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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 03/05/25 through 03/07/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the health care need of 1 of 5 sampled residents (#2) related to a delay in scheduling an appointment for a colonoscopy as ordered by the resident's primary care provider (PCP). The findings are: Review of Resident #2's current FL-2 dated 01/06/25 revealed: -Diagnoses included type 2 diabetes, below knee amputation of both legs, peripheral vascular disease, and hypertension. -The resident's recommended level of care was assisted living (AL). -The resident was non ambulatory. -The resident was continent of urine and bowel. -The resident required personal assistance with bathing and dressing. Review of Resident #2's Resident Register revealed he was admitted to the facility on 01/28/23. Review of Resident #2's Care Plan dated	D 273		

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01/25/25 revealed:
-The resident was oriented, and his memory was adequate.
-The resident was a double amputee and self-propelled himself in a wheelchair.
-He required limited assistance with bathing.

Review of a signed physician order for Resident #2 dated 01/21/25 revealed an order for a repeat colonoscopy next month (February 2025) due to a history of colonic polyps as requested by the resident's gastroenterologist (Colonic polyps are abnormal growth that form on the inner lining of the colon or rectum that can be benign or become precancerous or cancerous).

Review of a facility progress note dated 01/22/25 revealed the facility received an order from Resident #2's PCP for an outside specialist.

Review of a colonoscopy report for Resident #2 dated 02/06/24 revealed:
-Resident #2 was referred by his PCP for a screening colonoscopy for colon cancer prevention and for worsening diarrhea.
-The resident had no history of rectal bleeding.
-The resident had a 25 millimeter (mm) polyp removed that was benign in appearance.
-The resident had four polyps between 8mm to 10mm removed that were benign in appearance.
-The resident had diverticulosis of the left side of the colon.
-The resident had internal hemorrhoids.
-The plan for Resident #2 was that he return for a repeat colonoscopy in one year.

Interview with Resident #2 on 03/06/25 at 12:40pm revealed:
-He knew his doctor wanted him to have a colonoscopy in about a year after his last

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screening.
-He was not sure why he had not gone back for a colonoscopy yet.
-He experienced diarrhea occasionally and did not have any rectal bleeding.

Interview with the Administrator on 03/06/25 at 10:39am revealed the Transportation Coordinator was currently on the telephone to schedule the resident's colonoscopy.

Interview with the Transportation Coordinator on 03/06/25 at 10:43am revealed:
-She had misunderstood the PCP order and thought the PCP had made a mistake ordering the appointment because the resident had a colonoscopy appointment last year.
-She had just scheduled the resident's colonoscopy appointment today and it was scheduled for 03/12/25.

Interview with an Administrative Assistant who was also a medication aide (MA) on 03/07/25 at 2:04pm revealed:
-When the PCP ordered a referral for a resident, she reviewed the referral and usually gave the Transportation Coordinator the information so she could schedule the appointment for the resident.
-If needed she contacted the PCP for additional information about the referral.
-She realized at the end of last week and at the beginning of this week, that an appointment had not been made for Resident #2's colonoscopy.
-She contacted the PCP today (03/07/25) to request clarification of the referral for Resident #2 for a colonoscopy.
-The PCP still wanted the resident to have a colonoscopy.
-She informed the Transportation Coordinator to proceed with scheduling an appointment for

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D 273	Continued From page 3 Resident #2 to have a colonoscopy. -She was not sure how she and the Transportation Coordinator had missed scheduling the resident's appointment for a colonoscopy. -She and the Transportation Coordinator should have scheduled the resident's appointment within a day or two of receiving the PCP order for the appointment. Interview with the Administrator on 03/07/25 at 2:48pm revealed: -The Transportation Coordinator usually scheduled appointments for residents when the PCP made a referral. -There were times when the facility was unable to get an appointment quickly due to a provider's limited availability. -The Transportation Coordinator scheduled Resident #2's appointment for a consultation regarding a colonoscopy yesterday (03/06/25) for 03/12/25. -Sometimes there was a delay in scheduling resident's appointments due to a lack of information provided by the PCP, such as the procedure code. -It was an oversight by the Transportation Coordinator and the Administrative Assistant/MA that Resident #2's appointment for a colonoscopy was delayed. Attempted telephone interview with Resident #2's PCP on 03/06/25 at 2:16pm and on 03/07/25 at 12:07pm and 2:19pm were unsuccessful.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the	D 276		

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following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on interviews, and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#3) related blood pressure and pulse with parameters that was ordered to be checked daily was completed.

