Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: ________ B. WING ________	R-C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEBROOK RESIDENTIAL CENTER II	**304 HARRISON AVENUE YADKINVILLE, NC 27055**

(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 000	Initial Comments The Adult Care Licensure Section and Yadkin County Department of Social Services (DSS) conducted a follow-up and complaint investigation survey from 02/18/25 to 02/19/25.	D 000		
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 observations, interviews, and record reviews, the facility failed to ensure clarification or verification of medication and treatment orders for 2 of 3 residents (#1, #5) sampled including orders for fingerstick blood sugar checks (#1) and continuing a nebulizer treatment (#5). The findings are: 1. Review of Resident #1's current FL2 dated 08/21/24 revealed: -Diagnoses included type 2 diabetes mellitus, attention-deficit/hyperactive disorder, schizophrenia, and schizoaffective disorder.	D 344		

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-There was an order to check fingerstick (FSBS) before meals.
-There was an order for Novolog (a medication used to treat high blood sugar levels) flex pen 100 units/ml inject per sliding scale insulin (SSI) parameters: FSBS 0-70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units.

Review of Resident #1's record revealed signed physician's orders dated 10/10/24 for Novolog check FSBS three times a day before each meal and inject per SSI parameters: FSBS 00-70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units.

Review of Resident #1's record revealed physician's order from from Resident #1's Endocrinologist dated 01/20/25 for Novolog check FSBS three times a day before each meal and inject per SSI parameters: FSBS 0-70= 0 units, 70-130= 7 units, 131-180= 9 units, 181-250= 10 units, 251-300= 11 units, 301-350=12 units, 351-400= 14 units, and greater than 400= 16 units.

Review of Resident #1's January 2025 electronic medication administration record (eMAR) from 01/01/25 through 01/31/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400=

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14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm.
-There was no entry from 01/20/25 to 01/31/25 for Novolog check FSBS three times a day before each meal and inject per sliding scale: FSBS 0-70= 0 units, 70-130= 7 units, 131-180= 9 units, 181-250= 10 units, 251-300= 11 units, 301-350=12 units, 351-400= 14 units, and greater than 400= 16 units.

Review of Resident #1's February 2025 eMAR for 02/01/24 through 02/17/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm.
-There was no entry from 02/01/25 to 02/17/25 for Novolog check FSBS three times a day before each meal and inject per sliding scale: FSBS 0-70= 0 units, 70-130= 7 units, 131-180= 9 units, 181-250= 10 units, 251-300= 11 units, 301-350=12 units, 351-400= 14 units, and greater than 400= 16 units.

Review of Resident #1's progress notes and eMAR pass notes revealed there was no documentation Resident #1's primary care provider (PCP) or Endocrinologist had been contacted regarding clarification for an order on SSI parameters.

Interview with Resident #1 on 02/19/25 at 2:40pm revealed:
-They completed his FSBS frequently every day

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and sometimes his insulin changes.
-He was not sure how much insulin he received and was not sure if his insulin orders had changed recently, but he usually received insulin every day.
-He denied any current symptoms related to headaches or dizziness.

Telephone interview with Resident #1's PCP on 02/19/25 at 3:00pm revealed:
-She was not aware of the new SSI parameter orders from Resident #1's Endocrinologist visit on 01/20/25.
-She would have expected the facility to contact her and Resident #1's Endocrinologist to clarify orders for Novolog insulin administration regarding any SSI parameter changes.

Interview with a medication aide (MA) on 02/19/25 at 4:53pm revealed:
-She was not aware of the new order from 01/20/25 for Resident #1's SSI parameters.
-The Resident Care Coordinator (RCC) and the Operation Manager (OM) were responsible for reviewing physician notes for new orders and for following up with the residents PCP for clarification of orders.
-The MAs administered medications however they showed up on the eMAR and she had not been given an order to change Resident #1's Novolog administration.

Interview with the RCC on 02/19/25 at 5:13pm revealed:
-She was not aware of the new order from 01/20/25 for Resident #1's new SSI parameters.
--The OM performed physician visit notes monitoring and reviewing, but she would help when she was not working as an MA.

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Interview with the Operation Manager (OM) on 02/19/25 at 4:15pm revealed:
-She was not aware of the new SSI parameters from the Endocrinologist order on 01/20/25 because she had not reviewed the visit notes.
-The SSI parameters order from 01/20/25 should have been reviewed by the RCC or OM and then clarified with Resident #1's PCP and Endocrinologist.
-She and the RCC were responsible for contacting Resident #1's PCP and Endocrinologist for clarification of his SSI order, but she was not aware of the new order from 01/20/25.

Refer to interview with the Manager on 01/19/25 at 5:50pm.
-He was not aware of the new order from 01/20/25 for Resident #1's new SSI parameters.
-The SSI insulin order should have been clarified with Resident #1's PCP and Resident 1's Endocrinologist.
-The RCC and the OM should file the providers orders or changes in the order log to ensure orders are clarified and followed up on.
-He expected all orders to be clarified and followed up on.

Refer to interview with the Administrator on 01/19/25 at 5:30pm.

Attempted telephone interview with Resident #1's Endocrinologist on 02/19/25 at 3:30pm was unsuccessful.

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2. Review of Resident #5 current FL2 dated 12/16/24 revealed:
-Diagnosis included pulmonary emphysema, dyspnea and chronic respiratory insufficiency.

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-There was an order for budesonide (inhaled medication used to treat narrowing and inflammation in the lungs) 0.25mg inhale 1 vial via nebulizer 2 times a day.

