

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL023048</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
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| D 000                                                        | Initial Comments<br><br>The Adult Care Licensure Section and Cleveland County Department of Social Services conducted a follow-up survey and complaint investigations from July 29, 2026 to July 31, 2026.<br><br>The complaints were initiated by the Cleveland County Department of Social Services on 07/15/26 and 07/17/26.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | D 000                                                                                  |                                                                                                                          |                                                                |
| D 273                                                        | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A1 VIOLATION<br><br>Based on these findings, the previous Type A1 Violation was not abated.<br><br>Based on interviews and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 6 sampled residents (#6) when a physician was not notified when the resident first began complaining of pain, the pharmacy was not contacted to refill his pain medication and the physician was not informed that all views on a portable x-ray were able to be obtained.<br><br>Review of Resident #6's current FL2 dated 01/10/26 revealed:<br>-Diagnoses included senile degeneration of the brain and hemiplegia (paralysis of one side of the body).<br>-He was constantly disoriented.<br>-His level of care was Special Care Unit (SCU).<br>-There was an order for acetaminophen (a | D 273                                                                                  |                                                                                                                          |                                                                |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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| D 273                                                        | <p>Continued From page 1</p> <p>medication to treat pain) ES (extra strength) 500mg, two tablets every 8 hours as needed (PRN).</p> <p>Review of Resident #6's care plan dated 05/19/26 revealed he required one-person assistance with transfers.</p> <p>Review of Resident #6's signed physician's orders dated 05/27/26 revealed there was an order for acetaminophen ES 500mg, two tablets every 8 hours as needed for pain.</p> <p>Review of Resident #6's record revealed there was no other pain medication ordered except acetaminophen ES 500mg, two tablets every 8 hours as needed for pain with a start date of 11/12/25.</p> <p>Review of Resident #6's electronic staff observations notes revealed:</p> <ul style="list-style-type: none"> <li>-On 06/27/26 at 5:30pm, Resident #6 complained about his left leg hurting and that his wheelchair was too small and rubbing against his leg.</li> <li>-On 06/27/26 at 9:30pm, the resident was yelling in pain and complaining of "his hip hurting being broken" and when his PRN medication was "unavailable - reorder".</li> <li>-On 07/01/26 at 3:30am, Resident #6 was yelling out in pain in his left leg and hip, and acetaminophen was on order to be refilled.</li> <li>-On 07/01/26 at 11:15pm, the resident was yelling out in pain in his left leg and hip, staff repositioned resident to try to help but resident stated, "nothing helps" and a mobile x-ray was ordered.</li> <li>-On 07/02/26 at 8:15pm, Resident #6 had an x-ray on his leg around 7:30pm but the x-ray technician reported not all "pictures" were able to be completed.</li> </ul> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 2</p> <p>-On 07/03/26 at 9:30am, Resident #6 was "screaming out in pain when we try to move him, he says he wants to go to hospital" and PRN acetaminophen was "not helping at all".</p> <p>-On 07/03/26 at 11:00am, the resident was refusing all care, hitting, kicking and punching staff when they tried to help him get up.</p> <p>-On 07/03/26 at 11:45am, Resident #6 was hallucinating, seeing a black hole in the floor that was trying to swallow him, and someone was trying to kill him.</p> <p>-There was a second entry on 07/03/26 at 11:45am, the nurse looked at the resident's leg, and the resident was "still screaming in pain" and threatening everyone involved in his care.</p> <p>-On 07/03/26 at 1:45pm, staff notified Resident #6's partner of his "behaviors" and were informed of some things to try and get him to stop but "none of it worked" and the resident was "hallucinating and screaming in pain".</p> <p>Review of Resident #6's June 2026 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for acetaminophen ES 500mg, two tablets every 8 hours as needed.</p> <p>-There was no documentation acetaminophen ES 500mg, two tablets was administered to the resident.</p> <p>Review of Resident #6's July 2026 eMAR revealed:</p> <p>-There was an entry for acetaminophen ES 500mg, two tablets every 8 hours as needed.</p> <p>-On 07/01/26 at 3:08am acetaminophen ES 500mg, two tablets were not administered to the resident because there was none on the medication cart and it was "on for reorder".</p> <p>-There was a second entry for acetaminophen ES 500mg, two tablets every 8 hours as needed.</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 3</p> <p>-On 07/03/26 at 8:00am acetaminophen ES 500mg, two tablets were administered to the resident with no relief.</p> <p>Review of the Medication Staff Communication Logs revealed:</p> <p>-On 07/01/26 during the 6:00am to 6:00pm shift, Resident #6 requested PRN acetaminophen, and it was administered.</p> <p>-On 07/01/26 during the 6:00pm to 6:00am shift, Resident #6 was yelling out in pain in left leg and hip, and a mobile x-ray was ordered.</p> <p>-On 07/02/26, shift not documented, Resident #6 was complaining of pain.</p> <p>-On 07/02/26 during the 6:00pm to 6:00am shift, Resident #6 had x-ray performed on his leg.</p> <p>-On 07/03/26, shift not documented, Resident #6 was refusing care, punching and kicking staff and was sent to the hospital.</p> <p>-On 07/03/26 to 07/04/26, Resident #6 was at the hospital.</p> <p>-Medication Staff Communication Logs dated 06/27/26 through 07/03/26 were not available for review.</p> <p>Review of the personal care aides (PCA) end of shift reports revealed:</p> <p>-On 07/01/26 during the 6:00pm to 6:00am shift, Resident #6 was yelling and complaining his left leg was hurting.</p> <p>-On 07/03/26 during the 6:00am to 6:00pm shift, Resident #6 was at the hospital for left leg pain.</p> <p>-The PCA end of shift reports dated 06/27/26 through 07/03/26 were not available for review.</p> <p>Review of Resident #6's Emergency Department (ED) note dated 07/03/26 revealed:</p> <p>-Resident #6 was seen in the ED for left hip pain.</p> <p>-Resident #6 reported he had a fall about a week ago.</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 4</p> <p>-Resident #6 was diagnosed with a left hip fracture.</p> <p>Review of Resident #6's Health Care Personnel Registry (HCPR) Initial Allegation Report revealed:</p> <p>-Resident #6 had an injury of unknown source.</p> <p>-The facility became aware of the incident on 07/03/26 at 2:30pm.</p> <p>-Resident #6 complained of hip and leg pain.</p> <p>-Resident #6's Primary Care Provider (PCP) was treating his pain.</p> <p>-A mobile x-ray was attempted but failed.</p> <p>-Resident #6 was sent to the ED and was diagnosed with a fractured hip.</p> <p>Review of Resident #6's HCPR Investigation report dated 07/08/26 for the incident on 07/03/26 at 2:30pm revealed:</p> <p>-The resident complained of unspecified hip and leg pain but was able to stand and transfer from 06/24/26 to 06/30/26.</p> <p>-Resident #6's PCP was treating his pain.</p> <p>-A mobile x-ray was ordered for Resident #6 on 07/01/26 when his pain persisted.</p> <p>-Resident #6 was examined by an outside provider nurse on 07/03/26.</p> <p>Telephone interview with the facility's contracted pharmacy on 07/31/26 at 12:28pm revealed:</p> <p>-Resident #6 had an order for acetaminophen 500mg two tablets every 8 hours as needed.</p> <p>-Acetaminophen 500mg, 60 tablets was last dispensed for Resident #6 on 07/02/26.</p> <p>-Prior to that, acetaminophen 500mg, 60 tablets was dispensed for Resident #6 on 11/12/25.</p> <p>-There was one refill remaining after acetaminophen 500mg, 60 tablets was dispensed on 11/12/25.</p> <p>-The facility did not request a refill for</p> | D 273                                                                         |                                                                                                                          |  |                                                                |

