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D 000	Initial Comments The Adult Care Licensure Section and the Currituck County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 03/18/25 through 03/20/25.	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 needs of 1 of 5 sampled residents (#1) related to notify the residents primary care provider (PCP) or endocrinologist of refusals to have finger stick blood sugars (FSBSs) and refusal of short acting and long acting insulin per the facility's diabetic medication and treatment policy. The findings are: Review of the facilities undated diabetic medication and treatment policy revealed: -Residents receiving medication or treatments for diabetic care should be monitored according to physician orders. -The medication aide (MA) would notify the Care Coordinator of any refusals and/or abnormal results per parameters given by the resident's physician. -The Care Coordinator or designee should review any refusals and/or abnormal blood sugar	D 273		

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readings and notify the provider and document the notification and any new orders in the resident's chart.

Review of Resident #1's current FL-2 dated 09/10/24 revealed:
-Diagnoses included type 2 diabetes, congestive heart failure, peripheral vascular disease, and unspecified sequelae of cerebral infarction (sequelae of cerebral infarction is the long-term conditions or disabilities that may result from a stroke).
-The resident's recommended level of care was assisted living (AL).
-The resident was ambulatory.
-The resident was incontinent of urine and bowel.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 07/23/24.

Review of a lab report for Resident #1 dated 02/13/25 revealed the resident's hemoglobin A1C was 7.7 (A1C measures the average blood sugar level over the past 2 to 3 months; a normal A1C level is below 5.7%).

Review of Resident #1's current FL-2 dated 09/10/24 revealed there was an order for Insulin Lispro 100U/ml; inject 6 units of Lispro before breakfast, inject 8 units before lunch, and inject 10 units before dinner, there were no parameters (Lispro is a fast acting insulin).

Review of Resident #1's primary care provider (PCP) order dated 09/25/24 revealed the resident's finger stick blood sugar (FSBS) should be checked four times a day before meals and at bedtime due to fluctuating FSBS results.

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Review of a Resident #1's primary care provider (PCP) order dated 11/06/24 revealed Lantus Solostar (Basaglar) U-100 insulin, 100unit/mL (3mL), inject 12 units at 8:00pm.

Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed:
-On 01/08/24 at 11:30am, there was a FSBS documented for 198, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 01/10/25 at 6:00am, there was a FSBS documented for 172, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 01/24/25 at 6:00am, there was a FSBS documented for 110, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 01/25/25 at 8:00pm, Basaglar was not documented as administered, there was documentation on the exceptions that the resident refused Basaglar.

Review of Resident #1's February 2025 eMAR revealed:
-On 02/06/25 at 11:30am, there was a FSBS documented for 151, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 02/07/25 at 6:00am, there was a FSBS documented for 93, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 02/07/25 at 11:30am, there was a FSBS documented for 124, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 02/25/25 at 6:00am, there was a FSBS

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documented for 97, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 02/26/25 at 6:00am, there was a FSBS documented for 65, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.
-On 02/09/25 at 8:00pm, Basaglar was not documented as administered, there was documentation on the exceptions that the resident refused Basaglar.
-On 02/23/25 at 8:00pm, Basaglar was not documented as administered, there was documentation on the exceptions that the resident refused Basaglar.

Review of Resident #1's March 2025 eMAR revealed on 03/09/25 at 6:00am, there was a FSBS documented for 96, Lispro was not documented as administered, there was documentation on the exceptions that the resident refused Lispro.

Interview with Resident #1 on 03/19/25 at 3:45pm revealed:
-She had her blood sugar checked before meals at before bedtime.
-Sometimes she did not feel like getting insulin or having her blood sugar checked so she refused.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed:
-She had not contacted Resident #1's PCP about her refusals to take her FSBS or refusals to take her insulin because there was not an order from the PCP to contact her about refusals.
-She did not realize the facility had a policy that residents with diabetes should be monitored and the residents' PCP should be notified of any refusals.

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D 273	Continued From page 4 -She had not notified Resident #1's PCP of any refusals. Telephone interview with Resident #1's current PCP on 03/20/25 at 12:23pm revealed: -She had been the resident's PCP since October 2024, and the resident also was seen by an endocrinologist to help manage her diabetes. -Although there were no orders from her for staff to notify her if the resident's FSBS were greater than 400 or less than 60, she would still want to be notified due to the resident's history of high blood pressure. -She did not understand why the facility had not notified her that the resident had refused to have her FSBS checked and refused to receive units of insulin. Attempted telephone interview with Resident #1's endocrinologist on 03/19/25 at 4:08pm was 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 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 2 of 5 sampled residents (#1, #3) related blood pressure checks that were orders daily that	D 276		

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were not taken as ordered (#1), and blood pressure checks that were ordered weekly (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 09/10/24 revealed diagnoses included type 2 diabetes, congestive heart failure, peripheral vascular disease, and unspecified sequela of cerebral infarction (sequela of cerebral infarction is the long-term conditions or disabilities that may result from a stroke).

Review of Resident #1's physician order dated 11/20/24 revealed blood pressure was to be taken daily and as needed if symptomatic.

Review of Resident #1's electronic medication administration record (eMAR) for January 2025 revealed there was no entry for daily blood pressure checks.

Review of Resident #1's eMAR for February 2025 revealed there was no entry for daily blood pressure checks.

Review of Resident #1's eMAR for March 2025 revealed there was non entry for daily blood pressure checks.

Interview with Resident #1 on 03/19/25 at 3:45pm revealed she could not remember when staff had checked her blood pressure.

