STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			_			
		HAL027003	B. WING 03/31/2022			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING DI K, NC 27958	RIVE		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
{D 000}	Initial Comments		{D 000}			
	_	sure Section conducted a larch 30, 2022 through				
{D 310}	10A NCAC 13F .0904 Service	e(e)(4) Nutrition and Food	{D 310}			
	(e) Therapeutic Diets(4) All therapeutic die supplements and thic	Nutrition and Food Service in Adult Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.				
	interviews the facility diets as ordered by th (PCP) for 1 of 5 samp	as evidenced by: as, record reviews, and failed to serve therapeutic ae primary care provider bled residents who had a d diet and honey thickened				
	The findings are:					
	-Her level of care was -Resident #1 had a di with honey thickened	dementia and lux disease (GERD). ermittently disoriented. s Special Care Unit (SCU). et order of pureed foods				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1` '			X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL027003	B. WING		R-C 03/31	; /2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
CURRITU	CK HOUSE	141 MOYO	OCK LANDING I	DRIVE		
CORRITO	CK HOUSE	MOYOCK	, NC 27958			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE
{D 310}	Continued From page	e 1	{D 310}			
	foods that was ordere provider (PCP) on 01, -Resident #1 had an o					
	Observation of a printed diet order list in the kitchen for residents on the SCU on 03/30/22 at 11:30am revealed Resident #1 was listed as having a pureed diet with honey thickened liquids. Review of the facility's weekly diet menu revealed:					
	-The lunch menu for (sandwich, capri blend sandwich.	03/30/22 listed turkey deli I, milk, and ice cream				
	-Kielbasa sausage was substituted for the turkey deli sandwich, broccoli was substituted for the capri blend, and jello was substituted for the ice cream sandwich. -Baked beans were added to the menu. -The lunch menu for 03/31/22 listed chicken patty sandwich, mixed vegetables, sweet potato tots, milk, and fresh pears.					
	-Sweet potato fries we	ere substituted for sweet pple upside down cake was				
	the main kitchen on 0 revealed a dietary aid	le poured water and tea for prepackaged and labeled				
	11:56am-12:14pm rev -She was seated in a SCU dining room.	ent #1 on 03/30/22 from /ealed: wheelchair at a table in the				

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STATE FORM 5K0H12 If continuation sheet 2 of 9

DIVISION	n rieaitii Service Regu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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			D WING		R-	
HAL027003		B. WING		03/3	31/2022	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET A			TE, ZIP CODE		
CURRITU	CK HOUSE		OCK LANDING	DRIVE		
		MOYOCK	, NC 27958			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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{D 310}	Continued From page	2	{D 310}			
	. •					
	Kielbasa sausage wh					
	consistency, broccoli					
	consistency, and bake	ed beans which was a				
	pureed consistency.					
	-She was served water	er and tea which was a				
	honey thickened cons	sistency.				
	-The resident was be	ing fed by a medication aide				
	(MA).					
	-The resident took on	e bite of the pureed				
	sausage and stated s	he did not like it.				
	-The resident took on	e bite of the baked beans				
	and stated she did no	ot like it.				
	-The resident refused	to try the broccoli.				
		pts to get Resident #1 to try				
	the food again.	,				
		asked the resident if she				
	wanted jello instead o					
	_	er brought jello which was				
	•	resident's table in a bowl.				
		t #1 coughed while eating				
	-	gave her honey thickened				
	water to drink.	gave nor noney unexerted				
	-The resident ate 100	nercent of the jello				
	-THE TESIGETICALE TOO	percent of the jeno.				
	Observation of the SC	CU kitchen on 03/30/22 at				
	12:12pm revealed:	30 Interior on 00/00/22 at				
	-There was jello in the	a refrigerator				
	-	ernative dessert in the				
	refrigerator or on the					
	reingerator or on the	lood cart.				
	Interview with the DM	I on 03/30/22 at 11:31am				
	revealed:	1 011 03/30/22 at 11.3 falli				
		parad in the main kitchen				
	and then taken to SC	pared in the main kitchen				
	_	O to be served to the				
	residents there.					
	-The facility was servi					
	_	llo could be served as part				
	of Resident #1's orde					[
		oudding cup to be served to				[
	Resident #1 instead of	of jello.				