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| D 273                                                        | <p>Continued From page 5</p> <p>acetaminophen in the month of June 2026 for Resident #6.</p> <p>-The pharmacy received a new order on 07/02/26 for the acetaminophen 500mg, two tablets every 8 hours as needed, and that was the date 60 tablets were dispensed.</p> <p>Interview with Resident #6's PCP on 07/30/26 at 4:23pm and 5:06pm revealed:</p> <p>-She was notified by facility staff of Resident #6's pain on 07/01/26 at around 11:00pm.</p> <p>-She was informed the resident wanted medication for pain.</p> <p>-She did not know Resident #6 began complaining of pain on 06/27/26.</p> <p>-She sent an order for acetaminophen 500mg, two tablets every 8 hours as needed for pain for Resident #6.</p> <p>-She ordered a mobile x-ray at that time (07/01/26) due to Resident #6's complaints of hip and leg pain.</p> <p>-If a resident was in pain or the facility needed an order, she expected the facility to call her at any time.</p> <p>-The facility was aware that she took calls 24 hours a day, seven days a week.</p> <p>Interview with a Licensed Practical Nurse (LPN) on 07/31/26 at 11:56am revealed:</p> <p>-She worked with Resident 6's PCP and was in the facility on 07/03/26.</p> <p>-She was informed by facility staff that Resident #6 was complaining of pain and that PRN acetaminophen was not relieving the pain.</p> <p>-She observed Resident #6 and he said his hip was hurting.</p> <p>-She and the SCC assisted Resident #6 into his bed so she could assess the resident.</p> <p>-Resident #6 kept voicing his hip was hurting and did not fully relax his legs during the assessment.</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 6</p> <p>-She spoke to Resident #6's Power of Attorney (POA) and discussed sending him to the hospital.</p> <p>-The x-ray results were received on 07/03/26 that showed a fractured left hip but Resident #6 had already been sent to the hospital.</p> <p>Telephone interview with Resident #6's Power of Attorney (POA) on 07/31/26 at 1:43pm revealed:</p> <p>-The facility did not notify her of Resident #6 hurting, experiencing pain, or that he had reported to multiple staff he had fallen in the shower until 07/03/26 when the Special Care Coordinator (SCC) called to tell her the resident's leg was hurting and he had not wanted to get out of bed to eat breakfast in the dining room.</p> <p>-At 11:08am, she received a call from an LPN that worked with Resident #6's PCP, notifying her that Resident #6 was in a lot of pain.</p> <p>-Resident #6 did not ever complain of pain.</p> <p>-The LPN asked the POA if she wanted the resident sent to the Emergency Department (ED) and the POA agreed.</p> <p>-When the POA met Resident #6 at the ED, she was shocked to see him in that amount of pain, and that she had never seen him in that about of pain.</p> <p>-Resident #6 told her when she saw him in the ED that he had fallen in the shower a week ago.</p> <p>-Resident #6 had a history of stroke but he was clear headed.</p> <p>-Resident #6 told the ED Physician and the Orthopedist that he had fallen in the shower the week before he went to the ED.</p> <p>-Resident #6 had a left hip fracture and had left hip replacement surgery the next day (07/04/26).</p> <p>-When the POA took the resident to his follow-up orthopedist appointment on Wednesday (7/29/26) Resident #6 told the Orthopedist again that he had fallen in the shower.</p> <p>-On 07/03/26, the Administrator told the POA that</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
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| D 273                                                        | <p>Continued From page 7</p> <p>Resident #6 had been in pain since Sunday (06/28/26) night and that he had reported to staff that he had fallen in the shower.</p> <p>-The Administrator also told her the resident had increased levels of pain on Wednesday (07/01/26) when the facility contacted the NP who ordered an x-ray which the POA was not notified of.</p> <p>Interview with a PCA on 07/31/26 at 10:53am revealed:</p> <p>-She could not recall the dates but Resident #6 had been in pain for about two weeks before he went to the ED.</p> <p>-Resident #6 told her he fell in the shower.</p> <p>-During the time he was in pain, Resident #6 did not want to get out of bed and would yell "I'm hurting".</p> <p>-She told the medication aide (MA) that Resident #6 was in pain and the MA documented it.</p> <p>-She thought the SCC knew about Resident #6's pain.</p> <p>-When she changed his brief during the time he was in pain, she did not see any injuries, but he would yell out in pain or grunt.</p> <p>Interview with a MA on 07/30/26 at 4:47pm revealed:</p> <p>-She was the MA on duty on 06/27/26 from 6:00am to 6:00pm.</p> <p>-On that day (06/27/26) Resident #6 complained of hip pain and told her he fell in the shower.</p> <p>-She questioned the two personal care aides (PCA) on duty and was told they did not shower Resident #6 that day (06/27/26).</p> <p>-She had not heard of any staff reporting that Resident #6 had fallen in the shower.</p> <p>-Resident #6 did not appear confused when he reported his hip pain to her on 06/27/26.</p> <p>-She wrote Resident #6 was in pain on 06/27/26</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 8</p> <p>on the shift change report but did not know if she reported his pain to the SCC or any other member of the management team.</p> <p>-She worked the next day, 06/28/26, and administered Resident #6's morning medications to him while he was in his recliner.</p> <p>-Resident #6 did not complain of pain to her on 06/28/26 when she administered his morning medications.</p> <p>-Resident #6 was paralyzed on one side and would require assistance getting up if he fell.</p> <p>-Resident #6 usually required two-person assistance with transfers and toileting, although staff had "caught" him trying to walk down the hall without assistance.</p> <p>-She did not know the date but Resident #6 was sent out to the hospital about a week later and she found out he had a broken hip.</p> <p>-Prior to 06/27/26 she did not remember a time Resident #6 had complained of pain.</p> <p>Telephone interview with a medication aide (MA) on 07/30/26 at 4:08pm revealed:</p> <p>-She worked third shift on 06/27/26 when Resident #6 complained that his hip/leg was hurting.</p> <p>-He told her he had fallen in the shower, date unknown.</p> <p>-It did not seem like anything was broken when she looked at his hips and legs.</p> <p>-She tried to administer him PRN acetaminophen, but the resident did not have any available to administer.</p> <p>-She thought she had reordered Resident #6's acetaminophen the night of 06/27/26.</p> <p>-Resident #6 did not ever complain of pain.</p> <p>-She did not know that the resident's acetaminophen was not reordered/refilled until days later.</p> <p>-During shift report on 06/27/26, there was no</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 9</p> <p>mention of Resident #6 falling or that he had been in pain.</p> <p>-She did not report or document that Resident #6 had been in pain or that he had told her he had fallen in the shower on shift report.</p> <p>-She did document in an observation note in Resident #6's record of him being in pain and that his acetaminophen had been reordered.</p> <p>-She did not notify the Resident Care Coordinator (RCC) or the SCC of Resident #6 being in pain or that he reported he had fallen in the shower.</p> <p>-She did not notify Resident #6's POA or his PCP of him being in pain.</p> <p>-She worked 07/02/26 when mobile x-ray came to take images of Resident #6.</p> <p>-Resident #6 could not straighten his legs because he was in too much pain.</p> <p>-She heard Resident #6 was sent to a rehabilitation facility due to him having a broken hip.</p> <p>Interview with a MA on 07/31/26 at 10:12am revealed:</p> <p>-She worked on Resident #6's hall on 07/03/26 from 6:00am to 6:00pm.</p> <p>-When she arrived to work on 07/03/26, Resident #6 was in "excruciating" pain and yelling out.</p> <p>-Resident #6 told her and several other staff members that he fell in the shower.</p> <p>-If a resident complained of pain, the MAs were to report it to the SCC.</p> <p>-She did not report Resident #6's pain on 07/03/26 to the SCC because she thought the SCC was working as a PCA with her that day.</p> <p>-She did not administer any pain medication to Resident #6 because she checked his eMAR and he did not have an order for acetaminophen as needed.</p> <p>-She did not receive any report from the MA that worked the previous night shift that Resident #6</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 10</p> <p>was in pain.</p> <p>-The MAs were to report off to the on-coming MA but that did not always happen.</p> <p>-The MAs were responsible for giving verbal report to the on-coming MA and also document resident issues on the paper shift-to-shift report (Medication Staff Communication Log).</p> <p>-She did not know if the SCC, RCC, HWD or Administrator reviewed the Medication Staff Communication Log.</p> <p>-Management staff were supposed to take the Medication Staff Communication Log to morning meeting each weekday, but they did not always come get them.</p> <p>-If she had resident concerns, she usually told the SCC, RCC or Administrator.</p> <p>-She did not always document resident issues in the computer system because sometimes she was too busy or overwhelmed.</p> <p>-She did not know if any management reviewed resident observation notes in the computer system.</p> <p>-Resident #6 did not complain of pain in the past, just during the recent hip/leg pain.</p> <p>Interview with the lead MA on the Special Care Unit (SCU) on 07/31/26 at 1:32pm revealed:</p> <p>-She was a MA and became the lead MA on the SCU in October 2025.</p> <p>-She was the MOD from the evening of 06/26/26 to the morning of 06/29/26.</p> <p>-She was in the facility at least 4 hours on Saturday 06/27/26 and Sunday 06/28/26.</p> <p>-When she was in the facility on 06/27/26 and 06/28/26 she toured all halls, talked to staff members and checked on all the residents in the facility.</p> <p>-When she was MOD and in the facility on 06/27/26 and 06/28/26, no staff on Resident #6's hall told her the resident was in pain.</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | <p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-She did not review observation documentation or the Medication Staff Communication Log when she was MOD.</li> <li>-She would only know of Resident #6's pain if staff had told her.</li> <li>-If she had been told Resident #6 was in pain she would have reported it to management staff and the resident's PCP.</li> <li>-If facility staff had any issues or concerns on the weekend, they were to call the MOD and MOD passed it on to management.</li> <li>-Since she was the lead MA on the SCU, she participated in morning meetings during the week when she was not working on the floor which she did a few days each week.</li> <li>-She reviewed all documentation for her assigned hall, both paper and observation notes, each day she worked.</li> <li>-If she was not the MA and was able to participate in morning meeting, she took the paper Medication Staff Communication Log and the PCAs documentation with her to review with the management staff.</li> <li>- The SCC, RCC and the HWD were all able to review staff observation notes, but she did not know if they did.</li> </ul> <p>Interview with the SCC on 07/31/26 at 11:19am revealed:</p> <ul style="list-style-type: none"> <li>-She worked at the facility for a year prior to becoming the SCC on 06/15/26.</li> <li>-PCAs were responsible for reporting any change in conditions, such as pain, to the MAs.</li> <li>-Staff should notify her of resident changes but they often notified the RCC.</li> <li>-She did not know why staff did not notify the RCC of Resident #6's pain because that was who staff typically notified.</li> <li>-She had been trying to educate staff verbally to notify her if there were concerns with a resident</li> </ul> | D 273                                                                         |                                                                                                                          |                          |                                                                |