Interview with a medication aide (MA) on 03/19/25 at 1:00pm revealed:
-She was the Resident Care Coordinator (RCC) from the last week of October 2024 to 02/23/25.
-She was not aware that there was an order from the resident's primary care provider (PCP) to

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check her blood pressure daily.
-She was the RCC when the order was written by the resident's PCP on 11/20/24.
-She should have faxed the order to the facility's contracted pharmacy, which would have added the blood pressure checks to the eMAR.
-She did not realize that she missed the order from the PCP.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed:
-She had worked at times on the Assisted Living (AL) side of the building since the end of February 2025.
-She was not aware that Resident #1's PCP had ordered daily blood pressure checks.
-When a resident's PCP sent an order to the facility, she would fax the order to the facility's contracted pharmacy so the order could be added to the eMAR.
-The PCP order to check the resident's blood pressure daily had evidently been overlooked and should have been on the eMAR to ensure staff followed the PCP's order.

Telephone interview with Resident #1's PCP on 03/20/25 at 12:23pm revealed:
-She ordered the resident's blood pressure to be checked daily due to her chronic health conditions which included diabetes, hypertension, coronary artery disease, hyperlipidemia, and diastolic heart failure (diastolic heart failure is also known as heart failure).
-She was not aware that staff were not checking the residents' blood pressure daily as ordered and did not understand why staff had not followed her order.
-Staff at the facility should follow physician orders.
-The resident's blood pressure had not been controlled consistently in the past and the

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resident had a history of high blood pressure.
-Resident #1 was at a higher risk of additional cardiac complications due to her diagnoses.
-When the resident's blood pressure was not regulated, her diastolic heart failure was at risk of becoming worse which created a vicious cycle back and forth with the resident's high blood pressure and chronic kidney disease.

2. Review of Resident #3's current FL-2 dated 10/30/24 revealed diagnoses included chronic kidney disease and type II diabetes.

Review of Resident #3's physician's note dated 01/27/25 revealed:
-Resident #3's blood pressure was noted to be low on 01/20/25 with a reading of 94/76.
-Staff reported that his blood pressure had been even lower.
-There was an order for daily blood pressure checks for 1 week.

Review of Resident #3's electronic medication administration record for January 2025 revealed:
-There was no entry for daily blood pressure checks.
-There was an entry for monthly vital signs to be checked on the 6th of the month.
-Resident #3's blood pressure was documented as 100/54 on 01/06/25 pm on the 7:00am-3:00pm shift.

Review of Resident #3's electronic medication administration record for February 2025 revealed:
-There was no entry for daily blood pressure checks.
-There was an entry for monthly vital signs to be checked on the 6th of the month.
-Resident #3's blood pressure was documented as 80/66 on 02/06/25 pm the 7:00am-3:00pm

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shift.

Interview with Resident #3's primary care provider on 03/19/25 at 2:04pm revealed:
-Resident #3 had some very low blood pressure readings.
-She ordered blood pressure checks to be done daily for one week in order to monitor and adjust blood pressure medications as needed.
-Low blood pressure placed Resident #3 at risk for dizziness and falls which was a safety concern.
-She did not receive the results for blood pressure monitoring as ordered.

Interview with a medication aide (MA) on 03/19/25 at 8:41am revealed:
-All vital signs are entered onto the electronic medication administration record (eMAR).
-All residents get routine monthly vital signs completed.
-Orders for increased blood pressure monitoring were entered onto the eMAR and MA staff are alerted when to obtain the vital signs just as they were alerted when to administer a medication.
-MAs were responsible for obtaining vital signs as ordered but they would not know when to obtain the vital signs if it was not entered onto the eMAR.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed:
-She was not aware of increased blood pressure checks for Resident #3.
-New orders were sent to the pharmacy by the care managers.
-Blood pressure monitoring was entered into the eMAR system as ordered by the pharmacy.
-She was responsible for ensuring orders for increased monitoring of vital signs was entered

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D 276	Continued From page 9 as ordered and should follow-up to ensure completed. Interview with the Administrator on 03/20/25 at 3:32pm revealed: -New orders, including orders for increased monitoring of vital signs, should be faxed to the pharmacy to be entered onto the eMAR. -The SCC was responsible for ensuring Resident #3's orders were entered onto the eMAR correctly and should follow-up to ensure the daily blood pressure checks were completed by the MAs.	D 276		
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. 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 (#1) for finger stick blood sugars (FSBSs) that were abnormal and blood pressure checks.	D 344		

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D 344	Continued From page 10 The findings are: Review of the facilities undated diabetic medication and treatment policy revealed: -Residents receiving medication or treatments for diabetic care should be monitored according to physician orders. -The medication aide (MA) would notify the Care Coordinator of any refusals and/or abnormal results per parameters given by the resident's physician. -The Care Coordinator or designee should review any refusals and/or abnormal blood sugar readings and notify the provider and document the notification and any new orders in the resident's chart. Review of Resident #1's current FL-2 dated 09/10/24 revealed diagnoses included type 2 diabetes, congestive heart failure, peripheral vascular disease, and unspecified sequelae of cerebral infarction (sequelae of cerebral infarction is the long-term conditions or disabilities that may result from a stroke). a. Review of Resident #1's primary care provider (PCP) order dated 09/25/24 revealed the resident's FSBS should be checked four times a day before meals and at bedtime due to fluctuating FSBS results. -There were no parameters to notify the PCP if FSBSs were over 400. Interview with a MA on 03/19/25 at 1:00pm revealed: -She was the Resident Care Coordinator (RCC) from the last week of October 2024 to 02/23/25. -Resident #1 did not have parameters for her FSBS levels from the PCP. -She had not thought about notifying the PCP that	D 344		

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she did not have parameters for the resident's FSBS levels.
-MAs were expected to notify Resident #1's PCP when the resident had a FSBS over 400 and when the resident refused medications.
-When the resident refused to have her FSBS checked or refused insulin, it was standard practice to notify the resident's PCP and to document in the progress notes by the MAs.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed:
-Most residents that had FSBSs checks daily also had parameters from the resident's PCP clarifying when to notify the resident's PCP.
-She was not sure why staff had not notified the resident's PCP to request a clarification of orders to list parameters of when the PCP wanted to be notified of abnormal FSBS.

