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TERRABELLA GREENSBORO	1208 NEW GARDEN ROAD GREENSBORO, NC 27410

(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 09/09/25 through 09/11/25.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 7 sampled residents (#5) completed a tuberculosis (TB) skin test prior to admission in compliance with the control measures for the Commission for Health Services. The findings are: Review of Resident #5's current FL2 dated 06/24/25 revealed diagnoses included dementia, coronary artery disease hypertension, and hyperlipidemia. Review of the Resident # 3's Register revealed an admission date of 04/07/24.	D 234		

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Review of Resident #5's immunization records revealed:
-There was documentation a chest x-ray was completed on 04/03/24 to rule out tuberculosis.
-There was no documentation for a positive TB test to justify using a chest X-ray instead of a one-step TB test upon admission.

Review of Resident #5's record for a tuberculosis (TB) skin test revealed:
-There was no documentation for a single interferon-gamma release (IGRA) assay to detect TB had been administered.
-There was no documentation of a first step TB skin test upon admission.
-There was no documentation of a second TB skin test.

Interview with the Administrator on 07/10/25 at 2:40pm revealed Resident #3 had no documentation for a positive TB test to justify using a chest X-ray instead of a one-step TB test upon admission.

Interview with the Administrator on 09/11/25 at 10:50am revealed:
-The Health and Wellness Director (HWD) was responsible for ensuring residents admitted to the facility had the required screening for TB.
-All residents admitted to the facility should have at least one TB test, negative IGRA, or negative chest x-.
-The HWD should review documents obtained by the marketing staff for admission to the facility including TB test requirements.

Interview with the Health and Wellness Director's (HWD) on 09/11/25 at 10:45am revealed:
-Routinely, the facility's marketing staff would ensure residents had either negative test results

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for an IGRA, at least one TB test, or a chest x-ray to rule out TB prior to admitting a resident to the facility.
-She routinely audited residents' admission TB screening to determine if there was documentation for 2 step TB skin test or negative results documented for IGRA testing.
-She was responsible for administering a second step TB skin test if the resident had only one TB skin test.
-She did not know a chest x-ray could be used to rule out TB only if there was documentation the resident had an allergy to the TB antigen.
-She did not know Resident #5's chest x-ray could not be used for TB testing requirements for admission to the facility.

Interview with the Director of Marketing (DOM) on 09/11/25 at 11:25am revealed:
-Routinely, the facility marketing staff provides the requirements for admission, including TB skin testing or IGRA testing to the resident or resident's responsible person to complete requirements.
-Resident #5's admission requirements were reviewed by the former DOM in April 2024.
-Residents were required to bring admission paperwork, including TB requirements of at least results for one TB skin test, results of an IGRA, or documentation for a chest x-ray to rule out TB.
-The DOM was aware a chest x-ray could only be used if there was documentation the resident was allergic to the TB antigen used for TB skin testing.
-The HWD was responsible for auditing residents' admissions TB requirements and ensuring all requirements were completed.
-She had not reviewed Resident #5's admission TB testing.

Based on observations, interviews, and record

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D 234	Continued From page 3 review it was determined that Resident #5 was not interviewable.	D 234		
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 2 of 7 sampled residents including errors with sliding scale insulin (SSI) (#6, #1). The findings are: 1. Review of Resident #6's current FL2 dated 03/18/25 revealed: -Diagnoses included type 2 diabetes mellitus with chronic kidney disease, hyperlipidemia, essential hypertension, and retention of urine. -There was an order to check fingerstick (FSBS) before meals. Review of Resident #6's signed physician's orders dated 03/21/25 revealed an order for Aspart Mix (a fast-acting insulin used to lower blood sugar) 70/30 check FSBS twice a day	D 358		

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before breakfast and before dinner and inject per sliding scale insulin (SSI) parameters: 0-99=0u, 100-120=4u, 121-150=12u, 151-200=18u, and greater than 201=24u.

Review of Resident #6's signed physician's orders dated 08/07/25 revealed an order for Aspart Mix 70/30 check FSBS twice a day before breakfast and before dinner and inject per sliding scale insulin (SSI) parameters: 0-99=0u, 100-120=4u, 121-150=8u, 151-200=12u, 201-250=16u.

