STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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THE INDIGO AT PIKEVILLE	5383 US 117 NORTH PIKEVILLE, NC 27863

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 12/16/25 to 12/17/25.	{D 000}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 residents (#2, #4, #5) observed during the medication pass including errors with medications that lower heart rate and blood pressure (#2, #4), an iron supplement (#4), and a stool softener for constipation (#5); and 2 of 3 residents (#1. #3) sampled for record review including errors with an antibiotic (#3) and a laxative (#1). The findings are: 1. The medication error rate was 16% as evidenced by 4 errors out of 25 opportunities during the 8:00am medication pass on 12/17/25. a. Review of Resident #4's current FL-2 dated 09/16/25 revealed diagnoses included mixed Alzheimer's and vascular dementia, frontotemporal dementia, essential hypertension, iron deficiency anemia, mixed hyperlipidemia,	{D 358}		

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{D 358}	Continued From page 1 tardive dyskinesia, cerebral artery occlusion with cerebral infarction, and neuropathy. Review of Resident #4's primary care provider (PCP) order dated 11/05/25 revealed an order for Ferrous Sulfate EC (enteric coated) 325mg take 2 tablets (650mg) on Monday, Wednesday, and Friday. (Ferrous Sulfate EC is an iron supplement used to treat iron deficiency anemia. Ferrous Sulfate EC has an enteric coating to prevent stomach irritation and upset and reduce the risk of stomach bleeding. Ferrous Sulfate EC should not be crushed or chewed.) Review of Resident #4's physician's orders revealed no order to crush medications. Observation of the 8:00am medication pass on 12/17/25 revealed: -The medication aide (MA) prepared morning medications for Resident #4, including two Ferrous Sulfate EC 325mg tablets. -The MA crushed all of Resident #4's oral tablets, including the Ferrous Sulfate EC tablets, mixed them in applesauce, and administered them to Resident #4 at 7:54am. Observation of Resident #4's medications on hand on 12/17/25 at 12:44pm revealed: -There was a supply of Ferrous Sulfate EC 325mg tablets dispensed on 12/17/25, with instructions to take 2 tablets (=650mg) on Monday, Wednesday, and Friday for supplement. -There was no warning on the prescription label not to crush or chew the medication. Review of Resident #4's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Ferrous Sulfate EC	{D 358}		

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{D 358}	Continued From page 2 325mg take 2 tablets (=650mg) on Monday, Wednesday, and Friday scheduled at 8:00am. -Ferrous Sulfate EC was documented as administered on Mondays, Wednesdays, and Fridays from 12/01/25 - 12/17/25. -There was no information noted on the eMAR to indicate the medication should not be crushed. Interview with the MA on 12/17/25 at 12:47pm revealed: -She usually crushed Resident #4's medications because the resident would sometimes hold whole tablets in his mouth and not swallow them. -There was usually a sticker with "do not crush" (DNC) on the medication label or the eMAR would have documentation if a medication was not supposed to be crushed. -There used to be a DNC list at the mediation cart but she could not locate it. -She was not aware Resident #4's Ferrous Sulfate EC should not be crushed. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/17/25 at 3:58pm revealed: -The pharmacy usually tried to put DNC stickers on the labels of medications that should not be crushed. -If a resident had an order to crush medications, the pharmacy staff would enter "do not crush" instructions on the eMAR for any medications that should not be crushed. -The pharmacy did not have an order on file to crush Resident #4's medications. -Ferrous Sulfate EC should not be crushed due to the enteric coating. Interview with the Special Care Coordinator (SCC) on 12/17/25 at 1:13pm revealed: -She thought there should be documentation on	{D 358}		

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{D 358}	Continued From page 3	{D 358}		

the eMAR if a medication was not supposed to be crushed.
-There was no DNC list for medications that should not be crushed at the facility.
-Resident #4's Ferrous Sulfate EC should not have been crushed.

