Received 10/30/24

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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
	FCL079089	A. BUILDING: _____ B. WING _____	R 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAFE HAVEN # 2	157 GLENDALE DRIVE EDEN, NC 27288

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 09/11/24.	C 000	In Regards to 10A NCAC 13 G, 0206 Capacity Residents were immediately assessed to determine their ability to evacuate independently in the event of a fire or disaster. This assessment included a review of Residents' assessments, FL-2s and Careplan. All documentation stated that residents could ambulate independently with or without assistive devices. Upon admission to the facility Resident #'s FL-2 and assessment stated that she could ambulate independently . This was verified by the administrator upon entry into the facility by resident 1 demonstrating the following: •The resident must independently ambulate with a alone of with the aide of walker or cane as follows •Push off a chair or bed to come to a standing position . •Hold the cane walker on the hand grips for stability. •Lift the cane walker. Placing it in front of them while leaning their body slightly forward . Walk with the cane or walker. Supporting their body weight on their hands when advancing permitting partial weight bearing or non-weight bearing as prescribed •Balance themselves on their feet. •Lift the walker or cane. and place it in front them again •Look up as they walk. The administrator gave resident 1's family a notice of discharge on September 11, 2024.Resident had exited for DHSR Construction 2 weeks prior. due to resident's not responding to the fire alarm for the survey team. The administrator also provided for additional staff to be assist resident 1 should she need assistance until she was transferred. This additional staffer was available 24 hours a day and resides on the grounds of the facility. Resident #1 family was contacted again about the transfer of the resident.	9/12/24 9/11/24 and betond 9/25/24
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Health Service Regulation for review of any possible changes that may be required to	C 007		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sylvia L. Williamson — TITLE: Owner/Administrator — (X6) DATE: 10/23/24

STATE FORM 6899 O9Q011 If continuation sheet 1 of 18

Received and acknowledged 10/30/24 C. Harrison for Sheryl Dorin

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C 007	Continued From page 1 the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 6 residents (#1), who did not respond to the fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 6 residents resided in the facility on 09/11/24. Review of the facility's fire drill book on 09/11/24 revealed: -There was documentation that staff conducted 34 fire drills at various times from January 2024 through August 2024 and that all of the residents evacuated the facility independently. -There was documentation that staff conducted fire drills on 09/01/24 and 09/07/24 and all of the residents evacuated the facility during the drills. Interview with a medication aide/Supervisor-in-Charge (MA/SIC) on 09/11/24	C 007	The facility will re-assess and re-evaluate the ambulatory status of all residents. Any resident found to have decreased ambulatory status will be assessed by their physician. If residents are found incapable of the ability to ambulate and exit the facility independently, the administrator will notify OHSR and the facility will follow directives, Any resident unable to ambulate or found to be immobile will be discharged from the facility in accordance with applicable rules. All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers. Any resident incapable of ambulating will not be admitted. DHSR was notified on 9/11/24 about residents ability to exit as it was the first day that she had not exited for a fire drill. She had exited for all drills performed by the staff and she exited during the annual survey conducted by DHSR construction 2 weeks prior to the 9/11/24 survey.	9/12/24 and ongoing

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C 007	Continued From page 2 at 12:25pm revealed: -She did frequent fire drills at the facility. -Resident #1 never had trouble evacuating from the facility independently and without prompting. -Resident #1 did not require verbal cues or physical assistance during fire drills to exit the facility. Interview with a second MA on 09/11/24 at 1:10pm revealed: -She conducted fire drills at the facility two days out of the three days per week that she worked at the facility. -She never had a resident not leave the facility independently and without prompting during her fire drills. -Resident #1 did not need assistance with transfers or ambulation. -She did not know why Resident #1 did not leave the facility during either of the fire drills conducted on 09/11/24. Interview with the Administrator on 09/11/24 at 1:30pm revealed: -Resident #1 used to get up and out of the facility independently during fire drills. -That day, 09/11/24, was the first day Resident #1 did not exit the facility during a fire drill. -The MA/SICs conducted fire drills a couple of times per week and she had never been told by the staff that Resident #1 did not independently evacuate. -Resident #1 had not had any changes to her physical capabilities or mental capacity and had not started any new medications. -Resident #1 did not have a diagnosis of dementia so she did not know why she did not participate in the fire drill other than she did not want to. -She had not notified DHSR about Resident #1's	C 007		

