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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/22/25 and 04/23/25.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 5 sampled residents (#3, #4) related to failing to inform the cardiologist of blood pressures that were greater than 140/80 and failure to refer the resident to physical therapy for evaluation (#4), and failed to complete an order for labs (#3). The findings are: 1. Review of Resident #4's current FL-2 dated 05/13/24 revealed: -Diagnoses included vascular dementia and cerebral vascular accident. -There was an order to check the resident's blood pressure daily and to notify the cardiologist if the resident's blood pressure was greater than 140/80. -There was an order for Amlodipine/Olmesartan 5-40mg, take one tablet at 8:00am; check the resident's blood pressure daily and notify the cardiologist if the resident's blood pressure was greater than 140/80 (Amlodipine/Olmesartan is a combination of medications to treat high blood pressure).	D 273		

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a. Review of a physician order sheet for Resident #14 dated 01/09/25 revealed:
-There was an order to reduce vital sign checks to one time weekly on Monday morning; notify the cardiologist if the resident's blood pressure was greater than 140/80.
-There was an order for Amlodipine/Olmesartan (Amlodipine Besylate-Olmesartan Medoxomil) 5-40mg, take one tablet at 8:00am; check the resident's blood pressure daily and notify the cardiologist if the resident's blood pressure was greater than 140/80.

Review of a physician order sheet for Resident #14 dated 02/11/25 revealed:
-There was an order to check the resident's vital signs to one time weekly on Monday morning; notify the cardiologist if the resident's blood pressure was greater than 140/80.
-There was an order for Amlodipine/Olmesartan 5-40mg, take one tablet at 8:00am; check the resident's blood pressure daily and notify the cardiologist if the resident's blood pressure was greater than 140/80.

Review of Resident #4's February 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check the resident's vital signs and blood pressure reading every Monday morning; and to notify the resident's cardiologist if the blood pressure was greater than 140/80.
-There was an entry for Amlodipine/Olmesartan (Amlodipine Besylate-Olmesartan Medoxomil) 5-40mg, take one tablet at 8:00am; check the resident's blood pressure daily and notify the cardiologist if the resident's blood pressure was greater than 140/80.
-Resident #4's blood pressure was 150/70 on 02/13/25, 132/86 on 02/19/25, and 148/105 on

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02/21/25.
-There was no documentation on the eMAR or facility progress notes that the resident's cardiologist was notified on 02/13/25, 02/19/25, or 02/21/25.

Review of Resident #4's March 2025 eMAR revealed:
-There was an entry to check the resident's vital signs and blood pressure reading every Monday morning; and to notify the resident's cardiologist if the blood pressure was greater than 140/80.
-There was an entry for Amlodipine/Olmesartan (Amlodipine Besylate-Olmesartan Medoxomil) 5-40mg, take one tablet at 8:00am; check the resident's blood pressure daily and notify the cardiologist if the resident's blood pressure was greater than 140/80.
-Resident #4's blood pressure was 143/77 on 03/02/25, 152/82 on 03/07/25, 135/95 on 03/15/25, and 158/92 on 03/29/25.
-There was no documentation on the eMAR or facility progress notes that the resident's cardiologist was notified on 03/02/25, 03/07/25, 03/15/25, or on 03/29/25.

Interview with Resident #4 on 04/23/25 at 4:48pm revealed staff took her blood pressure every day and she was not aware of any times that her blood pressure was high.

Interview with the Resident Care Coordinator (RCC) on 04/23/25 at 5:00pm revealed:
-She was also a medication aide (MA).
-She was not sure why she did not notify the resident's cardiologist when her blood pressure was 152/82 on 03/07/25.
-Normally when she notified the PCP or provider she completed an electronic progress note.
-She should have notified the resident's

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cardiologist that her blood pressure was outside the parameters as ordered.

Interview with the Health and Wellness Director (HWD) on 04/23/25 at 5:45pm revealed:
-The MAs were expected to follow physician orders, if they did not understand an order they could contact her or the RCC with any questions.
-She was not aware that there were numerous times that Resident #4's blood pressure was over 140/80 and that the MAs had not notified the resident's cardiologist.
-She should have noticed it when she completed chart audits which were usually once a month.

Telephone interview with the facility's contracted primary care provider (PCP) on 04/23/25 at 1:07pm revealed:
-She was not the PCP for Resident #4.
-When a resident had high blood pressure which was 140/80 or 150/90 the resident was at a higher risk of stroke, kidney disease, and congestive heart failure.
-When she wrote an order for a resident's blood pressure to be monitored with parameters to notify the provider, staff should follow the providers orders and notify the provider when a resident's blood pressure was outside of the parameters the provider ordered.

Interview with the Administrator on 04/23/25 at 6:12pm revealed:
-The MAs were expected to follow physician orders and should have notified Resident #4's cardiologist when her blood pressure parameters were outside of the parameters as ordered.
-The HWD should have noticed that MAs had not contacted the resident's cardiologist when she completed chart audits.
-The resident's cardiologist needed to know if the

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blood pressure medication was working correctly.
-The mistake should not have continued for two months.

Attempted telephone interview with Resident #4's cardiologist on 04/23/25 at 1:05pm and 2:11pm was unsuccessful.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 04/23/25 at 1:06pm was unsuccessful.

b. Review of a physician's order for Resident #4 dated 09/30/24 revealed there was an order to evaluate and treat the resident for physical therapy (PT) for evaluation of the resident's left frozen shoulder and for occupational therapy (OT) due to her history of cerebral vascular accident and aphasia.

Request for the resident's PT and OT evaluation and treatment after 09/30/24 on 04/23/25 at 10:55am were not provided.

Review of Resident #4's previous PT evaluation and plan of care revealed:
-The start of care began 06/18/24 and the resident was certified to receive PT services from 06/18/24 to 08/16/24.
-The resident would receive PT three times a week for 60 days.
-The resident was diagnosed with adhesive capsulitis of the left shoulder (adhesive capsulitis is also known as frozen shoulder with the shoulder joint inflamed and thickened which could lead to pain and stiffness).
-She was also diagnosed with primary osteoarthritis, stiffness of her left shoulder, stiffness of left and right elbows, and disorders of muscle in diseases classified elsewhere, left

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D 273	Continued From page 5 shoulder. -There were no PT or OT visit notes past 08/16/24. -There were no PT and OT evaluation completed after 09/30/24. Observation of Resident #4 on 04/23/25 at 4:48pm revealed: -The resident was seated in an upright chair with her rollator in front of her. -She demonstrated that she was able to slowly inch her left hand to the back of the rollator seat to place an item in her bag at the back of the rollator. -She placed both her hands on the front of the rollator seat and was only able to raise her left hand and arm approximately 12 inches from the rollator seat. -The resident was unable to lift her left arm out in front of her chest and was unable to raise her left arm above her head. Interview with Resident #4 on 04/23/25 at 4:48pm revealed: -She had received PT and OT in the past. -They worked with her on her frozen left shoulder. -She was unable to lift her left arm. -She gained a small amount of increased movement in her left arm when she had physical therapy in the past. -She had pain in her left shoulder at times, but not every day. Interview with the Health and Wellness Director (HWD) on 04/23/25 at 5:45pm revealed: -She remembered the physical therapist that worked with the facility notified staff in a management meeting that Resident #4 did not qualify to receive PT or OT therapy after an order from the resident's PCP.	D 273		

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-She did not think about notifying the resident's PCP that the physical therapist denied the resident services.
-She should have notified the resident's PCP so the PCP could give her additional orders.