Review of Resident #5's signed physician's order from the Pulmonologist dated 01/13/25 revealed:
-There was an order for ensifentrine (inhaled medication to treat narrowing and inflammation in the lungs) 3mg by nebulizer 2 times a day.
-There was an order to discontinue budesonide 0.25mg 2 times a day.

Review of Resident #5's Pulmonologist progress notes dated 01/14/25 revealed:
-The communication provided by the facility was faxed to the facility on 01/14/25.
-The ensifentrine could not be ordered due to cost.
-Resident #5 was to continue to receive budesonide since she could not start ensifentrine.

Review of Resident #5's January 2025 eMAR revealed:
-There was no entry for ensifentrine 3mg in 2.5ml inhale 1 vial via nebulizer 2 times a day that started and stopped on 01/13/25.
-There was 1 entry on 01/13/25 at 8:00pm to document the ensifentrine 3mg was not administered due being a new medication order.
-There was an entry for budesonide 0.25mg/2ml inhale 1 vial via nebulizer 2 times a day that started on 01/01/25 and stopped on 01/13/25 schedule for 8:00am and 8:00pm.

Review of Resident #5's progress notes and eMAR pass notes revealed there was no documentation Resident #5's primary care provider (PCP) or Pulmonologist had been contacted regarding clarification or an order to

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continue budesonide.

Interview with Resident #5 on 02/19/25 at 2:30pm revealed:
-She had several inhalers and nebulizers for her breathing.
-She felt her breathing was not better but also no worse in the last month or so.
-She removed her oxygen several times a day to walk outside to smoke cigarettes.
-The Pulmonologist changed some of her breathing medications but she could not remember which ones were ordered now.

Telephone interview with a representative from Resident #5's Pulmonologist on 02/19/25 at 1:20pm revealed:
-Resident #5 had a consultation visit for severe COPD on 01/13/25.
-She was ordered ensifentrine 3mg 2 times a day via nebulizer but it did not receive insurance authorization and so was to continue budesonide 0.25mg 2 times a day via nebulizer as previously ordered.
-The facility was notified of the plan to continue budesonide via facsimile on 01/14/25.
-There was no documentation of the facility requesting another order for budesonide.
-Both medications have the same actions to treat shortness of breath in COPD.
-If Resident #5 did not receive COPD medications as order she could have an exacerbation.

Telephone interview with Resident #5's PCP on 02/18/25 at 2:59pm revealed:
-Resident #5 had chronic obstructive pulmonary disease (COPD) and had numerous inhalers and nebulizers.
-She was non-compliant and would use what medications she thought she needed and

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removed her oxygen multiple times a day to walk out of the facility to smoke cigarettes.
-She did not see the communication faxed to the facility on 01/14/25 to continue Resident #5's budesonide.
-The Pulmonologist should have written a new order but if they did not the facility notify her and she would have written the order to continue budesonide and any other plan from the specialist.
-She was not concerned that Resident #5 would have an exacerbation because she was ordered other inhalers and nebulizers to prevent that including another nebulizer medication that contained budesonide.

Interview with the Resident Care Coordinator (RCC) on 02/19/25 at 5:15pm revealed:
-She and the OM or the MA on duty when a resident returned to the facility from a hospital visit or medical appointment was responsible to review and orders or visit summary for medication changes.
-She did not see the note from Resident #5's pulmonologist to continue budesonide since the ensifentrine was too expensive for the resident.
-She had not contacted Resident #5's PCP or the Pulmonologist for clarification to continue budesonide as previously ordered.
-Resident #5 was historically non-compliant with her oxygen and her inhalers or nebulizers because she wanted to go outside to smoke cigarettes frequently.
-She had also worked as a MA in the past month and noted that Resident #5 did not have any changes in her breathing and had no complaints.

Interview with the OM on 02/19/25 at 4:17pm revealed:
-Resident #5 had an order to start ensifentrine

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3mg 2 times a day and to discontinue budesonide from her Pulmonologist in January 2025.
-She received the note from the Pulmonologist on 01/14/25 that ensifentrine could not be ordered for the resident due to cost and to continue budesonide as previously ordered.
-She thought she faxed the note back to the Pulmonologist and requested an order for budesonide.
-She and the RCC were responsible to clarify orders with residents' PCPs or specialists.

Interview with the Manager on 02/19/25 at 5:50pm revealed:
-He was aware Resident #5's insurance would not pay for ensifentrine ordered from the Pulmonologist but he did not see the note to continue budesonide.
- The RCC and the OM should file the providers orders or changes in the order log to ensure orders are clarified and followed up on.
-He expected all orders to be clarified and followed up on.

Refer to interview with the Administrator on 02/19/25 at 5:30pm.

Interview with the Administrator on 02/19/25 at 5:30pm revealed:
-The OM and RCC would be responsible to follow up on any provider visits to clarify orders.
- The RCC and the OM would be responsible to file the providers orders or notes in the order log to ensure every order is clarified and followed up on.
-She expected all orders to be clarified and followed up on.

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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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#1, #2, and #4) sampled residents including errors regarding sliding scale insulin (SSI) Novolog (#1), holding a long-acting insulin for fingerstick blood sugars (FSBS) less than 60 (#4) and administering a discontinued medication (#2). The findings are: 1. Review of Resident #1's current FL2 dated 08/21/24 revealed: -Diagnoses included type 2 diabetes mellitus, attention-deficit/hyperactive disorder, schizophrenia, and schizoaffective disorder. -There was an order to check fingerstick (FSBS) before meals. Review of Resident #1's record revealed Resident #1's signed physician's orders dated 10/10/24 for Novolog check FSBS three times a day before each meal and inject per sliding scale insulin (SSI) parameters: FSBS 00-70= 0 units,	D 358		

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70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units.

