STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL009025	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST BLADEN ASSISTED LIVING	714 BLADEN STREET BLADENBORO, NC 28320

(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 a annual survey and follow up survey on February 12-13, 2025.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on review of the Environmental Health Services report, observations, and interviews the facility failed to ensure food was free from contamination related to food stored on the floor of the dry storage room and dirty floors in the walk-in freezer. The findings are: Review of the local Environmental Health	D 283		

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Services (EHS) Inspection Report dated 02/10/25 revealed:
-The kitchen received a score of 90.
-1 point was deducted for boxes of food stored on the floor in the dry storage area.
-Food shall be stored at least 6 inches above the floor or stored less than 6 inches above the floor on case lot handling equipment.
-Food shall be stored to prevent cross contamination.
-The person in charge removed the boxes of food from the floor and stored them on racks.
-2 points were deducted for floors and walls needing additional cleaning in the kitchen and in walk-in units.

Observation of the dry storage room on 02/12/25 at 9:12am revealed:
-There were at least 3 boxes of apple juice stored on the floor under the bottom shelf.
-There was a box of sugar stored on the floor, in front of the shelves, with 2 boxes of Jello on top.
-There was a box of bananas stored on the floor next to the canned goods rack.
-There was a box of potato chips stored on the floor, between the canned goods rack and shelves, with 2 other boxes of potato chips on top.

Observation of the walk-in freezer on 02/12/25 at 9:14am revealed:
-There was debris scattered about the floor under the shelf of the freezer; including unwrapped bread sticks and what appeared to be individual butter packets.
-There was a dark colored substance under the shelf that the various food items appeared to be stuck in.

Telephone interview of the Environmental Health

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D 283	Continued From page 2 Program Specialist on 02/13/25 at 8:36am revealed: -Boxes of food should be stored 6 inches above the floor to avoid contamination. -Food could also be stored on pallets, which were less than 6 inches but not on the floor. -Contamination could occur due to floors being cleaned with chemicals. -Storing food 6 inches above the floor kept the food away from pests. -The food debris and spill were on the floor in the walk-in freezer during her visit (02/10/25) and was cited on her report. Interview of the dietary aide (DA) on 02/13/25 at 9:37am revealed: -She put away the dry foods when the food delivery driver brought the boxes in on Tuesdays. -The Dietary Manager (DM) put the cold and freezer items away when delivered on Tuesdays. -She was aware food was not to be stored on the floor, but they ran out of room and had no other place to store the food. -The bananas were heavy, and she could not lift them; and there was no space on the shelf for the bananas. -The potato chips were usually stored in a bin, but the bin was full. -The juice boxes were on the floor because the walk-in cooler needed to be repaired and the reach in cooler was full. -She had not told anyone about the lack of space/storage on the shelves because she assumed this was seen when they (Business Office Manager and DM) checked the dry storage to see what needed to be ordered. -She was not aware the boxes of food stored on the floor had been cited by Environmental Health Services on 02/10/25. -She assumed that, since the boxes of food had	D 283		

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not been opened, it was fine being stored on the floor.
-The food stored on the floor was delivered 02/11/25.

Interview of the DM on 02/13/25 at 10:09am revealed:
-She was aware food should not be stored on the floor, but they had overstock.
-Since the walk-in cooler went out, they had to leave some juice in the dry storage room.
-Food should be stored 6 inches off the floor.
-She was aware food stored on the floor was cited by Environmental Health Services on 02/10/25.
-She informed the Resident Care Coordinator (RCC) and Business Office Manager about the lack of storage space and was told they would find more storage space.
-She had no concern with food being stored on the floor.
-The food stored on the floor was delivered on Tuesday, 02/11/25.
-She was aware the cleaning of the walk-in freezer was cited by Environmental Health Services on 02/10/25.
-There was no set cleaning schedule.
-She was responsible for cleaning the walk-in freezer.
-There was no one else assigned to clean the walk-in freezer other than who she asked to clean it.
-The spot in the walk-in freezer was caused when a pie leaked and was not cleaned up.
-The food items that were in the spill were not picked up.
-She cleaned the walk-in freezer yesterday (02/12/25).
-Prior to 02/12/25, the walk-in freezer had not been cleaned in a "while."