Telephone interview with the facility's contracted primary care provider (PCP) on 04/23/25 at 1:07pm revealed:
-She was not the PCP for Resident #4.
-When any physician wrote an order for a resident to have an evaluation for PT or OT, staff should ensure the referral was completed.
-She would want staff to notify her if a resident was declined PT or OT.

Interview with the Administrator on 04/23/25 at 1:38pm revealed:
-She coordinated an at risk meeting for staff each week which included the facility's contracted physical therapist.
-The physical therapist informed staff at an at risk meeting that Resident #4 had recently completed PT and the physical therapy company would not be able to was not able to approve the resident for PT or OT services at the time of the PCP's referral on 09/30/24.
-The HWD should have notified the PCP that PT and OT services declined to complete the PT evaluation.
-She was not sure why the facility's contracted physical therapy company had denied Resident #4 for physical therapy.

Attempted telephone interview with Resident #4's PCP on 04/23/25 at 1:06pm was unsuccessful.
2. Review of Resident #3's current FL-2 dated 10/10/24 revealed:
-Diagnoses included atrial fibrillation, congestive heart failure and hypertension.

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-There was an order for clopidogrel and coumadin to be administered each day. (Clopidogrel and coumadin are anticoagulant medications used to prevent blood from clotting.)

Review of Resident #3's primary care provider's (PCP) routine visit summary dated 12/05/24 revealed there was an order for labs to be drawn including an order for prothrombin time/international normalized ratio (PT/INR) to be drawn for the end of December 2024. (PT/INR is a blood test that measures how quickly blood clots and is used to monitor coumadin therapy dosage to ensure the right level to prevent blood clots without causing excessive bleeding.)

Review of Resident #3's primary care provider's (PCP) routine visit summary dated 12/09/24 revealed:
-Resident #3 was on clopidogrel and coumadin.
-PT/INR was due on 12/27/24 and there were no results to review for that date.
-There was an order to obtain PT with INR entered 12/10/24 and to draw PT with INR every four weeks.

Review of Resident #3's resident record revealed:
-PT/INR was 27.8/2.46 on 11/27/24.
-PT/INR was 23.8/2.11 on 01/16/25.
-PT/INR was 22.6/2.01 on 02/13/25
-PT/INR was 30.1/2.66 on 03/13/25.
-PT/INR was 30.6/2.72 on 04/11/25.
-There were lab results dated 12/13/24 but there were no results for a PT/INR in December 2024.

Telephone interview with Resident #3's primary care provider (PCP) on 04/23/25 at 1:07pm revealed:
-Resident #3 was on 2 anticoagulant medications for atrial fibrillation and a history of stents being

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placed in her heart.
-Administering 2 anticoagulant medications was not common and placed Resident #3 at increased risk for bleeding.
-Resident #3's PT/INR was to be monitored monthly to see if anticoagulant medications, especially coumadin, needed to be adjusted.
-Resident #3's PT/INR was not drawn by the lab in December 2024.
-She was not notified by the facility of the missed labs and and she became aware of the missed lab monitoring when she went back to see Resident #3 on 01/09/25.
-She ordered PT/INR to be drawn earlier in January 2025 and Resident #3 remained stable which was an INR range 2-3.

Interview with the Health and Wellness Director (HWD) on 04/22/25 at 8:15am revealed:
-Resident #3 was the only resident in the facility that was on coumadin and her PT/INR was supposed to be monitored monthly.
-Resident #3's PT/INR was not drawn by the contracted lab in December 2024.
-She was responsible for ensuring the PT/INR was monitored as ordered.
-She should have called the contracted lab to see why the PT/INR was not drawn.
-There were a lot of residents with lab and medication orders at the facility and the PT/INR order was missed.

Second interview with the HWD on 04/23/25 at 5:45pm revealed:
-She did not review PCP visit summaries for orders because the PCP usually sent orders to the contracted pharmacy or the contracted lab.
-All orders should be reviewed during chart audits.
-When she conducted chart audits, she looked

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D 273	Continued From page 9 for level of care forms, assessments, licensed health professional support task assessments and any form that required periodic updates. -There was not enough time for her to go through all the orders in each chart during audits. Interview with the Administrator on 04/23/25 at 6:12pm revealed: -The HWD was responsible for reviewing PCP visit summaries for any new orders. -The HWD was responsible for following-up on each order to ensure all orders were completes and the residents received the services they deserved. -The HWD was trained on the expectations when she was hired and during on-going monthly trainings.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#1) pertaining to the application of compression hose. The findings are: Review of Resident #1's current FL-2 dated	D 276		

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10/03/24 revealed:
-Diagnoses included Type 2 diabetes and dementia.
-His level of care was Special Care Unit (SCU).
-He was intermittently disoriented.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 03/26/22.

Review of Resident #1's signed physician order form dated 04/07/25 revealed:
-There was an order to please provide the resident with compression hose.
-Apply compression hose every morning and remove at bedtime.
-The physician's order form was electronically signed by Resident #1's primary care provider on 04/07/25 at 11:33am.

Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed:
-There was no entry to apply compression hose every morning.
-There was no entry to remove compression hose at bedtime.

Review of Resident #1's electronic progress notes revealed:
-There was an entry "the resident has orders for compression socks".
-The progress note was dated 04/07/25 at 2:00pm and electronically signed by a medication aide (MA).

Based on observations, record review, and interviews, it was determined Resident #1 was not interviewable.

