Recieved via e-mail 11-14-25

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FORM APPROVED

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 10/16/2025

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 conducted an annual and follow-up survey, and a complaint investigation from October 14, 2025 to October 16, 2025. The complaint investigation wasa initiated by the Yadkin County Department of Social Services on September 26, 2015.	D 000		
D 225	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from theDivision of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/healthbenefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following: (A) the date of notice; (B) the date of transfer or discharge; (C) the reason for the notice; (D) the name of responsible person or contact person notified; (E) the planned discharge location; (F) the appeal rights; (G) the contact information for the long-term care ombudsman; and (H) the signature and date of the administrator. (2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered,	D 225	The Administrator or designee will ensure that written notice is hand delivered or sent by certified mail to the responsible party or legal representative for the resident prior to discharging the resident. — Ammended for correction date ~~11.15.25~~ 11-14-25 for all citations per telephone with Operation Specialist 12/11/25 MP	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Bell/AH TITLE: Administrator (X6) DATE: 11/14/25

STATE FORM 6899 L89A11 If continuation sheet 1 of 24

EVPO

reviewed and acknowledged 12/12/25
MP

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D 225	Continued From page 1 with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following: (A) the name of the resident; (B) the name of the facility; (C) the date of transfer or discharge; (D) the date of scheduled transfer or discharge; (E) the selection of how the hearing is to be conducted; (F) the name of the person requesting the hearing; and (G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request. (3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident: (A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter; (B) a copy of the resident's current physician's orders, including medication order; (4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the	D 225		

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D 225	Continued From page 2 discharge. (5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the requirements for a written notice of discharge were met prior to discharging residents including a written discharge notice was hand delivered or sent by certified mail to the responsible party or legal representative for 1 of 3 sampled resident (#1) prior to discharging the resident. The finding are: Review of Resident #1's FL2 dated 10/03/24 revealed: -Diagnoses included hypertension, chronic obstructive pulmonary disease, hyperlipidemia, history of traumatic brain injury and chronic kidney disease. -She had a colostomy. -The level of care was domiciliary (rest home). Review of Resident #1's current FL2 dated 09/09/25 revealed: -Diagnoses included hypertension, chronic	D 225		

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D 225	Continued From page 3 obstructive pulmonary disease, hyperlipidemia, history of traumatic brain injury, chronic kidney disease, anxiety disorder, and mild mental retardation. -She had a colostomy. -The level of care was skilled nursing facility. Review of Resident #1's Resident Register revealed: -The resident was admitted to the facility on 10/02/24. -The resident's responsible person was documented as self. -Resident #1 was discharged to a local hospital on 09/18/25. -Resident #1 signed the discharge information on the Resident Register on 09/18/25. Review of Resident #1's Home Health discharge summary notes dated 09/13/23 revealed: -Resident #1 was admitted to Home Health skilled nursing on 03/14/25 for ostomy education and monitoring of skin surrounding ostomy site. -Resident #1 was discharged on 07/02/25 having met goals with staff knowledgeable of ostomy care. Review of Resident #1's Home Health nurses notes revealed: -Home Health staff visited the resident weekly. -On 03/14/25, Resident #1 was seen by Home Health for initial visit. -On 03/27/25, Resident #1 was treated for irritation of skin surrounding the soma site and ordered a cream for irritation. -On 05/01/25, Resident #1 had reinforcement to leave colostomy bag intact and not remove herself. -On 05/13/25, Resident #1 was instructed to keep ostomy bag intact: not to remove.	D 225		

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D 225	Continued From page 4 -On 06/03/25, Resident #1 observed getting bath due to leakage from ostomy bag soiling the resident. Facility staff reapplied bag with good technique. -On 06/11/25, "Resident continues to remove colostomy bag." Resident #1 was instructed to not remove colostomy bag. -On 06/15/25, Resident #1 was instructed to not remove colostomy bag. Resident requires reinforcement. -On 06/24/25, Resident #1 was instructed to not remove colostomy bag. Resident requires reinforcement. -On 07/02/25, Resident #1 was discharged from Home Health skilled nursing assistance with ostomy care. Review of Resident #1's facility's charting notes dated 09/18/25 at 1:11pm revealed: -Resident #1 was issued an immediate discharge. -The last page of the Resident Register was signed by the resident for acknowledge receipt. -A copy of the discharge along with the resident's primary care NP documentation was provided to the hospital. -The resident was her own responsible person. -The local Department of Social Services (DSS) was provided paperwork. Telephone interview with a social work case manager at a local hospital revealed: -Resident #1 was admitted to the hospital emergency department on 09/18/25 for evaluation of the resident's colostomy site. -Resident #1 was treated and the facility was notified that the resident was to be returned to the facility. -The facility staff said the resident could not be readmitted to the facility due to requiring	D 225		