Review of Resident #1's December 2024 electronic medication administration record (eMAR) from 12/23/24 through 12/31/24 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm.
-FSBS's ranged from 56 to 600.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Novolog administered
-On 12/27/24 at 5:00pm, FSBS was 399 and 12 units of Novolog should have been administered but 14 units of Novolog was documented as administered on the eMAR.
-There was no additional notes for the amount of Novolog administered for 12/27/24.

Review of Resident #1's January 2025 eMAR from 01/01/25 through 01/31/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS 0-70= 0 units, 70-130= 6 units, 131-180= 8 units,

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181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm.
-FSBS's ranged from 65 to 600.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Novolog administered
-Examples of Resident #1's FSBS values documented on the January 2025 eMAR but documentation for the different amount of Novolog administered were as follows:
-On 01/02/25 at 5:00pm, FSBS was 330 and 11 units of Novolog should have been administered but 9 units of Novolog was documented as administered on the eMAR.
-On 01/03/25 at 12:00pm, FSBS was 400 and 12 units of Novolog should have been administered but 14 units of Novolog was documented as administered on the eMAR.
-On 01/29/25 at 12:00pm, FSBS was 400 and 12 units of Novolog should have been administered but 14 units of Novolog was documented as administered on the eMAR.
-On 01/30/25 at 12:00pm, FSBS was 312 and 11 units of Novolog should have been administered but 12 units of Novolog was documented as administered on the eMAR.
-There was no additional notes for the amount of Novolog administered for 01/02/05, 01/03/25, 01/29/25, and 01/30/25.

Review of Resident #1's February 2025 eMAR from 02/01/25 through 02/17/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 12 units/ml inject per SSI parameters: FSBS 0-70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and greater than 400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm. -FSBS's ranged from 114 to 596. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS value, and a space for documenting the amount of Novolog administered -Examples of Resident #1's FSBS values documented on the February 2025 eMAR but documentation for the different amount of Novolog administered were as follows: -On 02/08/25 at 5:00pm, FSBS was 223 and 9 units of Novolog should have been administered but 11 units of Novolog was documented as administered on the eMAR. -On 02/10/25 at 6:45am, FSBS was 158 and 8 units of Novolog should have been administered but 6 units of Novolog was documented as administered on the eMAR. -On 02/10/25 at 12:00pm, FSBS was 400 and 12 units of Novolog should have been administered but 14 units of Novolog was documented as administered on the eMAR. -On 02/14/25 at 6:45am, FSBS was 299 and 10 units of Novolog should have been administered but 9 units of Novolog was documented as administered on the eMAR. -On 02/15/25 at 6:45am, FSBS was 400 and 12 units of Novolog should have been administered but 14 units of Novolog was documented as administered on the eMAR. -There was no additional notes for the amount of Novolog administered for 02/08/25, 02/10/25, 02/14/25, and 02/15/25.	D 358		

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Observation of medications available for administration for Resident #1 on 02/19/25 at 10:00am revealed Novolog insulin was available for administration and was dispensed on 01/12/25.

Interview with Resident #1 on 02/19/25 at 2:40pm revealed:
-They completed his FSBS frequently every day and sometimes his insulin changes.
-He was not sure how much insulin he received and was not sure if his insulin orders had changed recently, but he usually received insulin every day.
-He denied any current symptoms related to headaches or dizziness.

Telephone interview with Resident #1's primary care provider (PCP) on 02/19/25 at 3:00pm revealed:
-She expected the facility staff to administer Resident #1's Novolog per the SSI parameters and document how many units of insulin were administered correctly.
-She would not be able to tell if Resident #1 received the correct amount of insulin if it was not documented correctly.

Interview with a medication aide (MA) on 02/19/25 at 4:53pm revealed:
-Resident #1 had Novolog insulin and FSBS 3 times a day.
-She could not say why Novolog insulin amounts were documented differently from the SSI parameter required amounts ordered by Resident #1's PCP.

Interview with the Resident Care Coordinator (RCC) on 02/19/25 at 5:15pm revealed:
-She also worked as an MA in the facility and

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performed FSBS and administered insulin to Resident #1.
-MAs should administer her Novolog insulin according to PCP orders.
-The Operations Manager (OM) performed medication administration monitoring, but she would help when she was not working as an MA.

Interview with the OM on 02/19/25 at 4:15pm revealed:
-Resident #1 had an order for FSBS 3 times a day.
-She expected MAs to administer his Novolog insulin as ordered.
-She and the RCC were responsible for auditing the eMARs for exceptions.
-She audited eMARs weekly but did not see that Resident #1's Novolog insulin amounts were administered differently than the SSI parameter requirements ordered by Resident #1's PCP.

Refer to interview with the Administrator on 02/19/25 at 5:30pm.

Refer to interview with the Manager on 02/19/25 at 5:50pm.
2. Review of Resident #4's FL2 dated 01/22/25 revealed:
-Diagnoses included insulin dependent diabetes type 2 and chronic pancreatitis.
-There was an order for basaglar insulin (long-acting insulin) inject 35 units 2 times a day.
-There was an order to hold all diabetic medications if finger stick blood sugar (FSBS) is less than 60.
-There was an order for finger stick blood sugar (FSBS) 3 times a day.

