg, 30 tablets dispensed on 07/08/26 and 30 remained.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/14/26 at 2:05pm revealed:
-The pharmacy received an electronic order for Oxycodone 5mg 1 tablet three times daily on 04/16/26.
-The pharmacy received an electronic order on 06/03/26 to change the oxycodone 5mg from three times daily to two times daily.

Interview with the Resident Care Coordinator

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(RCC) on 07/14/26 at 2:40pm revealed:
-The pharmacy entered new orders into the eMAR system and she, the Health and Wellness Director (HWD), or the Special Care Coordinator (SCC) approved all orders.
-She thought the oxycodone ordered on 06/03/26 for Resident #1 was not approved in a timely manner.
-Sometimes orders were confusing when a resident was a patient of hospice and another provider.

Interview with the SCC on 07/15/26 at 8:45am revealed:
-The pharmacy entered medication orders into the eMAR system and management approved the orders before the MAs administered them.
-She approved the oxycodone orders for Resident #1 dated 06/03/26 on 06/11/26.
-She did not recall the reason for the delay in approving the oxycodone orders.
-She saw that there were two orders for oxycodone in the eMAR but did not contact the pharmacy or the primary care provider (PCP).
-She "messed up".

Telephone interview with Resident #1's Hospice Registered Nurse (RN) on 07/14/26 at 3:20pm revealed the oxycodone 5mg was changed to twice daily on 06/03/26 because the resident was groggy and not in as much pain and did not need the oxycodone 5mg 3 times a day.

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 07/15/26 at 8:55am revealed:
-Resident #1 was prescribed oxycodone 5mg for pain control.
-He would experience sedation and loss of appetite by continuing to receive oxycodone three

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D 358	Continued From page 9 times daily instead of the ordered two times daily. Based observations, interviews and record review, Resident #1 was not interviewable. Refer to the interview with the Administrator on 07/16/26 at 9:10am. 3. Review of Resident #2's current FL2 dated 06/30/26 revealed: -Diagnosis included high blood pressure and neoplasm of the bladder (an abnormal growth of tissue in the bladder). -There was an order for latanoprost (treats elevated eye pressure) 0.005% eye drop, 1 drop in both eyes daily at bedtime. -There was an order for tamsulosin (treats enlarged prostate) 0.4mg daily at bedtime. Review of Resident #2's Resident Register revealed an admission date of 05/11/26. Interview with Resident #2 during the initial tour on 07/14/26 at 9:32am revealed: -He was out of the facility for a procedure on 07/13/26. -He arrived back to the facility on 07/13/26 at 7:30pm and staff did not administer his bedtime medications to him. a. latanoprost 0.005% eye drops Review of Resident #2's electronic medication administration record (eMAR) for 07/13/26 revealed: -There was an entry for latanoprost 0.005% 1 drop in both eyes at bedtime with an administration time of 9:00pm. -Latanoprost 0.005% was not documented as administered on 07/13/26 at 9:00pm with no	D 358		

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D 358	Continued From page 10 reason why. Observations of Resident #2's medications on hand on 07/15/26 at 10:25am revealed there was one bottle labeled latanoprost 0.005% eye drops instill 1 drop in both eyes at bedtime. Attempted telephone interview with Resident #2's primary care provider (PCP) on 0715/26 at 1:35pm was unsuccessful. Refer to the interview with the medication aide (MA) on 07/15/26 at 1:38pm. Refer to the interview with the Resident Care Coordinator (RCC) on 07/15/26 at 10:00am. Refer to the interview with the Administrator on 07/16/26 at 9:10am. b. tamsulosin 0.4mg daily at bedtime Review of Resident #2's eMAR for 07/13/26 revealed: -There was an entry for tamsulosin 0.4mg at bedtime with an administration time of 9:00pm. -The tamsulosin was not documented as administered on 07/13/26 at 9:00pm with no reason why. Observations of Resident #2's medications on hand on 07/15/26 at 10:25am revealed there were two bubble packs labeled tamsulosin 0.4mg, take 1 capsule at bedtime and there were 28 capsules in one bubble pack and 14 capsules in the second. Attempted telephone interview with Resident #2's primary care provider (PCP) on 0715/26 at 1:35pm was unsuccessful.	D 358		

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D 358	Continued From page 11 Refer to the interview with the medication aide (MA) on 07/15/26 at 1:38pm. Refer to the interview with the RCC on 07/15/26 at 10:00am. Refer to the interview with the Administrator on 07/16/26 at 9:10am. 4. Review of Resident #7's current FL2 dated 06/04/26 revealed diagnoses included dementia and anxiety. Review of Resident #7's Resident Register revealed an admission date of 08/22/22. Review of physician's orders for Resident #7 revealed there was an order for alendronate (treats osteoporosis a disease that causes brittle and weak bones) 70mg every week dated 02/04/25. Review of a physician's progress note dated 07/14/26 revealed: -She was notified on 07/08/26 that Resident #7 had not received her alendronate since at least April 2026. -This could have resulted in a fracture due to her known history of osteoporosis. Review of Resident #7's electronic medication administration record (eMAR) for April 2026 revealed: -There was an entry for alendronate 70mg administer once per week on 04/01/26, 04/08/26, 04/15/26, 04/22/26, and 04/29/26 at 7:30am. -Alendronate 70mg was not documentated as administered on 04/01/26, 04/08/26, 04/15/26, and 04/29/26 at 7:30am with no documentation	D 358		

