

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL080030	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/19/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TERRABELLA SALISBURY

**1915 MOORESVILLE ROAD
SALISBURY, NC 28147**

(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 August 18, 2026 and August 19, 2026.	{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: The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents for record review including errors with a calcium channel blocker (#2) and sliding scale insulin (#4). The findings are: 1. Review of Resident #2's FL2 dated 07/20/26 revealed: -Diagnoses included atrial fibrillation, pacemaker and hypertension. -There was an order for diltiazem (a medication used to control atrial fibrillation) 120mg daily, hold for systolic blood pressure (SBP) less than 120, for diastolic blood pressure (DBP) less than 60, or for heart rate (HR) less than 60.	{D 358}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{D 358}	Continued From page 1 Review of Resident #2's July 2026 electronic medication administration record (eMAR) from 07/30/26 to 07/31/26 revealed: -There was an entry for diltiazem extended release (ER) 120mg capsule daily, hold for SBP less than 120, for DBP less than 60, or for heart rate less than 60. -There was documentation diltiazem was administered on 07/31/26. -There was a blood pressure (BP) value documented on the eMAR. -There were no HR values documented on the eMAR. Review of Resident #2's August 2026 eMAR from 08/01/26 to 08/18/26 revealed: -There was an entry for diltiazem ER 120mg capsule daily, hold for SBP less than 120, for DBP less than 60, or for heart rate less than 60. -There was documentation diltiazem was administered from 08/01/26 through 08/03/26, 08/07/26, from 08/10/26 through 08/15/26, and 08/18/26. -There were BP values documented on the eMAR ranging from 102/72 to 158/88. -There was documentation diltiazem was held from 08/04/26 through 08/06/26, 08/08/26 and 08/09/26 due to Resident #2's BP being outside the order parameter. -There were no HR values documented on the eMAR and it could not be determined if diltiazem should have been administered. -There was documentation of medication refusal on 08/16/26 with a note, "awaiting medication." -There was documentation diltiazem was not available for administration on 08/17/26. Telephone interview with a representative from the facility's contracted pharmacy on 08/19/26 at	{D 358}			

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{D 358}	Continued From page 2 12:10pm revealed: -Resident #2 had an active order on file for diltiazem ER 120mg daily, hold for SBP less than 120, DBP less than 60, or HR less than 60. -Resident #2's diltiazem was dispensed twice for a quantity of 5 capsules on 07/24/26 and for a quantity of 8 capsules on 08/18/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/19/26 at 12:19pm revealed diltiazem was not a beta blocker and it was more important for the BP to be checked prior to administration than the HR. Observation of the medications on hand for Resident #2 on 08/18/26 at 2:41pm revealed there was no diltiazem available for administration on the medication cart. Second observation of the medications on hand for Resident #2 on 08/19/26 at 11:34am revealed there was a medication card with 7 of 8 diltiazem capsules available for administration with a dispensed date of 08/18/26. Interview with Resident #2 on 08/19/26 at 1:20pm revealed staff administered her medications and she thought she was normally administered her diltiazem. Telephone interview with Resident #2's primary care provider (PCP) on 08/19/26 at 2:20pm revealed: -She had become Resident #2's PCP yesterday on 08/19/26. -She had not written Resident #2's diltiazem order and she may have discontinued the parameters for Resident #2's diltiazem after further monitoring. -She did not know that it appeared Resident #2	{D 358}			

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{D 358}	Continued From page 3 missed somewhere between two and eight doses of diltiazem in August 2026 based on documentation, pharmacy dispense dates, and the oral medication count. -She would expect the facility to have Resident #2's diltiazem available for administration and for Resident #2 to not have missed doses of diltiazem. Interview with a medication aide (MA) on 08/19/26 at 1:31pm revealed: -She administered diltiazem to Resident #2 on 08/07/26, 08/11/26, 08/14/26 and 08/15/26. -She checked Resident #2's BP prior to administering diltiazem but she did not check Resident #2's HR. -If Resident #2's HR was checked, it would be documented on the eMAR. Telephone interview with a second MA on 08/19/26 at 2:37pm revealed: -She checked Resident #2's BP prior to administering diltiazem. -She did not know that part of Resident #2's diltiazem order was to check Resident #2's HR prior to administration. -She reordered medications from the pharmacy and if she had an issue with getting a resident's medication she asked someone to help her. Interview with the Resident Care Coordinator (RCC) on 08/19/26 at 2:10pm revealed: -Residents' HR values would be documented on the eMAR if they were completed. -The Health and Wellness Director (HWD) handled everything related to the residents' medications. Interview with the HWD on 08/19/26 at 2:43pm revealed:	{D 358}			