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D 283	Continued From page 4 -She had no concern with the walk-in freezer not being cleaned. Interview of the RCC on 02/13/25 at 2:16pm revealed: -No food should have been stored on the floor. -She was aware food was being stored on the floor. -The walk-in cooler was messed up, so food items had to be stored in other areas. -She was aware the facility had been cited by Environmental Health Services on 02/10/25 for food being stored on the floor. -Food was being stored on the floor after being cited by Environmental Health Services because they had no more storage room. -The food stored on the floor was delivered on Tuesday, 02/11/25. -The concern with food being stored on the floor was that "things could crawl in." -The DM and DA arranged the food in the dry storage area and walk-in freezer after the delivery driver places the food in those areas. -The DM was supposed to make sure all food was stored off the floor. -The storage areas would be rearranged so all food could be stored on the shelves. -She had not been in the walk-in freezer in the past couple of weeks. -She was aware cleaning on the walk-in freezer was cited by Environmental Health Services on 02/10/25. -The DM was responsible for cleaning the walk-in freezer. -She was unsure if there was a set cleaning schedule for dietary staff. -There used to be a cleaning schedule for dietary staff that included sweeping, mopping and cleaning appliances along with the frequency of cleanings.	D 283		

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D 283	Continued From page 5 Attempted interview of the Administrator on 02/13/25 at 5:00pm was unsuccessful.	D 283		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure mealtime table service included a non-disposable beverage container. The findings are: Observation of the lunch meal service in the Assisted Living (AL) dining room on 02/12/25 from 12:13pm to 12:35pm revealed: -There were place settings that consisted of a napkin, a non-disposable plate, a non-disposable fork, knife, a non-disposable cup for tea or lemonade, and a non-disposable cup for coffee. -There were 27 residents present for the meal at various times.	D 286		

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D 286	Continued From page 6 -Water was served to the residents that wanted water in plastic disposable cups. Interview with a dietary aide (DA) on 02/13/25 at 9:37am revealed: -She had been employed at the facility for 3 years. -Water had been served in Styrofoam cups ever since she had been at the facility -Water was usually served in Styrofoam cups to the residents because a water/ice machine was installed in the dining room. -Once the water/ice machine was installed in the dining room she was told she did not have to put a water pitcher out anymore for meal service. -They had enough non-disposable cups for all residents to use. -She was aware residents were served water in Styrofoam cups at lunch yesterday (02/12/25). -She was not aware that there was a regulation about not using disposable cups. Interview with the Dietary Manager (DM) on 02/13/25 at 10:09am revealed: -She had been employed at the facility for 3 years. -She was not aware residents were served water in Styrofoam cups at lunch yesterday (02/12/25). -The personal care aides (PCA) served the residents water from the water/ice machine in the dining room during meal service. -Styrofoam cups had always been used for snacks since she had been employed at the facility. -They recently started using Styrofoam cups for the residents that wanted water. -She was unsure who made the decision to use Styrofoam cups. -She was not aware that there was a regulation about not using disposable cups.	D 286		

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D 286	Continued From page 7 Interview with the Resident Care Coordinator (RCC) on 02/13/25 at 2:16pm revealed: -She was not aware residents were served water in Styrofoam cups at lunch yesterday (02/12/25). -She was aware the residents were to have all non-disposable place settings at each meal. -Disposable cups were out in the dining room for residents throughout the day so they could get their own ice and water from the water/ice machine in the dining room. -Disposable cups had not been used for any meals that she was aware of. -She did not know why disposable cups were used for water at lunch yesterday (02/12/25). -She expected staff to use non-disposable place settings for meal service. Attempted telephone interview with the Administrator on 02/13/25 at 5:00pm was unsuccessful.	D 286		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure a therapeutic diet menu was used for guidance in preparing meals for 4 of 4 sampled residents with a minced and moist diet order (#1, #2) and a puree diet order (#4, #5).	D 310		