The findings are:

Review of Resident #3's current FL-2 dated 08/30/24 revealed:
-Diagnoses included hypertension and chronic daily headaches.
-There was an order to monitor Resident #3's blood pressure monthly.

Review of Resident #3's physician's order dated 11/08/24 revealed blood pressure and pulse was to be taken daily and to call the doctor for systolic blood pressure greater than 150 and pulse less than 60.

Review of Resident #3's electronic medication administration record (eMAR) for January 2025 revealed:
-There was an electronic entry for blood pressure and pulse to be checked daily with parameters to notify the physician if the systolic blood pressure was over 150 and pulse was less than 60.
-The monitoring was scheduled for 9:00am.
-There was documentation from 01/01/25 through 01/31/25 that blood pressure and pulse were

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taken.
-There were no values documented for blood pressure and pulse.

Review of Resident #3's eMAR for February 2025 revealed:
-There was an electronic entry for blood pressure and pulse to be checked daily with parameters to notify the physician if the systolic blood pressure was over 150 and pulse was less than 60.
-The monitoring was scheduled for 9:00am.
-There was documentation from 02/01/25 through 02/28/25 that blood pressure and pulse were taken.
-There were no values documented for blood pressure and pulse.

Review of Resident #3's eMAR for February 2025 revealed:
-There was an electronic entry for blood pressure and pulse to be checked daily with parameters to notify the physician if the systolic blood pressure was over 150 and pulse was less than 60.
-The monitoring was scheduled for 9:00am.
-There was documentation from 03/01/25 through 03/05/25 that blood pressure and pulse were taken.
-There were no values documented for blood pressure and pulse.

Interview with Resident #3 on 03/07/25 at 2:15pm revealed:
-Staff did not check her pulse and blood pressure every day.
-Staff used to check her pulse and blood pressure daily but that stopped when she changed to a different primary care provider (PCP) in December 2024.

Interview with the Resident Care Coordinator

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(RCC) on 03/06/25 at 12:36pm revealed:
-She took the blood pressure and pulse for the facility's contracted provider daily, 5 days a week.
-Resident #3 was seen by the facility's contracted provider and had daily blood pressure and pulse checks ordered but the daily checks were stopped when she changed providers in December 2024.
-The medication aides (MAs) were responsible for obtaining the blood pressure and pulse if the daily blood pressure and pulse checks were on the eMAR.

Interview with a medication aide (MA) on 03/06/25 at 1:20pm revealed:
- MAs were responsible for obtaining the pulse and blood pressure check when they were alerted by the eMAR at the scheduled time.
-The blood pressure and pulse should be documented in the notes section of the eMAR but there were no notes entered for Resident #3.
-She would document vital signs in a notebook and in the notes on the computer when she worked.

Interview with a second MA on 03/07/25 at 12:17pm revealed:
-MAs were responsible for obtaining blood pressure and pulse when they were alerted to do so on the eMAR.
-MAs had to document their initials, whether the vital signs were obtained or not, to be able to move on with medications.
-Resident #3 did not have to have daily blood pressure and pulse taken since she changed providers.

Interview with the Administrator on 03/07/25 at 2:48pm revealed:
-MAs were responsible for obtaining blood

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D 276	Continued From page 7 pressure and pulse as they were ordered. -MAs were expected to document the blood pressure and pulse reading in the notes section of the eMAR if there was no place provided on the eMAR. -There were no vital signs documented in the notes and there was no order to discontinue daily blood pressure and pulse checks for Resident #3. -She thought Resident #3's order for daily blood pressure and pulse with the parameters changed because the ordering provider was no longer her PCP. Attempted telephone interview with Resident #3's PCP on 03/06/25 at 2:07pm and on 03/07/25 at 9:13am was unsuccessful.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions.	D 283		

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This Rule is not met as evidenced by:
Based on observations interviews, and record reviews, the facility failed to ensure foods were stored in a sanitary manner and free from contamination related to stored meat loaf on the same shelf as produce and cartons of liquid eggs that had expired.

The findings are:

Review of the Food Establishment Inspection Report dated 10/22/24 revealed:
-There was a total score of 99.
-There was 1 point assessed for the area of maintaining a plumbing system in good repair, a slow drain was observed in the hand sink and unsealed wood holding up wastewater line for a three compartment sink near the ice machine.