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D 225	Continued From page 5	D 225		

treatment for an irritated colostomy site.
-The facility issued an immediate discharge for Resident #1 with the reason for discharge being the facility could not meet the needs of the resident.
-She contacted the resident's guardian for information and learned the guardian was not aware of the discharge of Resident #1 from the facility.

Review of Resident #1's Notice of Transfer/Discharge revealed:
-The date of notice was documented as 09/18/25.
-The date of discharge was 09/18/25.
-The reason for the notice was documented as "it was necessary for welfare and your needs cannot be met in this facility as documented by the resident's physician, physician assistant, or Nurse Practitioner (NP).
-Resident #1 was identified as own responsible person for notification.
-Resident #1 was being discharged to the hospital's Emergency Department (ED).
-The Administrator signed the Notice of Discharge on 09/18/25.
-There was an Adult Care Home Hearing Request Form attached to the Notice of Discharge, but no documentation that a hearing was requested.

Review of Resident #1's primary care NP triage note dated 09/18/25 revealed:
-The note documented that the facility cannot accommodate the resident's needs. The resident needs a higher level of care.
-Staff reported that the facility cannot meet resident's needs because of complication from colostomy and she needed a higher level of care.

Interview with Resident #1's primary care NP on 10/14/25 at 12:05pm revealed:

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D 225	Continued From page 6 -She assessed Resident #1 during routine visit to the facility. -Resident #1 frequently had leakage from her colostomy bag. -Resident #1 had a history of a traumatic brain injury and cognitive mental disorders. -Resident #1 tampered with her colostomy bag making it hard for facility staff to keep the resident free of bag leakage. -On 09/18/25, the facility contacted her related to the ostomy site looking very inflamed, red and irritated. The facility sent her a photo via cell phone. The NP requested Resident #1 be sent to the local ED for colostomy site evaluation and treatment. -She was concerned that Resident #1 could have an infection of the colostomy site. -Based on the type of bacteria that could come in contact with the site (feces), the risk for a septic infection was increased. -Due to the risk of an infection and the resident's tampering with the colostomy bag and adhesive attachment, the NP agreed that the facility could not meet the resident's needs for colostomy care. Interview with a morning shift personal care aide (PCA) on 10/14/25 at 1:40pm revealed: -Resident #1 would not leave her colostomy bag alone. She would try to empty the bag or removed the adhesive wafer that attached the bag to her body almost daily. -Facility staff had to shower her to remove leakage 4 to 5 times a week. -She did not see the colostomy site the day Resident #1 was sent to the ED. Interview with the Operations Manager (OM) on 10/15/25 at 10:40am revealed: -She was responsible to notify a resident's guardian of discharge if the Resident Register or	D 225		

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D 225	Continued From page 7	D 225		

additional paperwork identified a resident had a guardian.
-She was not aware resident #1 had a guardian.
-She personally delivered the discharge/transfer paperwork to the local hospital ED for the resident (identified as responsible for self) to sign on 09/18/25.
-She had never talked with Resident #1's guardian.
-The previous Business Office Manager may have had paperwork related to Resident #1's guardian but had not seen guardian information.
-She had never seen a guardian visit Resident #1.

Later interview with the OM on 10/16/25 at 3:40pm revealed:
-She had attempted to transfer Resident #1 after the Primary Care Provider (PCP) generated a new FL2 on 09/09/25 for skilled nursing care for the colostomy.
-She contacted a couple of skilled facilities but had not secured a placement for Resident #1.
-She had emails from a facility dated 09/10/25 indicating the facility was considering taking the resident (Email reviewed by surveyor).

Telephone interview with Resident #1's guardian on 10/15/25 at 2:00pm revealed:
-She worked for a county DSS other than the county where the resident currently resides.
-The county had been Resident #1's guardian since February 2014.
-She had been assigned Resident #1's guardianship for several years.
-Resident #1 was displaced from her previous facility due flooding from a natural disaster in October 2024.
-She visited Resident #1 at the current facility monthly.

