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FOREST HILL FAMILY CARE	3510 CAMDEN ROAD FAYETTEVILLE, NC 28306

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on September 17, 2026 and September 18, 2026.	C 000		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure fire safety equipment was maintained in a safe operating condition for 3 fire extinguishers that had not been inspected annually. The findings are: Review of the National Fire Protection Association (NFPA) 10 Fire Extinguisher Requirements dated 05/18/26 revealed annual maintenance must be performed by a certified person, which in most jurisdictions was a licensed fire extinguisher technician or a company certified by the state Fire Marshal.	C 102		

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C 102	Continued From page 1 Review of the facility's current license effective 01/01/26 revealed: -The capacity was 6. -The license would expire on 12/31/26. Review of the facility's census report on 09/17/26 revealed there were 2 residents living in facility. Review of the facility's Fire Marshal Inspection Report dated 08/10/26 revealed: -Portable fire extinguishers were required to be serviced annually. -The portable fire extinguishers at the facility were overdue for service. -The re-inspection date was scheduled for 09/09/26. Observation of the facility on 09/18/26 at 10:15am and 4:56pm revealed: -There were 3 portable fire extinguishers. -The fire extinguisher in the hallway by the back door had the last inspection date as 08/22/25. -The fire extinguisher in the hallway in the middle of the facility had the last inspection date as "8/28/25". -The fire extinguisher in the kitchen had the last inspection date as "6/25". Telephone interview with the Fire Marshal's office inspector on 09/18/26 at 3:44pm revealed: -On 08/10/26, the facility's fire extinguishers were out of compliance for annual inspection. -He gave facilities 30 days to get their fire extinguishers inspected. -He had not returned to the facility to re-inspect due to scheduling conflicts with his office. -Although there was a re-inspection date listed on the inspection report, he conducted random re-inspection visits.	C 102		

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C 102	Continued From page 2 Interview with the Administrator on 09/18/26 at 4:41pm revealed: -The facility's owner was responsible for ensuring the fire extinguishers were inspected annually. -He was not aware the fire extinguishers were overdue for annual inspection. -He did not read the fire Marshal's inspection report from 08/10/26. -The fire extinguishers were overdue for their annual inspection because no one called the fire extinguisher inspection company to schedule the inspection. -He did not check behind the owner regarding the fire extinguishers being inspected annually because she had been operating the facility for years. -He expected the owner to make sure that the inspections were completed. Interview with the facility Owner on 09/18/26 at 4:58pm revealed: -Fire extinguishers were supposed to be inspected once per year. -She told the fire Marshall on 08/10/26 that she would get the fire extinguishers inspected. -The fire extinguishers were overdue for their annual inspection because of the cost the inspection. -She had to wait until after 09/23/26 to get the fire extinguishers inspected due to the cost.	C 102		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist	C 254		

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C 254	Continued From page 3 in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) reviews and evaluations for 2 of 2 sampled residents (#1, #2) with LHPS tasks including tasks for testing fingerstick blood sugars (#2) and colostomy care were completed quarterly. The findings are: 1. Review of Resident #2's current FL-2 dated 10/03/24 revealed: -Diagnoses included type 2 diabetes, congestive heart failure, hyperlipidemia, and paranoid schizophrenia. -There was an order for Novolog Flexpen (a rapid-acting insulin used to treat high blood	C 254		

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C 254	Continued From page 4	C 254		

sugar) 100units/ml, check blood sugar before meals and at bedtime, inject 3 units for blood sugar 201-250, 4 units for 251-300, 5 units for 301-350, 6 units for 351-400, 8 units for 401-450, 10 units for greater than 450 and call primary care provider (PCP).

Review of Resident #2's Resident Register revealed:
-The resident was admitted to the facility on 04/01/20.
-The did not require assistance for dressing, bathing, nail care, shaving, ambulation, hair/grooming, and skin care.
-The resident's memory was documented as adequate.
-The resident used a walker.

