Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL045126	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 06/17/25-06/18/25.	D 000		
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 observation, interviews, and record reviews, the facility failed to ensure implementation of a physician's order for 1 of 5 sampled residents (Resident #5) related to compression stockings. The findings are: Review of Resident #5's current FL2 dated 04/14/25 revealed: -Diagnoses included history of strokes, history of endocarditis (an infection of the heart's inner lining including the heart valves), thoracic spondylosis (a degenerative disease of the thoracic spine), congestive heart failure, stage 3 chronic kidney disease, history of pulmonary embolisms (a blockage of the artery in the lungs by a blood clot(s), and spinal cord compression. -He was semi-ambulatory with a wheelchair. Review of Resident #5's Resident Register revealed an admission date of 03/31/25 from a local health and rehabilitation facility.	D 276	The Regional Director of Clinical Services will in-service the ED/ Designee on the New Order Tracking Process by Wednesday, July 30th. The ED/Designee will in-service all Med Tech's on the New Order Tracking Process by Friday, August 1st. The ED/Designee will check the New Order Notebook Daily Monday-Friday. Should any questions arise, the ED/ Designee will reach out to the provider for clarification. The Regional Director of Clinical Services will review the New Order Tracking Notebook and compare to the MAR weekly times 4 weeks for oversight to the process. After 4 weeks, the ED/Designee will continue to check the New Order Notebook Daily Monday -Friday as per the New Order Tracking Process.	8/1/25

Review and acknowledged 08/01/25 Julie Grooms

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D 276	Continued From page 1 Review of Resident #5's physician's order dated 06/03/25 revealed an order to apply compression stockings daily for swelling. Review of Resident #5's electronic medication administration record (eMAR) from 06/03/25 through 06/18/25 revealed: -There was no entry to apply compression stockings daily. -There was no documentation compression stockings were applied between 06/03/25 through 06/18/25. Observation of Resident #5's legs on 06/18/25 at 10:22am revealed: -There was no compression stockings applied to Resident #5's lower extremities. -Resident #5 had a brace on the right lower leg that extended down into his right shoe. -Resident #5's lower extremities were visibly swollen. Interview with a medication aide (MA) supervisor on 06/18/25 at 10:24am revealed: -Resident #5 had an order for compression stockings dated 06/03/25. -She had not requested the stockings to be delivered to Resident #5. -Resident #5's legs had to be measured before the stocking were ordered to determined the correct size needed. -She did not know how to obtain the measurements of Resident #5's lower legs because he was in a wheelchair and unable to stand. -She usually obtained measurements for compression stockings while a person was standing.	D 276		

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D 276	Continued From page 2 Interview with Resident #5 on 06/18/25 at 10:30am revealed: -He had a lot of health conditions that contributed to partial paralysis of both legs. -His lower legs, including his ankles and feet, were swollen. -He visited his cardiologist on 06/03/25 and he was prescribed a medication to decrease the swelling in his legs and compression stockings to wear daily. -He was never supplied with compression stockings to wear daily. -Staff had not taken measurements of his lower legs since the compression stockings were ordered by his cardiologist on 06/03/25. -His family member asked a MA about a week after his cardiologist ordered compression stockings why he did not have the stockings and was told by the MA that they did not know why, and they would check on it. -He has not asked anyone again why he did not get the compression stockings. Interview with the Regional Director of Clinical Services on 06/18/25 at 11:45am revealed: -MAs were responsible for taking measurements for compression stockings when ordered and sending the measurements to the facility's contracted pharmacy to order the correct size of compression stockings for residents. -She was not aware Resident #5 had not received the compression stockings. -Resident #5's orders were faxed to the facility's contracted pharmacy on 06/03/25 at 1:17pm because the MA supervisor signed and dated the orders. -She did not know why the MA supervisor did not obtain Resident #5's lower leg measurements and fax them to the pharmacy to get the compression stockings ordered and delivered.	D 276		