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D 225	Continued From page 8 -Resident #1 was routinely outside smoking when she arrived. -She did not usually have contact with facility staff other than a PCA sometimes. -The facility was contacted in February 2025 for Paperwork related to renewing Resident #1 insurance. -She did not know who had been contacted for the paperwork. -Resident #1 had the colostomy from a bad accident years ago. -Resident #1 could not make decisions related to her health care. -She was informed Resident #1 had an immediate discharge from the facility when a local hospital case worker called her related to the immediate discharge. -She received had not information from the facility regarding the resident's discharge on 09/18/25. Interview with a medication aide (MA) on 10/15/25 at 4:25pm revealed: -She was working on 09/18/25 and sent Resident #1 to the ED for evaluation and treatment. -When she arrived 09/18/25 at 7:00am, she was cleaning Resident #1's colostomy bag and ostomy site. -The adhesive wafer was loose. -She observed the ostomy site was red and oozing blood when she tried to clean the site. -The resident grimaced in pain. -She contacted Resident #1's primary NP and sent a picture of the ostomy site to the provider. -She was told to send the resident to the local ED. Interview with the Administrator on 10/16/25 at 3:40pm revealed: -The OM was responsible for completing the discharge and right to appeal paperwork.	D 225		

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D 225	Continued From page 9 -Resident #1 came to the facility after her previous facility was flooded in October 2024. -The previous facility should have sent the guardianship paperwork along with the FL2 and admission package but she could not locate any paperwork for guardianship for Resident #1. -She reviewed the discharge paperwork for completeness and signed the discharge paperwork once reviewed. -The facility had new business office staff now. -The previous BOM would have provided paperwork if requested by a county DSS in February 2025. -If Resident #1 had a guardian , the Resident Register and all contact paperwork should have been updated by the BOM. -She did not know Resident #1 had a guardian, therefore no discharge paperwork was sent Resident #1's guardian.	D 225		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with respect, consideration, and dignity related to residents having to wake staff to administer as needed (PRN) medications. The findings are: Confidential interview with a resident on	D 338	The Administrator, RCC and/or designee will ensure that the rights of all residents are maintained and exercised without hinderence.The Administrator, RCC and/or designee will perform routine checks across all shifts to ensure compliance with the resident's rights.	

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D 338	Continued From page 10 10/14/2025 at 4:15pm revealed: -She said there is a medication aide (MA) that worked third shift who slept in her car during her shift. Last week she tried to find the MA to give her a PRN pain medication, but she was not in the building. -She went outside to the MA's car, and she was asleep in her car. -She woke up the MA and requested her PRN medication. -This was not the first time the MA had been asleep in her car. -The MA used to be in management, so she did not tell anyone. Confidential interview with a second resident on 10/15/2025 at 3:30pm revealed: -She was aware some staff sleep on third shift. -About two weeks ago she needed nose drops and had to wake a MA who was asleep in the television room. -Some staff on third shift also sleep in the phone room. -She had not told anyone in management because she did not want to be singled out. Confidential interview with a third resident on 10/15/2025 at 3:45pm revealed: -There was a staff member that slept in her car during third shift. -She did not have to wake her for any medications. -She became aware of it when she helped a new MA in training look for the other MA, and she was not in the building. -She was unsure of the date this occurred. -She had not reported this to management because the MA who was asleep was a manager before being demoted and she did not think	D 338		

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D 338	Continued From page 11 anything would be done. Interview with a MA on 10/16/2025 at 10:10am revealed: -She had only worked third shift twice since she was hired. -You were allowed to take a 30-minute break during the shift. -She never left the building during her breaks on third shift. -A staff member on third shift had complained about another staff member sleeping while in duty. -Several residents had complained to her about having to wake third shift staff to get their medication. -She had not reported anything to management. Interview with a second MA on 10/16/2025 at 10:35am revealed: -She worked third shift as a MA. -She was responsible for administering medications, doing rounds and two-hour checks on residents during her shift. -She did take one 30-minute break during her shift but never left the building. -She never went to sleep during her breaks. -She was not aware of anyone sleeping during their breaks. Interview with the on-call Supervisor on 10/16/2025 at 10:45am revealed: -She was the on-call Supervisor for third shift. -Staff were allowed a 30-minute break during their shift. -Some staff left the building and went to their cars for breaks. -She did not have a problem with staff sitting in their cars if she knew where they were if she needed them.	D 338		