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{D 358}	Continued From page 4 -Resident #2 was admitted to the facility with medication orders from her FL2. -She ordered Resident #2's medications from pharmacy. -She did not know part of Resident #2's diltiazem order was to hold for HR less than 60 until 08/19/26. -Resident #2's HR would be documented on the eMAR if it was documented. -She did not know Resident #2's diltiazem was not available to administer for between two and eight doses in August 2026 until 08/19/26. -She, the RCC or the MAs reordered medications. -She expected the MAs to complete medication cart audits when they were able. Interview with the Administrator on 08/19/26 at 3:05pm revealed: -She did not know Resident #2's diltiazem was not available to administer for between two and eight doses in August 2026 until 08/18/26. -She did not know part of Resident #2's diltiazem order was to hold for HR less than 60 until 08/19/26. -She would have expected Resident #2's diltiazem to be reordered two to three days prior to running out. -She would have expected the MAs to let the HWD know that Resident #2's diltiazem was not available to administer. -There was nowhere for the MAs to document Resident #2's HR on the eMAR because the order was not entered correctly. -She expected the HWD to audit all medication with parameters, including Resident #2's diltiazem. -She expected MAs to administer medications as ordered.	{D 358}			

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{D 358}	Continued From page 5 2. Review of Resident #4's current FL2 dated 01/20/26 revealed: -Diagnoses included type II diabetes, atrial fibrillation, chronic kidney disease stage 3 and acute cystitis. -She was constantly disoriented. -There was an order to check Finger Stick Blood Sugar (FSBS) three times daily before meals. Review of Resident #4's signed physician orders dated 05/19/26 revealed an order for insulin aspart flexpen; 100 units/mL; check FSBS and inject subcutaneously before each meal per sliding scale insulin (SSI); 151-200 = 2u; 201-250 = 4u; 251-300 = 6u; 301-350 = 8u; 351-400 = 10u. Less than 80 or greater than 350 notify MD. Review of Resident #4's July 2026 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS three times daily. -There was an entry to administer insulin aspart flexpen; 100 units/mL; check FSBS and inject subcutaneously before each meal per sliding scale insulin (SSI); 151-200 = 2u; 201-250 = 4u; 251-300 = 6u; 301-350 = 8u; 351-400 = 10u. Less than 80 or greater than 350 notify MD. -On 07/03/26 at 12:20pm, the FSBS reading was 241 and 4 units of insulin were documented as administered. -On 07/12/26 at 4:49pm, the FSBS reading was 255 and 255 units of insulin were documented as administered. -On 07/14/26 at 4:52pm, the FSBS reading was 388 and 8 units of insulin were documented as administered. -On 07/25/26 at 11:58am, the FSBS reading was 215 and 2 units of insulin were documented as administered.	{D 358}			

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{D 358}	Continued From page 6 Observation of medications on hand for Resident #4 on 08/19/26 at 9:50 am revealed there were three insulin aspart 100 unit/mL pens with one opened on 08/11/26. Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable. Telephone interview with the facility's contracted pharmacy on 08/19/26 at 12:18pm revealed: -The current order on file at the pharmacy matched the sliding scale order on the resident's physician orders. -The last 3 dispense dates for insulin apart were 04/14/26, 05/15/26 and 08/11/26. -Three pens (6 mL/600 units) were dispensed on each date and expired 28 days after opening. Interview with Resident #4's primary care provider (PCP) on 08/19/26 at 1:43pm revealed: -She was unaware that Resident #4's insulin units were not administered correctly on four occasions in July 2026. -Resident #4's diabetes was not well-controlled and she was a "feeble" diabetic whose blood glucose levels could go from 500 to 50 in a matter of hours. -Resident #4 would not likely suffer an adverse event if she received too little insulin but she was very concerned about her receiving too much insulin due to previous episodes of hypoglycemia. -If facility staff did not administer the sliding scale coverage correctly, there was the potential for either hypoglycemia or hyperglycemia. Interview with the Health and Wellness Director (HWD) on 08/19/26 at 2:35pm revealed: -She was aware of Resident #4's order for FSBSs	{D 358}		

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{D 358}	Continued From page 7 and SSI. -She was unaware that Resident #4's insulin units were not administered correctly on four occasions in July 2026 because she did not perform eMAR audits. -She was the supervisor for all clinical staff and was responsible for training medication aides (MA) when they were hired and then monthly. -She expected MAs to follow orders as written by the PCP. Interview with the Administrator on 08/19/26 at 2:59pm revealed: -The facility's contracted pharmacy was responsible for entering orders onto eMARs but the HWD entered parameters and supplemental information. -She was unaware that Resident #4's insulin units were not administered correctly on four occasions in July 2026. -She expected MAs to administer insulin to residents as ordered and the HWD to audit all medication parameters weekly with oversight from her. Attempted telephone interview with an MA on 08/19/26 at 2:30pm was unsuccessful.	{D 358}			