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| D 273                                                        | <p>Continued From page 12</p> <p>on the SCU.</p> <p>-The MAs were responsible for documenting any change in condition in the computer system, on the Medication Staff Communication Log and for notifying her and the HWD of the change in condition.</p> <p>-She did not know if anyone reviewed the residents' observation notes in the computer system.</p> <p>-If she was aware a resident had fallen, she would look at the observation notes in the computer system but did not review the notes routinely.</p> <p>-She looked at the paper Medication Staff Communication Log sheets a couple times a week, looking for falls or resident pain that was different.</p> <p>-She was not notified Resident #6 was complaining of pain on the weekend of 06/27/26 - 06/28/26 but she thought the RCC was notified because the resident needed acetaminophen and pharmacy would need to be notified to get it from the back-up pharmacy.</p> <p>-She worked on 06/29/26 but only heard staff were getting acetaminophen for Resident #6 but was not told anything else with regards to the resident.</p> <p>-She did not work 06/30/26, 07/01/26 and 07/02/26.</p> <p>-On 07/03/26 the MA informed her they were unable to get Resident #6 up and the resident was yelling out.</p> <p>-She knew something was wrong on 07/03/26 because Resident #6 was trying to hit staff and he never did that before.</p> <p>-There was a Manager-on-Duty (MOD) on the weekend, from the evening of 06/26/26 to the morning of 06/29/26, that should have made rounds throughout the facility and checked on all of the residents.</p> | D 273                                                                         |                                                                                                                          |                          |                                                                |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL023048</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |  |                                                                |
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| D 273                                                        | <p>Continued From page 13</p> <p>-The MOD should have known about Resident #6's pain, reported it to management and followed-up on it.</p> <p>Interview with the RCC on 07/31/26 at 3:13pm revealed:</p> <p>-If a resident needed a PRN medication and it was not available, the MA was to order it immediately and call the pharmacy to ensure they received the order.</p> <p>-The MA could have the pharmacy "stat" (immediately) send the medication out or, if necessary, pick up any over-the-counter medications.</p> <p>-She found out on 07/02/26 that Resident #6 was complaining of pain and contacted the pharmacy and had his acetaminophen delivered.</p> <p>-Resident #6 did not typically complain of pain, so for him to complain of pain, something was not right.</p> <p>-The facility's PCP was always available so there was no reason for a resident not to receive a medication when he/she was in pain.</p> <p>-All MAs or floor managers were able to send a resident to the hospital when necessary.</p> <p>-She had no idea why Resident #6's pain was not caught earlier.</p> <p>-She thought a lack of communication and/or care was the reason Resident #6's pain was not addressed when it began.</p> <p>Interview with the Administrator on 07/31/26 at 4:10pm revealed:</p> <p>-Resident #6 was not complaining of pain continually so staff did not report it.</p> <p>-Staff realized Resident #6 was in pain on 07/01/26.</p> <p>-She found out on 07/01/26, the day a x-ray was ordered for Resident #6, that he was complaining of pain.</p> | D 273                                                                         |                                                                                                                          |  |                                                                |

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| D 273                                                        | <p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-She notified Resident #6's POA of his pain on 07/01/26 or 07/02/26.</li> <li>-Management staff did not review observation notes in the computer system, only relied on the MAs and PCAs 24-hour reports (Medication Staff Communication Logs and the End of Shift Reports).</li> <li>-The hall managers/lead MAs were responsible to bring the 24-hour reports to the morning meeting for management to review.</li> <li>-If a hall manager/lead MA was unable to attend morning meeting, the RCC was responsible to pick up the 24-hour reports from each hall and bring them to morning meeting.</li> <li>-If Resident #6 did not have acetaminophen PRN for pain, it was the MAs responsibility to contact pharmacy and place the order.</li> <li>-She did not review Resident #6's observation notes until she started investigating his injury of unknown source on 07/03/26.</li> <li>-The MODs on the weekends were responsible to check on the residents and talk to the MAs.</li> <li>-The MAs did not report to the MOD on 06/27/26 and 06/28/26 that Resident #6 did not have PRN acetaminophen available for pain.</li> <li>-If she knew Resident #6 did not have acetaminophen available for administration on the weekend of 06/27/26 -06/28/26, she or a weekend staff member could have gone to the pharmacy to get it.</li> </ul> <p>The facility failed to notify Resident #6's PCP on 06/27/26 when Resident #6 began complaining his hip was hurting and he thought it was broken because he fell in the shower. Staff did not contact the pharmacy to refill his PRN pain medication until six days later, on 07/02/26. When Resident #6 did not get relief from the medication and an attempt to get all views of a portable x-ray was unsuccessful they did not</p> | D 273                                                                                  |                                                                                                                          |                                                                |

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| D 273                                                        | Continued From page 15<br><br>notify the PCP resulting in the resident remaining in excruciating pain, yelling out in pain, and unwilling to get out of bed until the LPN visited on 07/03/26 and he was sent to the hospital where he was diagnosed with a fractured hip. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation.<br><br>_____<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/31/26 for this violation.                                                                                                                                                                                                                                                                                                                                                                                                                                       | D 273                                                                                  |                                                                                                                          |                                                                |
| D 364                                                        | 10A NCAC 13F .1004 (g) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, and interviews, the facility failed to ensure medications were administered within one hour before or one hour after the scheduled time as ordered for 4 of 5 sampled residents (#1, #2, #3, and #5).<br><br>The findings are:<br><br>Review of the facility's Medication Services policy dated 06/11/24 revealed medications may be given up to one hour before and up to one hour after the prescribed time to accommodate the resident's schedule unless otherwise indicated by the resident's physician.<br><br>1. Review of Resident #5's current FL2 dated | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 16</p> <p>03/16/26 revealed diagnoses included compression fracture of T8 vertebrae, coronary artery disease, heart failure with improved ejection fraction, hyperlipidemia, hypertension, diabetes type 2, atrial fibrillation, and hyponatremia.</p> <p>Review of Resident #5's Physician's order dated 05/11/26 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for atorvastatin (to treat cholesterol) 40mg one at 7:00pm.</li> <li>-There was an order for artificial tears (to treat dry eyes) 2 drops in both eyes, twice daily 7:00am and 7:00pm.</li> <li>-There was an order for sodium chloride (to treat salt levels and rehydrate the body) 1gm three times daily, 7:00am, 3:00pm, and 7:00pm.</li> <li>-There was an order for metformin (to manage blood sugar levels) 500mg twice daily 7:00am and 7:00pm.</li> <li>-There was an order for magnesium oxide (to treat low magnesium levels) 400mg twice daily 7:00am and 7:00pm.</li> <li>-There was an order for metoprolol (to treat high blood pressure and heart failure) 25mg twice daily, 7:00am and 7:00pm.</li> <li>-There was an order for nystatin cream (to treat yeast) 100,000units/gm three times daily, 7:00am, 2:00pm, and 7:00pm.</li> <li>-There was an order for melatonin (to improve sleep) 5mg one at 7:00pm.</li> <li>-There was an order for docusate sodium (to treat constipation) 100mg 2 capsules twice daily, 7:00am and 7:00pm.</li> <li>-There was an order for lidocaine patch (to treat pain) 4% daily, on at 7:00am, remove at 7:00pm.</li> <li>-There was an order for guaifenesin (to treat cough) 100mg/5mls, 10ml three times a day 7:00am, 2:00pm, and 7:00pm for 10 days.</li> <li>-There was an order for tamsulosin (to treat</li> </ul> | D 364                                                                         |                                                                                                                          |  |                                                                |