Interview with the Administrator on 12/17/25 at 1:13pm revealed:
-All residents used to have standing orders at one time with an order that medications may be crushed.
-The facility's new company did not use standing orders.
-Resident #4 did not have swallowing problems but would sometimes hold medications in his mouth.
-Enteric coated medications should not be crushed.

Telephone interview with Resident #4's PCP on 12/17/25 at 4:31pm revealed:
-Ferrous Sulfate EC tablets should not be crushed.
-Crushing Ferrous Sulfate EC tablets could cause the resident to have gastrointestinal irritation and symptoms such as gastroesophageal reflux and stomach upset, which could cause the resident to not want to eat.

Based on observation, interview, and record review, it was determined that Resident #4 was not interviewable.

b. Review of Resident #4's current FL-2 dated 09/16/25 revealed an order for Metoprolol ER (extended-released) 25mg 1 tablet once a day. (Metoprolol ER lowers heart rate and blood pressure. Metoprolol ER is extended-released and should not be crushed or chewed.

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{D 358}	Continued From page 4 Metoprolol ER is designed to release the medication slowly over time. Crushing Metoprolol ER would lead to rapid release of the medication which could increase the risk of side effects and decrease its effectiveness.) Review of Resident #4's physician's orders revealed no order to crush medications. Observation of the 8:00am medication pass on 12/17/25 revealed: -The medication aide (MA) prepared morning medications for Resident #4, including one Metoprolol ER 25mg tablet. -The MA crushed all of Resident #4's oral tablets, including the Metoprolol ER tablet, mixed them in applesauce, and administered them to Resident #4 at 7:54am. Observation of Resident #4's medications on hand on 12/17/25 at 12:44pm revealed: -There was a supply of Metoprolol ER 25mg tablets dispensed on 12/17/25, with instructions to take 1 tablet daily for hypertension. -There was no warning on the prescription label not to crush or chew the medication. Review of Resident #4's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol ER 25mg take 1 tablet daily for hypertension scheduled at 8:00am. -Metoprolol ER 25mg was documented as administered daily from 12/01/25 - 12/17/25. -There was no information noted on the eMAR to indicate the medication should not be crushed. Interview with the MA on 12/17/25 at 12:47pm revealed:	{D 358}		

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{D 358}	Continued From page 5 -She usually crushed Resident #4's medications because the resident would sometimes hold whole tablets in his mouth and not swallow them. -There was usually a sticker with "do not crush" (DNC) on the medication label or the eMAR would have documentation if a medication was not supposed to be crushed. -There used to be a DNC list at the mediation cart but she could not locate it. -She was not aware Resident #4's Metoprolol ER should not be crushed. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/17/25 at 3:58pm revealed: -The pharmacy usually tried to put DNC stickers on the label of medications that should not be crushed. -If a resident had an order to crush medications, the pharmacy staff would enter "do not crush" instructions on the eMAR for any medications that should not be crushed. -The pharmacy did not have an order on file to crush Resident #4's medications. -Metoprolol ER should not be crushed due to the medication being extended-released. Interview with the Special Care Coordinator (SCC) on 12/17/25 at 1:13pm revealed: -She thought there should be documentation on the eMAR if a medication was not supposed to be crushed. -There was no DNC list for medications that should not be crushed at the facility. -Resident #4's Metoprolol ER should not have been crushed. Interview with the Administrator on 12/17/25 at 1:13pm revealed: -All residents used to have standing orders at one	{D 358}		

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{D 358}	Continued From page 6	{D 358}		

time with an order that medications may be crushed.
-The facility's new company did not use standing orders.
-Resident #4 did not have swallowing problems but would sometimes hold medications in his mouth.
-Extended-released medications should not be crushed.

Telephone interview with Resident #4's primary care provider (PCP) on 12/17/25 at 4:31pm revealed:
-Metoprolol ER should not be crushed.
-Crushing Metoprolol ER made the medication release all at once which could cause low heart rate and low blood pressure that could lead to dizziness and falls.