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C 007	Continued From page 3 evacuation capabilities because up until that day, 09/11/24, she had always evacuated the facility during fire drills without prompting. [Refer to Tag 0022 10A NCAC 13G .0302(b) Design and Construction.]	C 007	In regards tp 10 A NCAC 13 G. 0302 (b) Design and Construction Staff received in-service training on the facility fire safety and evacuation plan. Tne training included review of the facility disaster plan. the procedures for evacuation during a fire and other disasters, demonstration of evacuation procedures, fire drill procedures and the training on the- proper documentation of drills and rehearsals. The importance. of proper and accurate, documentation of drills was stressed as these reflect the staff competency and residents capability to evacuate and the accessibility of the facility for resident evacuation. Additionally, the administrator or dcsignee will conduct unannounced drills to insure staff competency and residents evacuation ability.	9/16/24 and ongoing
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 6 residents (#1), who did not exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire drill book on 09/11/24 revealed:	C 022	The facility will re-assess and re-evaluate the ongoing ambulatory status of all residents. Any resident found to have decreased ambulatory status will be assessed by their physician. If residents are found incapable of the ability to ambulate and exit the facility independently, the administrator will notify OHSR and the facility will follow directives, Any resident unable to ambulate or found to be immobile will be discharged from the facility in accordance with applicable rules.	9/12/24 and ongoing

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C 022	Continued From page 4 -There was documentation that staff conducted 34 fire drills at various times from January 2024 through August 2024 and that all of the residents evacuated the facility independently. -There was documentation that staff conducted fire drills on 09/01/24 and 09/07/24 and all of the residents evacuated the facility during the drills. Review of Resident #1's current FL2 dated 08/11/24 revealed: -Diagnoses included hypertension, type 2 diabetes, chronic kidney disease, lower back pain and osteoarthritis. -Resident #1 was ambulatory and was intermittently confused. -Functional limitations included hearing. Review of Resident #1's care plan dated 08/06/24 revealed: -Resident #1 had no problems documented with ambulation/locomotion. -She had limited strength and range of motion in her arms and hands. -She was sometimes disoriented. -She was forgetful and needed reminders. -Her vision was adequate but her hearing was documented as being very limited. -She was documented as being independent with transfers and requiring supervision with ambulation. -The care plan was signed by Resident #1's primary care provider (PCP) on 08/11/24. Observation of the facility on 09/11/24 at 8:53am revealed: -There were 6 residents present at the facility. -Resident #1 was sitting on the couch next to the front door. -The medication aide (MA)/Supervisor-in-Charge (SIC) activated the fire alarm.	C 022	All residents will be assessed upon admission to the facility to verify ambulation status as documented on residents' FL2 and admission papers. Any resident incapable of ambulating will not be admitted. Policy Interpretation and Implementation I. Fire drills are required at least quarterly on each shift. 2, The purpose of the drill is to familiarize all personnel with emergency procedures and to practice the skills needed to ensure the safety of all. 3. The drills are to focus on specific- tasks not routinely performed but critical to the safe management and evacuation of residents, visitors and staff in the event of a real fire. 4.Drills are- serious and not to be taken lightly. Professionalism is expected, and required. 5.Both residents and staff should be included in drill exercises. All facility employees on the premises at the time of a fire drill are required to participate and expected to follow all instructions issued. 6T he emphasis of a drill is to place an emphasis on orderly and safe evacuation procedures rather than on the. duration of an evacuation. 7.Visitors on the premises during a fire drill are required to evacuate the premises. Visitors must follow all instructions issued by staff members. 8.All procedures are expected to be carried out "'live" and not "simulated". 9.A post drill critique, staff discussion/debrief shall be conducted. The results of which will be documented on a standardized Fire Drill Report which shall include the following: o Date and Time of the drill o On which shift the drill was conducted o Staff Members present • Time for evacuation	

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C 022	Continued From page 5 -A loud beeping alarm could be heard throughout the facility. -Two other female residents who were in the living room with Resident #1 stood up and loudly informed Resident #1 there was a fire drill. -One of the other female residents called Resident #1 by name and told her to leave the house because there was a fire drill. -Resident #1 remained on the couch with her walker next to her and was looking at the television set. -After three minutes of the fire alarm sounding, the MA/SIC deactivated the alarm and Resident #1 had not evacuated the facility. Observation of the facility on 09/11/24 at 1:24pm revealed: -There were 5 residents present at the facility. -Resident #1 was sitting on a different couch in the living room. -The MA/SIC activated the fire alarm. -A loud beeping alarm could be heard throughout the facility. -Three residents came from their bedrooms down the hallway into the living room. -One resident told Resident #1 to get up and out of the house because they were doing a fire drill. -At 1:27pm, the MA/SIC deactivated the alarm and Resident #1 was still sitting on the couch. -At 1:29pm, the Administrator asked Resident #1 to get up from the couch to go on to the porch; Resident #1 laughed and did not get up from the couch. Observation of Resident #1 at various times on 09/11/24 from 8:45am to 3:10pm revealed: -At 12:00pm, the MA/SIC provided physical assistance to transfer and walk next to Resident #1 from the living room to her chair at the dining room table for lunch.	C 022	10. Residents must exit the facility independently. No physical assistance or verbal prompts may be used to aid the resident's evacuation. Any resident unable to perform the evacuation process due to physical or mental defect will be discharged. The administrator also provided for additional staff to be assist resident #11should she need one on one assistance until she is transferred. This additional staffer is available 24 hours a day and rsides on the grounds of the facility.	