Review of the facility's undated food safety policy revealed:
-Raw meat can contain harmful bacteria.
-The best way to thaw raw meat is in the refrigerator, with the thawing meat placed in a pan on the bottom of the refrigerator.
-Storing raw meat in a pan at the bottom of the refrigerator ensures that raw meat does not drip onto other items in the refrigerator and contaminate those items.

Observation of the facility's kitchen on 03/05/25 at 9:08am revealed:
-There were three storage areas in a refrigerator, with the top two areas having a shelf and the bottom of the refrigerator.
-There were two 48-ounce tubes of packaged ground beef in a plastic bin which was on top of a box of cucumbers.

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D 283	Continued From page 9 -There were 7 cucumbers in the case below the plastic bin with the stored tubes of packaged ground beef. -There were two unpackaged heads of lettuce at the back of the plastic bin with the stored tubes of packaged ground beef. -There were six heads of lettuce in a manufactures plastic package that were behind the plastic bin of stored meatloaf. Observation of the facility's kitchen on 03/05/25 at 9:12am revealed there were five unopened 32 ounce cartons of liquid egg yolks with a use by date of 02/03/25 on the second shelf of the refrigerator. Interview with a server on 03/05/25 at 9:14am revealed: -She thought the meatloaf would not contaminate the cucumbers and lettuce because it was in a plastic bin. -She was not aware who placed the meatloaf in the plastic bin in the refrigerator. -She was not aware that the five cartons of liquid egg yolk had expired. -She and dietary staff were responsible for disposing of any expired items daily and ensuring foods were stored properly to avoid contamination. Interview with the Dietary Manager (DM) on 03/06/25 at 7:30am revealed: -Staff knew they should not store raw meat anywhere except the bottom of the refrigerator. -There was a sign with pictures posted on each refrigerator and freezer that explained how foods should be stored. -He was not sure which dietary staff member placed the raw meatloaf on the shelf with cucumbers and lettuce.	D 283		

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D 283	Continued From page 10 -Staff were trained to store items properly and to discard items that had expired. Interview with the Administrator on 03/07/25 at 2:48pm revealed: -Dietary staff were trained on how to store raw meats to prevent contamination of other foods and the importance of disposing of items that had expired. -Dietary staff should have stored the tubes of packaged ground beef on the bottom shelf of the refrigerator and discarded the expired egg yolk cartons.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve a therapeutic diet as ordered by the primary care provider (PCP) for 1 of 5 sampled residents (#3) with a ground meat therapeutic diet ordered. The findings are: Review of the facility's undated therapeutic diet policy revealed: -Therapeutic diet menus are designed and written by registered dietitians. -The dieticians have written these menus to ensure that meals meet guidelines for treating	D 310		

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certain medical conditions and that they are nutritious, palatable, and provide a balance of different foods that will be tolerated by the resident.
-It is very important that staff follow menus in preparing special diets.
Following the menu helps to ensure that what is served to the resident is appropriate for the resident's medical condition and that tit will be tolerated by the resident.
-Mechanical soft diets are used for residents who have problems chewing food.
-Mechanical soft diets are typically chopped or ground.

Review of Resident #3's current FL-2 dated 08/30/24 revealed:
-Diagnoses included hypertension and chronic daily headaches.
-The resident was ordered a regular diet.

Review of Resident #3's diet order dated 10/17/24 revealed the resident was ordered a regular diet with ground meats.

Observation of the lunch meal service on 03/05/25 at 11:30am revealed:
-Resident #3 was served a ham and cheese sandwich, green beans, peaches, pudding, tea, water, and milk.
-The ham on the sandwich was not chopped.

Interview with the Dietary Manager (DM) on 03/05/25 at 11:33am revealed:
-The resident was on a ground meat diet.
-The resident's ham on her sandwich should have been ground.
-It was an oversight that the resident's ham was not ground.