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D 310	Continued From page 8 The findings are: 1. Review of Resident #1's current FL-2 dated 12/06/24 revealed: -Diagnoses included aspiration, seizures, chronic obstructive pulmonary disease (COPD), abdominal aortic aneurysm, and vascular dementia. -There was an order for a minced and moist diet. Observations during the initial kitchen tour on 02/12/25 at 9:07am revealed: -A list of residents on therapeutic diets was typed on hot pink paper and kept in the kitchen. -There was a black notebook that contained individual recipes with diets listed on each sheet. Review of the therapeutic diet list revealed Resident #1 required a minced and moist diet. Review of the lunch menu on 02/12/25 at 11:15am revealed the lunch menu included beef and noodles, peas and carrots, choice of roll, pineapple upside down cake, coffee/tea, 2% milk. Review of the therapeutic diet menu on 02/13/25 at 10:10am revealed residents on a minced and moist diet were to get a 2/3" slice of puree bread. Observations of food and tray preparation on 02/12/25 at 11:15am revealed: -Minced and moist foods were prepared by the Dietary Manager (DM) and put on the plates by the DM. -The dietary aide (DA) put the plates on the tray and cart to be transported to the dining room. -Residents on the minced and moist diet were not given bread at all.	D 310		

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Attempted telephone interview with the Administrator on 02/13/25 at 5:00pm was unsuccessful.

Refer to interview with the DA on 02/13/25 at 9:37am

Refer to interview with the DM on 02/12/25 at 11:15am.

Refer to interview with the DM on 02/13/25 at 10:09am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/13/25 at 2:16pm.

Refer to interview with the primary care provider (PCP) on 02/13/25 at 3:37pm.

2. Review of Resident #2's current FL-2 dated 01/08/25 revealed diagnoses included atrial fibrillation, stroke, and hypertension.

Review of Resident #2's diet order sheet dated 12/04/24 revealed the diet was minced and moist.

Observations during the initial kitchen tour on 02/12/25 at 9:07am revealed:
-A list of residents on therapeutic diets was typed on hot pink paper and kept in the kitchen.
-There was a black notebook that contained individual recipes with diets listed on each sheet.

Review of the therapeutic diet list revealed Resident #2 required a minced and moist diet.

Review of the lunch menu on 02/12/25 at 11:15am revealed the lunch menu included beef and noodles, peas and carrots, choice of roll, pineapple upside down cake, coffee/tea, 2% milk.

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D 310	Continued From page 10 Review of the therapeutic diet menu on 02/13/25 at 10:10am revealed residents on a minced and moist diet were to get a 2/3" slice of puree bread. Observations of food and tray preparation on 02/12/25 at 11:15am revealed: -Minced and moist foods were prepared by the Dietary Manager (DM) and put on the plates by the DM. -The dietary aide (DA) put the plates on the tray and cart to be transported to the dining room. -Residents on the minced and moist diet were not given bread at all. Attempted telephone interview with the Administrator on 02/13/25 at 5:00pm was unsuccessful. Refer to interview with the DA on 02/13/25 at 9:37am Refer to interview with the DM on 02/12/25 at 11:15am. Refer to interview with the DM on 02/13/25 at 10:09am. Refer to interview with the Resident Care Coordinator (RCC) on 02/13/25 at 2:16pm. Refer to interview with the primary care provider (PCP) on 02/13/25 at 3:37pm. 3. Review of Resident #4's current FL-2 dated 11/19/24 revealed diagnoses included dementia with behavioral disturbance, hyperglycemia, type 2 diabetes, and incontinent bladder and bowel. Review of a physician's order dated 12/09/24	D 310		

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revealed the diet was puree with thin liquids.