Division of Health Service Regulation

STATE FORM 5899 5K0H12 If continuation sheet 3 of 9

Division of	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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					R-C	
HAL027003		B. WING		03/3	1/2022	
NAME OF D	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	,		
CURRITU	CK HOUSE	141 MOY	OCK LANDING	DRIVE		
001111110	J. (110001	MOYOCH	K, NC 27958			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
{D 310}	Continued From page	. 2	{D 310}			
(D 310)	Continued From page	= 3	10 3107			
	Interview with the DM	1 on 03/30/22 at 12:17 pm				
	revealed:	областва на тели рин				
		that if jello was served				
		eceive pudding instead.				
		v the SCU staff knew this but				
	it was the "general co					
		sent back to the SCU				
		served to Resident #1 but it				
	was not labeled with	Residents #1's name.				
	Observation of Resid	ent #1 on 03/31/22 from				
	12:02pm-12:07pm re	vealed:				
	-The resident was sea	ated in a wheelchair at a				
	table in the SCU dinir	ng room.				
		rved a lunch which consisted				
	of a chicken patty wh					
	consistency, mixed ve					
		and sweet potato fries which				
	was a pureed consist					
		-				
		er and tea which was a				
	honey thickened cons					
		ches which were a pureed				
		ere labeled with Resident				
	#1's name and labele	•				
		ing fed by a personal care				
	aide (PCA).					
	-There was no cough	ing noted.				
	Interview with a MA o	n 03/31/22 at 10:15am				
	revealed:					
	-Residents' food was	delivered to the SCU by				
	kitchen staff.	•				
		eled according to what type				
	of diet it was.					
		labeled with residents'				
		IGNOTED WITH TESTUELLS				
	names.	which dieto to some to the				
		which diets to serve to the				
		ey had been working with				
	the residents long en	ough to know which diets to				

Division of Health Service Regulation

STATE FORM 5899 5K0H12 If continuation sheet 4 of 9

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		_	_
HAL027003		B. WING		R-C 03/31/2022		
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CURRITUO	CK HOUSE		CK LANDING I	DRIVE		
		моуоск,	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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 310}	Continued From page	÷ 4	{D 310}			
	serve to them. -If she saw that a resishe would see if some the resident and if the available in the SCU main kitchen to get arresident's diet. -Resident #1 was on liquids. -Jello was not a thicker-She fed Resident #1 was the only dessert. -She did not look to salternative dessert award fed her what was give member. Interview with the Adrit-40pm revealed:	dent received the wrong diet ething else was available for ere was not an alternative kitchen she would go to the n alternative which fit the a pureed diet with thickened ened liquid. jello on 03/30/22 because it provided for the resident. ee if there was an ailable for Resident #1 and en to her by another staff				
	therapeutic diets as of the diets are ordered conditions. -Resident #1 was plan thickened liquids by the resident was aspiratir	rdered by the PCP. the residents received their rdered by the PCP because based on the resident's ced on a pureed diet with				
{D 367}	(j) The resident's me	(j) Medication Medication Administration dication administration accurate and include the	{D 367}			