Review of Resident #2's current assessment and care plan dated 09/25/25 revealed:
-The resident was documented as having a cane but did not use it for assistance with ambulation.
-The resident had no issues with her upper extremities.
-The resident was documented as oriented with adequate memory.
-The resident was independent with eating, toileting, ambulation, dressing, bathing, grooming, and transferring.

Observation of Resident #2 on 09/17/26 and 09/18/26 revealed Resident #2 ambulated independently with a cane.

Interview with Resident #2 on 09/17/26 at 8:38am revealed:
-She ambulated with a cane.
-She bathed and dressed herself.
-Staff administered her medication.

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C 254	Continued From page 5 Second interview with Resident #2 on 09/18/26 at 5:00pm revealed staff checked her blood sugar daily at 8:00am, 12:00pm, 4:00pm and at bedtime. Review of Resident #2's last Licensed Health Professional Support (LHPS) review dated 03/03/26 revealed: -The nurse documented the resident's LHPS tasks as testing blood sugar before meals and at bedtime and medication administration through injection. -The nurse documented that Resident #2 was administered sliding scale Novolog Flexpen. -The recommendation was to continue the current plan, and the nurse would reassess quarterly. Refer to interview with the facility's contracted LHPS nurse on 09/17/26 at 2:34pm. Refer to interview with the Administrator on 09/17/26 at 2:47pm. Refer to interview with the facility's owner on 09/17/26 at 10:17am. 2. Review of Resident #1's current FL-2 dated 09/25/25 revealed: -Diagnoses included insomnia, depression, hypertension, constipation and colostomy. -The resident was semi-ambulatory and required assistance with bathing. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 02/16/18. -The resident required assistance for bathing and standby assist for hair/grooming.	C 254		

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C 254	Continued From page 6 -The resident's memory was documented as adequate. -The resident used a wheelchair. Review of Resident #1's current assessment and care plan dated 07/26/24 revealed: -The resident used a wheelchair for assistance with ambulation. -The resident had no problems with her upper extremities. -The resident was documented as oriented. -The resident had a colostomy bag. -The resident was independent with eating, toileting, ambulation, dressing, grooming and transferring. -The resident required limited assistance with bathing. Observation of Resident #1 on 09/17/26 and 09/18/26 revealed Resident #1 self-propelled herself around the facility and in and out of the facility's back door. Interview with Resident #1 on 09/17/26 at 2:06pm at 12:38pm revealed: -She self-transferred to and from her wheelchair. -She held on to her bed to transfer to and from her wheelchair. -The medication aide (MA) helped her with bathing and changing her clothes. Second interview with Resident #1 on 09/18/26 at 9:41am revealed: -She took care of her colostomy independently. -She used to receive home health services for management of her colostomy, but she was discharged from home health because she no longer needed their assistance. -She emptied her colostomy bag in the bathroom, rinsed the bag and put a new bag on.	C 254		

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C 254	Continued From page 7 -She had no issued with her colostomy. Review of Resident #1's last Licensed Health Professional Support (LHPS) review dated 03/03/26 revealed: -The nurse documented the resident's LHPS tasks as "N/A". -The nurse documented that Resident #1 was independent with most activities of daily living (ADL) and required assistance with bathing. -The nurse documented that Resident #1 had a colostomy but was independent with care of the colostomy bag. -The nurse documented that Resident #1 had no tasks. -The recommendation was to continue the current plan, and the nurse would reassess quarterly. Refer to interview with the facility's contracted LHPS nurse on 09/17/26 at 2:34pm. Refer to interview with the Administrator on 09/17/26 at 2:47pm. Refer to interview with the facility's owner on 09/17/26 at 10:17am. _____ Telephone interview with the facility's contracted LHPS nurse on 09/17/26 at 2:34pm revealed: -She had been completing the LHPS evaluations for the facility for years through different pharmacies. -She completed the LHPS on 03/03/26. -LHPS evaluations were to be completed quarterly. -The facility switched pharmacies at some point, and the new pharmacy did not realize the LHPS evaluations needed to be completed. -She had been waiting on the pharmacy to	C 254		