Observations during the initial kitchen tour on 02/12/25 at 9:07am revealed:
-A list of residents on therapeutic diets was typed on hot pink paper and kept in the kitchen.
-There was a black notebook that contained individual recipes with diets listed on each sheet.

Review of the therapeutic diet list revealed Resident #4 required a puree diet.

Review of the lunch menu on 02/12/25 at 11:15am revealed the lunch menu included beef and noodles, peas and carrots, choice of roll, pineapple upside down cake, coffee/tea, 2% milk.

Review of the therapeutic diet menu on 02/13/25 at 10:10am revealed residents on a puree diet were to get a 2/3" slice of puree bread.

Observations of food and tray preparation on 02/12/25 at 11:15am revealed:
-Puree foods were prepared by the Dietary Manager (DM) and put on the plates by the DM.
-The dietary aide (DA) put the plates on the tray and cart to be transported to the dining room.
-Residents on the puree diet were not given bread at all.

Attempted telephone interview with the Administrator on 02/13/25 at 5:00pm was unsuccessful.

Refer to interview with the DA on 02/13/25 at 9:37am

Refer to interview with the DM on 02/12/25 at 11:15am.

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Refer to interview with the DM on 02/13/25 at 10:09am.

Refer to interview with the Resident Care Coordinator (RCC) on 02/13/25 at 2:16pm.

Refer to interview with the primary care provider (PCP) on 02/13/25 at 3:37pm.

4. Review of Resident #5's current FL-2 dated 01/27/25 revealed:
-Diagnoses included Alzheimer's, seizures, and gastroesophageal reflux disease.
-There was an order for a puree diet.

Observations during the initial kitchen tour on 02/12/25 at 9:07am and 11:15am revealed:
-A list of residents on therapeutic diets was typed on hot pink paper and kept in the kitchen.
-There was a black notebook that contained individual recipes with diets listed on each sheet.

Review of the therapeutic diet list revealed Resident #5 required a puree diet.

Review of the lunch menu on 02/12/25 at 11:15am revealed the lunch menu included beef and noodles, peas and carrots, choice of roll, pineapple upside down cake, coffee/tea, 2% milk.

Review of the therapeutic diet menu on 02/13/25 at 10:10am revealed residents on a puree diet were to get a 2/3" slice of puree bread.

Observations of food and tray preparation on 02/12/25 at 11:15am revealed:
-Puree foods were prepared by the dietary manager (DM) and put on the plates by the DM.
-The dietary aide (DA) put the plates on the tray and cart to be transported to the dining room.

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D 310	Continued From page 13 -Residents on the puree diet were not given bread at all. Attempted telephone interview with the Administrator on 02/13/25 at 5:00pm was unsuccessful. Refer to interview with the DA on 02/13/25 at 9:37am Refer to interview with the DM on 02/12/25 at 11:15am. Refer to interview with the DM on 02/13/25 at 10:09am. Refer to interview with the Resident Care Coordinator (RCC) on 02/13/25 at 2:16pm. Refer to interview with the primary care provider (PCP) on 02/13/25 at 3:37pm. _____ Interview with the dietary aide (DA) on 02/13/25 at 9:37am revealed: -She did not know what the therapeutic diet menu was. -Her role was to assist the Dietary Manager (DM). -She did not decide who received what foods and how the food was prepared; she only made desserts. -She took a class at the facility that taught her how to prepare desserts for different diets. -She did not use any type of spreadsheet to guide her in preparing desserts for residents on therapeutic diets. Interview with the DM on 02/12/25 at 11:15am and 11:50am revealed: -She had been employed at the facility for 3 years.	D 310		