Division of Health Service Regulation

STATE FORM 5899 5K0H12 If continuation sheet 5 of 9

DIVISION	n Health Service Negu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
						_
		B. WING		R-C		
		HAL027003	3:		03/3	1/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		141 MOV	OCK LANDING	DRIVE		
CURRITU	CK HOUSE		, NC 27958	DINVE		
		MOTOCK	, NC 2/950			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
{D 367}	Continued From page	2 5	{D 367}			
	(2) name of the modic	nation or trootmont order.				
	• ,	cation or treatment order;				
	• •	ge or quantity of medication				
	administered;					
	• •	ministering the medication				
	or treatment;					
		tion for the administration of				
		nents as needed (PRN) and				
		ılting effect on the resident;				
	(6) date and time of a					
	(7) documentation of	_				
		nents and the reason for the				
	omission, including re					
		the person administering				
	the medication or trea	atment. If initials are used, a				
	signature equivalent t	to those initials is to be				
	documented and mail	ntained with the medication				
	administration record	(MAR).				
	This Rule is not met	as evidenced by:				
	Based on interviews a	and record reviews, the				
		e the electronic medication				
	•	s were accurate for 1 of 5				
	sampled residents inc	cluding errors with insulin				
	administration (#4).	Ü				
	()					
	The findings are:					
	3					
	Review of Resident #	4's current FL-2 dated				
		agnoses included diabetes				
	mellitus.	J				
	·=···====*					
	Review of Resident #	4's physician order sheet				
		led there was an order for				
		in give 35 units at 8:00am,				
		less than 150 (Lantus is a				
		ed to treat high blood sugar).				
	iong acting insulin use	eu to treat nigh blood sugar).				
	Deview of Deside 19	Ala Fahmiami 2000 ala atrassi				
	medication administra	4's February 2022 electronic				

Division of Health Service Regulation

revealed:

STATE FORM 5899 5K0H12 If continuation sheet 6 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: R-C B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 141 MOYOCK LANDING DRIVE	red ;
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 141 MOYOCK LANDING DRIVE	
CURRITUCK HOUSE 141 MOYOCK LANDING DRIVE	
CURRITUCK HOUSE 141 MOYOCK LANDING DRIVE	
CURRITUCK HOUSE	
MOYOCK, NC 27958	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 367} Continued From page 6 {D 367}	
There was an entry for Lantus Solostar Insulin, administer 35 units, with instructions to hold if blood sugar was less than 150, scheduled for administration at 8:00am. On 02/06/22 at 8:00am, Resident #4's blood sugar was 123 and Lantus Solostar Insulin was documented as administered. On 02/09/22 at 8:00am, Resident #4's blood sugar was 135 and Lantus Solostar Insulin was documented as administered. On 02/22/22 at 8:00am, Resident #4's blood sugar was 132 and Lantus Solostar Insulin was documented as administered. On 02/22/22 at 8:00am, Resident #4's blood sugar was 132 and Lantus Solostar Insulin was documented as administered. On 02/06/22, 02/09/22, and 02/22/22 at 8:00am the medication aide (MA) documented the blood sugar result in the area for parameters noted, previous site used, and site. Review of Resident #4's March 2022 eMAR revealed: There was an entry for Lantus Solostar Insulin, administer 35 units, with instructions to hold if blood sugar was less than 150, scheduled for administration at 8:00am. On 03/07/22 at 8:00am, Resident #4's blood sugar was 143 and Lantus Solostar Insulin was documented as administered. On 03/13/22 at 8:00am, Resident #4's blood sugar was 143 and Lantus Solostar Insulin was documented as administered. On 03/23/22 at 8:00am, Resident #4's blood sugar was 143 and Lantus Solostar Insulin was documented as administered. On 03/26/22 at 8:00am, Resident #4's blood sugar was 143 and Lantus Solostar Insulin was documented as administered. On 03/26/22 at 8:00am, Resident #4's blood sugar was 140 and Lantus Solostar Insulin was documented as administered. On 03/26/22 at 8:00am, Resident #4's blood sugar was 140 and Lantus Solostar Insulin was documented as administered.	