Review of Resident #6's July 2025 electronic medication administration record (eMAR) revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 7:30am, 11:30am, and 4:30pm.
-There was an entry for Aspart Mix 70/30 insulin pen inject twice a day before breakfast and before dinner per SSI parameters: 0-99=0u, 100-120=4u, 121-150=12u, 151-200=18u, and greater than 201=24u scheduled for 7:30am and 4:30pm.
-FSBS ranged from 86 to 244.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, a space for documenting the amount of Aspart administered from 07/01/25 to 7/22/25, and no space for documenting the amount of Aspart administered from 7/23/25 to 7/31/25.
-There was no documentation of the amount of Aspart insulin administered for 18 of 61 opportunities from 07/01/25 to 07/31/25 with Resident #6 being out-of-facility (OOF) during an additional opportunity on 07/30/25.

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Review of the printed July 2025 eMAR 'Scheduled Medication Notation" notes for Resident #6's Aspart revealed:
-FSBS values were documented for 31 days in July 2025 on the eMAR.
-Resident #6 had no notes or documentation for the amount of Aspart insulin administered for 18 of 61 opportunities.
-Examples were as follows:
-On 07/24/25 at 4:30pm, FSBS was 152 and 18 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 07/25/25 at 7:30am, FSBS was 208 and 24 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 07/27/25 at 4:30pm, FSBS was 143 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 07/28/25 at 4:30pm, FSBS was 162 and 18 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 07/31/25 at 7:30am, FSBS was 172 and 18 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-There was no additional notes for the amount of Aspart administered from 07/23/25 to 07/31/25.

Review of Resident #6's August 2025 eMAR revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 7:30am, 11:30am, and 4:30pm from.
-There was an entry from 08/01/25 to 08/07/25 for Aspart Mix 70/30 insulin pen inject twice a day before breakfast and before dinner per SSI

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parameters: 30 check FSBS twice a day before breakfast and before dinner and inject per sliding scale insulin (SSI) parameters: 0-99=0u, 100-120=4u, 121-150=12u, 151-200=18u, and greater than 201=24u scheduled for 7:30am and 4:30pm.
-There was another entry from 08/0/25 to 08/31/25 for Aspart Mix 70/30 insulin pen inject twice a day before breakfast and before dinner per SSI parameter0-99=0u, 100-120=4u, 121-150=8u, 151-200=12u, and 201-250=16u scheduled for 7:30am and 4:30pm.
-FSBS ranged from 56 to 257.
-The eMAR had a space for documentation of the staff member obtaining the FSBS and a space for documenting FSBS values from 08/01/25 to 08/31/25, and a space for the site of administration from 08/01/25 to 08/07/25.
-The eMAR had no space for the site of administration from 08/08/25 to 08/31/25 and had no space for documenting the amount of Aspart administered from 08/01/25 to 08/31/25.
-There was no documentation of the amount of Aspart administered for 60 of 60 opportunities from 08/01/25 to 08/31/25 with Resident #6 being OOF during an additional opportunity on 08/15/25 and had refused her insulin for another opportunity on 08/30/25.

Review of the printed August 2025 eMAR 'Scheduled Medication Notation" notes for Resident #6's Aspart revealed:
-FSBS values were documented for 31 days in August on the eMAR.
-Resident #6 had no notes or documentation for the amount of Aspart insulin administered for 60 of 60 opportunities.
-Examples were as follows:
-On 08/02/25 at 7:30am, FSBS was 257 and 24 units of Aspart should have been administered

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but no Aspart insulin was documented as administered on the eMAR.
-On 08/11/25 at 4:30pm, FSBS was 181 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 08/17/25 at 4:30pm, FSBS was 220 and 16 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 08/22/25 at 4:30pm, FSBS was 202 and 16 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-On 08/30/25 at 7:30am, FSBS was 214 and 16 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR.
-There was no additional notes for the amount of Aspart administered for 08/01/05 through 08/31/25.

Review of Resident #6's September 2025 eMAR from 09/01/25 through 09/09/25 revealed:
-There was an entry to check FSBS three times a day before each meal scheduled at 7:30am, 11:30am, and 4:30pm.
-There was no entry from 09/01/25 to 09/09/25 for Aspart Mix 70/30 insulin pen inject twice a day before breakfast and before dinner per SSI parameters: 0-99=0u, 100-120=4u, 121-150=8u, 151-200=12u, and 201-250=16u scheduled for 7:30am and 4:30pm.
-FSBS ranged from 118-312.
-The eMAR had a space for documentation of the staff member obtaining the FSBS and a space for documenting FSBS value.
-The eMAR had no space for the site of administration and had no space for documenting the amount of Aspart administered.