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D 276	Continued From page 3 -The former Resident Care Coordinator (RCC) was responsible to ensure new orders were completed. -The former RCC quit her position on 06/14/25. Interview with the Administrator on 06/18/25 at 11:53am revealed: -He was not aware Resident #5 had an order for compression stockings dated 06/03/25 or that the compression stockings order had not be processed. -The former RCC was the person responsible for making sure all orders were completed. -He expected the MAs or MA supervisors to take the measurements of Resident #5's legs for the correct compression stockings size and sent the measurements to the pharmacy to have the stockings delivered. -The MA supervisor was responsible for making sure all orders were completed, and the order was filed in the resident's record. Attempted telephone interview with Resident #5's cardiologist on 06/18/25 at 11:32am was unsuccessful.	D 276		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents.	D 292		

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D 292	Continued From page 4 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain a record of menu substitutions documenting what was served to residents. The findings are: Review of the facility's Spring/Summer 2025 menu for the week of 06/15/25 through 06/21/25 revealed: -The lunch menu for 06/17/25 was roasted pork tenderloin, onion roasted potatoes, sauteed green cabbage, choice of roll, fruit of choice, whipped butter cup or lemon pepper turkey and carrots, coffee/tea and 2% milk. -The breakfast menu for 06/18/25 was cereal, cheesy scrambled eggs, buttered croissants, jelly and whipped butter with orange juice, apple juice or cranberry juice and 2% milk, coffee and tea. Review of the daily menu posted in the hall next to the dining room door revealed: -The menu was dated incorrectly as "Tuesday 06/16/25". -The menu for 06/17/25 documented pork loin, carrots and roasted potatoes or turkey and cheese sandwich, onion rings and cake. Observation of the lunch meal service on 06/17/25 at 12:00pm revealed the residents were served pork loin, potatoes, carrots and cake or a turkey sandwich and onion rings. Coffee/tea,	D 292	•The Food Service Director updated the menu substitution log on 6/21/25, based on staff recollections so that the records reflect what was actually served going back from 06/18/25. •Kitchen staff members were re-educated on the importance of properly documenting all menu substitutions and maintaining the substitution log as a required record on 6/21/25. • A new menu substitution log was implemented, which requires all kitchen staff to document any substitutions daily and sign for accountability beginning 6/23/25. •The Executive Director/Designee now includes a daily review of this substitution log as part their routine duties. • The current Food Service staff were re-educated on facility policy defining roles starting on 6/21/25 to include responsibilities, and procedure for maintaining the menu substitution documentation. •This policy will be covered as part of ongoing training during the orientation process for new dining staff members. •The Food Service Designee and Clinical Service Designee will conduct monthly audits of resident diet orders and meal services provided to monitor compliance for the next 90 days. •Findings will be reviewed twice per month during CRR for further corrective action, as needed.	6/23/25

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D 292	Continued From page 5 milk, water and fruit punch. Observation of the breakfast meal service on 06/18/25 8:00am the residents were served scrambled eggs, choice of hot cereal, toast, bacon, juice, milk, coffee and water. Interview with the Cook on 06/18/25 at 8:32am revealed: -The Food Service Director left at the beginning of June 2025. -There was a substitution list, but it went missing after the dietary manager left. -She had not started another substitution list because she was more concerned with having staff in the kitchen. -She had not substituted any food in the past few days. Interview with the Administrator on 06/18/25 at 8:34am and 8:54am revealed: -The Food Service Director left sometime at the end of May 2025. -The kitchen kept a list of menu substitutions. -He was unable to locate a substitution list in the kitchen and did not know what happened to it.	D 292		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296	• Resident #2's diet order was reviewed and clarified with the primary care physician (PCP) to confirm the appropriate diet order (NCS vs. reduced carbohydrate). • The dietary and nursing staff were immediately informed of the correct diet order and ensured Resident #2 received the appropriate meals.	6/23/25