Review of Resident #4's signed physician's orders revealed:

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-There was an order dated 01/09/25 for basaglar insulin inject 35 units 2 times a day.
-There was an order dated 02/13/25 for basaglar insulin inject 40 units 2 times a day.
-There was an order dated 10/10/24 to administer orange juice if FSBS less than 60 and hold all diabetic medications.

Review of Resident #4's January 2025 electronic medication administration record (eMAR) from 01/09/25 to 01/31/25 revealed:
-There was an entry for basaglar insulin inject 35 units twice a day scheduled for administration at 8:00am and 8:00pm.
-There was an entry for humalog (short-acting insulin) insulin inject 13 units 3 times a day, hold for FSBS less than 100 scheduled at 7:00am, 12:00pm and 5:00pm with space to document FSBS values.
-There was an entry to administer orange juice if FSBS less than 60 and hold all diabetic medications ending 01/26/25.
-There was no documentation that orange juice was administered and diabetic medications held due to FSBS less than 60 from 01/09/25-01/26/25.
-Basaglar 35 units was documented as not administered for 5 opportunities due to no coverage needed BS (blood sugar) less than 100 for 01/11/25 12:00pm, 01/12/25 8:00am, 01/13/25 8:00am, 01/23/25 8:00am and 8:00pm.
-Basaglar 35 units was documented as not administered on 01/14/25 8:00pm due to no coverage needed BS 146 and 01/20/25 8:00pm no coverage needed BS 63.

Review of Resident #4's eMAR notes and progress notes revealed there was no documentation for an order to hold basaglar insulin 01/09/25-01/31/25.

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Review of Resident #4's February 2025 electronic medication administration record (eMAR) from 02/01/25 to 02/18/25 revealed:
-There was an entry 02/01/25-02/13/25 for basaglar insulin inject 35 units twice a day scheduled for administration at 8:00am and 8:00pm.
-There was a second entry 02/13/25-02/18/25 for basaglar insulin inject 40 units twice a day scheduled for administration at 8:00am and 8:00pm.
-There was an entry for humalog insulin inject 13 units 3 times a day, hold for FSBS less than 100 scheduled at 7:00am, 12:00pm and 5:00pm with space to document FSBS values.
-Basaglar 35 units was documented as not administered for 2 opportunities due to no coverage needed BS 49 for 02/04/25 08:00pm and 02/05/25 8:00am BS less than 100.
-Basaglar 40 units was documented as not administered on 02/16/25 8:00am due to no coverage needed BS less than 100.

Review of Resident #4's eMAR notes and progress notes revealed there was no documentation for an order to hold basaglar insulin 02/04/25, 02/05/25 or 02/16/25.

Observation of medication on hand for Resident #4 on 02/19/25 at 10:00am revealed there was basaglar insulin available for administration.

Interview with Resident #4 on 02/18/25 at 11:35am revealed:
-She received 2 insulins 2- or 3-times day but she did not know the names of them.
-She sometimes did not want her insulin when her stomach was upset or she felt her FSBS was low.

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-She allowed staff to obtain her FSBS but did not keep track of the values and just relied on staff to give her whatever her provider ordered.
-She had no recent hospitalizations due to high or low FSBS.

Telephone interview with Resident #4's primary care provider (PCP) on 02/19/25 at 3:03pm revealed:
-Resident #4 is ordered basaglar 40 units 2 times a day to control her blood sugar (BS) levels.
-The facility should have administered basaglar insulin unless her FSBS is less than 60.
-Resident #4 was non-compliant with medications and diet and therefore had fluctuation in her BS levels.
-She often walks to town and binge eats causing her BS to spike and basaglar was long-acting insulin to control the spikes.
.-Resident #4 had an as needed order to check FSBS because she often would tell staff her BS was low but most times it was not.

Interview with a MA on 02/19/25 at 4:53pm revealed:
-Resident #4 had humalog and basaglar insulin and FSBS 3 times a day.
-She had an order to hold lispro insulin if her FSBS was less than 100.
-She would refused her FSBS and insulin sometimes and say her stomach was bothering her.
-If Resident #4 had refused her insulin, she would have documented refused in the eMAR.
-She could not say why she held the basaglar and documented FSBS was less than 100 on any occasion.

Interview with the RCC on 02/19/25 at 5:15pm revealed:

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-She also worked as a MA in the facility and performed FSBS and administered insulin to Resident #4.
-Resident #4 had humalog and basaglar insulin but would refuse sometimes.
-She was aware Resident #4 had an order to hold all diabetic medications if FSBS was less 60.
-MAs should administer her basaglar insulin according to PCP orders.
-The Operations Manager (OM) performed medication administration monitoring but she would help when she was not working as a MA.

Interview with the OM on 02/19/25 at 4:17pm revealed:
-Resident #4 had an order to hold all diabetic medications if FSBS was less than 60.
-She expected MAs to administer or hold her basaglar insulin as ordered.
-She and the RCC were responsible for auditing the eMARs for exceptions.
-She audited eMARs weekly but did not see that Resident #4's basaglar insulin was being held for FSBS less than 100.

Refer to interview with the Administrator on 02/19/25 at 5:30pm.