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D 358	Continued From page 8 -There was no documentation of the amount of Aspart administered for 18 of 18 opportunities from 09/01/25 to 09/09/25. Review of the September 2025 eMAR 'Scheduled Medication Notation" notes from 09/01/25 through 09/09/25 for Resident #6's Aspart revealed: -FSBS values were documented for 9 days in September 2025 in the eMAR. -Resident #6 had no notes or documentation for the amount of Aspart insulin administered for 18 of 18 opportunities. -Examples were as follows: -On 09/01/25 at 4:30pm, FSBS was 181 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR. -On 09/03/25 at 7:30am, FSBS was 191 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR. -On 09/05/25 at 7:30am, FSBS was 192 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR. -On 09/06/25 at 4:30pm, FSBS was 174 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR. -On 09/08/25 at 4:30pm, FSBS was 172 and 12 units of Aspart should have been administered but no Aspart insulin was documented as administered on the eMAR. -There was no additional notes for the amount of Aspart administered from 09/01/05 through 09/09/25 due to no entry on the eMAR for Aspart insulin. Observation of medications available for administration for Resident #6 on 09/11/25 at	D 358		

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D 358	Continued From page 9 11:00am revealed: -Five pens of Aspart insulin were available for administration. -One pen of Aspart insulin was dispensed on 04/28/25, three pens of Aspart insulin were dispensed on 06/18/25, and another pen of Aspart insulin was dispensed on 08/07/25. Interview with Resident #6 on 09/11/25 at 10:57am revealed: -The medication aides (MA) obtained his FSBS frequently every day and sometimes his insulin amounts had changed in the past. -He was not sure how much insulin he received but he had not received insulin in the last two weeks. -He denied any current issues with blood sugar levels or having experienced symptoms related to low or high blood sugar such as headaches or dizziness. Telephone interview with a pharmacist at the contracted pharmacy on 09/10/25 at 12:25pm revealed: -Resident #6's Aspart insulin was last dispensed on 08/07/25. -The pharmacy was responsible for adding Resident #6's Aspart insulin entry to the eMAR for the facility, but the facility was responsible to review and update the eMAR for the parameters for the amounts of insulin administered. -There was no documentation the facility had contacted the pharmacy regarding Resident #6's eMAR not properly documenting the administration of Aspart SSI. -She would have worked with the facility to correct the problem because the system showed facility staff had entered the insulin parameters incorrectly for Resident #6. -The facility had not communicated with the	D 358		

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pharmacy to clarify if Resident #6's Aspart insulin was active in the pharmacy's system.

Telephone interview with Resident #6's endocrinologist on 09/11/25 at 12:00pm revealed:
-She expected the facility staff to administer Resident #6's Aspart per the sliding scale and document how many units of insulin were administered.
-She would not be able to tell if Resident #6 received the correct amount of insulin if it was not documented.
-She had ordered new SSI parameters for Resident #6's Aspart insulin on 08/07/25 and she expected the facility staff to administer Resident #6's Aspart insulin.
-She had not discontinued Resident #6's Aspart on 08/09/25 and she expected the facility staff to communicate with her if there was a concern related to Resident #6's insulin management.
-Resident #6's FSBS levels had averaged between 130-150 and she had no concerns for his insulin management at the present.
-If the facility staff continued not to administer his Aspart insulin as ordered, Resident #6 could experience hyperglycemia which could be detrimental with complications of fatigue and weakness.

Interview with a MA on 09/11/25 at 10:05am revealed:
-She was aware of Resident #6's previous insulin parameters and of his FSBS 3 times a day.
-She was aware the eMAR system did not have a space on the order entry to document the amount of insulin administered.
-She had not brought it to the attention of the Resident Care Coordinator (RCC) or the Health and Wellness Director (HWD) because she thought it was part of the new eMAR system

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process.
-She was not aware of any additional methods to document the amount of insulin units administered to Resident #6.
-She had administered Resident #6's Aspart insulin through the middle of August 2025, but they recently stopped administering Aspart insulin within the last couple weeks; but she was not sure of the reason.
-The HWD was responsible for auditing the eMARS for accuracy and for updating orders.