Interview with the Administrator on 03/19/25 at 3:06pm revealed:
-Staff usually contacted a resident's PCP when they needed a clarification order.
-She was not aware that the resident's FSBS order from the PCP did not have parameters.
-Staff should have notified the resident's PCP to request a clarification order for the residents FSBS so staff would know when to notify the resident when her FSBSs were abnormal.

Telephone interview with Resident #1's current PCP on 03/20/25 at 12:23pm revealed:
-Staff should have reached out to her for a clarification order for the resident's FSBS checks.
-She would want to be notified if the resident's FSBS was over 400 or below 60 so she could make recommendations to staff as needed.
-Resident #1 had a history of high FSBSs and it was important to her health to keep her FSBSs

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D 344	Continued From page 12 down. b. Review of Resident #1's primary care provider (PCP) order dated 11/20/24 revealed staff should check blood pressure daily and as needed if symptomatic. Review of Resident #1's electronic medication administration record (eMAR) for January 2025 revealed: -There was no electronic entry for the resident's blood pressure to be checked daily. -There were no entries for blood pressure checks on the January 2025 eMAR. Review of Resident #1's eMAR for February 2025 revealed: -There was no electronic entry for the resident's blood pressure to be checked daily. -There were no entries for blood pressure checks on the February 2025 eMAR. Review of Resident #1's eMAR for March 2025 revealed: -There was no electronic entry for the resident's blood pressure to be checked daily. -There were no entries for blood pressure checks on the March 2025 eMAR. Interview with Resident #1 on 03/19/25 at 3:45pm revealed she could not remember when her blood pressure was last taken by staff at the facility. Interview with a medication aide (MA) on 03/19/25 at 1:00pm revealed: -She was the Resident Care Coordinator (RCC) from the last week of October 2024 to 02/23/25. -She was currently a MA at the facility. -She was not aware that Resident #1's PCP had written an order to have the resident's blood	D 344		

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pressure checked daily and as needed if symptomatic.
-Normally a resident's blood pressure check would be displayed on the eMAR, but she had not seen a blood pressure check for the resident on her eMARs.
-She had evidently missed the resident's PCP order in November 2024 to have her blood pressure checked daily.
-She was not sure why she had not contacted the PCP for clarification of the blood pressure order, because staff were not able to judge when they should check the resident's blood pressure.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed:
-The RCC should have notified the resident's PCP to obtain a clarification order for her blood pressure checks because staff at the facility were not qualified to determine when they should take a resident's blood pressure.
-A clarification order would have ensured the resident's blood pressure was checked daily.
-The RCC would have faxed the PCP's clarification order to the facility's contracted pharmacy, which would have shown on the eMAR.
-If an order to check the resident's blood pressure was not on the eMAR, staff that administered medications did not know to check the resident's blood pressure.

Telephone interview with Resident #1's current PCP on 03/20/25 at 12:23pm revealed:
-She had ordered daily blood pressure checks for Resident #1 due to her history of high blood pressure and concern for the resident having an increased risk of cardiac issues.
-The resident's blood pressure needed to be checked due to her hypertension, coronary artery

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D 344	Continued From page 14 disease, diastolic heart failure, and hyperlipidemia. -Staff should have notified her that they needed a clarification order for the resident's blood pressure to be checked daily. -She was not aware that the facility had not checked the resident's blood pressure.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#8, #9) observed during the medication pass including errors with an antipsychotic medication (#8), a medication used to treat and prevent constipation (#8, #9) and a nasal spray used to treat seasonal allergies (#9); and for 1 of 5 residents sampled for record review including insulin administration (#1). The findings are: 1. The medication error rate was 9% as	D 358		

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evidenced by 4 errors out of 41 opportunities during the 8:00am medication pass on 03/19/25.

a. Review of Resident #8's current FL-2 dated 12/27/24 revealed:
-Diagnoses included Type 2 diabetes and hypertension.
-There was an order for risperidone 0.25mg to be administered each day. (Risperidone is a medication used to treat anxiety and depression associated with mental health disorders.)
-There was an order for polyethylene glycol 3350 powder, 34 GMs to be dissolved in at least 8 oz of water and administer each day. (Polyethylene glycol is a powder laxative medication used to manage constipation.)

Observation of the 8:00am medication pass on 03/19/25 revealed:
-The medication aide (MA) administered 13 pills from a multidose package which included a risperidone 0.25mg tablet to Resident #8 at 7:17am.
-The MA gave Resident #8 an 8 oz cup of plain water to assist with swallowing her medications.
-Polyethylene glycol was not observed to be mixed into the water and administered during the medication pass.

Review of Resident #8's electronic medication administration record (eMAR) for March 2025 revealed:
-There was no electronic entry for risperidone 0.25mg to be administered and no documentation that it was administered on 03/19/25.
-There was an electronic entry for polyethylene glycol 3350 powder, 34 GMs to be dissolved in at least 8 oz of water and administer each day with documentation that is was administered at 8:00am on 03/19/25.