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C 022	Continued From page 6 -At 1:05pm, the MA/SIC provided physical assistance to transfer Resident #1 from a chair on the front porch into the facility using her walker. -At 1:32pm and 3:02pm, Resident #1 transferred herself from the couch and used her walker to ambulate from the living room to the kitchen area. Interview with Resident #1 on 09/11/24 at 8:56am revealed: -She heard the fire alarm sounding. -She was not able to answer if she knew what to do when she heard the alarm or where she should go if there was a fire in the facility. Interview with a resident on 09/11/24 at 9:00am revealed: -The facility staff conducted fire drills every couple of days whenever a new staff came on duty. -All the residents were able to get out of the house without staff telling them to except for Resident #1. -Staff had to help Resident #1 by verbal prompting and physically helping her transfer by taking her by the arm and guiding her. -She did not think that Resident #1 understood what to do when she heard the fire alarm sounding. Interview with a second resident on 09/11/24 at 9:05am revealed: -Fire drills were conducted more often than once a month. -She and the other residents were able to independently get out of the facility when the fire alarm was sounding. -Resident #1 was the only resident in the facility who needed staff assistance to get up and out of the house during fire drills.	C 022		

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C 022	Continued From page 7 Interview with a third resident on 09/11/24 at 1:08pm revealed: -Most of the time during fire drills, Resident #1 was able to stand up and exit the facility by herself without staff helping her. -Sometimes Resident #1 did not leave the facility without prompting. Interview with the Licensed Health Professional Support (LHPS) nurse on 09/11/24 at 10:55am revealed: -He had assessed Resident #1 in the past but he could not remember when. -After his assessment of Resident #1 that morning, on 09/11/24, it was his opinion that she had not declined in her mobility status but she did seem to have a cognitive decline. -Resident #1 was oriented only to herself, not to time, location or situation. -Resident #1 was ambulatory with the use of her walker. Interview with a MA/SIC on 09/11/24 at 12:25pm revealed: -She conducted frequent fire drills at the facility. -Resident #1 never had trouble evacuating from the facility independently and without prompting. -Resident #1 did not require verbal cues or physical assistance during fire drills to exit the facility. Interview with a second MA on 09/11/24 at 1:10pm revealed: -She conducted fire drills at the facility two days out of the three days per week that she worked at the facility. -She never had a resident not leave the facility independently and without prompting during her fire drills.	C 022		

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C 022	Continued From page 8 -Resident #1 did not need assistance with transfers or ambulation. -She did not know why Resident #1 did not leave the facility during either of the fire drills conducted that day. Telephone interview with Resident #1's power of attorney (POA) on 09/11/24 at 1:11pm revealed: -He had last visited Resident #1 a couple of days prior. -Resident #1 normally transferred and ambulated independently. -Resident #1 had a "little dementia" but she should be able to remember to leave the facility if she heard a fire alarm. -He had not been at the facility during any of their fire drills. -Resident #1 had not had any change in her cognition in the previous few months. Second interview with Resident #1 on 09/11/24 at 1:28pm revealed: -She heard the beeping sound from the second fire drill. -She did not know what the beeping sound meant or where it had come from. Interview with the Administrator on 09/11/24 at 1:30pm revealed: -Resident #1 used to get up and out of the facility independently during fire drills. -That day, on 09/11/24, was the first day that Resident #1 did not exit the facility during a fire drill. -The MA/SICs conducted fire drills a couple of times per week and she had never been told by the staff that Resident #1 did not independently evacuate. -Resident #1 had not had any changes to her physical capabilities or mental capacity and had	C 022		