Interview with a second MA on 09/11/25 at 11:25am revealed:
-She was aware the eMAR system did not have a space to document the amount of insulin administered.
-She had not brought it to the attention of the RCC or HWD because she thought the system updated the amount of insulin when she entered the FSBS level.
-She was not aware of any additional methods to document the amount of insulin units administered to residents with sliding scale.
-The MAs did were unable to enter orders in the eMAR so the HWD was responsible for auditing the eMARS for accuracy and for updating orders.

Interview with the RCC on 09/11/25 at 10:35am revealed:
-Resident #6 had an order for FSBS 3 times a day.
-The MAs had not followed up with her regarding the eMAR system not having a space to document the amount of insulin administered to Resident #6.
-She thought the HWD was responsible for auditing and verifying the eMARs to ensure SSI parameter entries were correct for the residents.

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D 358	Continued From page 12 Interview with the HWD on 09/10/25 at 2:30pm revealed: -She was responsible for auditing the residents' eMARs for documentation and accuracy, but she had not noticed that Resident #6's FSBS order entry did not have a space to document the amount of Aspart SSI administered. -She had corrected previous errors related to the implementation of the facility's new eMAR system but she had not audited the SSI parameters. -No staff had followed up with her regarding the eMAR system not having a space to document the amount of insulin administered to Resident #6 and it must have been overlooked. -She was not aware Resident #6's Aspart insulin had been deleted off the eMAR and was not aware there was no documentation whether he had received his insulin since 08/10/25. -No MAs had followed up with her regarding Resident #6's Aspart insulin not reflecting on the eMAR and she was not sure if the order had been discontinued by Resident #6's physician. -There was no other documentation she could provide to monitor the amounts of Aspart SSI administered to Resident #6. -She expected all the MAs to document the amount of insulin units administered in the eMAR for all residents moving forward. -She expected the MAs to notify her if the eMAR was missing entries for documentation. Interview with the Administrator on 09/11/25 at 11:45am revealed: -He was not aware the amount of Aspart insulin administered to Resident #6 was not documented by the MAs. -The MAs should have let the RCC and the HWD know about the missing documentation areas for SSI. -He expected the HWD to audit the eMARS on a	D 358		

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weekly basis to address discrepancies related to insulin administration errors.
-He was not aware Resident #6 had not been administered Aspart insulin since 08/10/25 according to the eMAR.
-He expected the MAs to document the units of insulin administered correctly and for the HWD, RCC, or the MAs to clarify orders with a resident's physician for any questions related to changed or discontinued medications.

2. Review of Resident #1's current FL2 dated 07/14/25 revealed:
-Diagnoses included type 2 diabetes mellitus, chronic kidney disease stage 3, hyperlipidemia, anemia, essential hypertension, hyperthyroidism, and rhabdomyolysis.
-There was an order to check fingerstick (FSBS) before meals.

Review of Resident #1's signed physician's orders dated 07/15/25 revealed an order for Novolog (a fast-acting insulin used to lower blood sugar) 100units/ml flex pen check FSBS and inject before meals per SSI parameters: 0-120=0u, 121-150=1u, 151-200=2u, 201-250=3u, 251-300=5u, 301-350=7u, 351-400=9u, 401 and greater call provider.

Review of Resident #1's July 2025 electronic medication administration record (eMAR) from 07/18/25 through 07/31/25 revealed:
-There was an entry for Novolog 100units/ml flex pen check FSBS and inject before meals per SSI parameters: 0-120=0u, 121-150=1u, 151-200=2u, 201-250=3u, 251-300=5u, 301-350=7u, 351-400=9u, 401 and greater call provider scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-FSBS ranged from 43 to 235.

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-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, a space for documenting the amount of Novolog administered from 07/18/25 to 07/22/25.
-There was no space to document the amount of Novolog administered from 07/23/25 to 07/31/25.
-There was no documentation of the amount of Novolog insulin administered for 27 of 42 opportunities from 07/18/25 to 07/31/25.