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C 254	Continued From page 8 schedule the LHPS evaluation for the facility. -It was the facility's responsibility to schedule the LHPS evaluations. -The facility called her today, 09/17/26, to schedule the LHPS evaluations. Interview with the Administrator on 09/17/26 at 2:47pm revealed: -LHPS evaluations were supposed to be completed quarterly. -He was not aware the quarterly LHPS evaluations for Resident #1 and Resident #2 had not been completed. -The facility's owner and the MA were responsible for ensuring the LHPS evaluations were completed quarterly. -The MA was responsible for keeping a record of the LHPS evaluation schedule and informing the owner of when the LHPS evaluations were due. -Once notified that the LHPS evaluations were due, the owner was responsible for contacting the pharmacy to get the LHPS evaluations scheduled. -He did not know why the LHPS evaluations were not completed quarterly. Interview with the facility's owner on 09/17/26 at 10:17am revealed: -LHPS evaluations were supposed to be completed "some say every 3 to 6 months". -LHPS evaluations for Resident #1 and Resident #2 had not been completed since March 2026. -She was unsure why the LHPS nurse had been contacted to complete current LHPS evaluations for Resident #1 and Resident #2. -She and the MA were responsible for scheduling the LHPS evaluations.	C 254		

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C 257	Continued From page 9	C 257		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored and prepared by the facility were served under sanitary conditions related to food packages not sealed and food containers that were not properly labeled. The findings are: Review of the facility's Environmental Health Services inspection report dated 04/13/26 revealed the facility sanitation score was an	C 257		

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C 257	Continued From page 10 approved and the facility received 9 demerits. Review of the facility's current license effective 01/01/26 revealed: -The capacity was 6. -The license would expire on 12/31/26. Review of the facility's census report on 09/17/26 revealed there were 2 residents living in facility. Observation of the facility refrigerator on 09/17/26 at 8:54am revealed: -There were undated and unlabeled plastic grocery bags in the refrigerator and freezer that contained unknown items. -There were several undated and unlabeled storage bags in the freezer that contained meat; ice had formed inside the bags with the meat. Interview with a medication aide (MA) on 09/17/26 at 8:54am and 3:05pm revealed: -She and the owner were responsible for labeling and dating open food items. -She became distracted and forgot to label the items after removing them from the original bulk packaging. -Some of the items in the plastic grocery bags belonged to staff members. -She was aware that opened food items were supposed to be labeled and dated. Interview with the Administrator on 09/17/26 at 2:47pm revealed: -All open food items were supposed to be labeled and dated. -He was not aware there were open food items that were unlabeled and undated in the refrigerator and freezer. -He conducted a general walkthrough when he was at the facility once per week.	C 257		

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C 257	Continued From page 11 -The MA and owner were responsible for making sure all open food items were labeled. Interview with the Owner on 09/17/26 at 10:28am revealed: -She was aware all opened foods in the refrigerator and freezer were supposed to be labeled and dated. -Facility staff knew what the food was in the unlabeled and undated storage bags. -She and the MA were responsible for labeling and dating all opened food items. -She and the MA forgot to label and date the opened items.	C 257		
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued	C 291		

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C 291	Continued From page 12 activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to prepare a monthly calendar of planned group activities by the first day of each month. The findings are: Review of the facility's current license effective 01/01/26 revealed: -The capacity was 6. -The license would expire on 12/31/26. Review of the facility's census report on 09/17/26 revealed there were 2 residents living in facility. Review of the facility's activity calendar on 09/17/26 revealed: -There were at least 14 hours of scheduled activities weekly. -The calendar was dated for August 2025. Interview with a resident on 09/17/26 at 8:38am revealed: -The facility had plenty of games, cards, and puzzles.	C 291		