Based on observation, interview, and record review, it was determined that Resident #4 was not interviewable.

c. Review of Resident #5's current FL-2 dated 03/10/25 revealed diagnoses included dementia, gastroesophageal reflux disease, and hyperlipidemia.

Review of Resident #5's hospice order dated 08/27/25 revealed an order to start Colace 100mg 1 softgel capsule each morning for constipation. (Colace is a stool softener used to treat and prevent constipation.)

Review of Resident #5's hospice order dated 11/14/25 revealed an order to increase Colace 100mg to 2 softgel capsules each morning for constipation.

Observation of the 8:00am medication pass on

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{D 358}	Continued From page 7 12/17/25 revealed: -The medication aide (MA) prepared and administered one Colace 100mg softgel capsule to Resident #5 at 9:07am. -Resident #5 received one Colace 100mg softgel capsule instead of two capsules as ordered. Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Colace 100mg take 2 softgel capsules every morning for constipation scheduled at 8:00am. -Colace 100mg 2 softgel capsules every morning was documented as administered from 12/01/25 - 12/17/25. Observation of Resident #5's medications on hand on 12/17/25 at 9:07am revealed: -There was a supply of Colace 100mg softgel capsules for Resident #5 in the original manufacturer's container. -There was no prescription label on the bottle of Colace. Interview with the MA on 12/17/25 at 12:54pm revealed: -She usually administered two Colace 100mg softgel capsules to Resident #5 every morning. -She accidentally administered one Colace softgel capsule that morning instead of two. -Resident #5 had no current issues with constipation. Interview with the Special Care Coordinator (SCC) on 12/17/25 at 1:13pm revealed: -The MAs should read the eMARs and administer medications according to the instructions. -Resident #5 should have received two Colace 100mg softgel capsules.	{D 358}		

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{D 358}	Continued From page 8 -No one had reported Resident #5 was having any current issues with constipation. Interview with the Administrator on 12/17/25 at 1:13pm revealed: -The MAs were supposed to read and follow instructions on the eMAR and medication labels. -She was not aware of Resident #5 having any current issues with constipation. Interview with a hospice nurse for Resident #5's hospice provider on 12/17/25 at 12:25pm revealed: -Resident #5's Colace order was increased to two Colace 100mg softgel capsules because the resident was having problems with constipation, straining, and passing large, hard stools at that time. -Not receiving the full dosage of Colace could cause the resident to have ongoing issues with constipation. -Resident #5 was having some issues with constipation last week but Resident #5's last documented bowel movement was yesterday, 12/16/25. Telephone interview with Resident #5's primary care provider (PCP) on 12/17/25 at 4:31pm revealed: -She did not have any immediate concerns about Resident #5 receiving the wrong dosage of Colace today. -Resident #5 did not have any current issues with constipation, but staff should continue to monitor the resident. Based on observation, interview, and record review, it was determined that Resident #5 was not interviewable.	{D 358}		

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{D 358}	Continued From page 9 d. Review of Resident #2's current FL-2 dated 10/22/25 revealed: -Diagnoses included dementia and atrial fibrillation. -There was an order for Metoprolol Tartrate 25mg 1 tablet twice a day. (Metoprolol Tartrate lowers heart rate and blood pressure.) Review of Resident #2's hospice order dated 10/24/25 revealed an order for Metoprolol Tartrate 25mg 1 tablet twice a day for blood pressure, hold if heart rate is less than 60. Observation of the 8:00am medication pass on 12/17/25 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #2 including Metoprolol Tartrate 25mg at 8:12am. -The MA did not check Resident #2's heart rate prior to administering Metoprolol Tartrate to determine if the medication should have been held. Review of Resident #2's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol Tartrate 25mg take 1 tablet twice a day for blood pressure, hold if heart rate is less than 60. -Metoprolol Tartrate was scheduled for administration at 8:00am and 8:00pm. -Metoprolol Tartrate was documented as administered from 12/01/25 - 12/17/25 (8:00am). -Resident #2's heart rate was documented as 66 on 12/17/25 at 8:00am. Observation of Resident #2's medications on hand on 12/17/25 at 1:00pm revealed: -There was a supply of Metoprolol Tartrate 25mg tablets dispensed on 12/17/25.	{D 358}		