Review of the printed July 2025 eMAR 'Scheduled Medication Notation" notes from 07/18/25 through 07/31/25 for Resident #1's Novolog revealed:
-FSBS values were documented for 14 days in July 2025 in the eMAR.
-Resident #1 had no notes or documentation for the amount of Novolog insulin administered for 27 of 42 opportunities.
-Examples were as follows:
-On 07/23/25 at 11:30am, FSBS was 206 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 07/24/25 at 4:30pm, FSBS was 235 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 07/25/25 at 4:30pm, FSBS was 225 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 07/29/25 at 11:30am, FSBS was 209 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
On 07/30/25 at 4:30pm, FSBS was 202 and 3 units of Novolog should have been administered

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but no Novolog insulin was documented as administered on the eMAR.
-There was no additional notes for the amount of Novolog administered from 07/23/25 to 07/31/25.

Review of Resident #1's August 2025 eMAR from revealed:
-There was an entry for Novolog 100units/ml flex pen check FSBS and inject before meals per SSI parameters: 0-120=0u, 121-150=1u, 151-200=2u, 201-250=3u, 251-300=5u, 301-350=7u, 351-400=9u, 401 and greater call provider scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-FSBS ranged from 68 to 330.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, a space for documenting FSBS values, and no space to document the amount of Novolog administered from 08/01/25 to 08/31/25.
-There was no documentation of the amount of Novolog insulin administered for 91 of 91 opportunities from 08/01/25 to 08/31/25 with Resident #1 being out-of-facility (OOF) during two additional opportunities on 08/07/25 and 08/28/25.

Review of the printed August 2025 eMAR 'Scheduled Medication Notation" notes from 08/01/25 through 08/31/25 for Resident #1's Novolog revealed:
-FSBS values were documented for 31 days in August 2025 in the eMAR.
-Resident #1 had no notes or documentation for the amount of Novolog insulin administered for 91 of 91 opportunities.
-Examples were as follows:
-On 08/05/25 at 11:30am, FSBS was 220 and 3 units of Novolog should have been administered

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but no Novolog insulin was documented as administered on the eMAR.
-On 08/15/25 at 4:30pm, FSBS was 225 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 08/19/25 at 4:30pm, FSBS was 330 and 7 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 08/27/25 at 11:30am, FSBS was 229 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-On 08/31/25 at 11:30am, FSBS was 287 and 5 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR.
-There was no additional notes for the amount of Novolog administered from 08/01/25 to 08/31/25.

Review of Resident #1's September 2025 eMAR from 09/01/25 through 09/08/25 revealed:
-There was an entry for Novolog 100units/ml flex pen check FSBS and inject before meals per SSI parameters: 0-120=0u, 121-150=1u, 151-200=2u, 201-250=3u, 251-300=5u, 301-350=7u, 351-400=9u, 401 and greater call provider scheduled for administration at 7:30am, 11:30am, and 4:30pm.
-FSBS ranged from 91 to 268.
-The eMAR had a space for documentation of the staff member obtaining the FSBS, a space for the site of administration, and a space for documenting FSBS values.
-There was no space for documenting the amount of Novolog administered from 09/01/25 to 09/08/25.
-There was no documentation of the amount of Novolog insulin administered for 24 of 24

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D 358	Continued From page 17 opportunities from 09/01/25 to 09/08/25. Review of the printed September 2025 eMAR 'Scheduled Medication Notation" notes from 09/01/25 through 09/08/25 for Resident #1's Novolog revealed: -FSBS values were documented for 8 days in September 2025 in the eMAR. -Resident #1 had no notes or documentation for the amount of Novolog insulin administered for 24 of 24 opportunities. -Examples were as follows: -On 09/01/25 at 11:30am, FSBS was 268 and 5 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 09/03/25 at 4:30pm, FSBS was 231 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 09/05/25 at 11:30am, FSBS was 208 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 09/06/25 at 7:30am, FSBS was 240 and 3 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -On 09/08/25 at 4:30pm, FSBS was 198 and 2 units of Novolog should have been administered but no Novolog insulin was documented as administered on the eMAR. -There was no additional notes for the amount of Novolog administered from 09/01/25 to 09/08/25. Observation of medications available for administration for Resident #1 on 09/11/25 at 11:16am revealed Novolog insulin was available for administration and was dispensed on 07/16/25.	D 358		