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D 310	Continued From page 12 Interview with Resident #3 on 03/05/25 at 11:40am revealed: -She had not experienced any choking episodes. -She was able to eat the ham and cheese sandwich without any swallowing difficulties. Interview with the Administrator on 03/07/25 at 2:48pm revealed: -Dietary staff were expected to serve residents the correct therapeutic diet. -There was a therapeutic diet list posted in the kitchen above the area the staff prepared resident's meals, and there was no excuse for staff not following the resident's therapeutic menu correctly. -Resident #3 had requested that she be served ground meats because it took her a long time to chew meats. -The resident's PCP wrote an order to change her diet to regular with ground meats on 10/17/24. Attempted telephone interview with Resident #3's PCP on 03/06/25 at 2:07pm and on 03/07/25 at 9:13am was unsuccessful.	D 310		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.	D 344		

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D 344	Continued From page 13 The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#4) for blood pressure checks. The findings are: Review of Resident #4's current FL-2 dated 01/03/25 revealed: -Diagnoses included hypertension, diabetes, shortness of breath with exasperation, multiple sclerosis, and dysmetabolic syndrome (Dysmetabolic Syndrome is a metabolic syndrome that is a cluster of conditions that can increase the risk of developing heart disease and stoke). -There was an order to check the resident's blood pressure daily and to notify the primary care provider (PCP) if her systolic blood pressure reading was greater than 160 or diastolic blood pressure reading was greater than 90 (Systolic blood pressure measures the pressure your blood is pushing against your artery walls when the heart beats, and diastolic blood pressure measures the pressure your blood is pushing against your artery walls while the heart muscle rests between beats). Review of a physician order for Resident #4 dated 01/16/25 revealed there was an order to check the resident's blood pressure daily as needed and to notify the PCP if her systolic blood pressure was greater than 160 or her diastolic blood pressure was greater than 90.	D 344		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 14 Review of Resident #4's electronic medication administration record (eMAR) for January 2025 revealed: -There was an electronic entry for blood pressure to be checked daily and to notify the PCP for systolic blood pressure was greater than 160 and diastolic blood pressure was greater than 90. -There were no entries for blood pressure checks on the January 2025 eMAR. Review of Resident #4's eMAR for February 2025 revealed: -There was an electronic entry for blood pressure to be checked as needed for signs and symptoms of high or low blood pressure and to notify the PCP if systolic blood pressure was greater than 160 and diastolic blood pressure was great than 60. -There were no entries for blood pressure checks on the February 2025 eMAR. Review of Resident #4's eMAR for March 2025 revealed: -There was an electronic entry for blood pressure to be checked as needed for signs and symptoms of high or low blood pressure and to notify the PCP if systolic blood pressure was greater than 160 and diastolic blood pressure was great than 60. -There were no entries for blood pressure checks on the March 2025 eMAR. Interview with Resident #4 on 03/07/25 at 11:40am revealed: -She could not remember when her blood pressure was last checked by facility staff. -She was not able to check her blood pressure herself. -She was not aware of any times that her blood	D 344		

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D 344	Continued From page 15 pressure was too high or too low. Interview with a medication aide (MA) on 03/07/25 at 1:11pm revealed: -She could not remember the last time she took Resident #4's blood pressure. -She thought MAs were supposed to check the resident's blood pressure if the resident reported not feeling well. -Usually there were orders to check a resident's blood pressure every day with parameters, however the order for Resident #4 was to check her blood pressure as needed. -She should have sent a notification to the resident's PCP to request a clarification order on how often to check the resident's blood pressure. Interview with the Administrator on 03/07/25 at 2:48pm revealed: -She was not aware that Resident #4 had an order to check the resident's blood pressure daily as needed. -MAs were not qualified to determine when a resident may need their blood pressure checked. -The MAs should have notified Resident #4's PCP that a clarification order was needed on how often to check her blood pressure. -The MAs also knew that they could leave a note under her door and she would notify the PCP that a clarification order was needed for the resident's blood pressure checks. Attempted telephone interview with Resident #2's PCP on 03/06/25 at 2:16pm and on 03/07/25 at 12:07pm and 2:19pm were unsuccessful.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 16 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents (#2, #5) related to a medication for diabetes (#2) and a medication used to treat fungal infections (#5). The findings are: 1. Review of Resident #2's current FL-2 dated 01/06/25 revealed: -Diagnoses included type 2 diabetes, below knee amputation of both legs, peripheral vascular disease, and hypertension. -There was an order for Humalog Kwikpen 100U/ml; check FSBS before meals and at bedtime, inject Humalog per sliding scale insulin (SSI), 150-200=2 units, 210-250=4 units, 251-300=6 units, 301-350=8 units 351-400=10 units, if FSBS is greater than 400 notify the resident's primary care provider (PCP) (Humalog is a fast acting insulin). Review of Resident #2's January electronic medication administration record (eMAR) revealed: -There was an entry for Humalog Kwikpen 100U/ml, check FSBS four times per day at	D 358		