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D 276	Continued From page 11 Observation of Resident #1 on 04/23/25 at 1:23pm revealed: -Resident #1 was seated in a wheelchair in a common area of the SCU. -Resident #1 had white socks on that were just above the ankle. -Resident #1 was not wearing compression hose. Telephone interview with a pharmacist with the facility's contracted pharmacy on 04/23/25 at 2:24 pm revealed: -An order was received for compression hose for Resident #1 on 04/07/25. -Measurements were required to dispense compression hose for Resident #1 and a measurement form had been sent to facility for Resident #1 and had not been returned to the pharmacy. Interview with the Administrative Assistant (AA) on 04/23/25 at 9:18am revealed if a resident had orders for compression hose, application and removal of the compression hose should be on the resident's eMAR. Interview with a medication aide (MA) on 04/23/25 at 12:29 revealed: -Either the MAs or the personal care aides (PCAs) applied the compression hose to the residents. -It depended on whoever got the resident up for the day, if a PCA applied compression hose, the MAs made sure the resident had them on. -Resident #1 was on the list for the 11:00pm to 7:00am shift to get up and dressed for the day. -She checked the eMAR and Resident #1 did not have an entry for compression hose. -She then said there was an order for compression hose for Resident #1 but they had not come from the pharmacy and she was not	D 276		

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D 276	Continued From page 12 sure why Resident #1's compression hose were not here. Second interview with the MA on 04/23/25 at 1:20 pm revealed: -She was told by another MA that Resident #1 needed to be measured for compression hose. -She was not sure if Resident #1 had been measured for compression hose. Interview with a second MA on 04/23/25 at 2:11pm revealed: -The MAs faxed orders to the pharmacy then they were given to either the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD). -She remembered Resident #1 had an order for compression hose. -She could not remember if the order for Resident #1's compression hose was received by fax or if the provider left it but she thought the RCC gave it to her. -She faxed Resident #1's compression hose order to the pharmacy and documented a progress note on Resident #1's electronic record and placed it in the resident's record. -She had not been told that the order needed to be scanned or stamped. Second interview with the AA on 04/23/25 at 1:47pm revealed: -Orders that came to the facility via fax were scanned in and faxed to the pharmacy. -Once the order was scanned and faxed, it was supposed to be stamped with the red "scanned" stamp and placed in the resident's record. -If compression hose were ordered for a resident, the MA faxed the order to the pharmacy and scanned it in and the pharmacy faxed back a measurement form for the resident.	D 276		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF NEW BERN	1309 MCCARTHY BLVD NEW BERN, NC 28562

(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
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-Once the resident's measurements were taken and documented, the measurement form was faxed back to the pharmacy.

Interview with RCC on 04/23/25 at 5:00pm revealed:
-Orders came to the facility via either fax or email.
-If the order came via email or fax, it was faxed to the pharmacy.
-The MAs, the RCC, or the HWD could fax orders to the pharmacy.
-If the MA faxed an order to the pharmacy, they were to give the order to the RCC or the HWD.
-The RCC or the HWD initiated an order tracking sheet for all orders, not just medications.
-She remembered seeing an order for Resident #1 for compression hose and she gave it to a MA in the SCU but she did not remember which MA she gave it to.
-She was certain the MA had faxed the order for Resident #1's compression hose and the pharmacy sent back a measurement sheet.
-It was the MAs responsibility to complete the measurement sheet and return it to the pharmacy.
-An order tracking sheet should have been completed for Resident #1's compression hose but was not.
-She was not sure why an order tracking sheet was not completed for Resident #1's compression hose.

Interview with the HWD on 04/23/25 at 5:30pm revealed:
-The MAs or the RCC faxed orders to the pharmacy.
-The MAs or the RCC were responsible for initiating an order tracking sheet for all orders.
-The MAs checked the order tracking sheets throughout the day and the RCC checked the

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order tracking sheets each morning.
-The pharmacy delivered around 10:00pm each night and if a medication did not arrive, the pharmacy was contacted.
-The order tracking sheet was not complete until the medication arrived.
-When compression hose were ordered, the pharmacy sent a measurement sheet.
-She also had a "work space" with the facility's electronic system but never received a message from the pharmacy that Resident #1 needed measurements for compression hose.
-She was not aware of the compression hose order for Resident #1 and did not know what happened with the order.
-An order tracking sheet should have been initiated for Resident #1's compression hose.
-She did not know why an order tracking sheet had not been initiated for Resident #1's compression hose.
-She, the RCC, and the AA performed chart audits monthly.
-Chart audits consisted of making sure the residents had the required paperwork such as updated FL2s, quarterly Licensed Health Professional Support evaluations, and updated care plans and to review orders.
-She did not always have enough time during chart audits to review all the residents' orders.

Interview with the Administrator on 04/23/25 at 6:12pm revealed:
-All orders were to have an order tracking form.
-Resident #1 should have had an order tracking form initiated for his compression hose.
-It was HWD's responsibility to follow up on all orders and order tracking forms for the residents.
-It was HWD's responsibility to perform chart audits to ensure that all orders were completed.
-She expected all orders to be followed to

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D 276	Continued From page 15 completion for all the residents. Telephone interview with Resident #1's PCP on 04/23/25 at 1:26pm revealed: -She prescribed compression hose for Resident #1 for edema (swelling) in his legs. -Edema could be caused by poor circulation. -Resident #1 could have continued or increased edema in his legs without the compression hose.	D 276		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure orders were clarified for 1 of 5 sampled residents (#1) pertaining to duplicate orders for finger stick blood sugars (FSBSs). The findings are: Review of the facility's Diabetes, Insulin and Glucose Management policy dated 09/01/19	D 344		

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included:
-Procedure for administering insulin: Verify physician order using doctors order sheet and electronic medication administration records (eMAR).
-Procedure for portable blood glucose meter: verify physician order using doctors order sheet and eMAR.

Review of Resident #1's current FL-2 dated 10/03/24 revealed:
-Diagnoses included Type 2 diabetes and dementia.
-His level of care was Special Care Unit (SCU).
-He was intermittently disoriented.
-There was an order for insulin aspart (insulin aspart is a rapid-acting insulin) inject 10 units at breakfast, add 2 units for every 50 above 150.
-There was an order for insulin aspart, inject 6 units at lunch, add 2 units for every 50 over 150.
-There was an order for insulin aspart, inject 8 units at dinner, add 2 units for every 50 over 150.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 03/26/22.

Review of Resident #1's signed physicians order sheet dated 02/27/25 revealed:
-There was an order to check fasting FSBS every day before meals.
-There was an order for insulin aspart, check fingerstick blood sugar (FSBS) every morning prior to breakfast, inject 10 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use.
-There was an order for insulin aspart, check fingerstick blood sugar every day before lunch, inject 6 units, add an additional 2 units for every

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50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use.
-There was an order for insulin aspart, check fingerstick blood sugar every evening before dinner, inject 8 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use.
-There was an order to provide Resident #1 with a sandwich before bedtime.

Review of Resident #1's of signed physician order form dated 03/27/25 revealed:
-There was an order to discontinue insulin aspart.
-There was an order to check FSBS twice daily.

Review of Resident #1's signed physician order form dated 03/28/25 revealed:
-There was an order to check FSBS prior to meals.
-There was an order to administer insulin aspart 5 units for FSBS greater than 250.

Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check fasting blood sugar every day before meals.
-There was documentation of FSBSs obtained on 03/01/25 through 03/31/25 at 7:30am.
-There was documentation of FSBSs obtained on 03/01/25 through 03/31/25 at 11:30am.
-There was documentation of FSBSs obtained on 0301/25 through 03/31/25 at 5:00pm.
-There was a second entry to check FSBS twice a day scheduled at 8:00am and 8:00pm.
-There was documentation of FSBSs obtained on 03/28/25 through 03/31/25 at 8:00am.
-There was documentation of FSBSs obtained on 03/27/25 through 03/31/25 at 8:00pm.