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D 358	Continued From page 16 Interview with Resident #8 on 03/19/25 at 10:25am revealed: -She was not prescribed risperidone. -She did not think she was prescribed polyethylene glycol but constipation was always a problem for her. -The MA did not bring any medication or a cup of fluids to her after her medications were administered to her that morning. Observation of medications on hand for Resident #8 on 03/19/25 at 10:30am revealed risperidone 0.25mg was in the multidose pack and a bottle of polyethylene glycol that was approximately 1/4 full was available for administration. Interview with the MA on 03/19/25 at 10:30am revealed: -She administered risperidone 0.25mg to Resident #8 that morning during the 8:00am medication pass. -She thought she saw risperidone 0.25mg on the eMAR when she compared the multidose pack that contained the risperidone 0.25mg tablet to the eMAR during the medication pass. -She administered the polyethylene glycol 34GMs to Resident #8 after she finished administering the medications to other residents that morning. Second interview with the MA on 03/19/25 at 1:00pm revealed: -The risperidone for Resident #8 was discontinued and was dispensed by the pharmacy by accident in the current week multidose packs. -The multidose packs were sent each week for administration to begin each Tuesday. -MAs were to pull the medication and compare the label to the eMAR when preparing medications for administration.	D 358		

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-The risperidone should have been caught during the check and not administered if it was not on the eMAR.
-She overlooked the risperidone that was listed on the multidose pack that morning when she administered the medication to Resident #8.

Interview with Resident #8's primary care provider (PCP) on 03/19/25 at 2:04pm revealed:
-Resident #8 knew her prescribed medication well.
-The risperidone 0.25mg was discontinued at the end of 2024 but she was not sure exactly when.
-There had been problems with the facility's contracted pharmacy; often times orders would have to be re-faxed and calls made to add or discontinue a medication.
-Continuing to receive the risperidone could cause Resident #8 to be more drowsy that usual.
-Polyethylene glycol was prescribed to Resident #8 for constipation and not receiving the medication could cause constipation and discomfort for the resident.

Attempted telephone interview with Resident #8's mental health provider on 03/20/25 at 2:47pm was unsuccessful.

Refer to interview with the medication aide (MA) on 03/19/25 at 1:00pm.

Refer to attempted telephone interview with the facility's contracted pharmacy on 03/20/25 at 2:56pm.

Refer to interview with the Administrator on 03/19/25 at 3:06pm.

Refer to second interview with the Administrator on 03/20/25 at 3:32pm.

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b. Review of Resident #9's current FL-2 dated 04/23/24 revealed:
-Diagnoses included hypothyroidism and seizure disorder.
-There was an order for polyethylene glycol 17GMs to be mixed in 8 oz of liquid and drink each day.

Review of a physician's order dated 03/05/25 revealed fluticasone propionate spray 50mcg, 1 spray into each nostril was to be administered twice daily. (Fluticasone propionate spray is an intranasal medication used to sinus congestion related to seasonal allergies.)

Observation of the 8:00am medication pass on 03/19/25 revealed:
-The medication aide (MA) administered 8 pills from a multidose package to Resident #9 at 7:22am.
-The MA gave Resident #9 an 8 oz cup of plain water to assist with swallowing her medications.
-Polyethylene glycol was not observed to be mixed into the water and administered during the medication pass.
-Fluticasone propionate spray 50mcg, 1 spray into each nostril was not observed to be administered.

Review of Resident #9's electronic medication administration record (eMAR) for March 2025 revealed:
-There was an electronic entry for polyethylene glycol 17GMs to be mixed in 8 oz of liquid and drink each day with documentation of administration at 8:00am on 03/19/25.
-There was an electronic entry for fluticasone propionate spray 50mcg, 1 spray into each nostril twice daily with documentation of administration

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D 358	Continued From page 19 at 8:00am on 03/19/25. Interview with Resident #9 on 03/19/25 at 10:40am revealed: -She was not administered polyethylene glycol that morning after medication pass and the MA did not bring her any liquids to drink that could have contained polyethylene glycol but she did not have problems with constipation. -She was not administered any nasal spray that morning. -Fluticasone propionate spray was ordered for her in the past when she had an upper respiratory infection and she did not have any sinus congestion currently. Observation of medications on hand for Resident #9 on 03/19/25 at 10:30am revealed there was a bottle of polyethylene glycol that was approximately 1/3 full and fluticasone propionate spray that was approximately 1/2 full was available for administration. Interview with the MA on 03/19/25 at 10:30am revealed she administered the polyethylene glycol 17GM and fluticasone propionate spray to Resident #9 after she finished administering the medications to other residents that morning. Second interview with the MA on 03/19/25 at 1:00pm revealed: -She pulled the fluticasone propionate spray and documented administration before she was going to administer the medication but she got distracted and forgot. -She was suppose to administer the medications prior to documenting the administration but she did not want to show the medication as being administered late. -She would sometimes administer polyethylene	D 358		

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D 358	Continued From page 20 glycol and nasal sprays at the same time as she administered the pills. Interview with Resident #9's primary care provider (PCP) on 03/19/25 at 2:04pm revealed: -Fluticasone propionate spray was ordered to treat seasonal allergies and it was especially important she receive the medication since it was currently allergy season. -Polyethylene glycol was prescribed to Resident #8 for constipation and not receiving the medication could cause constipation and discomfort for the resident. Refer to interview with the medication aide (MA) on 03/19/25 at 1:00pm. Refer to attempted telephone interview with the facility's contracted pharmacy on 03/20/25 at 2:56pm. Refer to interview with the Administrator on 03/19/25 at 3:06pm. Refer to second interview with the Administrator on 03/20/25 at 3:32pm. _____ Interview with the medication aide (MA) on 03/19/25 at 1:00pm revealed: -MAs should pull the medications to be administered and compare the label to the electronic medication administration record (eMAR) prior to administration and document the administration of the medication after the medication was administered. -This was taught to her in medication aide training and during skills check off when she became a medication aide (MA). Attempted telephone interview with the facility's	D 358		