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D 338	Continued From page 12 -She never had a compliant from staff or residents about staff sleeping in their cars during their work shift. Interview with a personal care aide (PCA) on 10/16/2025 at 10:55am revealed: -She worked third shift as a PCA. -She did take a 30-minute break during her shift. -She never left the building during her breaks. -She usually took her breaks in the television room. -She was not aware of staff sleeping during their breaks. Interview with Operations Manager (OM) on 10/16/2025 at 3:05pm revealed: -She was not aware residents had complained about having to wake staff during third shift to administer medications ordered as needed (PRN). -Staff were allowed a 30-minute break but must stay in the building or in the outside smoking areas or they must clock. -All staff were expected to be awake during their shift to care for residents. Interview with the Administrator on 10/16/2025 at 3:20pm revealed: -She had never had a complaint about staff sleeping on third shift. -She did not have any complaints from residents about having to wake third shift staff to get their PRN medications. -There was no policy on being awake during your shift, but it was best practice not to sleep during a wake shift. -A staff member could go to their cars on their break but could not leave the grounds if they wanted to get paid during their break. -She expected there to always be staff coverage	D 338		

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D 338	Continued From page 13 when a staff member was on break. -No resident should ever have to wake staff up to administer medications.	D 338		
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 administer medications as ordered for 1 of 5 sampled residents (#3) with an order for an insulin medication used to treat diabetes. The findings are: Review of Resident #3's current FL2 dated 06/26/25 revealed: -Diagnoses included type 2 diabetes mellitus, schizoaffective disorder, anxiety, ADHD, brain tumor, hepatomegaly, neuropathy, constipation, COPD, vitamin D deficiency, GERD, nicotine dependency and allergic rhinitis. -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= 7 units,	D 358	The Administrator, RCC and/or designee will ensure that all medication orders are given as ordered by signing physician. The Adfministrator, RCC and/or designee will perform frequent audits of all insulin medication to ensure that all orders are being followed as written.	

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	HAL099016	A. BUILDING: _____ B. WING _____	R 10/16/2025

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D 358	Continued From page 14 131-180= 9 units, 181-250= 10 units, 251-300= 11 units, 301-350=12 units, 351-400= 14 units, and >400= 16 units. Review of Resident #1's signed physician's orders dated 09/18/25 revealed an order for Novolog check FSBS three times a day before each meal and inject per SSI parameters: FSBS <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 >400= 16 units. Review of Resident #1's July 2025 electronic medication administration record (eMAR) from 07/22/25 through 07/31/25 revealed: -There was an entry to check FSBS three times a day before each meal scheduled at 7:00am, 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= 7 units, 131-180= 9 units, 181-250= 10 units, 251-300= 11 units, 301-350=12 units, 351-400= 14 units, and >400= 16 units 7:00am, 12:00pm and 5:00pm. -The eMAR had a space for documentation of the FSBS, the site of administration, documenting FSBS values, and a space for documenting the amount of Novolog administered. -There was no documentation of the amount of Novolog insulin administered for 24 opportunities from 07/22/25 to 07/31/25. -Examples were as follows: -On 07/23/25 at 12:00pm, FSBS was 260 and 11 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 07/23/25 at 5:00 pm, FSBS was 145 and 9 units of Novolog should have been administered but no Novolog insulin was documented as	D 358		

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D 358	Continued From page 15 administered on the eMAR. -On 07/29/25 at 7:00 am, FSBS was 444 and 16 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 07/29/25 at 12:00pm, FSBS was 145 and 9 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 07/29/25 at 5:00pm, FSBS was 198 and 10 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 07/31/25 at 12:00pm, FSBS was 395 and 14 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 07/31/25 at 5:00pm, FSBS was 179 and 9 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. Review of Resident #3's August 2025 eMAR from 08/01/25 through 08/31/25 revealed: -There was an entry to check FSBS three times a day before each meal scheduled at 7:00am, 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= 7 units, 131-180= 9 units, 181-250= 10 units, 251-300= 11 units, 301-350=12 units, 351-400= 14 units, and >400= 16 units 7:00am, 12:00pm and 5:00pm. -The eMAR had a space for documentation of the FSBS, the site of administration, documenting FSBS values, and a space for documenting the amount of Novolog administered. -There was no documentation of the amount of Novolog insulin administered for 84 opportunities from 08/01/25 to 08/31/25.	D 358		