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D 344	Continued From page 18 Review of Resident #1's April 2025 eMAR revealed: -There was an entry to check fasting blood sugar every day before meals. -There was documentation of FSBSs obtained on 04/01/25 through 04/22/25 at 7:30am. -There was documentation of FSBSs obtained on 04/01/25 through 04/21/25 at 11:30am. -There was documentation of FSBSs obtained on 04/01/25 through 04/21/25 at 5:00pm. -There was a second entry to check FSBS twice a day scheduled at 8:00am and 8:00pm. -There was documentation of FSBSs obtained on 04/01/25 through 04/22/25 at 8:00am. -There was documentation of FSBSs obtained on 04/01/25 through 04/21/25 at 8:00pm. Based on observations, record review, and interviews, it was determined Resident #1 was not interviewable. Interview with a medication aide (MA) on 04/23/25 at 4:32pm revealed: -She always reviewed the residents' eMAR for orders. -Resident #1's insulin order had recently changed, he had been on a sliding scale insulin but now received insulin three times per day if his FSBS was over 250. -Resident #1 received FSBSs before meals and at bedtime. -She had not noticed that Resident #1 had 2 separate entries for FSBSs on the eMAR. Interview with a second MA on 04/23/25 at 4:41pm revealed: -Resident #1 received FSBSs with meals and at bedtime. -She had not questioned why Resident #1 had two separate FSBS orders.	D 344		

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D 344	Continued From page 19 Interview with the Resident Care Coordinator (RCC) on 04/23/25 at 5:21pm revealed: -She was not aware that Resident #1 had 2 entries for FSBSs on his eMAR. -She knew his insulin order had recently changed. -When orders were received, she or the MAs scanned the orders and faxed them to the pharmacy. -The Health and Wellness Director (HWD) was responsible for confirming all orders for the residents. Interview with the HWD on 04/23/25 at 5:45pm revealed: -The MAs or the RCC scanned and faxed orders to the pharmacy. -New orders were sent to her from the pharmacy to confirm, after she confirmed the orders, they became active on the eMAR. -She did not review the residents' eMARs before confirming new orders. -She was not aware that Resident #1 had two orders for FSBSs. -She did not catch that Resident #1 had two orders for FSBSs when she confirmed his most recent insulin aspart order. -She was responsible for making sure the residents' eMARs were accurate. -She, the RCC, and the administrative assistant (AA) were responsible for doing monthly audits of the residents' eMARs, -She did not review the residents' eMARs on a regular basis but tried to do it monthly. -She had not performed eMAR audits this month. -An eMAR audit looked for omissions of medications, refusals, duplicate orders, accurate orders and were compared to the physician orders in the residents' record. -She knew Resident #1's sliding scale insulin had	D 344		

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been discontinued and that he had a new order for insulin to be given with meals if his FSBS was over 250.
-She thought the pharmacy should have removed the order for FSBS twice daily when the new order insulin aspart three times a day was received on 03/28/25.
-She thought Resident #1's primary care provider (PCP) probably forgot to cancel the order for FSBSs twice daily for Resident #1.
-She expected the MAs to notify her if they had any questions about the medication orders or about the eMAR.
-She had not contacted Resident #1's PCP to clarify the orders for his FSBS.

Interview with the Administrator on 04/23/25 at 6:12pm revealed:
-The HWD was responsible for making sure all medication and procedure orders were accurate on the residents' eMARs.
-The HWD was responsible for a weekly sample of eMAR audits.
-The eMAR audits included review of the physician's orders for medications and treatments including FSBS, looking for omissions, refusals, order accuracy and duplicate orders.
-She expected the eMARs to be accurate.

Telephone interview with Resident #1's primary care provider (PCP) on 04/23/25 at 1:28pm revealed:
-She prescribed FSBSs and insulin aspart for Resident #1 for diabetes.
-She had recently discontinued the sliding scale insulin and prescribed insulin aspart 5 units before meals if his FSBS was above 250.
-She ordered FSBS three times per day with meals.
-She did not order Resident #1 to have FSBSs at

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D 344	Continued From page 21 8:00pm. -She was not aware that Resident #1 received FSBSs daily at bedtime. -She expected to be contacted if there were any questions or concerns regarding orders for the residents.	D 344		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#1) pertaining to a medication used to treat elevated blood glucose levels. The findings are: Review of the facility's Diabetes, Insulin and Glucose Management policy dated 09/01/19 included: -Procedure for administering insulin: Verify physician order using doctors order sheet and electronic medication administration records (eMAR). -Check information on the insulin bottle, or	D 358		

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pre-drawn syringe to verify correct, type dose and schedule of injection.
-Document the injection on the eMAR.
-Procedure for portable blood glucose meter: verify physician order using doctors order sheet and eMAR.

Review of Resident #1's current FL-2 dated 10/03/24 revealed:
-Diagnoses included Type 2 diabetes and dementia.
-His level of care was Special Care Unit (SCU).
-He was intermittently disoriented.
-There was an order for insulin aspart (insulin aspart is a rapid-acting insulin) inject 10 units at breakfast, add 2 units for every 50 above 150.
-There was an order for insulin aspart, inject 6 units at lunch, add 2 units for every 50 over 150.
-There was an order for insulin aspart, inject 8 units at dinner, add 2 units for every 50 over 150.

Review of Resident #1's Resident Register revealed he was admitted to the facility on 03/26/22.

Review of Resident #1's signed physicians order sheet dated 02/27/25 revealed:
-There was an order to check fasting FSBS every day before meals.
-There was an order for insulin aspart, check fingerstick blood sugar (FSBS) every morning prior to breakfast, inject 10 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use.
-There was an order for insulin aspart, check fingerstick blood sugar (FSBS) every day before lunch, inject 6 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use.

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-There was an order for insulin aspart, check fingerstick blood sugar (FSBS) every day before dinner, inject 8 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use.
-There was an order to provide Resident #1 with a sandwich before bedtime.

Review of Resident #1's of signed physician order form dated 03/27/25 revealed:
-There was an order to discontinue insulin aspart.
-There was an order to check FSBS twice daily.

Review of Resident #1's signed physician order form dated 03/28/25 revealed:
-There was an order to check FSBS prior to meals.
-There was an order to administer insulin aspart 5 units for FSBS greater than 250.

Review of Resident #1's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS every day before meals scheduled at 7:30am, 11:30am and 5:00pm.
-There was an entry for insulin aspart flex pen, inject 5 units subcutaneously before meals if FSBS is greater than 250, prime pen with 2 units, scheduled as needed (PRN).
-There was documentation of a FSBS obtained of 258 on 04/11/25 at 11:30am.
-There was no documentation 5 units of insulin aspart was administered on 04/11/25 at 11:30am.
-There was documentation of a FSBS obtained of 297 on 04/15/25 at 11:30am.
-There was no documentation 5 units of insulin aspart was administered on 04/15/25 at 11:30am.
-There was documentation of a FSBS obtained of 256 on 04/18/25 at 5:00pm.