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6:30am, 11:30am, 5:30pm, and 9:00pm, inject Humalog per SSI, 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, and 351-400=10 units, over 400 notify the PCP.
-On 01/13/25 at 6:30am, there was a FSBS documented for 145, Humalog 2 units were administered, when no units of Humalog should have been administered.
-On 01/17/25 at 6:30am, there was a FSBS documented for 240, Humalog 2 units were administered, when 4 units of Humalog should have been administered.
-On 01/01/25 at 6:30am, there was no FSBS documented.
-On 01/16/25 at 6:30am, there was no FSBS documented.
-On 01/20/25 at 6:30am, there was no FSBS documented.
-On 01/25/25 at 5:30pm, there was no FSBS documented.
-On 01/30/25 at 5:30pm, there was no FSBS documented.
-There was no documentation on the eMAR under exceptions for the reason the resident's FSBS were not documented.

Review of Resident #2's February eMAR revealed:
-There was an entry for Humalog Kwikpen 100U/ml, check FSBS four times per day at 6:30am, 11:30am, 5:30pm, and 9:00pm, inject Humalog per SSI, 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, and 351-400=10 units, over 400 notify the PCP.
-On 02/02/25 at 5:30pm, there was no FSBS documented.
-On 02/21/25 at 6:30am, there was no FSBS documented.
-On 02/25/25 at 6:30am, there was no FSBS documented.

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D 358	Continued From page 18 -On 02/28/25 at 6:30am, there was no FSBS documented. -There was no documentation on the eMAR under exceptions for the reason the resident's FSBS were not documented. Review of Resident #2's March eMAR revealed: -There was an entry for Humalog Kwikpen 100U/ml, check FSBS four times per day at 6:30am, 11:30am, 5:30pm, and 9:00pm, inject Humalog per SSI, 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, and 351-400=10 units, over 400 notify the PCP. -On 03/01/25 at 6:30am, there was no FSBS documented. -On 03/03/25 at 6:30am, there was no FSBS documented. -There was no documentation on the eMAR under exceptions for the reason the resident's FSBS were not documented. Interview with Resident #2 on 03/06/25 at 12:40pm revealed: -His blood sugar was checked before meals and at bedtime. -He usually needed his fast acting insulin when his blood sugar was checked before meals because his sugar was a little high. -He was not sure why his blood sugar was not checked several times in January, February and March. Interview with a medication aide (MA) on 03/07/25 at 12:17pm revealed: -The computer system for the eMAR popped up when she checked Resident #2's FSBS. -She was not sure why the resident had times in January 2025, February 2025, and March 2025 where the eMAR showed his FSBS was not checked.	D 358		

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-The resident's FSBS was ordered to be checked before each meal and before bedtime so she could administer the required number of units per the resident's SSI order.
-If the resident refused or if his FSBS did not require insulin, MAs documented it in the eMAR under the exceptions.
-Resident #2 should have his FSBS checked as ordered to avoid complications.
-The residents' blood sugar could become too low or too high and he could suffer from shaking, sweating, slurred speech, and confusion.

Interview with a second MA on 03/07/25 at 1:11pm revealed:
-When she checked the resident's FSBS, she administered the number of units needed per the SSI order from the PCP.
-She would record on the eMAR what the resident's blood sugar was and then administer insulin based on the SSI.
-If the resident refused or was out of the facility, she was able to document under exceptions on the eMAR why the resident did not have his blood sugar checked and why he did not receive any units of insulin.
-MAs were expected to document the residents' blood sugar in the eMAR and follow the PCP orders.
-She was not sure why a MA had documented the wrong number of units administered
-She was not sure why the resident's eMAR showed he missed his blood sugar being checked.
-Resident #2 had a bilateral above the knee amputation due to his diabetes.
-The resident was at risk of hypoglycemia if his blood sugar dropped too low or hyperglycemia if his blood sugars were too high.