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C 291	Continued From page 13 -Staff got the residents together and asked them if they wanted to do different things but she preferred to watch television. Interview with a second resident on 09/17/26 at 12:38pm revealed: -The staff did not do many activities. -She did not want to do other activities because she preferred to watch her television shows. Interview with medication aide (MA) on 09/17/26 at 3:05pm revealed: -The activity calendar dated August 2025 was completed by a previous staff member. -She was unsure when the calendar was last updated, so she guessed the calendar had not been updated since August 2025 since the date on the calendar was August 2025. -She did not use the calendar to engage the residents in activities because she knew what the residents liked to do. -The facility only had two residents, so she asked them daily what they wanted to do. -She offered activities to the residents, but they preferred to watch television. -The residents had a routine that included television shows that they liked to watch at certain times, watering the flowers, and feeding the cats. -She was not aware of the activity calendar was supposed to be updated monthly. Interview with the Administrator on 09/17/26 at 2:47pm revealed: -He was responsible for making sure the activities calendar was completed but he did not actually do the activities calendar. -The MA had been designated to complete the activities calendar along with the owner of the facility. -He was not aware the activity calendar was	C 291		

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C 291	Continued From page 14 dated August 2025. -The activity calendar was supposed to be updated monthly. -He was unsure why the activity calendar had not been updated.	C 291		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family 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 interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 2 sampled residents (#2) including a medication used to treat high blood sugar. The findings are: Review of Resident #2's current FL-2 dated 09/25/25 revealed: -Diagnoses included type 2 diabetes, congestive heart failure, hyperlipidemia, and paranoid schizophrenia. -There was an order for Novolog Flexpen (a rapid-acting insulin used to treat high blood sugar) 100units/ml, check blood sugar before	C 330		

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meals and at bedtime, inject 3 units for blood sugar 201-250, 4 units for 251-300, 5 units for 301-350, 6 units for 351-400, 8 units for 401-450, 10 units for greater than 450 and call primary care provider (PCP).

Review of an office visit note from Resident #2's Endocrinologist signed and dated 03/30/26 revealed:
-There was an order for Resident #2 to continue testing blood sugar four times per day and continue the sliding scale of Novolog before meals correction scale.
-Stapled to the front of the visit note was a sheet with a before meal correction scale and a 2 hour after meal correction scale.
-The correction scale sheet was unsigned and undated and had 2 different fax dates at the top: "Received 01/19/2024 4:14pm" and "10/05/2025 10:38".
-The before meal correction scale was: inject 2 units for 150-200, 3 units for 201-250, 4 units for 251-300, 5 units for 301-350, 6 units for 351 to 400, 8 units for 401-450 and 10 units for greater than 450 and call the PCP.
-The 2 hours after meal correction scale was: 2 units for 200-250, 3 units for 251-300, 4 units for 301-350, 5 units for 351-400, 6 units for 401-450, and 8-10 units for greater than 450.

Review of an electronic prescription (escript) from the facility's contracted pharmacy, electronically signed by Resident #2's PCP on 07/20/26, revealed there was an order for Novolog 100 unit/ml Flexpen, inject 2 units for blood sugar 200-250, 4 units for 251-300, 6 units for 301-350, 8 units for 351-400, 10 units for 401-450 and 12 units for greater than 450 and call PCP.

Review of Resident #2's July 2026 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Novolog Flexpen Syringe, check blood sugar before meals and at bedtime, inject 3 units for blood sugar of 201-250, 4 units for 251-300, 5 units for 301-350, 6 units for 351-400, 8 units for 401-450, and 10 units for greater than 450 and call PCP, scheduled to be administered 7:30am, 11:30am, 4:30pm and 8:00pm.
-Blood sugar readings and units of Novolog administered were documented on an attachment sheet titled Accucheck/Insulin report.
-Novolog was documented as 4 units administered on 07/05/26 at "noon" for a blood sugar of 305 when 5 units should have been administered.
-Novolog was documented as 2 units administered on 07/13/26 at "noon" for a blood sugar of 202 when 3 units should have been administered.
-Novolog was documented as 2 units administered on 07/15/26 at "noon" for a blood sugar of 229 when 3 units should have been administered.
-Novolog was documented as 2 units administered on 07/19/26 at "noon" for a blood sugar of 224 when 3 units should have been administered.
-Novolog was documented as 2 units administered on 07/04/26 at "bedtime" for a blood sugar of 215 when 3 units should have been administered.
-Novolog was documented as 2 units administered on 07/07/26 at "bedtime" for a blood sugar of 231 when 3 units should have been administered.
-There was a blank space for units of Novolog administered on 07/09/26 at "bedtime" for a blood sugar of 242 when 3 units should have been