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| D 364                                                        | <p>Continued From page 17</p> <p>enlarged prostate) 0.4mg once daily at 7:00am.<br/>-There was an order for duloxetine (to treat nerve pain) 20mg 2 capsules once daily at 7:00am.<br/>-There was an order for aspirin (to prevent blood clots) 81mg once daily at 7:00am.<br/>-There was an order for vitamin B12 (to treat vitamin B12 deficiency) 1000 mcg once daily at 7:00am.<br/>-There was an order for creave daily moisture lotion (to treat dry skin) apply once daily at 7:00am.<br/>-There was an order for pantoprazole (to treat gastroesophageal reflux disease) 40mg once daily at 7:00am.<br/>-There was an order for levothyroxine sodium (to treat thyroid) 100mcg once daily in the morning on empty stomach at 9:00am.<br/>-There was an order for hydrocodone acetaminophen (to treat pain) 5-325mg one every 8 hours at 6:00am, 2:00pm, and 10:00pm.</p> <p>Review of a physician's order dated 06/01/26 revealed an order for doxycycline (to treat bacterial infections) 100mg twice daily for 10 days at 7:00am and 7:00pm.</p> <p>Review of a physician's order dated 06/22/26 revealed an order for amoxicillin (to treat bacteria) 875/125mg one tablet by mouth every 12 hours for 10 days at 9:00am and 9:00pm.</p> <p>Review of a physician's order dated 07/01/26 revealed an order for guaifenesin (to treat cough) 100mg/15ml twice daily at 7:00am and 7:00pm.</p> <p>Review of Resident #5's June 2026 electronic medication administration record (eMAR) revealed:<br/>-There was an entry for atorvastatin 40mg in the evening at 7:00pm.</p> | D 364                                                                         |                                                                                                                          |  |                                                                |

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| D 364                                                        | Continued From page 18<br><br>-There was an entry for artificial tears twice daily at 7:00am and 7:00pm.<br>-There was an entry for sodium chloride 1gm three times a day at 7:00am, 3:00pm, and 7:00pm.<br>-There was an entry for metformin 500mg twice daily at 7:00am and 7:00pm.<br>-There was an entry for magnesium oxide 400mg twice daily at 7:00am and 7:00pm.<br>-There was an entry for metoprolol 25mg twice daily at 7:00am and 7:00pm.<br>-There was an entry for nystatin cream 100,000units/gm three times daily at 7:00am, 2:00pm, and 7:00pm.<br>-There was an entry for melatonin 5mg every evening at 7:00pm.<br>-There was an entry for docusate sodium 100mg twice daily at 7:00am and 7:00pm.<br>-There was an entry for lidocaine patch 4% apply once daily, on at 7:00am and remove at 7:00pm.<br>-There was an entry for doxycycline 100mg twice daily for 10 days at 7:00am and 7:00pm.<br>-There was an entry for guaifenesin 100mg/5ml take 10ml 3 times a day for 10 days at 7:00am, 2:00pm, and 7:00pm.<br>-There was an entry for tamsulosin 0.4mg once daily at 7:00am.<br>-There was an entry for duloxetine 20mg 2 capsules daily at 7:00am.<br>-There was an entry for aspirin 81mg once daily at 7:00am.<br>-There was an entry for vitamin B12 once daily at 7:00am.<br>-There was an entry for creave daily moisture lotion once daily at 7:00am.<br>-There was an entry for pantoprazole 40mg once daily at 7:00am.<br>-There was an entry for levothyroxine sodium 100mcg one in the morning at 9:00am.<br>-There was an entry for amoxicillin 875/125mg | D 364                                                                                  |                                                                                                                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 364                                                        | <p>Continued From page 19</p> <p>every 12 hours for 10 days at 9:00am and 9:00pm.</p> <p>Review of Resident #5's June 2026 Medication Administration Compliance report revealed:</p> <ul style="list-style-type: none"> <li>-Resident #5's scheduled 7:00am medications; tamsulosin, duloxetine, aspirin, vitamin B12, artificial tears, creave moisture lotion, amlodipine, sodium chloride, pantoprazole, metformin, magnesium oxide, metoprolol, nystatin cream, docusate sodium, duloxetine, lidocaine patch were documented as administered on 06/08/26 at 8:37am, and on 06/12/26 at 11:16am</li> <li>-Resident #5's scheduled 7:00am medications were administered late 2 out of 24 days.</li> <li>-Resident #5's scheduled 9:00am medications; levothyroxine, and amoxicillin were documented as administered on 06/22/26 at 10:46am, 06/25/26 at 10:54am.</li> <li>-Resident #5's scheduled 9:00am medications were administered late 2 out of 24 days for levothyroxine and 1 out of 10 days for amoxicillin.</li> <li>-Resident #5's scheduled 3:00pm medications; sodium chloride was documented as administered on 06/23/26 at 4:45pm.</li> <li>-Resident #5's scheduled 3:00pm medication was administered late 1 out of 24 days.</li> <li>-Resident #5's scheduled 7:00pm medications; atorvastatin, artificial tears, metformin, magnesium oxide, metoprolol, nystatin cream, melatonin, docusate sodium, lidocaine patch, doxycycline, guaifenesin, sodium chloride were documented as administered on 06/06/26 at 8:18pm, 06/07/26 at 8:49pm, on 06/12/26 at 8:29pm, on 06/23/26 at 8:38pm, 06/30/26 at 8:43pm.</li> <li>-Resident #5's scheduled 7:00pm medications were administered late 5 out of 24 days.</li> <li>-Resident #5's scheduled 9:00pm medications; amoxicillin was documented as administered on</li> </ul> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL023048</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 364                                                        | <p>Continued From page 20</p> <p>06/27/26 at 10:45pm.</p> <p>-Resident #5's scheduled 9:00pm medication was administered late 1 out of 10 days.</p> <p>Review of Resident #5's July 2026 eMAR revealed:</p> <p>-There was an entry for atorvastatin 40mg in the evening at 7:00pm.</p> <p>-There was an entry for artificial tears twice daily at 7:00am and 7:00pm.</p> <p>-There was an entry for sodium chloride 1gm three times a day at 7:00am, 3:00pm, and 7:00pm.</p> <p>-There was an entry for metformin 500mg twice daily at 7:00am and 7:00pm.</p> <p>-There was an entry for magnesium oxide 400mg twice daily at 7:00am and 7:00pm.</p> <p>-There was an entry for metoprolol 25mg twice daily at 7:00am and 7:00pm.</p> <p>-There was an entry for nystatin cream 100,000 three times daily at 7:00am, 2:00pm, and 7:00pm.</p> <p>-There was an entry for melatonin 5mg every evening at 7:00pm.</p> <p>-There was an entry for docusate sodium 100mg twice daily at 7:00am and 7:00pm.</p> <p>-There was an entry for lidocaine patch 4% apply once daily, on at 7:00am and remove at 7:00pm.</p> <p>-There was an entry for tamsulosin 0.4mg once daily at 7:00am.</p> <p>-There was an entry for duloxetine 20mg 2 capsules daily at 7:00am.</p> <p>-There was an entry for aspirin 81mg once daily at 7:00am.</p> <p>-There was an entry for vitamin B12 once daily at 7:00am.</p> <p>-There was an entry for creave daily moisture lotion once daily at 7:00am.</p> <p>-There was an entry for pantoprazole 40mg once daily at 7:00am.</p> <p>-There was an entry for levothyroxine sodium</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 364                                                        | <p>Continued From page 21</p> <p>100mcg one in the morning at 9:00am.<br/>-There was an entry for hydrocodone acetaminophen 5-325mg every 8 hours at 6:00am, 2:00pm, and 10:00pm.<br/>-There was an entry for amoxicillin 875/125mg every 12 hours for 10 days at 9:00am and 9:00pm.</p> <p>Review of Resident #5's July Medication Administration Compliance report revealed:<br/>-Resident #5's scheduled 6:00am medication; hydrocodone acetaminophen was documented as administered on 07/01/26 at 7:13am, 07/06/26 at 7:36am, 07/07/26 at 7:43am, 07/09/26 at 10:50am, and 07/29/26 at 7:22am.<br/>-Resident #5's scheduled 6:00am medications were administered late 5 out of 29 days.<br/>-Resident #5's scheduled 7:00am medications; aspirin, vitamin B12, artificial tears, creave moisture lotion, amlodipine, sodium chloride, pantoprazole, metformin, magnesium oxide, metoprolol, nystatin, docusate, tamsulosin, duloxetine, lidocaine patch, guaifenesin were documented as administered on 07/09/26 at 10:50am.<br/>-Resident #5's scheduled 7:00am medications were administered late 1 out of 29 days.<br/>-Resident #5's scheduled 9:00am medication; levothyroxine was documented as administered on 07/09/26 at 10:50am, 07/23/26 at 7:30am, 07/26/26 at 7:30am.<br/>-Resident #5's scheduled 9:00am medication was administered late 3 out of 29 days.