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{D 358}	Continued From page 10 -The instructions were to take 1 tablet twice a day for blood pressure, hold if heart rate is less than 60. Interview with the MA on 12/17/25 at 1:00pm revealed: -She checked Resident #2's heart rate earlier that morning at about 7:20am and it was 66. -She would sometimes check residents' vital signs prior to starting the administration of the 8:00am medication pass so the vital signs would already be documented. Interview with the Special Care Coordinator (SCC) on 12/17/25 at 1:13pm revealed: -The MAs should read the eMARs and administer medications according to the instructions. -Resident #2's heart rate should be checked just prior to the administration of Metoprolol to see if the medication should be held. Interview with the Administrator on 12/17/25 at 1:13pm revealed: -The MAs were supposed to read and follow instructions on the eMAR and medication labels. -The MAs should check Resident #2's heart rate just prior to administering Metoprolol Tartrate. Telephone interview with Resident #2's primary care provider (PCP) on 12/17/25 at 4:31pm revealed: -The MAs should check Resident #2's heart rate just prior to (at least within a 15-minute window) of administration of Metoprolol. -Holding Metoprolol should be based on the resident's heart rate just prior to administration of the medication. -If Metoprolol Tartrate was not held when the resident's heart rate was too low, it could cause a lower heart rate, which could lead to falls.	{D 358}		

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{D 358}	Continued From page 11 Based on observation, interview, and record review, it was determined that Resident #2 was not interviewable. 2. Review of Resident #3's current FL-2 dated 07/03/25 revealed diagnoses included Alzheimer's dementia, diabetes mellitus - type 2, hypertension, peripheral artery disease, and osteomyelitis of the left foot. Review of Resident #3's electronic prescription dated 12/03/25 at 12:42pm revealed an order for Levofloxacin 500mg daily for 7 days for a right heel wound infection. (Levofloxacin is an antibiotic used to treat infection.) Review of Resident #3's second electronic prescription dated 12/10/25 at 9:42am revealed an order for Levofloxacin 500mg 1 tablet once a day for 7 days for wound infection. Review of Resident #3's December 2025 electronic medication administration record (eMAR) dated 12/01/25 - 12/16/25 revealed: -There was an entry for Levofloxacin 500mg 1 tablet once daily for 7 days for wound infection. -Levofloxacin 500mg was documented as administered daily for 7 days from 12/04/25 - 12/10/25. -There was a second entry for Levofloxacin 500mg 1 tablet once daily for 7 days for wound infection scheduled at 9:00am. -The blocks for 12/01/25 - 12/12/25 were grayed out with no staff initials. -The start date was documented as 12/13/25. -On 12/13/25, it was documented Levofloxacin was not administered due to the resident being out of the facility. -The first dose of Levofloxacin was documented	{D 358}		

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as being administered on 12/14/25.
-There were 3 doses of Levofloxacin 500mg documented as administered daily from 12/14/25 - 12/16/25.

Observation of Resident #3's medications on hand on 12/16/25 at 2:55pm revealed there were no Levofloxacin 500mg tablets available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/17/25 at 3:58pm revealed:
-The pharmacy received Resident #3's electronic prescription for Levofloxacin 500mg on 12/10/25.
-The pharmacy dispensed 7 Levofloxacin 500mg tablets on 12/10/25 and delivered them to the facility on the night of 12/10/25.
-The pharmacy entered the order for Levofloxacin 500mg into the eMAR system on 12/10/25.
-They entered the Levofloxacin 500mg order into the eMAR system with a start date of 12/11/25 at 8:00am so the last dose for the seventh day should be administered on 12/17/25.
-The facility staff was responsible for approving orders entered into the eMAR system by the pharmacy to activate the order in the system.
-She was unable to see when the facility approved orders in the eMAR system.
-The facility staff could make changes to orders in the eMAR system or contact the pharmacy if there were any issues.