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administered.
-Novolog was documented as 3 units administered on 07/12/26 at "bedtime" for a blood sugar of 262 when 4 units should have been administered.
-Novolog was documented as 0 units administered on 07/17/26 at "bedtime" for a blood sugar of 217 when 3 units should have been administered.
-Novolog was documented as 2 units administered on 07/18/26 at "bedtime" for a blood sugar of 211 when 3 units should have been administered.
-Novolog was documented as 3 units administered on 07/21/26 at "bedtime" for a blood sugar of 300 when 4 units should have been administered.
-Novolog was documented as 4 units administered on 07/23/26 at "bedtime" for a blood sugar of 345 when 6 units should have been administered.

Review of Resident #2's August 2026 eMAR revealed:
-There was an entry for Novolog Flexpen Syringe, check blood sugar before meals and at bedtime, inject 2 units for blood sugar of 200-250, 4 units for 251-300, 6 units for 301-350, 8 units for 351-400, 10 units for 401-450, and 12 units for greater than 450 and call PCP, scheduled to be administered 7:30am, 11:30am, 4:30pm and 8:00pm.
-Blood sugar readings and units of Novolog administered were documented on an attachment sheet titled Accucheck/Insulin report.
-Novolog was documented as 3 units administered on 08/04/26 at "Dinner" for a blood sugar of 251 when 4 units should have been administered.
-Novolog was documented as 3 units

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administered on 08/11/26 at "Dinner" for a blood sugar of 251 when 4 units should have been administered.
-Novolog was documented as 0 units administered on 08/12/26 at "Dinner" for a blood sugar of 237 when 2 units should have been administered.
-There was a blank space for units of Novolog administered on 08/16/26 at "bedtime" for a blood sugar of 204 when 2 units should have been administered.
-There was a blank space for units of Novolog administered on 08/18/26 at "bedtime" for a blood sugar of 283 when 4 units should have been administered.
-Novolog was documented as 0 units administered on 08/24/26 at "bedtime" for a blood sugar of 200 when 2 units should have been administered.

Review of Resident #2's September 2026 eMAR revealed:
-There was an entry for Novolog Flexpen Syringe, check blood sugar before meals and at bedtime, inject 2 units for blood sugar of 200-250, 4 units for 251-300, 6 units for 301-350, 8 units for 351-400, 10 units for 401-450, and 12 units for greater than 450 and call PCP, scheduled to be administered 7:30am, 11:30am, 4:30pm and 8:00pm.
-Blood sugar readings and units of Novolog administered were documented on an attachment sheet titled Accucheck/Insulin report.
-Novolog was documented as 3 units administered on 09/03/26 at "Dinner" for a blood sugar of 251 when 4 units should have been administered.
-Novolog was documented as 3 units administered on 09/04/26 at "Dinner" for a blood sugar of 256 when 4 units should have been