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D 358	Continued From page 16 -Examples were as follows: -On 08/08/25 at 7:00 am, FSBS was 309 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/08/25 at 12:00pm, FSBS was 355 and 14 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/08/25 at 5:00pm, FSBS was 86 and 7 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/18/25 at 7:00 am, FSBS was 600 and 16 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/18/25 at 12:00pm, FSBS was 318 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/18/25 at 5:00 pm, FSBS was 119 and 7 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/30/25 at 7:00 am, FSBS was 331 and 12 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/30/25 at 12:00pm, FSBS was 152 and 9 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 08/30/25 at 5:00pm, FSBS was 381 and 14 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. Interview with Resident # 3 on 10/15/2/2025 at 3:00pm revealed:	D 358		

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D 358	Continued From page 17 -The Medication Aid (MA) checked his FSBS three times day. -He was not sure how much insulin he received each day. -He denied any current symptoms related to his bold sugar dropping or being too high. Interview with the Operations Manager (OM) on 10/16/2025 at 11:05am revealed: -She started working at the facility at the end of August. -She became aware there were no units documented on the eMAR for Novolog administered for the months of July and August when she completed the cart and eMAR audit. -She put a stop change order on the eMAR on 09/01/2025 that would not allow MA to click the administered tab until the units given were entered. -After 09/01/2025, all units given were documented on the eMAR. Interview with a medication aide (MA) on 10/16/2025 at 12:20pm revealed: -She had administered Resident #3 Novolog insulin for FSBS greater than (>) 70 3 times a day. -There was not a place to document how any units of Novolog insulin unit administered on the eMAR for July or August. -There was a place on the eMAR to document units of Novolog insulin given on the October eMAR. Interview with Resident #3's primary care provider (PCP) on 10/16/2025 at 12:30pm revealed: -She was not aware there were no units documented on the eMAR for Novolog administered for month of July and August. -She would not be able to tell if Resident #3	D 358		

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D 358	Continued From page 18	D 358		

received the correct amount of insulin if it was not documented correctly.
- Resident #3 had not had any episodes of hyperglycemia (high blood glucose levels) or hypoglycemia (low blood glucose levels) during the month of July or August.
-She expected the MAs to administer Resident #3's Novolog per the SSI parameters and document how many units of insulin were administered.

Telephone interview with facility pharmacy on 10/16/2025 at 2:35pm revealed:
-There was an order for a Novolog flex pen 100 units/ml inject per SSI parameters: FSBS <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 >400= 16 units 7:00am, 12:00pm and 5:00pm.
-Once the pharmacy received the order from the provider; the pharmacy staff would check the order for accuracy and enter the order on the eMAR.
-The pharmacy was responsible for ensuring there was an administration tab to enter units administered for Novolog, but the facility was responsible for approving and checking the order for accuracy.

Interview with the Administrator on 10/16/2025 at 3:30pm revealed:
-She was not aware there were no units documented on the eMAR for Novolog administered for the month of July and August.
-The OM was responsible for cart and eMAR audits.
-She expected MAs to document how many units of Novolog administered on the eMAR at the time of administration.

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D 367	Continued From page 19	D 367		
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). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#4) including documentation of blood sugars (BS). The findings are: Review of Resident #4's current FL-2 dated	D 367	The Administrator, RCC and/or designee will ensure that all medication orders are given as ordered by the signing physician. The Administrator, RCC and/or designee will check and approve all medication orders to ensure the Blood Sugars are to be recorded appropriately on the MAR. The Administrator, RCC and/or designee will perform routine audits of all insulin medication orders to ensure that all blood sugars are being recorded as ordered.	