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D 358	Continued From page 21 contracted pharmacy on 03/20/25 at 2:56pm was unsuccessful. Interview with the Administrator on 03/19/25 at 3:06pm revealed: -The MAs should follow all physician orders. -Staff should document communication with providers in the residents' progress notes. Second interview with the Administrator on 03/20/25 at 3:32pm revealed: -Staff were expected to administer all medications as the physician ordered. -MAs should compare medications listed on the multidose pack to ensure the correct medications are administered. 2. Review of the facilities undated diabetic medication and treatment policy revealed: -Residents receiving medication or treatments for diabetic care should be monitored according to physician orders. -The medication aide (MA) would notify the Care Coordinator of any refusals and/or abnormal results per parameters given by the resident's physician. -The Care Coordinator or designee should review any refusals and/or abnormal blood sugar readings and notify the provider and document the notification and any new orders in the resident's chart. Review of Resident #1's current FL-2 dated 09/10/24 revealed diagnoses included type 2 diabetes, congestive heart failure, peripheral vascular disease, and unspecified sequelae of cerebral infarction (sequelae of cerebral infarction is the long-term conditions or disabilities that may result from a stroke).	D 358		

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Review of a lab report for Resident #1 dated 02/13/25 revealed the resident's hemoglobin A1C was 7.7 (A1C measures the average blood sugar level over the past 2 to 3 months; a normal A1C level is below 5.7%).

a. Review of Resident #1's current FL-2 dated 09/10/24 revealed there was an order for Insulin Lispro 100U/ml; inject 6 units of Lispro before breakfast, inject 8 units before lunch, and inject 10 units before dinner, there were no parameters (Lispro is a fast acting insulin).

Review of Resident #1's primary care provider (PCP) order dated 09/25/24 revealed the resident's finger stick blood sugar (FSBS) should be checked four times a day before meals and at bedtime due to fluctuating FSBS results.

Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS four times per day at 6:00am, 11:30am, 4:30pm, and 8:00pm.
-There was an entry for Insulin Lispro Insulin Pen; 100U/ml, inject 6 units once a day with breakfast, inject 8 units once a day with lunch, and inject 10 units once a day with dinner.
-On 01/08/25 at 6:00am, there was a FSBS documented for 88, Lispro was not administered, when 6 units of Lispro should have been administered and there was documentation on the exceptions that Lispro was not administered due to condition of FSBS of 88.
-On 01/08/24 at 11:30am, there was a FSBS documented for 198, Lispro was not administered, when 8 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro.

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D 358	Continued From page 23 -On 01/09/25 at 6:00am, there was a FSBS documented for 138, Lispro was not administered, when 6 units of Lispro should have been administered and there was documentation on the exceptions that Lispro was not administered due to condition of FSBS of 138. -On 01/10/25 at 6:00am, there was a FSBS documented for 172, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro. -On 01/12/25 at 6:00am, there was a FSBS documented for 96, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that Lispro was not administered due to condition of FSBS of 96. -On 01/12/25 at 4:30pm, there was no documentation of a FSBS, Lispro was not administered, when 10 units of Lispro should have been administered and there was no documentation on the exceptions as to why the Lispro was not administered. -On 01/16/25 at 11:30am, there was no documentation of a FSBS, Lispro was not administered, when 8 units of Lispro should have been administered and there was no documentation on the exceptions as to why the Lispro was not administered. -On 01/24/25 at 6:00am, there was a FSBS documented for 110, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro. -On 01/28/25 at 6:00am, there was a FSBS documented for 56, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that Lispro was not administered due to condition of FSBS of 56.	D 358		

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D 358	Continued From page 24 -On 01/31/25 at 4:30pm, there was a FSBS documented for 127, Lispro was not administered, when 10 units of Lisrpo should have been administered, there was documentation on the exceptions that Lispro was not administered due to condition of FSBS of 127. Review of Resident #1's February 2025 eMAR revealed: -There was an entry to check FSBS four times per day at 6:00am, 11:30am, 4:30pm, and 8:00pm. -There was an entry for Insulin Lispro Insulin Pen; 100U/ml, inject 6 units once a day with breakfast, inject 8 units once a day with lunch, and inject 10 units once a day with dinner. -On 02/06/25 at 11:30am, there was a FSBS documented for 151, Lispro was not administered, when 8 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro. -On 02/07/25 at 6:00am, there was a FSBS documented for 93, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro. -On 02/07/25 at 11:30am, there was a FSBS documented for 124, Lispro was not administered, when 8 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro. -On 02/15/25 at 6:00am, there was a FSBS documented for 173, Lispro was not administered, when 6 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1. -On 02/25/25 at 6:00am, there was a FSBS documented for 97, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the	D 358		

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exceptions that the resident refused Lispro.
-On 02/26/25 at 6:00am, there was a FSBS documented for 65, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro.

Review of Resident #1's March 2025 eMAR revealed:
-There was an entry to check FSBS four times per day at 6:00am, 11:30am, 4:30pm, and 8:00pm.
-There was an entry for Insulin Lispro Insulin Pen; 100U/ml, inject 6 units once a day with breakfast, inject 8 units once a day with lunch, and inject 10 units once a day with dinner.
-On 03/07/25 at 6:00am, there was a FSBS documented for 78, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that Lispro was not administered due to condition of FSBS of 78.
-On 03/09/25 at 6:00am, there was a FSBS documented for 96, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro.
-On 03/13/25 at 6:00am, there was a FSBS documented for 187, Lispro was not administered, when 6 units of Lispro should have been administered, there was documentation on the exceptions that Lispro was not administered due to the medication being on hold.

b. Review of Resident #1's primary care provider (PCP) order dated 03/13/25 revealed the resident's finger stick blood sugar (FSBS) should be checked four times a day before meals, and at bedtime, increase Lispro to 8 units before breakfast, 10 units before lunch and dinner, and

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to use a sliding scale (SS) to administer additional Lispro based on premeal blood sugars; FSBS 150-200=1 unit, 201-250=2 units, and greater than 250=3 units.

Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS four times per day at 6:00am, 11:30am, 4:30pm, and 8:00pm.
-There was an entry for Insulin Lispro Insulin Pen; 100U/ml, inject 8 units once a day before breakfast, inject 10 units twice daily before lunch and dinner.
-There was no sliding scale insulin (SSI) entry on the March eMAR.
-On 03/15/25 at 11:30am, there was a FSBS documented for 187, at 12:00pm Lispro was not administered, when 11 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/15/25 at 4:30pm, there was a FSBS documented for 264, at 5:00pm 10 units of Lispro was administered, when 12 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/16/25 at 6:00am, there was a FSBS documented for 126, at 8:00am Lispro was not administered, when 8 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/16/25 at 11:30am, there was a FSBS documented for 199, at 12:00pm Lispro was not administered, when 11 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/16/25 at 4:30pm, there was a FSBS documented for 281, at 5:00pm Lispro was not administered, when 13 units of Lispro should

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have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/17/25 at 6:00am, there was a FSBS documented for 115, at 8:00am Lispro was not administered, when 8 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/17/25 at 11:30am, there was a FSBS documented for 137, at 12:00pm Lispro was not administered, when 10 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/17/25 at 4:30pm, there was a FSBS documented for 139, at 5:00pm Lispro was not administered, when 10 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/18/25 at 6:00am, there was a FSBS documented for 176, at 8:00am Lispro was not administered, when 9 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/18/25 at 11:30am, there was a FSBS documented for 249, at 12:00pm Lispro was not administered, when 12 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/19/25 at 11:30am, there was a FSBS documented for 85, at 12:00pm Lispro was not administered, when 10 units of Lispro should have been administered, there was documentation on the exceptions that the resident refused Lispro.
-On 03/19/25 at 4:30pm, there was a FSBS documented for 191, at 5:00pm Lispro was not administered, when 11 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/20/25 at 6:00am, there was a FSBS documented for 183, at 8:00am Lispro was not

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administered, when 9 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.
-On 03/20/25 at 11:30am, there was a FSBS documented for 244, at 12:00pm Lispro was not administered, when 12 units of Lispro should have been administered, there was no documentation on the exceptions for Resident #1.

c. Review of Resident #1's current FL-2 dated 09/10/24 revealed there was an order for Lantus Solostar U-100 insulin, 100unit/mL (3mL), inject 10 units once a day (Lantus SoloStar also known as Basaglar contains insulin glargine which is a long acting insulin).

Review of a Resident #1's primary care provider (PCP) order dated 11/06/24 revealed Lantus Solostar (Basaglar) U-100 insulin, 100unit/mL (3mL), inject 12 units at 8:00pm.

Review of an order from Resident #1's endocrinologist dated 03/13/25 revealed an order to decrease Basaglar KwikPen to 10 units at bedtime.

Review of Resident #1's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Basaglar KwikPen U-100 (insulin glargine) insulin pen, 100 unit/mL (3mL) inject 12 units at bedtime.
-On 01/25/25 at 8:00pm, Basaglar was not administered, when 12 units of Basaglar should have been administered, there was documentation on the exceptions that the resident refused Basaglar.
-On 01/26/25 at 8:00pm, 11 units of Basaglar was documented as administered, when 12 units of Basaglar should have been administered.

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Review of Resident #1's February 2025 eMAR revealed:
-There was an entry for Basaglar KwikPen U-100 insulin pen, 100 unit/mL (3mL) inject 12 units at bedtime.
-On 02/08/25 at 8:00pm, 10 units of Basaglar was documented as administered, when 12 units of Basaglar should have been administered.
-On 02/09/25 at 8:00pm, Basaglar was documented as not administered, when 12 units of Basaglar should have been administered, there was documentation on the exceptions that the resident refused Basaglar.
-On 02/21/25 at 8:00pm, 15 units of Basaglar was documented as administered, when 12 units of Basaglar should have been administered.
-On 02/23/25 at 8:00pm, Basaglar was documented as not administered, when 12 units should have been administered, there was documentation on the exceptions that the resident refused Basaglar.
-On 02/26/25 at 8:00pm, 10 units of Basaglar was documented as administered, when 12 units should have been administered.

Review of Resident #1's March 2025 eMAR revealed:
-There was an entry for Basaglar KwikPen U-100 insulin pen, 100 unit/mL (3mL) inject 12 units at bedtime from 03/01/25 to 03/15/25, with a discontinue date of 03/15/25.
-On 03/10/25 at 8:00pm, Basaglar was documented as not administered, when 12 units should have been administered.
-On 03/15/25 at 8:00pm, Basaglar was documented as not administered, when 10 units should have been administered.
-On 03/16/25 at 8:00pm, Basaglar was documented as not administered, when 10 units

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should have been administered.
-On 03/17/25 at 8:00pm, Basaglar was documented as not administered, when 10 units should have been administered.

Interview with Resident #1 on 03/19/25 at 3:45pm revealed:
-She assumed she received the correct amount of insulin during the day and at bedtime.
-She had her blood sugar checked before meals at before bedtime.
-Sometimes she did not feel like getting insulin or having her blood sugar checked so she refused.
-She had not felt tired, shaky, or weak that she could remember.