Refer to interview with the Manager on 02/19/25 at 5:50pm.
3. Review of Resident #2's FL2 dated 05/01/24 revealed:
-Diagnosis included type 2 diabetes mellitus, hypertension, thyroid dysfunction, rheumatoid arthritis, seizures, and schizoaffective disorder.
-There was an order for Ibuprofen 400MG Tab, take one tablet by mouth twice a day for pain.

Review of Resident #2's signed physician order dated 07/06/24 revealed there was an order for

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ibuprofen 400mg Tab take 1 tablet by mouth twice a day for pain.

Review of Resident #2's signed physician order dated revealed there was an order dated 01/31/25 to discontinue ibuprofen 400mg Tab take 1 tablet by mouth twice a day for pain.

Review of Resident #2's January 2025 electronic medication administration record (eMAR) from 01/01/25 to 01/31/25 revealed:
-There was an entry for Ibuprofen 400MG 1 tablet twice a day for pain from 01/01/25-01/30/25.
-There was an entry to discontinue Ibuprofen 400MG 1 tablet on 01/31/25.

Review of Resident #2's February eMAR from 02/01/25 to 02/18/25 revealed there was an entry for Ibuprofen 400MG Tab with a discontinue date of 01/31/25.

Observation of medication on hand for Resident #2 on 2/19/25 at 12:45pm revealed:
-There was one bubble pack card of Ibuprofen 400MG with 2 of 28 pills left in the pack with a writing on the card that read "card 2 of 2".
-The bubble pack card of Ibuprofen 400MG had a start date of 01/23/25.

Attempted interview with Resident #2 on 02/19/25 at 12:55pm was unsuccessful.

Interview with the facility's local pharmacy on 02/19/25 at 2:48pm revealed Resident #2's Ibuprofen was not returned to the pharmacy.

Interview with Resident #2's PCP on 02/19/25 at 3:02pm revealed:
-She had discontinued Resident #2's order for Ibuprofen 400MG Tab on 01/31/25.

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-She was unaware Resident #2 was administered the Ibuprofen after following her orders to discontinue the medication.
-She expected facility staff to follow her orders for discontinued medications and return unused medications to the pharmacy for disposal.

Interview with a medication aide (MA) on 02/19/25 at 4:57pm revealed:
-There was no process for ensuring a resident's discontinued medication was returned to the pharmacy.
-Third shift MAs was responsible for returning discontinued medications to the pharmacy.
-The RCC was responsible for reviewing and ensuring discontinued medications were returned to pharmacy.

An interview with the RCC on 2/19/25 at 12:35pm revealed:
-She worked as an MA in the facility and administered medication to residents.
-Resident #2's PCP discontinued the residents order for Ibuprofen on 01/31/25.
-MAs were expected to stop administering discontinued medication to residents and were responsible for sending discontinued medication back to the pharmacy.
-She was aware an MA administered Resident #2's discontinued Ibuprofen after the medication was discontinued.
-She was responsible for ensuring discontinued medications were returned to the pharmacy.
-She had not returned Resident #2's discontinued Ibuprofen to the pharmacy after the physician discontinued Resident #2's order because she had worked more often as an MA.

Interview with the OM on 02/19/25 at 4:25pm revealed:

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-She expected MAs to not administer discontinued medications to residents and returned any discontinued medications to the pharmacy.
-MAs, the RCC, and the OM were responsible for reviewing discontinued orders from the physician and for returning the medication back to the pharmacy.
-It was her and the RCC's responsibility for auditing the medication carts for discontinued medication and for ensuring discontinued medications were returned to the pharmacy.
-She was responsible for conducting medication cart audits every 2 to 3 weeks.

Refer to interview with the Administrator on 02/19/25 at 5:29pm.

Refer to interview with the Manager on 02/19/25 at 5:50pm.

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Interview with the Administrator on 02/19/25 at 5:30pm revealed:
-The OM and RCC would be responsible to audit the residents' eMARs.
-MAs were to print an exceptions report from the eMAR for each resident at the end of each shift to include FSBS and medications not administered.
-The RCC and the OM would be responsible to ensure medication errors were addressed with MAs and corrected.
-She expected staff to administer or hold all medications as ordered by the provider and to return discontinued medication to the pharmacy.

Interview with the Manager on 02/19/25 at 5:50pm revealed:
-The OM and RCC were responsible to audit the residents' eMARs.

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D 358	Continued From page 22 -MAs were to print an exceptions report for every residents eMAR at the end of each shift for medications not administered. -The RCC and the OM would be responsible to ensure address and correct medication errors with MAs. -He expected staff to administer or hold all medications as ordered by the provider and to return discontinued medication to the pharmacy.	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; (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).	D 367		

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This Rule is not met as evidenced by:
Based on observation, record reviews, and interviews, the facility failed to assure the electronic Medication Administration Records (eMARS) were accurate for 3 of 5 sampled residents (#1, #3, and #4) regarding sliding scale insulin (SSI) Novolog (#2), relating to short-acting insulin (#4), and regarding to rapid-acting insulin (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 08/21/24 revealed:
-Diagnoses included type 2 diabetes mellitus, attention-deficit/hyperactive disorder, schizophrenia, and schizoaffective disorder.
-There was an order to check fingerstick (FSBS) before meals.
-There was an order for Novolog (a medication used to treat high blood sugar levels) flex pen 100 units/ml inject per sliding scale insulin (SSI) parameters: FSBS <70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and >400= 14 units.

Review of Resident #1's record revealed Resident #1's signed physician's orders dated 10/10/24 for Novolog check FSBS three times a day before each meal and inject per SSI parameters: FSBS 0<70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and >400= 14 units.