<br/>-Resident #5's scheduled 7:00pm medications; atorvastatin, artificial tears, sodium chloride, metformin, magnesium oxide, metoprolol, nystatin, melatonin, docusate, lidocaine, and guaifenesin were documented as administered on 07/03/26 at 8:27pm, 07/11/26 at 8:21pm.<br/>-Resident #5's scheduled 7:00pm medications</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| D 364                                                        | <p>Continued From page 22</p> <p>were administered late 2 out of 29 days.</p> <p>-Resident #5's scheduled 10:00pm medication; hydrocodone acetaminophen was documented as administered on 07/13/26 at 7:16pm.</p> <p>-Resident #5's scheduled 10:00pm medication was administered early 1 out of 29 days.</p> <p>Interview with Resident #5 on 07/29/26 at 10:22am revealed:</p> <p>-He thought he got all his medications on time.</p> <p>-He had no issues or concerns with his medications.</p> <p>Telephone interview with Resident #5's Nurse Practitioner (NP) on 07/31/26 at 9:09am revealed:</p> <p>-She did not know Resident #5 was receiving medications late.</p> <p>-She did not have any concerns with Resident #5's medications being late if he received them that day.</p> <p>-His blood sugars could be high if he did not take his metformin on time, but that was the only detriment.</p> <p>-She expected medications to be administered within a two-hour time frame either one hour before the scheduled medication time or one hour after the scheduled medication time.</p> <p>Telephone interview with the facility's contracted Pharmacist on 07/31/26 at 12:39pm revealed:</p> <p>-If Resident #5 did not receive his pain medications on time, he may experience more pain.</p> <p>-If Resident #5 did not receive his metformin on time, he could experience higher blood sugars.</p> <p>-If the medications were not missed more than half a day, there was no other detriment.</p> <p>Interview with the medication aide (MA) on 07/31/26 at 2:46pm revealed:</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
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| D 364                                                        | <p>Continued From page 23</p> <p>-She was not sure why Resident #5's medications were documented as late unless she was helping another resident who had fallen or needed incontinent care.</p> <p>-Sometimes Resident #5 was asleep or "groggy" and could not take his medications on time.</p> <p>Attempted telephone interview with a third MA on 07/31/26 at 1:37pm was unsuccessful.</p> <p>Refer to the interview with a MA on 07/30/26 at 12:02pm.</p> <p>Refer to the interview with a second MA on 07/30/26 at 2:31pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 07/31/26 at 1:42pm.</p> <p>Refer to the interview with the Administrator on 07/31/26 at 4:09pm.</p> <p>2. Review of Resident #2's current FL-2 dated 05/04/26 revealed:</p> <p>-Diagnoses included dementia, altered mental status and Alzheimer's disease.</p> <p>-She was semi-ambulatory.</p> <p>-She was constantly disoriented.</p> <p>-Her level of care was Special Care Unit (SCU).</p> <p>Review of Resident #2's Resident Register revealed an admission date of 09/22/23.</p> <p>Review of Resident #2's record revealed he was admitted under Hospice services on 10/11/23.</p> <p>Review of Resident #2's Nurse Practitioner (NP) progress note dated 06/15/26 revealed diagnoses of anxiety, pain, nerve pain and seizure disorder.</p> | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 24</p> <p>Review of Resident #2's signed Physician orders dated 05/27/26 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for oxycodone (to relieve moderate to severe pain) 5mg by mouth every 12 hours.</li> <li>-There was an order for levetiracetam (to treat epilepsy) 750mg by mouth every 12 hours.</li> <li>-There was an order for buspirone (to treat anxiety) 5mg by mouth twice daily.</li> <li>-There was an order for gabapentin (to treat seizures and nerve pain) 100mg, take two capsules by mouth twice daily.</li> <li>-There was an order for senexon-s (to treat constipation) 8.6-50mg by mouth twice daily.</li> <li>-There was an order for Baza protect cream (to treat skin irritation) 12%, apply to buttocks twice daily.</li> <li>-There was an order for mupirocin (to treat skin infections) 2%, apply to skin around toenail once daily.</li> </ul> <p>Review of Resident #2's June 2026 electronic medication administration record (eMAR) revealed there was an entry for mupirocin 2%, apply to skin around toenail once daily.</p> <p>Review of Resident #2's June 2026 Medication Administration Compliance report revealed:</p> <ul style="list-style-type: none"> <li>-Mupirocin was scheduled for 10:00am and was documented as administered on 06/21/26 at 11:23am and on 06/25/26 at 11:49am.</li> <li>-Resident #2's scheduled 10:00am medications were administered late 2 out of 30 opportunities.</li> </ul> <p>Review of Resident #2's July 2026 electronic eMAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for oxycodone 5mg by mouth every 12 hours.</li> <li>-There was an entry for levetiracetam 750mg by mouth every 12 hours.</li> </ul> | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 25</p> <ul style="list-style-type: none"> <li>-There was an entry for buspirone 5mg by mouth twice daily.</li> <li>-There was an entry for gabapentin 100mg, take two capsules by mouth twice daily.</li> <li>-There was an entry for senexon-s 8.6-50mg by mouth twice daily.</li> <li>-There was an entry for Baza protect cream 12%, apply to buttocks twice daily.</li> <li>-There was an entry for mupirocin 2%, apply to skin around toenail once daily.</li> </ul> <p>Review of Resident #2's July 2026 Medication Administration Compliance report revealed:</p> <ul style="list-style-type: none"> <li>-Mupirocin was scheduled for 10:00am and was documented as administered on 07/04/26 at 11:16am, on 07/11/26 at 11:07am, on 07/18/26 at 11:09am and on 07/24/26 at 11:37am.</li> <li>-Resident #2's scheduled 10:00am medications were administered late 4 out of 31 opportunities.</li> <li>-Resident #2's scheduled 8:00pm medications; oxycodone, levetiracetam, buspirone, gabapentin, senexon-s and Baza protect cream were documented as administered on 07/07/26 at 9:25pm, on 07/18/26 at 9:09pm, on 07/20/26 at 9:11pm and on 07/28/26 at 9:31pm.</li> <li>-Resident #2's scheduled 8:00pm medications were administered late 28 out of 372 opportunities.</li> </ul> <p>Interview with a Medication Aide (MA) on 07/30/26 at 2:51pm revealed:</p> <ul style="list-style-type: none"> <li>-The MAs were responsible for administering medications within one hour before to one hour after the scheduled time.</li> <li>-She did not know why medications were administered late to Resident #2 the days she worked.</li> <li>-She never documented why medications were administered late to residents and was not instructed to do so.</li> </ul> | D 364                                                                                  |                                                                                                                          |                                                                |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL023048</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                                       |
| D 364                                                        | <p>Continued From page 26</p> <p>Refer to the interview with a MA on 07/30/26 at 12:02pm.</p> <p>Refer to the interview with a second MA on 07/30/26 at 2:31pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 07/31/26 at 1:42pm.</p> <p>Refer to the interview with the Administrator on 07/31/26 at 4:09pm.</p> <p>3. Review of Resident #3's current FL2 dated 05/18/26 revealed diagnoses included hypertension, chronic kidney disease, diabetes mellitus type II, chronic obstructive pulmonary disease (COPD), vascular dementia and hyperlipidemia.</p> <p>Review of Resident #3's FL2 dated 05/18/26 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for atorvastatin (to treat hyperlipidemia) 40mg daily.</li> <li>-There was an order for aspirin (to treat heart disease) 81mg daily.</li> <li>-There was an order for amlodipine (to treat high blood pressure) 10mg daily.</li> <li>-There was an order for breo (to treat COPD) 100/25mcg, one inhalation daily.</li> <li>-There was an order for bumetanide (to treat excess fluid) 2mg, one tablet twice daily.</li> <li>-There was an order for carvedilol (to treat high blood pressure) 25mg, one tablet twice daily.</li> <li>-There was an order for chlorthalidone (to treat high blood pressure and excess fluid) 25mg daily.</li> <li>-There was an order for clopidogrel (to decrease blood clotting) 75mg daily.</li> <li>-There was an order for donepezil (to treat dementia) 5mg at bedtime.</li> </ul> | D 364                                                                                  |                                                                                                                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