Interview with a medication aide (MA) on 03/19/25 at 1:00pm revealed:
-She was the Resident Care Coordinator (RCC) from the last week of October 2024 to 02/23/25.
-Resident #1 did not have parameters for her FSBS levels from the PCP.
-She had not thought about notifying the PCP that she did not have parameters for the resident's FSBS levels.
-She was not sure why there was no documentation when she notified the PCP when the resident's FSBS was over 400.
-MAs were expected to notify Resident #1's PCP when the resident had a FSBS over 400 and when the resident refused medications.
-When the resident refused to have her FSBS checked or refused insulin, it was standard practice to notify the resident's PCP and to document in the progress notes by the MAs.
-She was not sure why there was no documentation that she notified the resident's PCP about her refusals.
-When she was the RCC she expected the MAs to also notify her when Resident #1's FSBS was

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over 400 or when the resident refused her medications.
-The resident was at risk of fainting when her FSBS was over 400.
-When she was RCC she would perform medication audits to compare the PCP orders with the eMAR and medications on hand.
-When she was RCC she had not noticed Resident #1 had refused her insulin, the MAs had not documented her FSBSs, and the PCP had not been notified.

Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed:
-She had not realized that she and MAs had not followed the PCP or endocrinologist orders.
-The eMAR system automatically calculated the number of units of insulin the resident required after staff entered her FSBS.
-She was not sure why she and MAs had not administered the correct amount of insulin to Resident #1.
-Mistakes should not occur with the resident's insulin due to the risks it could cause to her health.
-When the resident's FSBS were too high the resident was at risk of going into a coma and possibly death.

Interview with the Administrator on 03/19/25 at 3:06pm revealed:
-The resident had an order from her endocrinologist for a SSI on 03/13/25.
-The SCC sent a discontinue order to the endocrinologist on 03/13/25 because the facility did not provide SSI to residents.
-The endocrinologist had not yet signed the request to discontinue the order.
-Staff were expected to follow the endocrinologists order until there was a signed

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discontinue order.
-Diabetes could be life threatening and if staff were unable to reach the provider, they were able to reach the resident's PCP 24 hour triage coverage.

Interview with Resident #1's previous PCP on 03/19/25 at 2:03pm revealed:
-The RCC or MA should have notified her to request parameters for Resident #1's FSBSs.
-Staff were expected to administer the correct units of insulin to the resident to prevent complications from her diabetes.
-When staff failed to administer the correct units of insulin, they placed the resident at risk of hyperglycemia (Hyperglycemia is a condition when an individual's blood glucose is too high which can lead to DKA.
-Hyperglycemia could be fatal to Resident #1.
-Hyperglycemia over time could lead to organ failure.

Telephone interview with Resident #1's current PCP on 03/20/25 at 12:23pm revealed:
-She had been the resident's PCP since October 2024.
-Resident #1 required the correct number of units of Lispro and Basaglar to help keep her blood sugars down, the resident had a history of high blood sugars.
-The SSI ordered by the resident's endocrinologist gave specific instructions on how many units of Lispro MAs should administer.
-The SSI order had a protocol, and MAs should not "just kind of think" on their own how many units of Lispro to administer to the resident.
-The MAs should notify her when the resident refused FSBSs or insulin injections.
-The FSBS checks, and orders for insulin were in place to help keep the resident's blood sugars

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D 358	Continued From page 33 from being too high. Attempted telephone interview with Resident #1's endocrinologist on 03/19/25 at 4:08pm was unsuccessful. _____ The facility failed to administer medications as ordered for 2 of 4 residents observed during the 8:00am medication pass on 03/19/25. Resident #8 did not receive an antipsychotic medication, or a medication used to treat and prevent constipation. Resident #9 did not receive a medication used to treat and prevent constipation and a medication used to treat seasonal allergies. Resident #1 did not receive the correct amount of fast acting and long-acting insulin, which resulted in FSBSs 400 once in January 2025 and six times in February with a FSBS as high as 498, placing the resident at risk of diabetic ketoacidosis and hyperglycemia. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/19/25 with amendment on 03/20/25 for this violation. CORRECTION DATE FOR TYPE B VIOLATION SHALL NOT EXCEED May 4, 2025.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	D 367		

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D 367	Continued From page 34 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 2 of 4 residents (#8,#9) observed during the medication pass related to medications used to treat mental health disorders (#8), constipation (#8,#9) and seasonal allergies (#9). The findings are: 1. Review of Resident #8's current FL-2 dated 12/27/24 revealed: -Diagnoses included Type 2 diabetes and hypertension. -There was an order for risperidone 0.25mg to be administered each day.(Risperidone is a medication used to treat anxiety and depression associated with mental health disorders.)	D 367		

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D 367	Continued From page 35 -There was an order for polyethylene glycol 3350 powder, 34 GMs to be dissolved in at least 8 oz of water and administer each day. (Polyethylene glycol is a powder laxative medication used to manage constipation.) Observation of the 8:00am medication pass on 03/19/25 revealed: -The medication aide (MA) administered 13 pills from a multidose package which included a risperidone 0.25mg tablet to Resident #8 at 7:17am. -The MA gave Resident #8 an 8 oz cup of plain water to assist with swallowing her medications. -Polyethylene glycol was not observed to be mixed into the water and administered during the medication pass. Review of Resident #8's electronic medication administration record (eMAR) for March 2025 revealed: -There was no electronic entry for risperidone 0.25mg to be administered and no documentation that it was administered on 03/19/25. -There was an electronic entry for polyethylene glycol 3350 powder, 34 GMs to be dissolved in at least 8 oz of water and administer each day with documentation that is was administered at 8:00am on 03/19/25. Interview with Resident #8 on 03/19/25 at 10:25am revealed: -She was not prescribed risperidone. -She did not think she was prescribed polyethylene glycol but constipation was always a problem for her. -The MA did not bring anything, including a cup of water after her medications were administered to her that morning.	D 367		