Review of Resident #1's December 2024 electronic medication administration record (eMAR) from 12/23/24 through 12/31/24 revealed:

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D 367	Continued From page 24 -There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm. -There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS <70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and >400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm. -FSBS's ranged from 56 to 600. -The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Novolog administered -There was no documentation of the amount of Novolog administered for 6 of 27 opportunities 12/23/24 to 12/31/24 for Resident #1. -Examples of Resident #1's FSBS values documented on the December 2024 eMAR notes but not documentation for the amount of Novolog administered were as follows: -On 12/24/24 at 6:45am, FSBS was 123 and 6 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 12/25/24 at 6:45am, FSBS was 394 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 12/26/24 at 6:45am, FSBS was 123 and 6 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 12/26/24 at 5:00pm, FSBS was 400 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 12/27/24 at 6:45am, FSBS was 279 and 10	D 367		

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units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 12/29/24 at 6:45am, FSBS was 169 and 8 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.

Review of Resident #1's January 2025 eMAR from 01/01/25 through 01/31/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS <70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and >400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm.
-FSBS's ranged from 65 to 600.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and a space for documenting the amount of Novolog administered
-There was no documentation of the amount of Novolog administered for 21 of 93 opportunities 01/01/25 to 01/31/25 for Resident #1.
-Examples of Resident #1's FSBS values documented on the September 2024 eMAR notes but not documentation for the amount of Novolog administered were as follows:
-On 01/03/25 at 6:45am, FSBS was 393 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 01/06/25 at 6:45am, FSBS was 354 and 12 units of Novolog should have been administered but no Novolog insulin was documented as

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administered on the eMAR.
-On 01/12/25 at 12:00pm, FSBS was 177 and 8 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 01/20/25 at 5:00pm, FSBS was 388 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 01/25/25 at 12:00pm, FSBS was 244 and 9 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 01/30/25 at 5:00pm, FSBS was 338 and 11 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.

Review of Resident #1's February 2025 eMAR from 02/01/25 through 02/17/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 6:45am, 12:00pm, and 5:00pm.
-There was an entry for Novolog flex pen 100 units/ml inject per SSI parameters: FSBS <70= 0 units, 70-130= 6 units, 131-180= 8 units, 181-250= 9 units, 251-300= 10 units, 301-350=11 units, 351-400= 12 units, and >400= 14 units scheduled for 6:45am, 12:00pm, 4:30pm, and 5:00pm.
-FSBS's ranged from 114 to 596.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS value, and a space for documenting the amount of Novolog administered
-There was no documentation of the amount of Novolog administered for 10 of 51 opportunities from 02/01/25 to 02/17/25.
-Examples of Resident #1's FSBS values

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documented on the October 2024 eMAR notes but not documentation for the amount of Novolog administered were as follows:
-On 02/02/25 at 6:45am, FSBS was 350 and 11 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 02/06/25 at 12:00pm, FSBS was 415 and 14 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 02/09/25 at 12:00pm, FSBS was 380 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 02/12/25 at 6:45am, FSBS was 412 and 14 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 02/13/25 at 5:00pm, FSBS was 329 and 11 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 02/15/25 at 12:00pm, FSBS was 332 and 11 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.

Observation of medications available for administration for Resident #1 on 02/19/25 at 10:00am revealed Novolog insulin was available for administration and was dispensed on 01/12/25.

Interview with Resident #1 on 02/19/25 at 2:40pm revealed:
-They completed his FSBS frequently every day and sometimes his insulin changes.
-He was not sure how much insulin he received and was not sure if his insulin orders had

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changed recently, but he usually received insulin every day.
-He denied any current symptoms related to headaches or dizziness.

Telephone interview with Resident #1's primary care provider (PCP) on 02/19/25 at 3:00pm revealed:
-She expected the facility staff to administer Resident #1's Novolog per the SSI parameters and document how many units of insulin were administered correctly.
-She would not be able to tell if Resident #1 received the correct amount of insulin if it was not documented correctly.
-If his Novolog was administered incorrectly, Resident #1 could have episodes of hyperglycemia (high blood glucose levels) or hypoglycemia (low blood glucose levels).

Interview with a medication aide (MA) on 02/19/25 at 4:53pm revealed:
-Resident #1 had Novolog insulin and FSBS 3 times a day.
-She could not say why Novolog insulin amounts were not documented as administered according to the SSI parameter requirements ordered by Resident #1's PCP.

Interview with the Resident Care Coordinator (RCC) on 02/19/25 at 5:13pm revealed:
-She also worked as a MA in the facility and performed FSBS and administered insulin to Resident #1.
-MAs should document when Resident #1's Novolog insulin was administered according to PCP orders.
-The Operations Manager (OM) performed medication administration monitoring but she would help when she was not working as an MA.

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-She was unaware MAs had not documented the amounts of Novolog insulin administered for each FSBS check.

Interview with the Operation Manager (OM) on 02/19/25 at 4:15pm revealed:
-Resident #1 had an order for FSBS 3 times a day.
-She expected MAs to administer his Novolog insulin as ordered.
-She and the RCC were responsible for auditing the eMARs for exceptions.
-She audited eMARs weekly but did not see that Resident #1's Novolog insulin amounts were not administered according to the SSI parameter requirements ordered by Resident #1's PCP.

Refer to interview with the Administrator on 02/19/25 at 5:30pm.