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-There was no documentation 5 units of insulin aspart was administered on 04/18/25 at 5:00pm.
-There was documentation of a FSBS obtained of 324 on 04/19/25 at 11:30am.
-There was no documentation 5 units of insulin aspart was administered on 04/19/25 at 5:00pm.
-There was a second entry to check FSBS twice a day scheduled at 8:00am and 8:00pm.
-There was documentation of a FSBS obtained of 596 on 04/04/25 at 8:00pm (a FSBS above 200 is considered hyperglycemia).
-There was documentation 5 units of insulin aspart was administered at 8:23pm.
-There was documentation of a FSBS obtained of 251 on 04/08/25 at 8:00pm.
-There was documentation 5 units of insulin aspart was administered at 7:41pm.
-There was documentation of a FSBS obtained of 66 on 04/09/25 at 7:30am (a FSBS below 70 is considered hypoglycemia).

Telephone interview with a pharmacist with the facility's contracted pharmacy provider on 04/23/25 at 2:24pm revealed:
-An order was received for Resident #1 to discontinue insulin aspart and to check FSBS on 03/27/25.
-An order was received for Resident #1 for insulin aspart, inject 5 units prior to meals for FSBS greater than 250.
-Insulin apart 1 pen of 3 mls for 300 units was dispensed on 03/28/25 to inject 5 units prior to meals if FSBS greater than 250.

Observation of Resident #1's medications on hand on 04/23/25 at 1:00pm revealed there was one insulin aspart flex pen of 3 mls dispensed on 03/28/25.

Based on observations and record reviews it was

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D 358	Continued From page 25 determined Resident #1 was not interviewable. Interview with a medication aide (MA) on 04/23/25 at 4:32pm revealed: -She always reviewed the residents' eMAR for orders. -Resident #1's insulin order had recently changed, he had been on a sliding scale insulin but now received insulin three times per day if his FSBS was over 250. -Resident #1 received FSBSs before meals and at bedtime. -Resident #1 received insulin aspart with meals if his FSBS was over 250, she knew he did not receive insulin at bedtime. -She had not noticed that Resident #1 had 2 separate entries for FSBSs on the eMAR. -She had documented Resident #1's FSBS on 04/19/25 at 11:30am as 324. -She was certain she administered insulin aspart to Resident #1 on 04/19/25 at 11:30am when his FSBS was documented as 324. -She thought she must have forgotten to document that she administered insulin aspart to Resident #1 on 04/19/25 at 11:30am when his FSBS was 324. -Anytime medications were administered to the residents, it was documented on their eMAR. Interview with a second MA on 04/23/25 at 4:41pm revealed: -Resident #1 received FSBSs with meals and at bedtime. -She had documented Resident #1's FSBS as 596 on 04/04/25 at 8:00pm. -She did not contact Resident #1's primary care provider but contacted the facility's Health and Wellness Director (HWD) by phone when Resident #1's FSBS was 596 on 04/04/25 at 8:00pm because the FSBS was so high and she	D 358		

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reviewed the insulin aspart order with her and was told to administer insulin aspart 5 units to Resident #1.
-She administered insulin aspart 5 units to Resident #1 on 04/04/25 at 8:23pm and rechecked his blood sugar later that evening to make sure it came down but was not sure if she documented the repeat FSBS but she did document the insulin aspart was effective since it was a PRN.
-She administered insulin aspart 5 units to Resident #1 on 04/08/25 at 7:41pm because his FSBS was 251 and she considered the insulin aspart order to be a PRN order since it was labeled as a PRN order on the eMAR.
-She knew the insulin aspart order was to be administered at meals if the FSBS was greater than 250 but it was on the eMAR as a PRN order and she thought she could use it anytime even though it said to administer with meals.

Interview with the Resident Care Coordinator (RCC) on 4/23/25 at 5:21pm revealed:
-The MAs were expected to review the eMAR and administer medications per the orders on the eMAR.
-She was not aware that Resident #1 had 2 entries for FSBSs on his eMAR.
-She knew his insulin order had recently changed.
-When orders were received, she or the MAs scanned the orders and faxed them to the pharmacy.
-The HWD was responsible for confirming orders for the residents in the eMAR system.
-She was not aware that Resident #1 had received insulin at bedtime on 2 occasions and had not received insulin when his FSBS was documented above 250 on 4 occasions this month.
-It was important for the residents to receive

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medications as ordered, especially insulin, because not administering the insulin could cause the blood sugar to be too high and administering insulin when it was not ordered could cause the blood sugar to be too low.

Interview with the HWD on 04/23/25 at 5:45pm revealed:
-The MAs or the RCC scanned and faxed orders to the pharmacy.
-New orders were sent to her from the pharmacy to confirm, after she confirmed the orders, they became active on the eMAR.
-She did not review the residents' eMARs before confirming new orders.
-She was not aware that Resident #1 had two orders for FSBSs.
-She did not catch that Resident #1 had two orders for FSBSs when she confirmed his most recent insulin aspart order.
-She was responsible for making sure the residents' eMARs were accurate.
-She, the RCC, and the administrative assistant (AA) were responsible for doing monthly audits of the residents' eMARs,
-She did not review the residents' eMARs on a regular basis but tried to do it monthly.
-She had not performed eMAR audits this month.
-An eMAR audit looked for omissions of medications, refusals, duplicate orders, accurate orders and were compared to the physician orders in the residents' record.
-She knew Resident #1's sliding scale insulin had been discontinued and that he had a new order for insulin to be given with meals if his FSBS was over 250.
-She thought Resident #1's PCP probably forgot to cancel the order for FSBSs twice daily for Resident #1.
-She expected the MAs to notify her if they had

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any questions about the medication orders or about the eMARs.
-She was not aware that Resident #1 received insulin in the evening when it was not ordered on two occasions and that he received evening FSBSs.
-She was not notified when Resident #1 had an evening FSBS of 596 and received insulin.
-Resident #1 did not have parameters related to his FSBSs except to administer the insulin if his FSBS was greater than 250 but his PCP should have been notified of the FSBS of 596.
-The facility did not have standing orders or a policy for blood sugar parameters and physician notification.
-She thought the MA that administered the evening doses of insulin to Resident #1 was probably working off of memory because she thought Resident #1 had a previous evening insulin order.
-She was not aware that Resident #1 had not received insulin on 4 occasions when his FSBS were over 250.
-She did not know why Resident #1's insulin was not administered when his FSBS was greater than 250
-She thought it was possible that since the insulin aspart order for Resident #1 was entered as a PRN medication and not on a scheduled basis could account for the errors with Resident #1's insulin.
-The MAs were expected to administer all medications as directed by the eMAR.