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D 367	Continued From page 20 07/31/25 revealed: -Diagnoses included diabetes mellitus and hypertension. -There was an order for insulin aspart (a medication used to treat diabetes mellitus) 100 unit/mL pen (3mL) inject 25 units subcutaneously with meals, hold if blood sugar (BS) less than 100 and/or patient was not eating. Review of Resident #4's signed physician order dated 08/14/25 revealed there was an order for insulin aspart 100 unit/mL pen inject 23 units with meals, hold if glucose (BS) under 90. Review of Resident #4's clinic after visit summary dated 08/14/25 revealed there was a hemoglobin A1C (a blood test that provides an average of blood sugar levels over the past 2 to 3 months) result of 7.8% dated 08/14/25. Review of Resident #4's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for aspart flexpen 100 unit/ml, inject 25 units subcutaneously with meals, hold if BS less than 100 and/or patient was not eating. -There was an entry for aspart flexpen 100 unit/ml, inject 23 units subcutaneously with meals, hold if BS less than 90 or if not eating. -There were no documented BS values from 08/15/25 at 7:00am to 08/31/25 at 5:00pm except for 08/16/25 at 11:30am, 08/23/25 at 11:25am, 08/23/25 at 4:37pm, 08/26/25 at 6:30pm, 8/28/25 at 12:09pm and 08/30/25 at 11:25am. -Resident #4's insulin aspart was held due to Resident #4 not eating or BS below hold parameter on 08/15/25 at 5:42pm, 08/16/25 at 11:30am, 08/21/25 at 1:03pm, 08/22/25 at 6:28pm, 08/30/25 at 11:25am, 08/30/25 at	D 367		

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D 367	Continued From page 21 5:00pm and 08/31/25 at 11:38am. -It was unable to be determined if Resident #4's insulin aspart should have been administered because there were no documented BS values from 08/15/25 to 08/31/25 excluding 08/16/25 at 11:30am, 08/23/25 at 11:25am, 08/26/25 at 6:30pm, 8/28/25 at 12:09pm and 08/30/25 at 11:25am. Review of Resident #4's September 2025 eMAR revealed: -There was an entry for aspart flexpen 100 unit/ml, inject 23 units subcutaneously with meals, hold if BS less than 90 or if not eating. -There were no documented BS values from 09/01/25 at 7:00am to 09/02/25 at 12:00pm. -It was unable to be determined if Resident #4's insulin aspart should have been administered from 09/01/25 at 7:00am to 09/02/25 at 12:00pm because there were no documented BS values. Observation of the medications on hand for Resident #4 on 10/15/25 at 3:30pm revealed there was a 3mL insulin aspart pen opened on 10/13/25 available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/16/25 at 2:26pm revealed: -Resident #4 had an active order for insulin aspart inject 23 units with meals, hold for BS less than 90 or if not eating. -Resident #4's insulin aspart was dispensed on 10/16/25, 09/15/25, 08/14/25 and 07/22/25 for a quantity of five 3mL insulin aspart pens. -The pharmacy placed order entries on the eMAR but the facility approved order entries. -A selection box in the eMAR system had to be selected in the insulin aspart order for BS values to be recorded on the eMAR.	D 367		

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D 367	Continued From page 22 Interview with Resident #4's primary care provider (PCP) on 10/16/25 at 12:21pm revealed: -She did not know some of Resident #4's BS values were not documented from 08/15/25 to 09/02/25. -She would have expected facility staff to document BS values to know whether to hold Resident #4's insulin aspart. Interview with Resident #4 on 10/16/25 at 2:54pm revealed staff always checked his BS and checked his BS the last few months since August 2025. Interview with a medication aide (MA) on 10/15/25 at 4:25pm revealed: -She thought she documented Resident #4's BS values in August 2025 because the eMAR system required her to input a BS value before she could administer Resident #4's insulin aspart. -She thought someone approved Resident #4's insulin aspart order dated 08/14/25 incorrectly in the eMAR system because BS values were not documented on the eMAR. -BS values started being documented on the eMAR again on 09/03/25 after a staff member changed the order to record Resident #4's BS values on the eMAR. Interview with the Resident Care Coordinator (RCC) on 10/16/25 at 3:45pm revealed: -She knew all of Resident #4's BS values were not being documented on the eMAR from 08/15/25 to 09/02/25 because of an audit she completed on 09/02/25. -She changed Resident #4's insulin aspart order in the eMAR system on 09/02/25 so BS values would be recorded. -She completed audits weekly.	D 367		

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D 367	Continued From page 23 -MAs were responsible for documenting BS values on the eMAR. Interview with the Administrator on 10/16/25 at 3:50pm revealed: -She deferred to the RCC for eMAR audits. -The RCC had to put "record blood sugars" in the eMAR system for insulin orders. -She and the RCC were responsible to ensure the eMARs were accurate.	D 367		