Refer to interview with the Manager on 02/19/25 at 5:50pm.
2. Review of Resident #4's FL2 dated 01/22/25 revealed:
-Diagnoses included insulin dependent diabetes type 2 and chronic pancreatitis.
-There was an order for humalog insulin (short-acting insulin) inject 13 units 3 times a day with meals hold FSBS is less than 100 or not eating.
-There was an order for finger stick blood sugar (FSBS) 3 times a day.

Review of Resident #4's signed physician's orders revealed:
-There was an order dated 12/19/24 for humalog insulin inject 9 units 3 times a day with meals hold FSBS is less than 100.
-There was an order dated 01/02/25 for humalog insulin inject 11 units 3 times a day with meals

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hold FSBS is less than 100 or not eating.
-There was an order dated 01/09/25 for humalog insulin inject 13 units 3 times a day with meals hold FSBS is less than 100 or not eating.

Review of Resident #4's January 2025 electronic medication administration record (eMAR) from 01/01/25 to 01/31/25 revealed:
-There was an entry 01/01/25-01/02/25 for humalog insulin inject 9 units 3 times a day, hold for FSBS less than 100 or not eating scheduled at 7:30am, 12:00pm and 5:30pm with space to document FSBS values.
-There was an entry 01/03/25-01/09/25 for humalog insulin inject 11 units 3 times a day, hold for FSBS less than 100 or not eating scheduled at 7:30am, 12:00pm and 5:30pm with space to document FSBS values.
-There was an entry beginning 01/10/25 for humalog insulin inject 13 units 3 times a day, hold for FSBS less than 100 or not eating scheduled at 7:00am, 12:00pm and 5:00pm with space to document FSBS values.
-There was documentation humalog was held due to no coverage needed FSBS 68 on 01/13/25 at 12:00pm.
-Humalog was documented as held due to no coverage needed FSBS less than 100 on 16 of 93 opportunities with no FSBS value documented.
-Some examples are as follows; 01/01/25 at 7:30am, 01/11/25 at 12:00pm, 01/15/25 at 12:00pm, 01/21/25 at 5:00pm and 01/31/25 at 5:00pm.

Review of Resident #4's February 2025 eMAR from 02/01/25 to 02/18/25 revealed:
-There was an entry for lispro insulin inject 13 units 3 times a day, hold for FSBS less than 100 or not eating scheduled at 7:00am, 12:00pm and

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D 367	Continued From page 31 5:00pm with space to document FSBS values. -Humalog was documented as held due to no coverage needed 02/10/25 at 5:00pm FSBS 67 and 02/17/25 resident did no eat breakfast. -Humalog was documented as held due to no coverage needed FSBS less than 100 on 10 of 52 opportunities with no FSBS value documented. -Some examples are as follows; 02/03/25 at 12:00pm, 02/07/25 at 12:00pm, 02/13/25 at 12:00pm, 02/14/25 at 5:00pm and 02/16/25 at 7:00am. Observation of medication on hand for Resident #4 on 02/19/25 at 10:00am revealed there was humalog insulin available for administration. Interview with Resident #4 on 02/18/25 at 11:35am revealed: -She received 2 insulins 2- or 3-times day but she did not know the names of them. -She sometimes did not want her insulin when her stomach was upset or she felt her FSBS was low. -She allowed staff to obtain her FSBS but did not keep track of the values and just relied on staff to give her whatever her provider ordered. -She had no recent hospitalizations due to high or low FSBS. Telephone interview with Resident #4's primary care provider (PCP) on 02/19/25 at 3:03pm revealed: -Resident #4 was ordered FSBS and humalog insulin 13 units 3 times a day to control her blood glucose levels. -The facility staff should document each FSBS so that she could assess the effectiveness of her insulin regiment and make changes as needed. -Resident #4 was non-compliant with medications	D 367		

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and diet and therefore had fluctuation in her FSBS levels.
-If her humalog was held or administered incorrectly, she could have episodes of hyperglycemia (high blood glucose levels) or hypoglycemia (low blood glucose levels).

Interview with a medication aide (MA) on 02/19/25 at 4:53pm revealed:
-Resident #4 had lispro and basaglar insulin and FSBS 3 times a day.
-She had an order to hold insulin if her FSBS was less than 100.
-She would refused her FSBS and insulin sometimes and say her stomach was bothering her.
-If Resident #4 had refused her insulin, she would have documented refused in the eMAR.
-She did not know MAs should document each FSBS value instead of FSBS less than 100.

Interview with the Resident Care Coordinator (RCC) on 02/19/25 at 5:15pm revealed:
-She also worked as a MA in the facility and performed FSBS and administered insulin to Resident #4.
-Resident #4 had humalog and basaglar insulin but refused her insulting sometimes.
-She was aware Resident #4 had an order to hold humalog insulin if FSBS was less than 100.
-MAs should document when Resident #4's humalog insulin was held due according to PCP orders.
-The Operations Manager (OM) performed medication administration monitoring but she would help when she was not working as an MA.
-She thought MAs documenting FSBS was less than 100 was sufficient and had not instructed MAs to document each FSBS value for each FSBS check.

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Interview with the OM on 02/19/25 at 4:17pm revealed:
-Resident #4 had an order to hold all humalog insulin if FSBS was less than 100.
-She expected MAs to administer or hold her humalog insulin as ordered.
-She and the RCC were responsible for auditing the eMARs for exceptions.
-She audited eMARs weekly but did not see that Resident #4's humalog insulin did not have FSBS values and MAs documented FSBS less than 100.