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| D 364                                                        | <p>Continued From page 27</p> <ul style="list-style-type: none"> <li>-There was an order for ferrous gluconate (to treat low iron levels) 324mg daily.</li> <li>-There was an order for fluticasone (to treat allergy symptoms) one spray each nostril twice daily.</li> <li>-There was an order for montelukast (to treat COPD) 10mg daily.</li> <li>-There was an order for multivitamin (vitamin supplement) one tablet daily.</li> <li>-There was an order for olmesartan (to treat high blood pressure) 40mg daily.</li> <li>-There was an order for protonix (to decrease stomach acid) ER (extended release) 40mg daily.</li> <li>-There was an order for sodium bicarbonate (to treat heartburn) 650mg, one tablet twice daily.</li> <li>-There was an order for spironolactone (to treat high blood pressure and excess fluid) 50mg, one tablet twice daily.</li> <li>-There was an order for hydralazine (to treat high blood pressure) 100mg, one tablet three times daily.</li> <li>-There was an order for lantus (to lower blood sugar levels) 100u/ml, 15 units at bedtime.</li> <li>-There was an order for novolog (to lower blood sugar levels) 100u/ml 5 units three times daily.</li> </ul> <p>Review of Resident #3's Physician's order dated 06/08/26 revealed there was an order to discontinue lantus 15 units and to start lantus 30 units daily.</p> <p>Review of Resident #3's Physician's order dated 06/09/26 revealed there was an order to discontinue lantus 30 units and to start lantus 40 units daily.</p> <p>Review of Resident #3's Physician's orders dated 06/29/26 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for atorvastatin 40mg, one tablet at bedtime at 10:00pm.</li> </ul> | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 28</p> <ul style="list-style-type: none"> <li>-There was an order for aspirin 81mg daily at 10:00am.</li> <li>-There was an order for amlodipine 10mg daily at 10:00am.</li> <li>-There was an order for breo 100/25mcg, one inhalation daily at 10:00am.</li> <li>-There was an order for bumetanide 2mg, one tablet twice daily at 10:am and 10:00pm.</li> <li>-There was an order for carvedilol 25mg, one tablet twice daily at 10:00am and 5:00pm.</li> <li>-There was an order for chlorthalidone 25mg daily at 10:00am.</li> <li>-There was an order for clopidogrel 75mg daily at 10:00am.</li> <li>-There was an order for donepezil 5mg daily at 10:00am.</li> <li>-There was an order for ferrous gluconate 324mg daily at 10:00am.</li> <li>-There was an order for fluticasone 50mcg/act one spray each nostril twice daily at 10:00am and 10:00pm.</li> <li>-There was an order for montelukast 10mg daily at 10:00am</li> <li>-There was an order for multivitamin one tablet daily at 10:00am.</li> <li>-There was an order for olmesartan 40mg daily 10:00am.</li> <li>-There was an order for protonix ER 40mg daily at 10:00am.</li> <li>-There was an order for sodium bicarbonate 650mg, one tablet twice daily at 10:00am and 10:00pm.</li> <li>-There was an order for spironolactone 50mg, one tablet twice daily at 10:00am and 10:00pm.</li> <li>-There was an order for hydralazine 100mg, one tablet three times daily at 10:00am, 4:00pm and 10:00pm.</li> <li>-There was an order for lantus 100u/ml, 40 units at bedtime at 10:00pm.</li> <li>-There was an order for novolog 100u/ml 5 units</li> </ul> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 364                                                        | <p>Continued From page 29</p> <p>three times daily at 8:00am, 2:00pm and 8:00pm.<br/>-There was an order for ondansetron 4mg one tablet every morning at 8:00am.</p> <p>Review of Resident #3's June 2026 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for atorvastatin 40mg, one tablet at bedtime at 8:00pm from 06/01/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.</p> <p>-There was an entry for aspirin 81mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.</p> <p>-There was an entry for amlodipine 10mg daily 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.</p> <p>-There was an entry for breo 100/25mcg, one inhalation daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.</p> <p>-There was an entry for bumetanide 2mg, one tablet twice daily at 8:00am from 06/01/26 to 06/20/26, at 10:00am from 06/21/26 to 06/30/26, at 8:00pm from 06/01/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.</p> <p>-There was an entry for carvedilol 25mg, one tablet twice daily at 8:00am from 06/01/26 to 06/20/26, at 10:00am from 06/21/26 to 06/30/26 and at 5:00pm from 06/01/26 to 06/30/26.</p> <p>-There was an entry for chlorthalidone 25mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.</p> <p>-There was an entry for clopidogrel 75mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.</p> <p>-There was an entry for donepezil 5mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.</p> <p>-There was an entry for ferrous gluconate 324mg</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL023048</b>          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
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| D 364                                                        | Continued From page 30<br><br>daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.<br>-There was an entry for fluticasone 50mcg/act one spray each nostril twice daily at 8:00am from 06/01/26 to 06/20/26, at 10:00am from 06/21/26 to 06/30/26, at 8:00pm from 06/01/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.<br>-There was an entry for montelukast 10mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.<br>-There was an entry for multivitamin one tablet daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.<br>-There was an entry for olmesartan 40mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.<br>-There was an entry for protonix ER 40mg daily at 8:00am from 06/01/26 to 06/20/26 and at 10:00am from 06/21/26 to 06/30/26.<br>-There was an entry for sodium bicarbonate 650mg, one tablet twice daily at 8:00am from 06/01/26 to 06/20/26, at 10:00am from 06/21/26 to 06/30/26, at 8:00pm from 06/01/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.<br>-There was an entry for spironolactone 50mg, one tablet twice daily at 8:00am from 06/01/26 to 06/20/26, at 10:00am from 06/21/26 to 06/30/26, at 8:00pm from 06/01/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.<br>-There was an entry for hydralazine 100mg, one tablet three times daily at 8:00am from 06/01/26 to 06/20/26, at 10:00am from 06/21/26 to 06/30/26, at 2:00pm from 06/01/26 to 06/20/26, at 4:00pm from 06/21/26 to 06/30/26, at 8:00pm from 06/01/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.<br>-There was an entry for lantus 100u/ml, 15 units at bedtime at 9:00pm from 06/01/26 to 06/07/26.<br>-There was an entry for lantus 100u/ml, 30 units at bedtime at 8:00pm from 06/08/26 to 06/09/26. | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 31</p> <p>-There was an entry for lantus 100u/ml, 40 units at bedtime at 8:00pm from 06/10/26 to 06/20/26 and at 10:00pm from 06/21/26 to 06/30/26.</p> <p>-There was an entry for novolog 100u/ml 5 units three times daily at 7:00am from 06/01/26 to 06/21/26, at 8:00am from 06/22/26 to 06/30/26, at 12:00pm from 06/01/26 to 06/20/26, at 2:00pm from 06/21/26 to 06/30/26, at 5:00pm from 06/01/26 to 06/20/26 and at 8:00pm from 06/21/26 to 06/30/26.</p> <p>-There was an entry for ondansetron 4mg one tablet every morning at 8:00am from 06/18/26 to 06/30/26.</p> <p>Review of Resident #3's June 2026 Medication Administration Compliance report revealed:</p> <p>-Resident #3's scheduled 7:00am medication novolog was documented as administered on 06/09/26 at 8:09am, 06/12/26 at 9:49am, and 06/17/26 at 8:32am.</p> <p>-Resident #3's scheduled 8:00am medications; amlodipine, aspirin, breo, bumetanide, carvedilol, chlorthalidone, clopidogrel, donepezil, ferrous gluconate, fluticasone, montelukast, multivitamin, olmesartan, pantoprazole, sodium bicarbonate, spironolactone, and hydralazine were documented as administered on 06/08/26 at 9:23am, 06/09/26 at 9:08am, 06/12/26 at 9:49am, and 06/19/26 at 9:21am.</p> <p>-Resident #3's scheduled 8:00am medications; novolog and ondansetron were documented as administered on 06/25/26 at 10:19am and 06/29/26 at 9:13am.</p> <p>-Resident #3's schedule 2:00pm medication novolog was documented as administered on 06/24/26 at 3:24pm and on 06/29/26 at 3:19pm.</p> <p>-Resident #3's scheduled 4:00pm medication hydralazine was documented as administered on 06/26/26 at 5:32pm and 06/29/26 at 5:07pm.</p> <p>-Resident #3's scheduled 8:00pm medications;</p> | D 364                                                                                  |                                                                                                                          |                                                                |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL023048</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R-C<br/>07/31/2026</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                |
| D 364                                                        | <p>Continued From page 32</p> <p>atorvastatin, bumetanide, fluticasone, sodium bicarbonate, spironolactone, hydralazine and lantus were documented as administered on 06/08/26 at 9:11pm, 06/12/26 at 10:24pm, 06/15/26 at 9:17pm and 06/18/26 at 9:06pm.</p> <p>-Resident #3's schedule scheduled 7:00am medications were administered late 3 out of 24 days.</p> <p>-Resident #3's schedule scheduled 8:00am medications were administered late 6 out of 24 days.</p> <p>-Resident #3's schedule scheduled 2:00pm medications were administered late 2 out of 24 days.</p> <p>-Resident #3's schedule scheduled 4:00pm medications were administered late 2 out of 24 days.</p> <p>-Resident #3's schedule scheduled 8:00pm medications were administered late 4 out of 24 days.</p> <p>Review of Resident #3's July 2026 eMAR revealed:</p> <p>-There was an entry for lantus 100u/ml, 40 units at bedtime at 10:00pm.</p> <p>-There was an entry for novolog 100u/ml 5 units three times daily at 8:00am, 2:00pm and at 8:00pm.</p> <p>-There was an entry for ondansetron 4mg one tablet every morning at 8:00am.</p> <p>Review of Resident #3's July 2026 Medication Administration Compliance report revealed:</p> <p>-Resident #3's scheduled 8:00am medication novolog was documented as administered on 07/18/26 at 10:39am and 07/26/26 at 9:12am.</p> <p>-Resident #3's scheduled 8:00am medication ondansetron was documented as administered on 07/18/26 at 10:39am and on 07/23/26 at 9:51am.</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b> |                                                                                                                          |                                                                |