Interview with a medication aide (MA) on 12/16/25 at 2:55pm revealed:
-Resident #3 had been on Levofloxacin twice for his foot wound.
-She administered the last Levofloxacin 500mg tablet to Resident #3 that morning, 12/16/25.
-She was working on 12/13/25 when Resident #3

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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 358}	Continued From page 13	{D 358}		

was out of the facility.
-She never prepared or administered Levofloxacin 500mg to Resident #3 on 12/13/25 because the resident was not in the facility when it was scheduled to be administered.
-She did not know why there was a delay in starting Levofloxacin or why only 3 of 7 tablets had been documented as administered.
-She could not explain what happened to the other 4 tablets that were not documented as administered.

Interview with the Special Care Coordinator (SCC) on 12/16/25 at 4:07pm revealed:
-The pharmacy usually entered orders into the eMAR system.
-She or the Administrator were the only ones with access to approve orders in the eMAR system so the orders would become active.
-She was not sure why there was a delay in starting Resident #3's Levofloxacin ordered on 12/10/25.

Interview with the Administrator on 12/16/25 at 4:07pm revealed:
-Resident #3's Levofloxacin 500mg tablets should have started on 12/11/25 if they were available in the facility.
-She was not sure why Resident #3's Levofloxacin was not started on 12/11/25 or why the resident had only received 3 doses and none were remaining.
-The pharmacy usually entered orders into the eMAR system and either her or the SCC had to approve orders for the orders to become active in the eMAR system.
-It looked like the Levofloxacin order for Resident #3 was not approved by the facility until 12/13/25.
-She was not sure why there was a delay in approving Resident #3's Levofloxacin order.

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{D 358}	Continued From page 14 Interview with a hospice nurse for Resident #3's hospice provider on 12/17/25 at 11:47am revealed: -Resident #3 had a right heel wound that was healing but it was difficult to heal because of the resident's diagnosis of diabetes. -The hospice provider ordered a second round of Levofloxacin on 12/10/25 because the 7-day course ordered around the beginning of December 2025 did not fully treat the infection. -It sometimes took a 14-day course of Levofloxacin to treat an infection. -The resident took the last dose of the first course on 12/10/25 so she would have expected the second course of Levofloxacin to start on 12/11/25. -The resident should receive the full course of the antibiotic. -She did not think the delay in starting the second course of Levofloxacin would have affected the outcome much because Levofloxacin was a long-acting antibiotic. -Not receiving an antibiotic as ordered could result in the infection not clearing up or could cause antibiotic resistance. -Resident #3's right heel wound was healing when she changed the dressing today, 12/17/25. Telephone interview with Resident #3's primary care provider (PCP) on 12/17/25 at 4:31pm revealed: -She expected antibiotics to be started within 24 hours of being ordered and antibiotics were more effective if the full course was taken. -A delay in starting an antibiotic and not receiving the full course of an antibiotic could cause the wound to worsen and could lead to sepsis (a serious condition that could lead to organ damage or death).	{D 358}		

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{D 358}	Continued From page 15 -Resident #3 had poor vasculature, so she did not expect his foot wound to heal completely. -The goal in ordering the antibiotic was to try to lessen the odor and drainage coming from the foot wound. -On Tuesday, 12/16/25, the odor and drainage from Resident #3's foot wound had improved. Based on observation, interview, and record review, it was determined that Resident #3 was not interviewable. 3. Review of Resident #1's current FL-2 dated 06/03/25 revealed diagnoses included dementia, diabetes type II, hypertension (HTN), and gastroesophageal reflux disease (GERD). Review of Resident #1's physician's order dated 11/24/25 revealed an order for Polyethylene glycol, mix 17grams in 8 ounces of orange juice or water daily. (Polyethylene glycol also called Miralax is used to manage and treat constipation). Review of Resident #1's November 2025 electronic medication administration records (eMAR) revealed: -There was an entry for Polyethylene glycol, mix 17grams in 8 ounces of orange juice or water daily scheduled at 9:00am. -There was documentation that Polyethylene glycol was administered from 11/01/25 to 11/30/25 at 9:00am. Review of Resident #1's December 2025 eMAR revealed: -There was an entry for Polyethylene glycol, mix 17grams in 8 ounces of orange juice or water daily scheduled at 9:00am. -There was documentation that Polyethylene	{D 358}		