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C 022	Continued From page 9 not started any new medications. -Resident #1 did not have a diagnosis of dementia so she did not know why she did not participate in the fire drill other than she did not want to. Attempted telephone interview with Resident #1's PCP on 09/11/24 at 1:00pm was unsuccessful. The facility failed to ensure the facility was in compliance with its current license for ambulatory residents resulting in a resident (#1), who was intermittently confused and had memory impairment, and did not respond to its fire alarm, which could cause the resident to not be able to independently vacate the facility in an emergency, such as a fire. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/24 for this violation. CORRECTION DATE OF THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2024	C 022		
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident.	C 236	In regards to 10A NCAC 13G. 0802 (a) Resident Care Plan The administrator contacted the PCP for the resident and a signed care plan was faxed to the facility and placed in the resident's record. A review of all residents records was conducted to ensure that all required documentation was in the residents records.	9/12/24

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C 236	Continued From page 10 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#2) had a care plan completed within 30 days of admission and annually thereafter. The findings are: Review of Resident #2's current FL2 dated 02/24/24 revealed: -Diagnoses included congestive heart failure, moderate protein-calorie malnutrition, history of acute renal failure, history of pneumonia and history of sepsis. -Resident #2 was ambulatory. -Resident #2 was continent of bowel and incontinent of bladder. -She required personal care assistance with bathing and dressing. Review of Resident #2's Resident Register revealed she was admitted to the facility on 05/09/23. Review of Resident #2's record revealed there was no care plan available for review. A copy of Resident #2's current care plan was requested from the medication aide/Supervisor-in-Charge (MA/SIC) on 09/11/24 at 10:10am but was not provided. Interview with Resident #2 on 09/11/24 at 11:40am revealed: -She was mostly independent with her personal care and could get around the facility independently. -The staff helped her with meals, medications, and sometimes with dressing, toileting and washing up.	C 236	The administrator will audit resident records on a quarterly basis to ensure that all required documentation is in the resident record. Additionally, the facility will ensure that the care plan for a resident is done within 30 days of the admission of a resident and is maintained in the resident record.	9/12/24 and ongoing

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C 236	Continued From page 11 Interview with a MA/SIC on 09/10/24 at 11:26am revealed: -Resident #2 was independent with eating, transfers, and ambulation, but she sometimes had to help her with bathing, dressing and personal hygiene. -She was not responsible for preparing or scheduling care plan assessments. Telephone interview with a staff member at Resident #2's primary care provider's (PCP) office on 09/11/24 at 2:40pm revealed: -She did not see a signed care plan on record for Resident #2. -She was not familiar with Resident #2's care needs. Interview with the Administrator on 09/11/24 at 1:30pm revealed: -She was responsible for ensuring all residents had a care plan upon admission and annually thereafter. -She thought that Resident #2 had a care plan completed since her admission. -Resident #2's care plan must have been misplaced at some point. -She was not aware that Resident #2 did not have a care plan in her resident record. -She had not audited the resident records since May 2024.	C 236		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist,	C 254	In regards to 10A NCAC 13G .0903(c) Licensed Health Professional Support	

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	FCL079089	A. BUILDING: _____ B. WING _____	R 09/11/2024

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C 254	Continued From page 12 respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 1 of 3 sampled residents (#1) who had LHPS tasks of fingerstick blood sugar (FSBS) checks and administration of medications via injection. The findings are: Review of Resident #1's current FL2 dated 08/11/24 revealed diagnoses included type 2 diabetes, hypertension, and chronic kidney disease. Review of Resident #1's LHPS evaluations on 09/11/24 revealed:	C 254	The facility contacted the LHPS nurse for the facility and the nurse completed a LHPS assessment on the resident. The administrator also audited other residents tasks to ensure that anyone needed a LHPS assessment was completed. The administrator will make sure that the LHPS nurse is contacted on quarterly basis to ensure that all residents requiring a LHPS task are assessed in accordance with state regulations. Also that new residents are assessed in 30 days upon admission or the onset of a task.	9/11/24 9/12/24 and ongoing

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C 254	Continued From page 13 -The most recent LHPS evaluation was completed on 01/26/23 with tasks documented as FSBS and the administration of medication via injection. -The date of the LHPS evaluation prior to 01/26/23 was on 10/20/22. A copy of Resident #1's current LHPS evaluation was requested from the medication aide/Supervisor-in-Charge (MA/SIC) on 09/11/24 at 10:26am and was not provided. a. Review of Resident #1's current FL2 dated 08/11/24 revealed there was an order for FSBS checks three times daily. Review of Resident #1's July 2024 medication administration record (MAR) revealed: -There was an entry for FSBS checks three times daily scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Resident #1's FSBS was checked three times daily from 07/01/24 through 07/31/24. -Resident #1's FSBS values from 07/01/24 through 07/31/24 ranged from 88 to 344. Review of Resident #1's August 2024 MAR revealed: -There was an entry for FSBS checks three times daily scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Resident #1's FSBS was checked three times daily from 08/01/24 through 08/31/24. -Resident #1's FSBS values from 08/01/24 through 08/31/24 ranged from 83 to 344. Review of Resident #1's September 2024 MAR from 09/01/24 through 09/11/24 revealed:	C 254		