Interview with the Administrator on 04/23/25 at 6:12pm revealed:
-The HWD was responsible for making sure all medication and procedure orders were accurate on the residents' eMARs.
-The HWD was responsible for approving and

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confirming all orders for the residents.
-The HWD was responsible for a weekly sample of eMAR audits.
-The eMAR audits included review of the physician's orders for medications and treatments including FSBS, looking for omissions, refusals, order accuracy and duplicate orders.
-She expected the eMARs to be accurate.
-The MAs were expected to review and follow the orders on the residents' eMARs.
-The MAs were expected to administer all medications and treatments as ordered.

Telephone interview with Resident #1's primary care provider (PCP) on 04/23/25 at 1:28pm revealed:
-She prescribed insulin aspart for Resident #1 for diabetes.
-His last Hgb A1C (Hgb A1c is a blood test that measures average blood sugar levels over the past 2-3 months, a normal HgbA1C was considered to be below 5.7) was 5 and he had been on sliding scale insulin, and she was trying to get him off the rapid acting insulin.
-She had recently discontinued the sliding scale insulin and prescribed insulin aspart 5 units before meals if his FSBS was above 250.
-She preferred his blood sugar to run a little higher above 150.
-She was more concerned about Resident #1's blood sugar being too low.
-She did not order Resident #1 to have FSBSs or insulin aspart at 8:00pm.
-She was not aware that Resident #1 received FSBSs daily at bedtime and received insulin on 2 occasions at bedtime.
-She ordered Resident #1 to have a sandwich at bedtime to keep his blood sugar from dropping too low.
-Resident #1 should have received insulin aspart

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D 358	Continued From page 30 when his FSBS was above 250 at mealtimes. -She was not aware that Resident #1 did not receive insulin aspart on 4 occasions when his FSBS was above 250 at mealtimes. -Receiving insulin aspart when not ordered could result in hypoglycemia (low blood sugar) which could cause Resident #1 to experience fatigue, irritability, nervousness, nausea, shaking, dizziness, lightheadedness or diabetic coma and can be life-threatening. -Not receiving insulin aspart when ordered could result in hyperglycemia (elevated blood sugar) which could lead to fatigue, thirst, drowsiness, weakness, or diabetic coma and could be life-threatening. -The long-term effects of elevated blood sugar are kidney disease, hypertension, vision damage in the form of diabetic retinopathy and increased risk of stroke. _____ The facility failed to administer medications as ordered for 1 of 5 sampled residents. Resident #1 did not receive fast acting insulin on four occasions in April 2025, when his FSBS was greater than 250 which put him at risk for hyperglycemia and received fast acting insulin in the evening at bedtime on two occasions in April 2025 when it was not ordered, one of which resulted in a FSBS of 66 the following morning putting the resident at risk for hypoglycemia The failure of the facility to administer medications as ordered 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 04/23/25 for this violation. CORRECTION DATE FOR TYPE B VIOLATION	D 358		

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D 358	Continued From page 31 SHALL NOT EXCEED JUNE 07, 2025.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure an accurate electronic medication administration record (eMAR) to include the amount of insulin administered for a resident on sliding scale insulin .for 1 of 5 residents sampled (#1). The findings are:	D 367		

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D 367	Continued From page 32 Review of the facility's Diabetes, Insulin and Glucose Management policy dated 09/01/19 included: -Procedure for administering insulin: Verify physician order using doctors order sheet and electronic medication administration records (eMAR). -Check information on the insulin bottle, or pre-drawn syringe to verify correct, type dose and schedule of injection. -Document the injection on the eMAR. Review of Resident #1's current FL-2 dated 10/03/24 revealed: -Diagnoses included Type 2 diabetes and dementia. -His level of care was Special Care Unit (SCU). -He was intermittently disoriented. -There was an order for insulin aspart (insulin aspart is a rapid-acting insulin) inject 10 units at breakfast, add 2 units for every 50 above 150. -There was an order for insulin aspart, inject 6 units at lunch, add 2 units for every 50 over 150. -There was an order for insulin aspart, inject 8 units at dinner, add 2 units for every 50 over 150. Review of Resident #1's Resident Register revealed he was admitted to the facility on 03/26/22. Review of Resident #1's signed physicians order sheet dated 02/27/25 revealed: -There was an order for insulin aspart, check fingerstick blood sugar (FSBS) every morning prior to breakfast, inject 10 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use. -There was an order for insulin aspart, check	D 367		

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D 367	Continued From page 33 FSBS every day before lunch, inject 6 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use. -There was an order for insulin aspart, check FSBS every day before dinner, inject 8 units, add an additional 2 units for every 50mg/dl if FSBS is greater than 150, prime the pen with 2 units prior to each use. Review of Resident #1's of signed physician order form dated 03/27/25 revealed: -There was an order to discontinue insulin aspart. -There was an order to check FSBS twice daily. Review of Resident #1's February 2025 electronic medication record (eMAR) revealed: -There was an entry for insulin aspart, check FSBS every morning prior to breakfast, inject 10 units subcutaneously, add additional 2 units for every 50mg/dl if FSBS is greater than 150, prime pen with 2 units prior to each use, scheduled at 7:30am. -At 7:30am on 02/01/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 110. -At 7:30am on 02/02/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 135. -At 7:30am on 02/03/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 224. -At 7:30am on 02/04/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 147. -At 7:30am on 02/05/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 138. -At 7:30am on 02/06/25, an undetermined amount of insulin aspart was documented as	D 367		

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administered for a FSBS of 148.
-At 7:30am on 02/07/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 105.
-At 7:30am on 02/08/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 143.
-At 7:30am on 02/09/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 124.
-At 7:30am on 02/10/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 111.
-At 7:30am on 02/11/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 126.
-At 7:30am on 02/12/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 130.
-At 7:30am on 02/13/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 138.
-At 7:30am on 02/14/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 109.
-At 7:30am on 02/15/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 101.
-At 7:30am on 02/16/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 90.
-At 7:30am on 02/17/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 110.
-At 7:30am on 02/18/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 128.
-At 7:30am on 02/19/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 127.

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D 367	Continued From page 35 -At 7:30am on 02/20/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 127. -At 7:30am on 02/21/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 126. -At 7:30am on 02/22/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 124. -At 7:30am on 02/23/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 113. -At 7:30am on 02/24/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 127. -At 7:30am on 02/25/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 136. -At 7:30am on 02/26/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 85. -At 7:30am on 02/27/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 115. -At 7:30am on 02/28/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 110. -There was no space on the eMAR to document the units of insulin aspart administered at 7:30am on 02/01/25 through 02/28/25. -There was an entry for insulin aspart, check FSBS every day prior to lunch, give 6 units subcutaneously, add additional 2 units for every 50mg/dl if FSBS is greater than 150, prime pen with 2 units prior to each use, scheduled at 11:30am. -At 11:30am on 02/01/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 193 -At 11:30am on 02/02/25, an undetermined	D 367		