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D 296	Continued From page 6 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to have a matching therapeutic diet menu for food service guidance for 1 of 1 sampled residents (#2) who had a physician's order for a no concentrated sweets diet. The findings are: Review of Resident #2's current FL2 dated 03/31/25 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order for a no concentrated sweets diet. Review of Resident #2's diet order sheet dated 03/31/25 revealed: -Diets provided by the facility included a no concentrated sweets (NCS) diet was offered -Resident #2's diet order was documented as no concentrated sweets. Review of Resident #2's physician's orders dated 04/16/25 revealed there was an order for a no concentrated sweets diet. Review of Resident #2's diet order in a notebook in the kitchen revealed he was to be served a no concentrated sweets diet. Review of the residents diets orders provided upon entry on 06/17/25 revealed Resident #2 was on a reduced carbohydrate diet. Review of the facility's Spring/Summer 2025 menu revealed:	D 296		

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D 296	Continued From page 7 -There was documentation of a reduced carbohydrate menu. -No menu was available for a no concentrated sweets diet. Observation of the lunch meal service on 06/17/25 between 12:00pm and 12:35pm revealed: -Resident #2 was served pork loin, onion rings, a half portion of frosted cake, sugar free fruit punch and milk. -Resident #2 consumed 75% of the meal. Based on observation of the lunch meal service on 06/17/25, it could not be determined if Resident #2 was served the correct therapeutic diet because a no concentrated sweets diet menu was not available for staff guidance. Interview with the Cook on 06/18/25 at 8:32am revealed: -The Food Service Director left at the beginning of June 2025 and the facility Manager was now responsible for providing the menus for kitchen staff guidance. -Dietary staff did not refer to the spreadsheets in the Spring/Summer 2025 menu book. -There were no menus available for a no concentrated sweets diet. Interview with the Manager on 06/18/25 at 8:40am revealed: -She was responsible for providing dietary staff with menus since the Food Service Director left at the end of May 2025. -She used the Spring/Summer 2025 menu book in the kitchen to develop the menu for each day. Interview with the facility's Regional Dietary Manager on 06/18/25 at 10:44am and 11:32am	D 296		

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D 296	Continued From page 8 revealed: -The facility's corporate office changed menus effective 05/01/25. -All residents who were ordered no concentrated sweet diets should have changed to reduce carbohydrate diets by 05/01/25. -The facility staff were in-serviced on the pending changes on 03/31/25. -The Administrator was trained on the diets when he was hired in April 2025. -The corporate office updated the facility's available diet list and replaced the no concentrated sweets diet with a reduced carbohydrate diet. -She did not know if Resident #2's PCP changed his diet orders to reflect the new diets. Telephone interview with the facility's consulting Dietician on 06/18/25 at 10:59am revealed: -She approved menus for the facility. -No concentrated sweets diet was an "outdated diet" diet and was replaced with a reduced carbohydrate diet. -If Resident #2's PCP did not change the order to reduced carbohydrate then Resident #2 should continue with a no concentrated sweets diet and a note should be written on his diet card. Interview with the Administrator on 06/18/25 at 11:11am revealed: -He was not aware the facility had new menus that went into effect on 05/01/25 that eliminated the no concentrated sweets diet. -He was not aware that dietary orders were to be changed by 05/01/25. Interview with the Regional Director of Clinical Services on 06/18/25 at 11:15am revealed: -New menus were implemented on 05/01/25 that eliminated the no concentrated sweets diet.	D 296		

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D 296	Continued From page 9 -Resident #2's diet was supposed to be changed to reduced carbohydrate by the facility's nurse and she did not know why that was not done.	D 296		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure snacks were made available to all residents three times daily. The findings are: Interview with 7 residents during the initial tour on 06/17/25 from 9:00am to 10:15am revealed: -Snacks were only offered during an activity. -Staff had not brought the snack cart to the resident rooms in two week. -Snacks were "not happening". -Snacks were not offered three times a day. -One resident was suppose to receive two snacks daily around 10:00am and 2:00pm but they had not been offered any snacks for the past week.	D 298	• Food Service and Clinical Staff members were re-educated starting the week of 6/21/25 the policy requiring snacks to be offered three times daily. • The snack cart schedule was reviewed, and specific staff responsibilities were assigned to ensure consistent stocking and delivery. • This policy will be covered as part of ongoing training during the orientation process for new staff members. •Findings will be reviewed twice per month during CRR for further corrective action, as needed.	6/23/25