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C 330	Continued From page 19 administered. -Novolog was documented as 0 units administered on 09/17/26 at "bedtime" for a blood sugar of 242 when 2 units should have been administered. Interview with Resident #2 on 09/18/26 at 5:00pm revealed: -Staff checked her blood sugar at 8:00am, 12:00pm, 4:00pm and at bedtime. -She received insulin based on a sliding scale provided by her doctor. -She thought her insulin was administered correctly. -She had not had any blood sugar issues. Telephone interview with a pharmacist with the facility's contracted pharmacy on 09/19/26 at 12:54pm revealed: -The most recent Novolog 100unit/ml order for Resident #2 was dated 07/20/26 and ordered by Resident #2's PCP through escript. -The order was to check Resident #2's blood sugar before meals and at bedtime. -The sliding scale for Resident #2 from the 07/20/26 order was to inject 2 units of insulin for a blood sugar of 200-250, 4 units for 251-300, 6 units for 301-350, 8 units for 351-400, 10 units for 401-450 and 12 units for greater than 450 and call the PCP. -The previous order from Resident #2's PCP for Novolog was transferred to this pharmacy from a previous pharmacy in September 2025 with an order date of 09/17/24 and sliding scale of inject 3 units for a blood sugar of 201-250, 4 units for 251-300, 5 units for 301-350, 6 units for 351-400, 8 units for 401-450, and 10 units for greater than 450 and all PCP. -Pharmacy added orders to the eMAR based on orders received from medical providers.	C 330		

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-Novolog was filled for Resident #2 on 07/21/26 with 1 box of 5 pens that equaled 15ml; this was a 30 day supply if the maximum does was used every time administered.
-Based on the current order from 07/20/26, Resident #2 was not to be administered insulin for a blood sugar reading below 200.
-The risk associated with being administered less insulin than what was ordered was elevated blood sugar which could lead to negative effects on the kidneys, eyesight, and nerve damage over time.

Observation of Resident #2's medication on hand on 09/19/26 at 3:54pm revealed there was a Novolog Flexpen labeled with Resident #2's name and an expiration date of 01/31/28.

Interview with a medication aide (MA) on 09/17/26 at 4:08pm revealed:
-She administered insulin to Resident #2.
-She knew Resident #2's sliding scale from memory.

Interviews with the MA on 09/18/26 at 11:36am, 1:55pm and 2:02pm revealed:
-She used the sliding scale from Resident #2's Endocrinologist that was attached to the 03/30/26 visit note.
-She checked Resident #2's blood sugar before meals between 7:00am and 8:00am, 10:30 and 11:00am and 4:00pm and again after meals.
-The facility's owner checked Resident #2's blood sugar at bedtime.

Interview with the Administrator on 09/18/26 at 11:48am revealed:
-The MA and facility's owner were responsible for checking Resident #2's blood sugar and administering her insulin.
-The staff member who transported Resident #2

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to her appointments was responsible for making sure any order was specific and clear.
-If an order was not understood or was not clear, the MA was responsible for getting clarification from the prescriber.
-He was unsure what order and sliding scale the MA was using to administer Resident #2's insulin.

Interviews with the Administrator on 09/18/26 at 1:40pm and 2:00pm revealed:
-He was not aware of the Novolog order from Resident #2's PCP on 07/20/26.
-The facility's owner took Resident #2 to her appointments.
-Resident #2 went into her appointments alone.
-If the PCP did not write orders down, the facility did not know about the orders.
-Staff were supposed to request visit notes and signed orders from PCPs when they transported residents to their appointments.
-He did not know why the 07/20/26 Novolog order was not obtained from Resident #2's PCP.

Interview with the facility's owner on 09/18/26 at 12:20pm revealed:
-She checked Resident #2's blood sugar before breakfast, lunch, dinner and at bedtime.
-She did not think Resident #2 was supposed to get insulin if her blood sugar was below 200.

Interview with the medical assistant at Resident #2's Endocrinology office on 09/18/26 at 10:57am revealed the Endocrinologist would be better able to answer questions regarding Resident #2 but was not available.

Attempted telephone interview with Resident #2's PCP on 09/18/26 at 1:22pm was unsuccessful.

The facility failed to administer medication as

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C 330	Continued From page 22 ordered to 1 of 2 sampled residents (#2). Resident #2 received less insulin than ordered on 21 occasions putting the resident at risk for increased blood sugars which could lead to negative effects on the kidneys and eyesight and cause nerve damage. This failure 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 09/18/26 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 2, 2026.	C 330		