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amount of insulin aspart was documented as administered for a FSBS of 104.
-At 11:30am on 02/03/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 103.
-At 11:30am on 02/04/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 146.
-At 11:30am on 02/05/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 173.
-At 11:30am on 02/06/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 149.
-At 11:30am on 02/07/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 126.
-At 11:30am on 02/08/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 81.
-At 11:30am on 02/09/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 256.
-At 11:30am on 02/10/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 191.
-At 11:30am on 02/11/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 142.
-At 11:30am on 02/12/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 213.
-At 11:30am on 02/13/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 91.
-At 11:30am on 02/14/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 153.
-At 11:30am on 02/15/25 an undetermined amount of insulin aspart was documented as

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administered for a FSBS of 120.
-At 11:30am on 02/16/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 151.
-At 11:30am on 02/17/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 118.
-At 11:30am on 02/18/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 155.
-At 11:30am on 02/19/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 147.
-At 11:30am on 02/20/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 154.
-At 11:30am on 02/21/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 97.
-At 11:30am on 02/22/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 137.
-At 11:30am on 02/23/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 261.
-At 11:30am on 02/24/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 154.
-At 11:30am on 02/25/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 197.
-At 11:30am on 02/26/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 188.
-At 11:30am on 02/27/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 208.
-At 11:30am on 02/28/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 260.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 38 -There was no space on the eMAR to record units of insulin aspart administered at 11:30am on 02/01/25 through 02/28/25. -There was an entry for insulin aspart, check FSBS every evening prior to dinner, give 8 units subcutaneously, add additional 2 units for every 50mg/dl if FSBS is greater than 150, prime pen with 2 units prior to each use, scheduled at 5:00pm. -At 5:00pm on 02/01/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 132. -At 5:00pm on 02/02/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 212. -At 5:00pm on 02/03/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 89. -At 5:00pm on 02/04/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 101. -At 5:00pm on 02/05/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 71. -At 5:00pm on 02/06/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 163. -At 5:00pm on 02/07/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 134. -At 5:00pm on 02/08/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 88. -At 5:00pm on 02/09/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 299. -At 5:00pm on 02/10/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 121. -At 5:00pm on 02/11/25 an undetermined amount	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 39 of insulin aspart was documented as administered for a FSBS of 161. -At 5:00pm on 02/12/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 96. -At 5:00pm on 02/13/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 140. -At 5:00pm on 02/14/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 138. -At 5:00pm on 02/15/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 262. -At 5:00pm on 02/16/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 98. -At 5:00pm on 02/17/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 87. -At 5:00pm on 02/18/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 67. -At 5:00pm on 02/19/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 81. -At 5:00pm on 02/20/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 75. -At 5:00pm on 02/21/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 202. -At 5:00pm on 02/22/25 insulin aspart was documented as not required for a FSBS of 53. -At 5:00pm on 02/23/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 105. -At 5:00pm on 02/24/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 72.	D 367		

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D 367	Continued From page 40 -At 5:00pm on 02/25/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 87. -At 5:00pm on 02/26/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 156. -At 5:00pm on 02/27/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 133. -At 5:00pm on 02/28/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 120. -There was a space on the eMAR to record units of insulin administered at 5:00pm on 02/01/25 through 02/28/25, there was no documentation of units of insulin aspart administered at 5:00pm 02/01/25 through 02/28/25 except on 02/22/25 at 5:00pm. -There was no way to determine how much insulin aspart was administered on 02/01/25 through 02/28/25 at 7:30am,11:30am, and 5:00pm except on 02/22/25 at 5:00pm. Review of Resident #1's March 2025 eMAR revealed: -There was an entry for insulin aspart, check FSBS every morning prior to breakfast, inject 10 units subcutaneously, add additional 2 units for every 50mg/dl if FSBS is greater than 150, prime pen with 2 units prior to each use, scheduled at 7:30am. -At 7:30am on 03/01/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 111. -At 7:30am on 03/02/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 87. -At 7:30am on 03/03/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 114.	D 367		

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D 367	Continued From page 41 -At 7:30am on 03/04/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 125. -At 7:30am on 03/05/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 106. -At 7:30am on 03/06/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 83. -At 7:30am on 03/07/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 87. -At 7:30am on 03/08/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 118. -At 7:30am on 03/09/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 116. -At 7:30am on 03/10/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 123. -At 7:30am on 03/11/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 86. -At 7:30am on 03/12/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 89. -At 7:30am on 03/13/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 133. -At 7:30am on 03/14/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 111. -At 7:30am on 03/15/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 101. -At 7:30am on 03/16/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 132. -At 7:30am on 03/17/25 an undetermined amount	D 367		

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D 367	Continued From page 42	D 367		

of insulin aspart was documented as administered for a FSBS of 106.
-At 7:30am on 03/18/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 142.
-At 7:30am on 03/19/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 117.
-At 7:30am on 03/20/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 154.
-At 7:30am on 03/21/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 112.
-At 7:30am on 03/22/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 111.
-At 7:30am on 03/23/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 124.
-At 7:30am on 03/24/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 107.
-At 7:30am on 03/25/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 91.
-At 7:30am on 03/26/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 87.
-At 7:30am on 03/27/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 121.
-There was no space on the eMAR to record units of insulin aspart administered at 7:30am on 03/01/25 through 03/31/25.
-There was an entry for insulin aspart, check FSBS every day prior to lunch, give 6 units subcutaneously, add additional 2 units for every 50mg/dl if FSBS is greater than 150, prime pen with 2 units prior to each use, scheduled at

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D 367	Continued From page 43 11:30am. -At 11:30am on 03/01/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 159. -At 11:30am on 03/02/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 156. -At 11:30am on 03/03/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 142. -At 11:30am on 03/04/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 135. -At 11:30am on 03/05/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 126. -At 11:30am on 03/06/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 143. -At 11:30am on 03/07/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 104. -At 11:30am on 03/08/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 199. -At 11:30am on 03/09/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 149. -At 11:30am on 03/10/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 137. -At 11:30am on 03/11/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 127. -At 11:30am on 03/12/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 111. -At 11:30am on 03/13/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 176.	D 367		

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D 367	Continued From page 44 -At 11:30am on 03/14/25 there was documentation of insulin aspart held due to FSBS too low for a FSBS of 66. -At 11:30am on 03/15/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 88. -At 11:30am on 03/16/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 90. -At 11:30am on 03/17/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 224. -At 11:30am on 03/18/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 192. -At 11:30am on 03/19/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 187. -At 11:30am on 03/20/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 154. -At 11:30am on 03/21/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 81. -At 11:30am on 03/22/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 138. -At 11:30am on 03/23/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 188. -At 11:30am on 03/24/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 91. -At 11:30am on 03/25/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 85. -At 11:30am on 03/26/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 132. -At 11:30am on 03/27/25 an undetermined	D 367		