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D 298	Continued From page 10 -Another resident received a snack once a day "at best". -A third resident was not offered snacks daily and received a snack twice since April 2024. Observation of the kitchen on 06/18/25 at 9:46am revealed: -There was a snack cart in a pantry with chips, cookies, and dried fruit. -There were bags of chips and boxes of cookies on a shelf. Interview with the medication aide (MA) on 06/18/25 at 9:20am revealed: -The kitchen staff stocks a cart with snacks three times a day at 10:00am, 2:00pm, and 7:00pm. -The personal care aides (PCAs) take the snack cart to the residents and it is assigned to a PCA on the staffing schedule. -She did not know residents were not offered a snack three times daily. Interview with a dietary aide on 06/18/25 at 9:41am revealed: -The dietary staff were responsible for stocking the cart with snacks and beverages three times daily. -The PCAs were responsible for offering the snacks to the residents. -At times the kitchen was short of staff and there was not any time to get the snack cart ready for the PCAs. Interview with the Cook on 06/18/25 at 9:55am revealed: -The kitchen staff were responsible for stocking the cart with snacks and beverages at 10:00am, 2:00pm, and 7:00pm. -Sometimes there was not enough staff in the kitchen and stocking the snack cart gets missed.	D 298		

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D 298	Continued From page 11 -She would inform the Administrator when she did not have enough help in the kitchen to get the cart stocked. -Interview with the Administrator on 06/18/25 at 9:50am revealed: -The kitchen staff were responsible for stocking the snack cart three times daily. -The PCAs were responsible for offering snacks to the residents. -He did not know snacks were not offered to the residents three times daily.	D 298		
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 serve therapeutic diets as ordered by the physician for 1 of 2 sampled residents (#2) who had an order for a no concentrated sweets diet. The findings are: Review of Resident #1's current FL2 dated 03/31/25 revealed: -Diagnoses included diabetes mellitus type 2. -There was an order for a no concentrated sweets diet. Review of Resident #2's diet order form dated	D 310	• The Executive Director and Food Service Designee updated the therapeutic diet board using current diet orders for all residents on 6/21/25. • All resident diet orders were audited and updated by 6/23/25, as needed, to align with the current facility-approved menus. • Staff members were immediately re-educated on the importance of verifying physician diet orders and referencing current menus for meal preparation on 6/21/25.	6/23/25

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D 310	Continued From page 12 04/16/25 revealed an order for a no concentrated sweets diet. Review of the residents' diets orders revealed Resident #2 was on a reduced carbohydrate diet. Observation of the lunch meal service on 06/17/25 between 12:00pm and 12:35pm revealed: -Resident #2 was served pork loin, onion rings, frosted chocolate cake, sugar free fruit punch and milk. -Resident #2 consumed 75% of the meal. Observation of the breakfast meal on 06/18/25 at 8:20am revealed Resident #2 was scrambled eggs, bacon, one slice of toast, oatmeal with walnuts, coffee, juice and milk. Based on observation of the lunch meal service on 06/17/25 and the breakfast meal on 06/18/25 it could not be determined if Resident #2 was served the correct therapeutic diet because a no concentrated sweets diet menu was not available for staff guidance. Interview with a personal care aide (PCA) on 06/17/25 at 12:30pm revealed she knew Resident #2 was diabetic and was to be served half portions of dessert and sugar free drinks. Interview with the Cook on 06/18/25 at 8:32am revealed: -There were no menus available for a no concentrated sweets diet. -She served Resident #2 a regular diet although he was listed to receive a reduced carbohydrate diet according to his diet order. -Residents choose what to eat based from the menus provided the Manager.	D 310		

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CAROLINA RESERVE OF LAUREL PARK	1825 PISGAH DRIVE HENDERSONVILLE, NC 28791