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{D 358}	Continued From page 16	{D 358}		

glycol was administered from 12/01/25 to 12/15/25 and 12/17/25 at 9:00am.

Observation of Resident #1's medications on hand on 12/16/25 at 3:30pm revealed:
-There was a bottle of Polyethylene glycol with a dispensed date of 06/25/25.
-The bottle of Polyethylene glycol was 3/4 full.

Interview with Resident #1 on 12/17/25 at 12:44pm revealed she did not have a problem with constipation and did not need to take Polyethylene glycol.

Interview with a medication aide (MA) on 12/17/25 at 10:10am revealed:
-She administered the Polyethylene glycol to Resident #1 when she worked.
Interview with a medication aide (MA) on 12/17/25 at 10:10am revealed:
-She did not look at the dispensing date for Resident #1's Polyethylene glycol.
-Resident #1's Polyethylene glycol should have been reordered because it should have been gone by December if she was administered it every day.

Interview with the Special Care Coordinator on 12/17/25 at 9:16am revealed:
-She conducted medication cart audits weekly.
-It was an oversight she missed the date on the Polyethylene glycol bottle for Resident #1.

Interview with a Pharmacist at the facility's contracted pharmacy on 12/17/25 at 12:33pm revealed:
-Resident #1 had an active order for Polyethylene glycol.
-The Polyethylene glycol for Resident #1 was dispensed as a 30-day supply on 12/16/25 and

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{D 358}	Continued From page 17 previously on 06/25/25. Interview with the Administrator on 12/17/25 at 8:05am revealed: -There was not a dispensing record for the Polyethylene glycol for Resident #1. -The bottle of Polyethylene glycol for Resident #1 was on the medication cart with a date from June. -If Resident #1 was administered the Polyethylene glycol daily the bottle from June would not be on the medication cart.	{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).	{D 367}		

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{D 367}	Continued From page 18 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 06/03/25 revealed diagnoses included dementia, diabetes type II, hypertension (HTN), and gastroesophageal reflux disease (GERD). a. Review of Resident #1's physician's order dated 11/24/25 revealed an order for Insulin Lispro 100, inject 3 units three times a day after meals, hold if fasting blood sugar (FSBS) is less than 100. (Lispro is used to manage blood sugar levels). Review of Resident #1's October 2025 electronic medication administration records (eMAR) revealed: -There was entry the FSBS was 97 on 10/18/25, 99 on 10/22/25, 75 on 10/25/25, 86 on 10/26/25, and 87 on 10/27/25 scheduled at 6:30am. -There was an entry for Insulin Lispro 100, inject 3 units three times a day after meals, hold if FSBS is less than 100, scheduled at 8:00am. -There was documentation the Insulin Lispro 100 was administered on 10/18/25, 10/22/25, 10/25/25 to 10/27/25 at 8:00am. Review of Resident #1's November 2025 eMAR revealed: -There was entry the FSBS was 79 on 11/02/25, 74 on 11/08/25, 91 on 11/15/25, 88 on 11/24/25, and 99 on 11/29/25 scheduled at 6:30am.	{D 367}		