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C 254	Continued From page 14 -There was an entry for FSBS checks three times daily scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Resident #1's FSBS was checked three times daily from 09/01/24 through 09/11/24. -Resident #1's FSBS values from 09/01/24 through 09/11/24 ranged from 96 to 344. Interview with a MA on 09/11/24 at 1:10pm revealed: -She checked Resident #1's FSBS three times daily as ordered. -The MAs were not responsible for keeping track of or scheduling LHPS evaluations. Based on attempted interview with Resident #1 on 09/11/24 at 1:28pm, it was determined Resident #1 was not interviewable. Refer to the interview with the facility's contacted LHPS nurse on 09/11/24 at 10:55am. Refer to the interview with the Administrator on 09/11/24 at 1:30pm. b. Review of Resident #1's current FL2 dated 08/11/24 revealed: -There was an order for Levemir (a long-acting insulin used to control blood sugar levels) 6 units every morning and 4 units every evening. -There was an order for Novolog (a fast-acting insulin used to control blood sugar spikes at meal times) sliding scale insulin (SSI) as follows for FSBS: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 100 units, or if FSBS was less than 60 or greater than 400 to contact the primary care provider (PCP).	C 254		

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C 254	Continued From page 15 Review of Resident #1's July 2024 medication administration record (MAR) revealed: -There was an entry for Levemir 6 units every morning scheduled at 8:00am, and 4 units every evening scheduled at 8:00pm. -There was documentation Levemir was administered twice daily from 07/01/24 through 07/31/24. -There was an entry for Novolog SSI three times daily with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Novolog SSI was administered three times daily with meals from 07/01/24 through 07/31/24. Review of Resident #1's August 2024 MAR revealed: -There was an entry for Levemir 6 units every morning scheduled at 8:00am, and 4 units every evening scheduled at 8:00pm. -There was documentation Levemir was administered twice daily from 08/01/24 through 08/31/24. -There was an entry for Novolog SSI three times daily with meals scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Novolog SSI was administered three times daily with meals from 08/01/24 through 08/31/24. Review of Resident #1's September 2024 MAR from 09/01/24 through 09/11/24 revealed: -There was an entry for Levemir 6 units every morning scheduled at 8:00am, and 4 units every evening scheduled at 8:00pm. -There was documentation Levemir was administered twice daily from 09/01/24 through 09/11/24. -There was an entry for Novolog SSI three times daily with meals scheduled at 8:00am, 12:00pm,	C 254		

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C 254	Continued From page 16 and 5:00pm. -There was documentation Novolog SSI was administered three times daily with meals from 09/01/24 through 09/11/24. Interview with a MA on 09/11/24 at 1:10pm revealed: -She administered Resident #1's long-acting insulin twice daily, and her short-acting insulin three times daily as ordered. -The MAs were not responsible for keeping track of or scheduling LHPS evaluations. Based on attempted interview with Resident #1 on 09/11/24 at 1:28pm, it was determined Resident #1 was not interviewable. Refer to the interview with the facility's contacted LHPS nurse on 09/11/24 at 10:55am. Refer to the interview with the Administrator on 09/11/24 at 1:30pm. Interview with the facility's contracted LHPS nurse on 09/11/24 at 10:55am revealed: -He had assessed Resident #1 in the past but could not remember the last time he saw her. -The facility's staff were responsible for keeping track of when LHPS assessments were due and contacting him to go to the facility to complete the LHPS evaluations. -After evaluating Resident #1 that morning, 09/11/24, he thought she had declined cognitively as she was only oriented to who she was, not to time, place, or situation. -Resident #1 had LHPS tasks of FSBS checks and the administration of medications via injection. Interview with the Administrator on 09/11/24 at	C 254		

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C 254	Continued From page 17 1:30pm revealed: -She was not aware that Resident #1 did not have a current LHPS evaluation in her resident record. -She was responsible for ensuring all residents with LHPS tasks had LHPS evaluations. -She kept a calendar at her house to keep track of when LHPS evaluations were due so she could call the LHPS nurse to go to the facility to complete the assessment on time. -She had overlooked getting Resident #1's LHPS evaluations scheduled. -She was aware that LHPS evaluations were due for each resident who had LHPS tasks quarterly. -She had not audited the resident records since May 2024.	C 254		