(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 310	Continued From page 13 Interview with the Manager on 06/18/25 at 8:40am revealed: -She was responsible for providing dietary staff with menus since the Food Service Director left at the end of May 2025. -She used the Spring/Summer 2025 menu book in the kitchen to develop the menu for each day. -She mixed and matched menu items between lunch and dinner based on what was available in the kitchen. Telephone interview with consulting Dietician on 06/18/25 at 10:59am revealed: -She approved menus for the facility. -Residents on no concentrated sweet diets should have their diets changed to reduce carbohydrate diets on 05/01/25". -Residents on reduced carbohydrate diets were allowed to have items with sugar but portions are smaller. -Residents on no concentrated sweets residents should only receive sugar free desserts and sugar free beverages. -If Resident #2's PCP did not want to change the order to reduced carbohydrates then Resident #2 should continue with a no concentrated sweets diet with a note put on his diet card stating he should only get sugar free desserts and beverages. Interview with the Administrator on 06/18/25 at 11:11am revealed: -He was not aware the facility had new menus that went into effect on 05/01/25 that eliminated the no concentrated sweets diet. -He was not aware that dietary orders were to be changed by 05/01/25.	D 310		

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D 344	Continued From page 14	D 344	The ED/Designee need to review all self-administer orders and assessments for compliance. Any resident found not to have self-admin orders, needs to be clarified ASAP should they be self-administering. All quarterly assessments should be reviewed for current, not expired, and accuracy. This will be tracked monthly on the Resident Compliance Tracker by the ED/Designee going forward.	7/30/25
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to contact the primary care provider for verification of medication orders for 2 of 5 sampled residents (#1 and #2) related to a blood thinner, herbal supplement, antifungal cream, and a steroid medication (#1) and sliding scale insulin (#2). The findings are: 1. Review of Resident #1's current FL2 dated 04/16/25 revealed diagnoses included asthma, chronic obstructive pulmonary disease (COPD) and high blood pressure. Review of Resident #1's Resident Register revealed an admission date of 10/24/22. Observation of Resident #1's room on 06/17/25 at 9:18am revealed: -There was one bottle labeled aspirin (used as a	D 344		

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D 344	Continued From page 15 blood thinner) 81mg 500 tablets on a counter in the living room. -There was one bottle labeled Relaxium Sleep (herbal supplement containing magnesium, valerian, ashwagandha, chamomile, passionflower, melatonin, gamma-aminobutyric acid, and l-tryptophan) 60 capsules on a counter in the living room. -There was one bottle labeled fluticasone nasal spray (a steroid medication used to treat allergy symptoms) on a counter in the living room and one bottle on the bathroom counter. -There was one tube labeled nystatin (an antifungal medication used to treat yeast infections) 100,000 units ointment on the bathroom counter. Review of Resident #1's physician's orders on 06/17/25 revealed there were no orders for aspirin, Relaxium Sleep, fluticasone, and nystatin ointment. Interview with Resident #1 on 06/17/25 at 2:30pm revealed: -He administered the aspirin, fluticasone, nystatin ointment, and Relaxium Sleep to himself daily. -He obtained the medications himself because they were available over the counter. -All of his medications were kept in his room because he administered them to himself. -He did not know his primary care provider (PCP) should be informed that he took these medications. -Staff at the facility never informed him that a physician's order was required for each of the medications. Interview with the medication aide (MA) on 06/18/25 at 7:20am revealed: -Resident #1 had a physician's order to	D 344		

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D 344	Continued From page 16 self-administer his medications. -Resident #1 did not have physician's orders for the aspirin, fluticasone, nystatin ointment, and Relaxium Sleep. -She did not know the medications were in the resident's room. -The Resident Care Coordinator (RCC) or lead supervisor were responsible for completing an assessment every quarter on residents who self-administer medications and at that time they observe all medications in the resident's room. -She did not know if an assessment was completed for Resident #1. Review of Resident #1's Self Administration of Medication Assessments on 06/17/25 revealed: -There was documentation of a completed assessment on 06/07/24 and another on 12/26/24. -There was no documentation of any other assessments. Interview with the MA Supervisor on 06/18/25 at 8:40am revealed: -She did not know the medications were in Resident #1's room. -She was not responsible for completing the self-administration assessments for residents and did not know who was. Interview with the Administrator on 06/17/25 at 3:30pm revealed: -The RCC was responsible for assessments for residents who self-administered medications, but the RCC position was currently vacant. -The assessments should be completed every quarter, but he did not know if that was being done. -The MA supervisor was responsible for completing them in the absence of the RCC.	D 344		