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D 358	Continued From page 12 why it was not administered. Review of Resident #7's eMAR for May 2026 revealed: -There was an entry for alendronate 70mg once per week on 05/06/26, 05/13/26, 05/20/26, and 05/27/26 at 7:30am. -Alendronate 70mg was not administered the month of May 2026 and there was documentation on 05/06/26, 05/13/26, 05/20/26, and 05/27/26 that the medication was not in the medication cart. Review of Resident #7's eMAR for June 2026 revealed: -There was an entry for alendronate 70mg once per week on 06/03/26, 06/10/26, 06/17/26, and 06/24/26 at 7:30am. -Alendronate 70mg was not administered the month of June 2026 and there was documentation on 06/03/26 the medication was not in the medication cart. -There was documentation on 06/10/26, 06/17/26 and 06/24/26 the medication was pending the pharmacy, Review of Resident #7's eMAR for 07/01/26 - 07/15/26 revealed: -There was an entry for alendronate 70mg once per week on 07/01/26, 07/08/26, and 07/15/26 at 7:30am. -There was documentation the alendronate was not administered on 07/01/26 and there was documentation on 07/01/26 the alendronate was pending delivery. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/15/26 at 10:00am revealed: -There received an order for alendronate 70mg	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045130	A. BUILDING: _____ B. WING _____	07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRABELLA OF HENDERSONVILLE	3851 HOWARD GAP ROAD HENDERSONVILLE, NC 28792

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D 358	Continued From page 13	D 358		

weekly for Resident #7 in October 2023.
-There were 4 tablets dispensed on 03/31/26, 4 tablets dispensed on 04/28/26, 4 tablets dispensed on 05/26/26, and 4 tablets dispensed on 06/23/26.
-There was no documentation that the facility contacted the pharmacy to request a refill or to find out if the medication was delivered.

Review of the pharmacy packing slip proof of delivery sheets on 07/15/26 revealed:
-There were 4 tablets of alendronate 70mg delivered on 04/02/26 at 12:06pm for Resident #7 and signed for by the Administrator.
-There were 4 tablets of alendronate 70mg delivered on 04/30/26 at 12:50pm for Resident #7 and signed for by the Health and Wellness Director (HWD).
-There were 4 tablets of alendronate 70mg delivered on 05/28/26 at 11:30am for Resident #7 and signed for by the HWD.

Observation of Resident #7's medications on hand on 07/15/26 at 10:23am revealed there was one box labeled alendronate 70mg weekly and 4 tablets were dispensed on 06/30/26.

Interview with a medication aide (MA) on 07/15/26 at 10:20am revealed:
-He could not find Resident #7's alendronate in the medication cart.
-He called the pharmacy and informed the HWD that the medication was not in the medication cart.
-The HWD informed him she would call the pharmacy.
-He always called or faxed the pharmacy when a medication was not available and also informed the HWD.
-He knew that 3rd shift was responsible for

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D 358	Continued From page 14 medication cart audits to ensure medications were available. Interview with a second MA on 07/15/26 at 10:23am revealed: -She could not locate Resident #7's alendronate. -She knew she notified the HWD. -She did not call or fax the pharmacy about the medication and could not explain why. Interview with the HWD on 07/15/26 at 10:30am revealed: -She was informed that Resident #7's alendronate was not available and she reordered the medication from the pharmacy. -She used various methods, telephone, computer, or fax, to reorder medications. -She was not aware that Resident #7 was not administered the alendronate since before April 2026. -The MAs were responsible for pushing the refill button on the medication cart, calling the pharmacy, and faxing the pharmacy when there was an issue with a medication and then to inform her and the Resident Care Coordinator (RCC). -The staff on 3rd shift was responsible for medication cart audits weekly. -Staff were expected to check for expired medications, discontinued medications, and to ensure active medications were available. Interview with the RCC on 07/15/26 at 11:27am revealed: -She did not know Resident #7 was not administered her alendronate. -The MAs should have notified her or the HWD and they would have notified the pharmacy. -She knew medication cart audits were conducted by the 3rd shift staff but she did not know how	D 358		

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D 358	Continued From page 15 often. -The audits included checking for expired medications, discontinued medications, and to ensure medications were available. Interview with the Administrator on 07/15/26 at 1:50pm revealed: -Batch medications delivered from the pharmacy were locked in her office until the next day and then the 3rd shift staff puts the medications in the medication carts. -She did not know what happened with Resident #7's alendronate. Interview with the facility's contracted Primary Care Provider (PCP) on 07/15/26 at 9:26am revealed: -Resident #7 was prescribed alendronate for bone health. -The resident had not received any alendronate since before April 2026. -The resident was at risk of fractures going without her alendronate. Refer to the interview with the Administrator on 07/16/26 at 9:10am. _____ Telephone interview with the medication aide (MA) on 07/15/26 at 1:38pm revealed: -She knew Resident #2 was out of the facility on 07/13/26 because it was marked as such on the eMAR. -She did not go into his room to check to see if he was back in the facility. -She "assumed" he was still out of the facility during the bedtime medication pass because there were not any lights on in his room. Interview with the Resident Care Coordinator (RCC) on 07/15/26 at 10:00am revealed the MA	D 358		

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D 358	Continued From page 16 should have physically checked to see if the resident had returned to the facility. Interview with the Administrator on 07/16/26 at 9:10am revealed: -She did not know the medication process after a physician wrote medication orders and the orders were sent to the pharmacy. -The clinical management team was responsible for ensuring the eMARs were accurate. -She knew the facility had a process for medication cart audits, but she did not know what was included in the process. -She knew "in the past" the night shift staff was responsible for medication cart audits. _____ The facility failed to administer medications as ordered for Resident #8 resulting in the possibility of bradycardia, hypotension and a malignant (lethal) heart arrythmia due to overmedication, Resident #1 resulting in decreased appetite and sedation due to overmedication and Resident #7 not receiving medication for several months placing her at risk for fractures. This failure resulted in a substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 15, 2026 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 15, 2026	D 358		