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{D 367}	Continued From page 19 -There was an entry for Insulin Lispro 100, inject 3 units three times a day after meals, hold if FSBS is less than 100, scheduled at 8:00am. -There was documentation the Insulin Lispro 100 was administered on 11/02/25,11/08/25,11/15/25,11/24/25, and 11/29/25 at 8:00am. Interview with Resident #1 on 12/17/25 at 11:22am revealed she was administered insulin three times per day unless her blood sugar was low, then staff did not administer it. Interview with a medication aide (MA) on 12/17/25 at 9:53am revealed: -Resident #1 had an order for 3 units of Lispro after breakfast, lunch, and supper. -If Resident #1's blood sugar was less than 100 it was to be held after her meals. -If the Lispro was held it should be documented drug not given in the eMAR with a note stating the reason it was held -She never administered the Lispro if the blood sugar was less than 100. -If the eMAR showed she administered the Lispro when it was to be held, she did not administer the medication and clicked on the medication too fast. Interview with the Special Care Coordinator (SCC) on 12/17/25 at 9:16am revealed: -Resident #1 was administered her Lispro after meals, if her blood sugar was less than 100. -When Resident #1's Lispro was held staff should document in the eMAR it was held and make a note. -When she administered Lispro to Resident #1 she followed the orders and forgot to document that she held the Lispro.	{D 367}		

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{D 367}	Continued From page 20 Interview with the Administrator on 12/17/25 at 8:05am and 10:55am revealed: -The eMAR would not indicate the amount of insulin administered to Resident #1 because the order was for a scheduled amount. -The only documentation included in the eMAR would be if staff had to hold the medication and made a note which should state the medication was not administered. -She did not know if the Lispro was held. -The MAs should document on the eMAR 'did not give' and state the reason. b. Review of Resident #1's physician's order dated 11/24/25 revealed an order for Polyethylene glycol, mix 17grams in 8 ounces of orange juice or water daily. (Polyethylene glycol, also called Miralax, is used to manage and treat constipation). Review of Resident #1's November 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Polyethylene glycol, mix 17grams in 8 ounces of orange juice or water daily scheduled at 9:00am. -There was documentation Polyethylene glycol was administered from 11/01/25 to 11/30/25. Review of Resident #1's December 2025 eMAR revealed: -There was an entry for Polyethylene glycol, mix 17grams in 8 ounces of orange juice or water daily scheduled at 9:00am. -There was documentation Polyethylene glycol was administered from 12/01/25 to 12/15/25 and 12/17/25. Observation of Resident #1's medications on hand on 12/16/25 at 3:30pm revealed:	{D 367}		

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{D 367}	Continued From page 21 -There was a bottle of Polyethylene glycol with a dispensed date of 06/25/25. -The bottle of Polyethylene glycol bottle was 3/4 full. Interview with Resident #1 on 12/17/25 at 12:44pm revealed she did not have a problem with constipation and did not need to take Polyethylene glycol. Interview with a medication aide (MA) on 12/17/25 at 10:10am revealed: -She did not look at the dispensing date for Resident #1's Polyethylene glycol. -Resident #1's Polyethylene glycol should have been reordered because it should have been gone by December if she was administered it every day. -She administered the Polyethylene glycol to Resident #1 when she worked. Interview with the Special Care Coordinator (SCC) on 12/17/25 at 9:16am revealed: -She conducted medication cart audits weekly. -It was an oversight she missed the date on the Polyethylene glycol bottle for Resident #1. Interview with a Pharmacist at the facility's contracted pharmacy on 12/17/25 at 12:33pm revealed: -Resident #1 had an active order for Polyethylene glycol. -The Polyethylene glycol for Resident #1 was last dispensed on 12/16/25 and previously on 06/25/25. -Polyethylene glycol was dispensed as a 30-day supply. Interview with the Administrator on 12/17/25 at 8:05am revealed:	{D 367}		

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{D 367}	Continued From page 22 -There was not a dispensing record for the Polyethylene glycol for Resident #1. -The bottle of Polyethylene glycol for Resident #1 was on the medication cart with a date from June. -If Resident #1 was administered the Polyethylene glycol daily the bottle from June would not be on the medication cart.	{D 367}		