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D 344	Continued From page 17 -Facility managers made daily room rounds and may have thought the medications in Resident #1's room were ordered by his PCP. Interview with the Regional Director of Clinical Services on 06/18/25 at 8:52am revealed: -The Registered Nurse (RN) who was responsible for the self-administration assessments left their employment on 06/14/25. -She felt sure the RN completed an assessment in March 2025 but could not locate it. -The assessments included viewing all medications in the resident's room and having a discussion with the resident. -The RN should have seen the medications in the room and obtained a physician's order for them. Interview with Resident #1's PCP on 06/18/25 at 11:18am revealed: -He was not notified that Resident #1 was administering medications to himself without a physician's order. -He should be informed because medications and herbal supplements can interact adversely with other medications. 2. Review of Resident #2's current FL2 dated 03/31/25 revealed diagnoses included diabetes mellitus type 2. Review of Resident #2's Resident Register revealed an admission date of 10/22/21. Review of Resident #2's physician orders dated 04/16/25 revealed: -There was an order for Humalog (a rapid acting insulin used to manage elevated blood sugar levels) KwikPen inject as directed three times daily before meals per sliding scale. -There were no orders for a sliding scale to	D 344		

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D 344	Continued From page 18 indicate the amount of Humalog sliding scale insulin (SSI) to be administered for the blood sugar readings. Review of Resident #2's previous order dated 11/18/22 revealed: -Check blood sugar readings before meals at 8:00am, 12:00pm, and 5:00pm. -Administer Humalog SSI when the blood sugar values were less than 70=notify the primary care provider (PCP), 70-150=0 units (u), 151-200=2u, 201-250=4u, 251-300=6u, 301-350=8u, greater than 350=10u, greater than 400=notify the PCP. Review of Resident #2's physician's orders from 11/18/22-04/16/25 revealed there were no updated orders for Humalog SSI for Resident #2. Interview with a medication aide (MA) supervisor on 06/17/25 at 2:35pm revealed: -Resident #2's blood sugar readings were monitored with a continuous glucose monitoring device. -She knew how much Humalog SSI to administer to Resident #2 because when she entered the blood sugar value in the electronic medication administration record (eMAR) a box popped up with the amount of SSI to administer. -Resident #2's current orders for Humalog SSI were signed on 04/16/25 and just indicated to administer the SSI as directed. -Resident #2's SSI did not print out on the physician's orders that were signed by the PCP. -She, another MA supervisor, or the former Resident Care Coordinator (RCC) were responsible for clarifying medication orders. -She did not call to clarify or obtain current SSI orders for Resident #2 and used the same SSI ordered on 11/18/22.	D 344		

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D 344	Continued From page 19 Interview with the Regional Director of Clinical Services on 06/17/25 at 2:30pm revealed: -The most current order for Resident #2's Humalog SSI was dated 11/18/22. -The former RCC was responsible for printing out the physician's orders and getting the PCP to sign the orders every 6 months. -The physician's orders that were printed did not include the sliding scale for Resident #2's Humalog, only to administer the insulin as directed. -The former RCC was responsible for clarifying the medication orders when they were not complete orders. Telephone interview with Resident #2's PCP on 06/17/25 at 2:53pm revealed: -She did not realize Resident #2's Humalog SSI did not print on the last physician's orders she signed on 04/16/25. -She had not changed the amounts of Humalog SSI to be administered to Resident #2 since the sliding scale was ordered on 11/18/22. -The facility staff did not call her to clarify the Humalog SSI order. Interview with the Administrator on 06/17/25 at 3:15pm revealed: -The facility was using a "newish" computer system. -He was not aware that Resident #2's physician's orders Humalog SSI did not indicate how much to administer when were printed and given to Resident #2's PCP to sign. -The MA supervisor was responsible for clarifying all incomplete orders with the PCP. -He did not know why the MA supervisor did not clarify Resident #2's Humalog SSI by the PCP. -He expected the MA supervisor to clarify all incomplete orders.	D 344		

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