Refer to interview with the Administrator on 02/19/25 at 5:30pm.

Refer to interview with the Manager on 02/19/25 at 5:50pm.
3. Review of Resident #3's current FL2 dated 09/26/24 revealed:
-Diagnosis included diabetes, seizure disorder, and schizoaffective disorder.
-There was an order for an Aspart (rapid-acting insulin) flex pen 100units/ml inject 25 units before each meal hold for blood sugar (FSBS) level below 100.
-There was an order for finger stick blood sugar (FSBS) 3 times a day.

Review of Resident #3's signed physicians orders revealed:
-There was an order dated 09/19/24 for Aspart flex pen 100units/ml inject 25 units before each meal, hold if FSBS is less than 100.
-There was an order dated 03/10/24 for Aspart flex pen 100units/ml inject 15 units before each meal, hold if FSBS is less than 100.
-There was an order dated 07/11/24 for Aspart flex pen 100units/ml inject 7 units before each

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meal, hold if FSBS is less than 100.

Review of Resident #3's January 2025 electronic medication administration record from 01/01/25 to 01/31/25 revealed:
-There was an entry for Aspart flex pen inject 7 units with meals, hold if FSBS less than 100, scheduled for administration at 6:45am, 11:45am, and 4:30pm with space to document FSBS values.
- Aspart flex pen was documented as not administered due to no coverage needed for 5 opportunities when Resident #3's FSBS value was documented above 100.
-Examples are as follows; 01/01/25 at 6:45am, 01/03/25 at 6:45am, 01/04/25 at 6:45am, 01/09/25 at 6:45am, and 01/15/25 at 6:45am.
-Aspart flex pen was documented as administered on 01/03/25 at 4:30pm when FSBS was 83.
-There was no documentation that Aspart flex pen was administered on 01/29/25 at 4:30pm or documentation the resident received a FSBS.

Review of Resident #3's February 2025 eMAR from 02/01/25 to 02/18/25 revealed:
-There was an entry for Aspart flex pen inject 7 units subcutaneously with meals, hold if FSBS less than 100, scheduled for administration at 6:45am, 11:45am, and 4:30pm with space to document FSBS values.
-There was no documentation of FSBS or administration of Aspart flex pen on 02/01/25 at 6:45am.
-There was no documentation of FSBS or administration of Aspart flex pen on 02/12/25 at 6:45am.

Observation of medication on hand for Resident #4 on 2/19/25 at 12:20pm revealed there was

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Aspart insulin available for administration.

Attempted interview with Resident #3 on 2/19/25 at 1:05pm was unsuccessful.

Telephone interview with Resident #3's primary care provider (PCP) on 02/19/25 at 3:02pm revealed:
-Resident #3 was ordered Aspart insulin 7 units before every meal to control FSBS levels.
-Resident #3 was non-compliant with his medication and medications that fluctuated his FSBS levels.
-She had access to every resident's eMAR and reviewed the FSBS values periodically.
-She was unaware Resident #3's Aspart insulin was not administered when it was needed.
-She was unaware there was no documentation for FSBS values or no documentation for medication administration on the eMAR.

Interview with a medication aide (MA) on 02/19/25 at 4:20pm revealed:
-Resident #3 had Aspart insulin and FSBS before every meal.
-Resident #3 had an order to hold the insulin if his FSBS was less than 100.
-MAs should perform FSBS and administer insulin according to PCP orders.
-She was unaware Resident #3 had refused any FSBS checks but was aware he had refused his insulin.
-She was unaware insulin medication was not administered when coverage was needed.
-She was not instructed to enter FSBS levels less than 100 on the eMAR.

Interview with the Resident Care Coordinator (RCC) on 02/19/25 at 5:14pm revealed:
-She also worked as a MA in the facility and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 36	D 367		

performed FSBS and administered insulin to Resident #3.
-Resident #3 had Aspart and Lantus insulin but would refuse administration of medications.
-MAs should administer insulin according to PCP orders.
-The Operations Manager (OM) was responsible for performing medication administration monitoring but she would assist when she was not working as MA.

Interview with the OM on 02/19/25 at 5:29pm revealed:
-Resident #3 had an order to hold insulin if FSBS was less than 100.
-She expected MAs to administer medication according to PCP orders.
-She and the RCC were responsible for auditing the eMAR for exceptions.
-She audited the electronic medication record weekly.
-She was unaware of any instances where Resident #3's Aspart insulin was not administered when it was needed.

Refer to interview with the Administrator on 02/19/25 at 5:30pm.

Refer to interview with the Manager on 02/19/25 at 5:50pm.

Interview with the Administrator on 02/19/25 at 5:30pm revealed:
-The OM and RCC would be responsible for auditing the residents' eMARs.
-MAs were to print an exceptions report from the eMAR for each resident at the end of each shift to include FSBS and medications not administered.
- The RCC and the OM would be responsible to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099016	A. BUILDING: ______ B. WING ______	R-C 02/19/2025

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D 367	Continued From page 37 ensure medication errors were addressed with MAs and corrected. -She expected staff to administer or hold all medications as ordered by the provider and document each FSBS value. Interview with the Manager on 02/19/25 at 5:50pm revealed: -The OM and RCC were responsible for auditing the residents' eMARs. -MAs were to print an exceptions report for every residents eMAR at the end of each shift for medications not administered. -The RCC and the OM would be responsible to ensure address and correct medication errors with MAs. -He expected staff to administer or hold all medications as ordered by the provider and document each FSBS value.	D 367		