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| D 364                                                        | <p>Continued From page 33</p> <p>-Resident #3's schedule scheduled 8:00am medications were administered late 3 out of 20 days.</p> <p>Telephone interview with Resident #3's Nurse Practitioner (NP) on 07/31/26 at 9:09am revealed:</p> <p>-She did not know Resident #3 was receiving medications late.</p> <p>-She did not have any concerns with Resident #3's medications being late.</p> <p>-She expected medications to be administered within a two-hour time frame either one hour before the scheduled medication time or one hour after the scheduled medication time.</p> <p>Refer to the interview with a MA on 07/30/26 at 12:02pm.</p> <p>Refer to the interview with a second MA on 07/30/26 at 2:31pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 07/31/26 at 1:42pm.</p> <p>Refer to the interview with the Administrator on 07/31/26 at 4:09pm.</p> <p>4. Review of Resident #1's current FL2 dated 04/29/26 revealed diagnoses included hypertension, dementia, lipids, depression, Parkinson's, and hypothyroid.</p> <p>Review of Resident #1's Physician's orders dated 05/22/26 revealed:</p> <p>-There was an order for carbidopa-levodopa (to treat tremors) 25/100mg twice daily at 8:00am and 8:00pm.</p> <p>-There was an order for donepezil (to treat memory) 10mg once daily at 8:00pm.</p> <p>-There was an order for fluoxetine (to treat</p> | D 364                                                                                  |                                                                                                                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 364                                                        | <p>Continued From page 34</p> <p>depression) HCL 20mg once daily at 8:00am.<br/>-There was an order for levothyroxine (to treat thyroid) 25mcg once daily at 8:00am.<br/>-There was an order for memantine (to treat memory) ER 28mg 24hr once daily at 8:00am<br/>-There was an order for multivitamin (supplement) once daily at 9:00am.<br/>-There was an order for quetiapine (to treat behaviors) 25mg three times a day at 9:00am, 2:00pm, and 9:00pm.<br/>-There was an order for rosuvastatin (to treat cholesterol) 10mg once daily at 8:00am.<br/>-There was an order for compression socks (to treat edema) apply every morning and remove at bedtime at 8:00 am and 8:00 pm.<br/>-There was an order for torsemide (to treat edema) 20mg once daily at 9:00 am.<br/>-There was an order for vitamin D3 2000 IU once daily at 9:00am.</p> <p>Review of Resident #1's June 2026 and July 2026 electronic medication administration record (eMAR) revealed:<br/>-There was an entry for carbidopa-levodopa 25/100mg twice daily at 8:00am and 8:00pm.<br/>-There was an entry for donepezil 10mg once daily at 8:00pm.<br/>-There was an entry for fluoxetine HCL 20mg once daily at 8:00am.<br/>-There was an entry for levothyroxine 25mcg once daily at 8:00am.<br/>-There was an entry for memantine ER 28mg 24hr once daily at 8:00am<br/>-There was an entry for multivitamin once daily at 9:00am.<br/>-There was an entry for quetiapine 25mg three times a day at 9:00am, 2:00pm, and 9:00pm.<br/>-There was an entry for rosuvastatin 10mg once daily at 8:00am.<br/>-There was an entry for compression socks apply</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 364                                                        | <p>Continued From page 35</p> <p>every morning and remove at bedtime most days.<br/>-There were days Resident #1 refused her compression socks.<br/>-There was an entry for torsemide 20mg once daily at 9:00 am.<br/>-There was an entry for vitamin D3 2000 lu (50mcg) once daily at 9:00am.</p> <p>Review of #1's June 2026 and July 2026 Medication Administration Compliance report revealed:<br/>-Resident #1's scheduled 7:00pm medication donepezil, 8:00pm medications carbidopa-levodopa and compression socks were documented as administered on 06/12/26 at 11:55pm<br/>-Resident #1's scheduled 9:00pm medication quetiapine was documented as administered on 07/18/26 at 11:20pm.<br/>-Resident #1's scheduled 8:00am medications carbidopa-levodopa, rosuvastatin, torsemide, fluoxetine, levothyroxine, and memantine was documented as administered on 07/23/26 at 10:06am.<br/>-Resident #1's scheduled 8:00am medications carbidopa-levodopa, rosuvastatin, torsemide, fluoxetine, levothyroxine, and memantine was documented as administered on 07/24/26 at 10:44am. Scheduled 9:00am medications quetiapine, vitamin D3 2000, and multivitamin tab were documented as administered on 07/24/26 at 10:44am.<br/>-Resident #1's scheduled 8:00am medications were administered late 2 out of 29 days, 9:00am medications were administered late 1 out of 29 days, 7:00pm medication was administered late 1 out of 30 days, two 8:00pm medications were administered late 1 out of 30 days, and one 9:00pm medication was administered late 1 out of 30 days and 1 out of 29 days.</p> | D 364                                                                         |                                                                                                                          |                          |                                                                |

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| D 364                                                        | <p>Continued From page 36</p> <p>Telephone interview with Resident #1's physician on 07/31/26 at 9:10am revealed:<br/>-She did not know Resident #1 received his scheduled 8:00am, 9:00am, 7:00pm, and 9:00pm medications late.<br/>-She expects the facility to give medications at scheduled times, but understands situations happen.<br/>-There was no detriment to resident when medications were administered two hours later.</p> <p>Refer to the interview with a MA on 07/30/26 at 12:02pm.</p> <p>Refer to the interview with a second MA on 07/30/26 at 2:31pm.</p> <p>Refer to the interview with the Resident Care Coordinator (RCC) on 07/31/26 at 1:42pm.</p> <p>Refer to the interview with the Administrator on 07/31/26 at 4:09pm.</p> <p>Interview with a MA on 07/30/26 at 12:02pm revealed:<br/>-Medication administration could be late due to helping other residents when they fall or assisting the personal care aide (PCA) with incontinent care.<br/>-She did not know why medications were administered sometimes a few hours late.<br/>-She felt she had enough time to pass the medications within the one hour before and one hour after the scheduled time unless something else was going on in the facility that required her attention.<br/>-When medications were late, she did not document it anywhere because she had never been told to document when medications were</p> | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 37</p> <p>late, but she would tell the resident care coordinator (RCC).</p> <p>-She thought the RCC did audits sometimes because she had asked her about late medications in the past if she forgot to tell her about it.</p> <p>-The RCC would help if she ever needed her to.</p> <p>-She did not always ask for help because sometimes management were in meetings and she did not want to bother anyone.</p> <p>-She tried to start her morning medication pass at 6:15am.</p> <p>Interview with a second MA on 07/30/26 at 2:31pm revealed:</p> <p>-Medication administration could be late due to power outages, system going down, or helping other residents with incontinent care, activities of daily living, or meals.</p> <p>-She never asked for any help with medication passes.</p> <p>-The special care coordinator (SCC), RCC, and Administrator helped when needed.</p> <p>-She did document when her medications were late and gave the documentation to the SCC.</p> <p>Interview with the RCC on 07/31/26 at 1:32pm revealed:</p> <p>-She trained MAs on medication administration.</p> <p>-If MAs got behind with medication administration, they had been instructed to ask her for help.</p> <p>-Medications should be administered within a two-hour time frame either one hour before the scheduled medication time or one hour after the scheduled medication time.</p> <p>-She expected MAs to document refusals or late medication administration, but she did not think MAs were documenting.</p> <p>-The MAs should document late medications on the 24-hour reports.</p> | D 364                                                                                  |                                                                                                                          |                                                                |

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| D 364                                                        | <p>Continued From page 38</p> <ul style="list-style-type: none"> <li>-She was not sure why medications were late other than MAs could get pulled to help the PCA with a resident to provide care or the internet may go down.</li> <li>-She expected morning medication administration to start at 6:00am and night medication administration to start at 6:00pm.</li> <li>-She had been doing weekly medication audits, but she did not know how to print the medication administration compliance reports.</li> </ul> <p>Interview with the Administrator on 07/31/26 at 4:09pm revealed:</p> <ul style="list-style-type: none"> <li>- She expected medications to be administered within a two-hour time frame either one hour before the scheduled medication time or one hour after the scheduled medication time.</li> <li>-Sometimes medications were administered late due to circumstances happening in the facility.</li> <li>-The MAs were to document in the resident's staff progress notes the reason medications were administered late.</li> <li>-The MAs were trained to look at the eMAR and make sure everything matched up before administering medications.</li> <li>-After the medications were dispensed, MAs checked a box and it would time stamp when medications were given.</li> <li>-She thought medications were sometimes late due to the internet going out.</li> <li>-She did not know medications were administered late.</li> <li>-She expected late medications to be documented, but she did not think they were documenting like they were supposed to.</li> <li>-She, the RCC, and the Nurse audited medication administration weekly and looked at the medication variance sheets.</li> </ul> | D 364                                                                         |                                                                                                                          |  |                                                                |