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-Residents on the puree diet did not get bread.
-Residents on the minced and moist diet did not get bread.
-It had been a long time since she used a therapeutic diet menu to prepare the meals.
-She had not used the therapeutic diet menu to prepare the meals since being employed at the facility.
-She was taught how to prepare therapeutic diets 3 years ago when she first started working at the facility by the DM at that time.
-She took a class at the facility on preparing different diets.
-She prepared therapeutic diets based on what she was taught and not by using the therapeutic diet menu.
-She only used the menu for regular diets.
-She was unable to locate the therapeutic diet menus.
-She had individual recipes that listed each therapeutic diet on that same sheet.
-She used the recipe sheets to prepare the diet for items that were new or that she was unfamiliar with.

Interview with the DM on 02/13/25 at 10:09am revealed:
-The therapeutic diet menus were in a different book from what she was looking in yesterday (02/13/25).
-She was not aware residents on a puree diet should have received a 2/3" slice of puree bread.
-She was not aware residents on a minced and moist diet should have received a 2/3" slice of puree bread.
-The purpose of the therapeutic diet menu was to make sure everyone received the food they were supposed to get.
-Her concern with not following the therapeutic diet menu was that the residents on puree and

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D 310	Continued From page 15 minced and moist diets did not get the proper diet on yesterday (02/12/25). Interview with the Resident Care Coordinator (RCC) on 02/13/25 at 2:16pm revealed: -The DM was using the regular diet menu to prepare all meals. -The DM was not using the therapeutic diet menu to prepare food for residents on therapeutic diets. -Once the therapeutic diet menu book was located last night, she reviewed it with the DM. -The DM was using what she learned in a class that was taken last year at the facility on preparing therapeutic diets. -She did not know there were different therapeutic diet menus until yesterday. Interview with the primary care provider (PCP) on 02/13/25 at 3:37pm revealed: -He was not aware that the residents on puree diets and minced and moist diets were not receiving bread. -He had no concern with the residents not receiving bread.	D 310		
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.	D 358		

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This Rule is not met as evidenced by:
The facility failed to ensure that medications were administered as ordered for 1 of 5 sampled residents (#2) including a medication used to treat high blood pressure.

The findings are:

Review of Resident #2's current FL-2 dated 01/08/25 revealed diagnoses included atrial fibrillation, hypertension, stroke, and incontinence.

Review of Resident #2's physician orders dated 01/21/25 revealed an order to discontinue Metoprolol 25mg daily and to begin Metoprolol Succinate 25mg ½ tablet daily (metoprolol Succinate is used to treat hypertension).

Review of Resident #2's physician orders dated 02/04/25 revealed an order to monitor blood pressure, pulse, respirations, and temperature daily.

Review of Resident #2's vitals report on 02/13/25 revealed there was an entry for blood pressure, pulse, respirations, and temperature daily from 02/04/25 to 02/13/25.

Review of Resident #2's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Succinate 25mg administer ½ tablet = 12.5mg daily, "DO NOT CRUSH".
-Metoprolol Succinate 25mg was documented as administered at 8:30am on 01/01/25 to 01/22/25.
-Metoprolol Succinate 25mg was documented as discontinued at 8:30am on 01/23/25.
-Metoprolol Succinate 25mg ½ tablet was

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D 358	Continued From page 17 documented as administered at 8:30am on 01/24/25 to 01/31/25. Review of Resident #2's February 2025 eMAR revealed: -There was an entry for Metoprolol Succinate 25mg administer ½ tablet daily, "DO NOT CRUSH". -Metoprolol Succinate 25mg ½ tablet was documented as administered at 8:30am on 02/01/25 to 02/12/25. Observation of Resident #2's medications on hand on 02/13/25 at 10:47am revealed: -There was a medication card for Metoprolol Succinate 25mg daily. -The instructions were to administer one tablet every day "DO NOT CRUSH". -The start date was 01/27/25. -The card was dispensed with 28 tablets for a 28-day supply -There were 12 tablets remaining. Second observation of Resident #2's medications on hand on 02/13/25 at 1:50pm revealed: -There as a medication card for Metoprolol Succinate 25mg and the instructions were to administer ½ tablet=12.5mg daily "DO NOT CRUSH" with 7 halved tables remaining. -The medication card was located behind the medication drawer. -The start date was 01/24/25. -The card was dispensed with 14 tablets that had been halved for a 28-day supply. -There were 7 half tablets remaining. Interview with the medication aide (MA) on 02/13/25 at 11:19am revealed: -She reviewed the eMAR and the medication card 3 times before administering medications.	D 358		