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D 358	Continued From page 18 Interview with Resident #1 on 09/09/25 at 11:10am revealed: -The medication aides (MA) obtained his FSBS frequently every day and sometimes his insulin amounts had changed in the past. -He was not sure how much insulin he received but the MAs administered his insulin 3 times a day. -He denied any current issues with low blood sugar levels or having experienced symptoms related to headaches or dizziness. Telephone interview with a pharmacist at the contracted pharmacy on 09/10/25 at 12:25pm revealed: -Resident #1's Novolog insulin was last dispensed on 07/16/25. -The pharmacy was responsible for adding Resident #1's Novolog insulin entry to the eMAR for the facility, but the facility was responsible to review and update the eMAR for the parameters for the amounts of insulin administered. -There was no documentation the facility had contacted the pharmacy regarding Resident #1's eMAR not providing a space to document the administration of Novolog SSI. - She would have worked with the facility to correct the problem because the system showed facility staff had entered the insulin parameters incorrectly for Resident #1. Telephone interview with Resident #1's primary care provider (PCP) on 09/11/25 at 12:00pm revealed: -He expected the facility staff to administer Resident #1's Novolog per the sliding scale and document how many units of insulin were administered. -He would not be able to tell if Resident #1	D 358		

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received the correct amount of insulin if it was not documented.

Interview with a MA on 09/11/25 at 10:05am revealed:
-She was aware the eMAR system did not have a space for a FSBS order entry to document the amount of insulin administered.
-She had not brought it to the Resident Care Coordinator (RCC) or the Health and Wellness Director's (HWD) attention because she assumed it was part of the new eMAR system process.
-She was not aware of any additional methods to document the amount of insulin units administered to residents with sliding scale.
-The HWD was responsible for auditing residents' eMARS for accuracy and for updating orders.
-The MAs did not have access to update orders in the eMAR system.

Interview with another MA on 09/11/25 at 11:25am revealed:
-She was aware the eMAR system did not have a space on Resident #1's FSBS order entry to document the amount of insulin administered.
-She had not brought it to RCC or HWD's attention because she thought the system updated the amount of insulin when she entered the FSBS level.
-She was not aware of any additional methods to document the amount of insulin units administered to Resident #1.
-The HWD was responsible for auditing the eMARS for accuracy and for updating orders.

Interview with the RCC on 09/11/25 at 9:54am revealed:
-She was not aware the eMAR system did not have a space on Resident #1's FSBS order entry to document the amount of insulin administered.

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D 358	Continued From page 20 -The MAs had not followed up with her regarding the eMAR system not having a space to document the amount of insulin administered to Resident #1. -The HWD was responsible for auditing and verifying the eMAR to ensure SSI parameter entries were correct for the residents. -She expected the MAs to administer Resident #1's Novolog insulin as ordered and to communicate with her or the HWD about missing information on the eMARS. Interview with the HWD on 09/10/25 at 2:30pm revealed: -She was responsible for auditing the residents' eMARs for documentation and accuracy, but she had not noticed that Resident #1's FSBS order entry did not have a space to document the amount of Novolog SSI administered. -She had corrected previous errors related to the implementation of the facility's new eMAR system but she had not audited the SSI parameters. -No staff had followed up with her regarding the eMAR system not having a space to document the amount of insulin administered to Resident #1 and it must have been overlooked. -There was no other documentation she could provide to monitor the amounts of Novolog SSI administered to Resident #1. -She expected all the MAs to document the amount of insulin units administered in the eMAR for all residents moving forward. -She expected the MAs to notify her if the eMAR was missing entries for documentation. Interview with the Administrator on 09/11/25 at 11:45am revealed: -He was not aware Resident #1's amount of Novolog insulin administered was not being documented by the MAs.	D 358		

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D 358	Continued From page 21 -The MAs should have let the RCC and the HWD know about the missing documentation areas for SSI. -He expected the HWD to audit the eMARS on a weekly basis to address discrepancies related to insulin administration errors. -He expected the MAs to document the units of insulin administered correctly. _____ The facility failed to ensure medications were administered as ordered for 2 of 5 residents including a resident who did not receive a short acting insulin to control blood sugars from 08/11/25 to 09/09/25 (#6) which could result in a rise of blood sugar levels. The amount of insulin administered was not documented for two residents (#1, #6) so it could not be determined if the residents received the correct number of units of insulin according to SSI parameter orders. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED October 26, 2025.	D 358		