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D 358	Continued From page 20 Interview with the Resident Care Coordinator (RCC) on 03/07/25 at 1:37pm revealed: -There was an order to check the resident's FSBS before meals and at bedtime and to administer insulin based on the SSI directions. -She had been employed at the facility as the RCC for approximately a week and was not aware that Resident #2 was administered the wrong amount of insulin based on his sliding scale. -She was not aware that Resident #2 had not had his FSBS checked several times in January 2025, February 2025, and March 2025. -Where there was no documentation of the resident's FSBS checks on the eMAR, it was unacceptable. -The resident's PCP wrote orders to be followed. -Humalog was a fast acting insulin that could be dangerous if not administered correctly. -The resident was placed at risk of death if his Humalog was not administered correctly. Interview with the Administrator on 03/07/25 at 2:48pm revealed: -She was not aware that Resident #2 was administered the incorrect amount of Humalog twice. -MA were supposed to follow the SSI orders on the eMAR to ensure the resident received the correct amount of insulin. -MAs needed to slow down and pay attention when they administered the resident Humalog due to the risk of administering the incorrect number of units of Humalog which could lead to complications for the resident. -She was not aware that Resident #2 had not had his FSBS checked several times from January 2025 to March 2025. -She had provided each MA with a notebook so they could write down what a resident's blood	D 358		

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sugar was in case they got busy and did not enter it into the eMAR immediately.
-There should not have been any missed blood sugar checks for Resident #2.
-Resident #2 had complications from his diabetes, and she expected the MA to follow PCP orders as written for the resident.
-The resident was at risk of hypoglycemia or hyperglycemia which could lead to increased complications.

Attempted telephone interview with Resident #2's PCP on 03/06/25 at 2:16pm and on 03/07/25 at 12:07pm and 2:19pm were unsuccessful.

2. Review of Resident #5's current FL-2 dated 11/12/24 revealed:
-Diagnoses included psoriasis, diabetes, and congestive heart failure.
-There was an order for Lotrisone cream, apply topically to the right elbow and under the right breast fold twice a day (Lortisone cream is used to treat or prevent fungal infections of the skin).

Review of Resident #5's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Lortisone cream, apply topically to the right elbow and under the right breast fold twice a day for rash or skin irritation, at 10:00am and 4:00pm.
-Lortisone cream was documented as not administered on 01/09/25 at 4:00pm.
-Lortisone cream was documented as not administered on 01/10/25 at 4:00pm.
-Lortisone cream was documented as not administered on 01/11/25 at 4:00pm.
-Lortisone cream was documented as not administered on 01/15/25 at 4:00pm.
-Lortisone cream was documented as not

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administered on 01/16/25 at 4:00pm.
-Lortisone cream was documented as not administered on 01/17/25 at 4:00pm.
-Lortisone cream was documented as not administered on 01/29/25 at 4:00pm.
-Lortisone cream was documented as not administered on 01/30/25 at 4:00pm.
-There was no documentation related to why Resident #5 was not administered Lortisone cream.

Review of Resident #5's February 2025 eMAR revealed:
-There was an entry for Lortisone cream, apply topically to the right elbow and under the right breast fold twice a day for rash or skin irritation, at 10:00am and 4:00pm.
-Lortisone cream was documented as not administered on 02/02/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/03/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/04/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/07/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/08/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/09/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/12/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/13/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/17/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/21/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/23/25 at 4:00pm.
-Lortisone cream was documented as not

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administered on 02/26/25 at 4:00pm.
-Lortisone cream was documented as not administered on 02/27/25 at 4:00pm.
-There was no documentation related to why Resident #5 was not administered Lortisone cream.

Review of Resident #5's March 2025 eMAR revealed:
-There was an entry for Lortisone cream, apply topically to the right elbow and under the right breast fold twice a day for rash or skin irritation, at 10:00am and 4:00pm.
-Lortisone cream was documented as not administered on 03/03/25 at 4:00pm.

Interview with Resident #5 on 03/06/25 at 9:10am revealed:
-Her skin needed cream at times when she had problems with itching.
-She had not been itching lately and had not needed cream for her elbow or breasts.

Interview with a medication aide (MA) on 03/07/25 at 1:11pm revealed:
-Resident #5 received Lortisone cream for rashes and boils.
-The resident was peculiar with who she allowed to apply cream to her body and was self conscious.
-She was able to apply the Lortisone cream daily at 10:00am.

Interview with the Administrator on 03/07/25 at 2:48pm revealed:
-She last completed an audit of medications administered in February 2025.
-She did not realize that Resident #5 had not received Lortisone cream numerous times in January 2025 and February 2025.

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D 358	Continued From page 24 -She knew the resident was self-conscious and was only comfortable with a few MAs to apply the Lortisone cream. -MAs should have documented why the resident was not administered the Lortisone cream on the eMAR. Attempted telephone interview with Resident #2's PCP on 03/06/25 at 2:16pm and on 03/07/25 at 12:07pm and 2:19pm were unsuccessful.	D 358		