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D 367	Continued From page 45 amount of insulin aspart was documented as administered for a FSBS of 413. -There was no space on the eMAR to record units of insulin aspart administered at 11:30am on 03/01/25 through 03/31/25. -There was an entry for insulin aspart, check FSBS every evening prior to dinner, give 8 units subcutaneously, add additional 2 units for every 50mg/dl if FSBS is greater than 150, prime pen with 2 units prior to each use, scheduled at 5:00pm. -At 5:00pm on 03/01/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 147. -At 5:00pm on 03/02/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 182. -At 5:00pm on 03/03/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 83. -At 5:00pm on 03/04/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 150. -At 5:00pm on 03/05/25, there was documentation insulin aspart was not administered for a FSBS of 51, the resident was given a sandwich and FSBS was rechecked and documented as 171. -At 5:00pm on 03/06/25, an undetermined amount of insulin aspart was documented as administered for a FSBS of 57. -At 5:00pm on 03/07/25, there was documentation, the resident's FSBS was 61, insulin aspart was not given until after dinner for a FSBS of 152, there were no number of units of insulin aspart documented. -At 5:00pm on 03/08/25, there was documentation the FSBS was low normal and the FSBS went up to 115 and 8 units of insulin aspart were administered.	D 367		

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D 367	Continued From page 46 -At 5:00pm on 03/09/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 264. -At 5:00pm on 03/10/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 110. -At 5:00pm on 03/11/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 148. -At 5:00pm on 03/12/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 101. -At 5:00pm on 03/13/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 75. -At 5:00pm on 03/14/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 182. -At 5:00pm on 03/15/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 79. -At 5:00pm on 03/16/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 180. -At 5:00pm on 03/17/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 133. -At 5:00pm on 03/18/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 148. -At 5:00pm on 03/19/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 68. -At 5:00pm on 03/20/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 84. -At 5:00pm on 03/21/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 80. -At 5:00pm on 03/22/25 insulin aspart was	D 367		

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D 367	Continued From page 47	D 367		

documented as not required for a FSBS of 81.
-At 5:00pm on 03/23/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 143.
-At 5:00pm on 03/24/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 171.
-At 5:00pm on 03/25/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 118.
-At 5:00pm on 03/26/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 165.
-At 5:00pm on 03/27/25 an undetermined amount of insulin aspart was documented as administered for a FSBS of 59.
-There was no space on the eMAR to record units of insulin administered.
-There was no way to determine how much insulin aspart was administered on 03/01/25 through 03/31/25 at 7:30am,11:30am, and 5:00pm except on 03/14/25 at 11:30am, on 03/08/25 and on 03/22/25 at 5:00pm

Based on observations, record review, and interviews, it was determined Resident #1 was not interviewable.

Interview with a medication aide (MA) on 04/23/25 at 12:29pm revealed:
-She did not document the number of insulin units administered to Resident #1.
-She knew his insulin order had recently changed.
-She had never been instructed to document the number of insulin units administered on the eMAR.

Interview with a second MA on 04/23/25 at 2:11pm revealed:
-She did not document the number of sliding

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D 367	Continued From page 48 scale insulin units administered to Resident #1. -There was no place on the eMAR to document the number of sliding scale insulin units administered. -She had never been instructed to document the number of sliding scale insulin units administered. Interview with a third MA on 04/23/25 at 4:32pm revealed: -There was no place on the eMAR to document the number of sliding scale insulin units administered to Resident #1. -When insulin was administered to the residents, she recorded the FSBS, location of the injection and the time. -She had never been told to record the number of insulin units administered. Interview with a fourth MA on 04/23/25 at 4:41pm revealed: -When she administered insulin to Resident #1, she obtained the FSBS, then administered insulin per the results of the FSBS. -She documented the results of the FSBS, location of the injection and the time the injection was administered on the eMAR.. -She had never been instructed to document the number of units administered on the MAR. Interview with the Resident Care Coordinator (RCC) on 04/23 at 5:21pm: -The MAs could document the number of insulin units administered in the electronic progress notes. -It was important to record the number of insulin units administered to make sure the resident received the correct dosage of insulin and not too much or too little insulin depending on their FSBS.	D 367		

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D 367	Continued From page 49 Interview with the Health and Wellness Director (HWD) on 04/23/25 at 5:45pm revealed: -The MAs did not notify her there was no place on the sliding scale insulin order on the eMAR to document the number of sliding scale insulin units administered. -When the facility used paper MARs, the number of insulin units administered was documented on the paper MAR, the facility had switched to eMARs about a year ago. -The MAs should have used the electronic progress notes to document the number of sliding scale insulin units administered each time to Resident #1. -She was not sure if the pharmacy could add a place to document the number of insulin units administered to the eMAR. -It was important that the units of insulin administered were recorded so the facility could be certain Resident #1 received the correct dosage of insulin. -She was responsible for making sure the residents' eMARs were accurate. -She, the RCC, and the administrative assistant (AA) were responsible for doing monthly audits of the residents' eMARs. -She did not review the residents' eMARs on a regular basis but tried to do it monthly. -She had not performed eMAR audits this month. -An eMAR audit looked for omissions of medications, refusals, duplicate orders, accurate orders and were compared to the physician orders in the residents' record. -She knew Resident #1's sliding scale insulin had been discontinued. Interview with the Administrator on 04/23/25 at 6:12pm revealed: -She was not aware the number of units of insulin aspart administered were not documented when	D 367		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMEPLACE OF NEW BERN	1309 MCCARTHY BLVD NEW BERN, NC 28562

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 50 Resident #1 had the sliding scale insulin orders. -The eMAR should always reflect the number of insulin units administered to make sure the residents receive the correct dose of medication, without this documentation there was no way to tell if Resident #1 received the correct dose of insulin. -The HWD was responsible for making sure all medication and procedure orders were accurate on the residents' eMARs. -The HWD was responsible for a weekly sample of eMAR audits. -The eMAR audits included review of the physician's orders for medications and treatments including FSBS, looking for omissions, refusals, order accuracy and duplicate orders to make sure the residents received their medications as ordered. Telephone interview with Resident #1's primary care provider (PCP) on 04/23/25 at 1:28pm revealed: -She prescribed insulin aspart for Resident #1 for diabetes. -His last Hgb A1C (Hgb A1c is a blood test that measures average blood sugar levels over the past 2-3 months, a normal HgbA1C was considered to be below 5.7) was 5 and he had been on sliding scale insulin, and she was trying to get him off the rapid acting insulin. -Staff should have recorded the number of units insulin aspart administered to Resident #1 based on his FSBSs to ensure he received the proper dose, so she could make adjustments in his insulin aspart if needed. -Receiving too much insulin aspart could result in hypoglycemia (low blood sugar) which could cause Resident #1 to experience fatigue, irritability, nervousness, nausea, shaking, dizziness, lightheadedness or diabetic coma and	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL025039	A. BUILDING: _____ B. WING _____	04/23/2025

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D 367	Continued From page 51 can be life-threatening. -Receiving too little insulin aspart could result in hyperglycemia (elevated blood sugar) which could lead to fatigue, thirst, drowsiness, weakness, or diabetic coma and could be life-threatening. -The long-term effects of elevated blood sugar are kidney disease, hypertension, vision damage in the form of diabetic retinopathy and increased risk of stroke.	D 367		