Division of Health Service Regulation

-On 03/07/22, 03/13/22, 03/23/22, and 03/26/22

STATE FORM 5K0H12 If continuation sheet 7 of 9

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION HALDZ7003 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 141 MOYOCK LANDING DRIVE MOYOCK, NC 27988 TAG TAG SUMMARY STATEMENT OF DEFICIENCES 10 PROVIDER SPLAN OF CORRECTION MAY SEE PRECEDED BY FULL PRETATOR STREET ADDRESS, CITY, STATE, 2P CODE COURTING TAG TAG TO STATE ADDRESS, CITY, STATE, 2P CODE 141 MOYOCK, NC 27988 TAG TO STATE ADDRESS, CITY, STATE, 2P CODE 142 MOYOCK, NC 27988 TAG TO STATE ADDRESS, CITY, STATE, 2P CODE CROSS ARFEIGHAND CORRECTION MAY SEE PRECEDED BY FULL PRETATOR STATEMENT OF DEFICIENCES SEED TO STATEMENT OF TAKE SEED TO STATEME	Division of	<u>of Health Service Regu</u>	lation				
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NAME OF PROVIDER OR SUPPLIER SIRRET ADDRESS, CITY, STATE, ZIP CODE 141 MOYOCK LANDING DRIVE MOYOCK, NC. 27958 PROVIDERS IN ALL OF CORRECTION (FAGI LORTHOCK MOYOR LISC IDENTIFYING INFORMATION) (FAGI LORTHOCK MOYOR LISC IDENTIFYING INFORMATION) (FAGI LORTHOCK MOYOR LISC IDENTIFYING INFORMATION) (TAGI LORTHOCK MOYOR LISC IDENTIFY MOYOR LISC IDENTIFYING INFORMATION) (TAGI LORTHOCK MOYOR LISC IDENTIFY MOYOR LIS	AND PLAN C)F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
NAME OF PROVIDER OR SUPPLIER SIRRET ADDRESS, CITY, STATE, 2PP CODE 141 MOYOCK LANDING DRIVE MOYOCK, NC. 27988 PRICING PRECINATION OF THE PRECINCIPACES OF TULL PRECINATION OF THE PRECINCIPACING OF THE PRECINCIPACES OF TULL PRECINATION OF THE PRECINCIPACING OF THE PRECINCIPACES OF TULL PRECINATION OF THE PRECINCIPACING OF THE PRECINCIPACING OF THE PRECINCIPACING OF THE PRECINCIPACING OF THE PRECIDENCY (D 367) Continued From page 7 at 8:00 am the MA documented the blood sugar result in the area for parameters noted, previous site used, and site. Interview with Resident #4 on 03/30/22 at 9:15 am revealed: -The MA was responsible for administering her insulinThe MA always checked her blood sugar before giving her insulinShe was not able to recall if there were times when the MA held her insulin because of a lower result. Interview with an MA on 03/31/22 at 11:57 am revealed: -She was responsible for administering Resident #4 be medications on 02/22/22, 03/37/22, 03/37/32,						R ₋ C	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 141 MOYOCK LANDING DRIVE MOYOCK, NC 27958 MAJ ID SUMMARY STATEMENT OF DEPICIENCIES ID PREPIX (EACH CORRECTION SHOULD BE (PACH DEPICIENCY) AUST BE PRECEDED BY FULL PREPIX (EACH CORRECTION SHOULD BE (PACH DEPICIENCY) AUST BE PRECEDED BY FULL PREPIX (EACH CORRECTION SHOULD BE (PACH DEPICIENCY) DOWN FITE COMP. (D 367) at 8:00am the MA documented the blood sugar result in the area for parameters noted, previous site used, and site. Interview with Resident #4 on 03/30/22 at 9:15am revealed: -The MA awas responsible for administering her insulin. -She was not able to recall if there were times when the MA held her insulin because of a lower result. Interview with an MA on 03/31/22 at 11:57am revealed: -She was responsible for administering Resident #4 her medications on 02/22/22, 03/07/22, 03/37/22 (03/37/22), 03/37/22 (03/			HAI 027003	B. WING		1	
CURRITUCK HOUSE SUMMARY STATEMENT OF DEFICIENCIES MOYOCK, NO. 27958			TIALUZI 000			1 03/3	1/2022
COUNTING	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MOYOCK, NC 27988 MOYOCK, NC	CURRITU	CK HOUSE	141 MOY	OCK LANDING I	DRIVE		
(D 367) Continued From page 7 at 8:00am the MA documented the blood sugar result in the area for parameters noted, previous site used, and site to result in the manufaction on 02/22/22, 03/07/22. When Resident #4 on 03/30/22 at 9:15am revealed: -The MA was responsible for administering her insulin. -The MA always checked her blood sugar before giving her insulin. -The MA had her insulin because of a lower result. Interview with an MA on 03/31/22 at 11:57am revealed: -She was responsible for administering Resident #4 her medications on 02/22/22, 03/07/22. -When Resident #4's blood sugar was below 150, she held her