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>TERRABELLA SHELBY</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1550 CHARLES ROAD<br/>SHELBY, NC 28152</b>                                   |                          |                                                                |
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| D 482                                                        | Continued From page 39                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | D 482                                                                         |                                                                                                                          |                          |                                                                |
| D 482                                                        | <p>10A NCAC 13F .1501 (a) Use Of Physical Restraints And Alternatives</p> <p>10A NCAC 13F .1501Use Of Physical Restraints And Alternatives</p> <p>(a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and that restricts freedom of movement or normal access to one's body, shall be:</p> <p>(1) used only in those circumstances in which the resident has medical symptoms for which the resident's physician or physician extender has determined warrant the use of restraints and not for discipline or convenience purposes;</p> <p>(2) used only with a written order from a physician or physician extender except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule;</p> <p>(3) the least restrictive restraint that would provide a safe environment for the resident and prevent physical injury;</p> <p>(4) used only after alternatives that would provide a safe environment for the resident to prevent physical injury and prevent a potential decline in the resident's functioning have been tried and documented by the administrator or their designee in the resident's record as being unsuccessful;</p> <p>(5) used only after an assessment and care planning process has been completed, except in emergencies where the health or safety of the resident is threatened, according to Paragraph (d) of this Rule;</p> <p>(6) applied correctly according to the manufacturer's instructions and the physician's or</p> | D 482                                                                         |                                                                                                                          |                          |                                                                |

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| D 482                                                        | <p>Continued From page 40</p> <p>the physician extenders' order; and<br/>(7) used in conjunction with alternatives in an effort to reduce restraint use. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.</p> <p>This Rule is not met as evidenced by:<br/>Based on observations, interviews, and record reviews, the facility failed to ensure physical restraints were used only after completing the assessment and care planning process, the use of less restrictive alternatives, and a physician's order for 1 of 1 sampled residents (#2) who had a lap tray secured on the resident's Geri-chair.</p> <p>The findings are:</p> <p>Review of the facility's Restraints policy dated 06/11/24 revealed:<br/>-Resident will be free from any physical obstruction of movement, including but not limited</p> | D 482                                                                                  |                                                                                                                          |                                                                |

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| D 482                                                        | <p>Continued From page 41</p> <p>to; restricting the use of hands and/or feet, blocking a resident's pathway, restricting a resident from the freedom to wander or getting out of bed or chair, locking a resident in their room/apartment or restraining or blocking a resident in a sitting or lying position.</p> <p>-Restraints will not be used for discipline of any kind for any resident.</p> <p>-Restraints will not be used for convenience of the community or staff at any time.</p> <p>-Any observation of above by a staff member will be reported to their supervisor.</p> <p>-The use of any restraint requires a physician order; all orders for restraint use will be reviewed by the Executive Director and Director of Health and Wellness (HWD) per state regulations, the Executive Director must approve any use of restraints, and the resident's physician will be notified within twenty-four hours.</p> <p>-The HWD is responsible for ensuring compliance with state regulations for restraint use including but not limited to staff training, documentation, resident assessment and resident care planning.</p> <p>Review of Resident #2's current FL-2 dated 05/04/26 revealed:</p> <p>-Diagnoses included dementia, altered mental status and Alzheimer's disease.</p> <p>-She was semi-ambulatory.</p> <p>-She was constantly disoriented.</p> <p>-Her level of care was Special Care Unit (SCU).</p> <p>Review of Resident #2's Resident Register revealed an admission date of 09/22/23.</p> <p>Review of Resident #2's record revealed she was admitted under Hospice services on 10/11/23.</p> <p>Review of Resident #2's care plan dated 05/22/26</p> | D 482                                                                                  |                                                                                                                          |                                                                |

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| D 482                                                        | <p>Continued From page 42</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-She required two-person assistance for bathing, dressing, transferring, and toileting.</li> <li>-She required one-person assistance for eating and grooming.</li> <li>-She was dependent on staff for mobility.</li> </ul> <p>Observation of Resident #2 on 07/29/26 at 9:59am revealed upon entering the SCU, Resident #2 was slightly reclined in a Geri-chair, laying partially on her right side with a lap tray secured onto the Geri-chair.</p> <p>Observation of Resident #2 on 07/30/26 at 8:20am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had the lap tray attached to her Geri chair.</li> <li>-Resident #2 was sitting at the dining room table in her Geri chair while staff were feeding her.</li> </ul> <p>Review of Resident #2's signed Physician order dated 05/18/26 revealed an order for a Geri-chair due to the resident having a hard time sitting up, sliding out of chairs and falls.</p> <p>Interview with Resident #2's Hospice Registered Nurse on 07/29/26 at 11:01am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 had received a Geri-chair due to her not being able to sit up in her wheelchair without sliding out of it.</li> <li>-She had seen staff use the lap tray at mealtimes.</li> <li>-She had seen Resident #2 sit at the table for meals without the lap tray.</li> <li>-Resident #2 did not need the lap tray.</li> </ul> <p>Telephone interview with Resident #2's Nurse Practitioner (NP) on 07/29/26 at 2:40pm revealed:</p> <ul style="list-style-type: none"> <li>-She had ordered Resident #2 a Geri-chair due to the resident sliding out of her wheelchair.</li> <li>-All Geri-chairs came with a lap tray.</li> </ul> | D 482                                                                                  |                                                                                                                          |                                                                |

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| D 482                                                        | <p>Continued From page 43</p> <p>-She did not know staff had been placing the lap tray on Resident #2 Geri-chair at mealtimes.<br/>-She did not give an order for staff to use a lap tray.</p> <p>Telephone interview with Resident #2's Power of Attorney (POA) on 07/29/26 at 3:23pm revealed:<br/>-She had not seen Resident #2 with the lap tray on her Geri chair.<br/>-She did visit frequently and usually stayed to feed the resident a meal.<br/>-Staff had asked if the POA wanted the lap tray placed on Resident #2's Geri chair when she was feeding the resident, but she always said no.<br/>-She did not feel Resident #2 needed a lap tray but was okay with it being used if the staff wanted it.<br/>-She was never asked to give consent for the use of the lap tray.</p> <p>Interview with a personal care aide (PCA) on 07/29/26 at 2:35pm revealed:<br/>-Staff placed the lap tray on Resident #2's Geri chair only at mealtimes.<br/>-Resident #2 could not remove the lap tray.<br/>-Resident #2 was able to sit at the dining room table in her Geri chair.</p> <p>Interview with the Administrator on 07/31/26 at 4:19pm revealed:<br/>-She did not know staff were using the lap tray at mealtimes for Resident #2 until Wednesday (07/29/26) when the surveyor brought it to her attention.<br/>-Staff were not instructed to use the lap tray.<br/>-Staff did not know a lap tray was considered a restraint.</p> | D 482                                                                                  |                                                                                                                          |                                                                |