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-She was not sure why she did not notice the difference of the order between the eMAR and medication card.
-She was not involved in the process of new or changed orders the Resident Care Coordinator (RCC) or the shift coordinator took care of them.
-She was out of work for 8 days at the end of January and when she returned to work, she had not administered Metoprolol 25mg 1/2 tablet, she was administering Metoprolol 25mg to Resident #2.

Interview with the assisted living MA shift coordinator on 02/13/25 at 11:06am revealed:
-The RCC received the new or changed orders from the provider and faxed them to the pharmacy.
-The pharmacy entered the orders into the eMARs and the RCC accepted them.
-The medications usually arrived on night shift the day they were sent to pharmacy.
-The MA and herself were not involved in the new or changed orders.
-She received the physician order sheet once the RCC completed accepting the order from pharmacy.
-She made sure that the medication arrived, and the previous medication card was removed.
-She was not sure why the previous medication card was still on the medication cart.

Interview with Special Care Unit (SCU) MA shift coordinator on 02/13/25 at 12:15pm revealed she signed that the facility received the Metoprolol Succinate 25mg on 01/24/25 and it was placed on the medication cart.

Interview with the RCC on 02/13/25 at 11:11am revealed:
-She faxed all new or changed provider orders to

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the pharmacy, and she kept a copy of the fax report.
-The pharmacy entered the orders into the eMAR, and then she accepted the orders.
-The shift coordinator then would receive the physician order sheets to ensure that the medication arrived.
-She performed medication cart audits monthly where she compared the FL-2, provider orders, discontinued orders, and the eMARs to the medications.
-She was not sure why Resident #2's old medication card was not removed when the new medication card arrived.

Interview with a pharmacist at the facility's contracted pharmacy on 2/13/25 at 11:41am revealed:
-The pharmacy received a medication order change for Resident #2 on 01/21/25.
-Metoprolol Succinate 25mg daily was discontinued and Metoprolol Succinate 25mg ½ tablet daily was ordered on 01/21/25.
-Resident #2's medication was on a cycle fill.
-Metoprolol 25mg ½ tablet daily was filled on 01/22/25 for 2.5 tablets which was a 5-day supply to get Resident #2 back on his routine cycle fill.
-Metoprolol 25mg ½ tablet daily was filled on 01/24/25 for 14 tablets which was a 28-day supply.
-The Metoprolol 25mg daily medication card dated 01/27/25 was his old cycle fill and should have been sent back to pharmacy.
-The Metoprolol 25mg ½ tablet daily for 2.5 tablets was signed for by the facility on 01/24/25 at 1:38am.
-The Metoprolol 25mg ½ tablet daily for 14 tablets was signed for by the facility on 01/25/25 at 12:43am.

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D 358	Continued From page 20 Interview with Resident #2's primary care provider (PCP) on 02/13/25 at 3:37pm revealed: -He had proactively reduced the Metoprolol Succinate from 25mg daily to 12.5mg daily because his blood pressure was consistently running on the lower side of normal. -He did not have any concerns with the reduced dose of Metoprolol not starting when it was ordered. -Resident #2's blood pressure was monitored daily. -He had reviewed Resident #2's vital signs at the end of January and there was no change from his norm. Attempted telephone interview with the Administrator on 02/13/25 at 5:00pm was unsuccessful.	D 358		