Lantus Solostar Insulin per the order. -When a medication was held, there was an option on the computerized charting to hold and state the reason such as parameters not met. -For insulin documentation, she was not able to choose that option so she would document the blood sugar in the area for parameters not met. -For insulin documentation, she was not able to choose that option so she would document the blood sugar in the area for parameters not met. -She had not notified the Resident Care Coordinator (RCC) that insulin documentation was an issue when parameters were not met. Interview with the RCC on 03/31/22 12:36pm revealed: -She expected MA to document on the eMAR	CURRITU	JK HOUSE	MOYOCK	, NC 27958			
(D 367) Continued From page 7 at 8:00am the MA documented the blood sugar result in the area for parameters noted, previous site used, and site. Interview with Resident #4 on 03/30/22 at 9:15am revealed: -The MA awas responsible for administering her insulinThe MA always checked her blood sugar before giving her insulinShe was not able to recall if there were times when the MA held her insulin because of a lower result. Interview with an MA on 03/31/22 at 11:57am revealed: -She was responsible for administering Resident #4 her medications on 02/22/22, 03/07/22. 03/13/22, 03/23/22, and 03/26/22When Resident #4's blood sugar was below 150, she held her Lantus Solostar Insulin per the order: -When a medication was held, there was an option on the computerized charting to hold and state the reason such as parameters not metFor insulin documentation, she was not able to choose that option so she would document the blood sugar in the area for parameters not metShe had not notified the Resident Care Coordinator (RCC) that insulin documentation was an issue when parameters were not met. Interview with the RCC on 03/31/22 12:36pm revealed: -She expected MA to document on the eMAR				ID			
(D 387) Continued From page 7 at 8:00am the MA documented the blood sugar result in the area for parameters noted, previous site used, and site. Interview with Resident #4 on 03/30/22 at 9:15am revealed: -The MA was responsible for administering her insulin. -The MA was responsible for administering her insulin. -She was not able to recall if there were times when the MA held her insulin because of a lower result. Interview with an MA on 03/31/22 at 11:57am revealed: -She was responsible for administering Resident #4 her medications on 02/22/22, 03/07/22, 03/13/22, 03/23/22, and 03/26/22. -When Resident #4's blood sugar was below 150, she held her Lantus Solostar Insulin per the order. -When a medication was held, there was an option on the computerized charting to hold and state the reason such as parameters not met. -For insulin documentation, she was not able to choose that option so she would document the blood sugar in the area for parameters noted, previous site used, and site to show that she did not administer the insulin. -She had not notified the Resident Care Coordinator (RCC) that insulin documentation was an issue when parameters were not met. Interview with the RCC on 03/31/22 12:36pm revealed: -She expected MA to document on the eMAR		,					
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			document on the eMAR				
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eMAR in parenthesis to show it was held and

STATE FORM 6899 5K0H12 If continuation sheet 8 of 9

PRINTED: 04/22/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C
HAL027003			B. WING		03/31/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CURRITU	CK HOUSE	141 MOYO MOYOCK, I	CK LANDING I	DRIVE	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 367}	Continued From page	e 8	{D 367}		
{D 367}	there would be a reas parameters not met. -She was not aware t the blood sugar result previous site used, ar documenting that the Interview with the Adr 12:40pm revealed she	hat MAs were documenting ts under parameter notes, and results rather than medication was held.	{D 367}		

Division of Health Service Regulation

STATE FORM 5K0H12 If continuation sheet 9 of 9