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D 367	Continued From page 36 Observation of medications on hand for Resident #8 on 03/19/25 at 10:30am revealed risperidone 0.25mg was in the multidose pack and polyethylene glycol was available for administration. Interview with the MA on 03/19/25 at 10:30am revealed: -She administered risperidone 0.25mg to Resident #8 that morning during the 8:00am medication pass. -She thought she saw risperidone 0.25mg on the eMAR when she compared the multidose pack that contained the risperidone 0.25mg tablet to the eMAR during the medication pass. -She administered the polyethylene glycol 34GMs to Resident #8 after she finished administering the medications to other residents that morning. Second interview with the MA on 03/19/25 at 1:00pm revealed: -The risperidone for Resident #8 was discontinued and was dispensed by the pharmacy by accident in the current weeks multidose packs. -The multidose packs were sent each week for administration to begin each Tuesday. -MAs were to pull the medication and compare the label to the eMAR when preparing medications for administration. -The risperidone should have been caught during the check and not administered if it was not on the eMAR. -She overlooked the risperidone that was listed on the multidose pack that morning when she administered the medication to Resident #8. Interview with Resident #8's primary care provider (PCP) on 03/19/25 at 2:04pm revealed: -Resident #8 knew her prescribed medication well.	D 367		

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-The risperidone 0.25mg was discontinued at the end of 2024 but she was not sure exactly when.
-There had been problems with the facility's contracted pharmacy; often times orders would have to be re-faxed and calls made to add or discontinue a medication.
-Polyethylene glycol was prescribed to Resident #8 for constipation and not receiving the medication could cause constipation and discomfort for the resident.
-It was important for the eMAR to be complete and accurate so providers could monitor and adjust medications effectively.

Attempted telephone interview with Resident #8's mental health provider on 03/20/25 at 2:47pm was unsuccessful.

Refer to interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm.

Refer to interview with the Administrator on 03/19/25 at 3:06pm.

Refer to attempted telephone interview with the facility's contracted pharmacy on 03/20/25 at 2:56pm.

2. Review of Resident #9's current FL-2 dated 04/23/24 revealed:
-Diagnoses included hypothyroidism and seizure disorder.
-There was an order for polyethylene glycol 17GMs to be mixed in 8 oz of liquid and drink each day.

Review of a physician's order dated 03/05/25 revealed fluticasone propionate spray 50mcg, 1 spray into each nostril was to be administered twice daily. (Fluticasone propionate spray is an

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D 367	Continued From page 38 intranasal medication used to sinus congestion related to seasonal allergies.) Observation of the 8:00am medication pass on 03/19/25 revealed: -The medication aide (MA) administered 8 pills from a multidose package to Resident #9 at 7:22am. -The MA gave Resident #8 an 8 oz cup of plain water to assist with swallowing her medications. -Polyethylene glycol was not observed to be mixed into the water and administered during the medication pass. -Fluticasone propionate spray 50mcg, 1 spray into each nostril was not observed to be administered. Review of Resident #9's electronic medication administration record (eMAR) for March 2025 revealed: -There was an electronic entry for polyethylene glycol 17GMs to be mixed in 8 oz of liquid and drink each day with documentation of administration at 8:00am on 03/19/25. -There was an electronic entry for fluticasone propionate spray 50mcg, 1 spray into each nostril twice daily with documentation of administration at 8:00am on 03/19/25. Interview with Resident #9 on 03/19/25 at 10:40am revealed: -She was not administered polyethylene glycol that morning after medication pass and the MA did not bring her any liquids to drink that could have contained polyethylene glycol but she did not have problems with constipation. -She was not administered any nasal spray that morning. -Fluticasone propionate spray was ordered for her in the past when she had an upper respiratory	D 367		

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infection and she did not have any sinus congestion currently.

Observation of medications on hand for Resident #9 on 03/19/25 at 10:30am revealed polyethylene glycol and fluticasone propionate spray was available for administration.

Interview with the MA on 03/19/25 at 10:30am revealed she administered the polyethylene glycol 17GM and fluticasone propionate spray to Resident #9 after she finished administering the medications to other residents that morning.

Second interview with the MA on 03/19/25 at 1:00pm revealed:
-She pulled the fluticasone propionate spray and documented administration before she was going to administer the medication but she got distracted and forgot.
-She was suppose to administer the medications prior to documenting the administration but she did not want to show the medication as being administered late.
-She would sometimes administer polyethylene glycol and nasal sprays at the same time as she administered the pills.

Interview with Resident #9's primary care provider (PCP) on 03/19/25 at 2:04pm revealed:
-Fluticasone propionate spray was ordered to treat seasonal allergies and it was especially important she receive the medication since we were currently in allergy season.
-Polyethylene glycol was prescribed to Resident #8 for constipation and not receiving the medication could cause constipation and discomfort for the resident.
-It was important for the eMAR to be complete and accurate so providers could monitor and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL027003	A. BUILDING: _____ B. WING _____	R 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CURRITUCK HOUSE	141 MOYOCK LANDING DRIVE MOYOCK, NC 27958

(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 367	Continued From page 40 adjust medications effectively. Refer to interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm. Refer to interview with the Administrator on 03/19/25 at 3:06pm. Refer to attempted telephone interview with the facility's contracted pharmacy on 03/20/25 at 2:56pm. _____ Interview with the Special Care Coordinator (SCC) on 03/20/25 at 2:02pm revealed: -Medications should be documented appropriately after administration of the medication. -The eMAR should be accurate so the PCP would know what was administered in case they needed to change anything. Interview with the Administrator on 03/19/25 at 3:06pm revealed each residents' eMAR should be accurate so the providers would know what is given and when. Attempted telephone interview with the facility's contracted pharmacy on 03/20/25 at 2:56pm was unsuccessful.	D 367		