| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513<br><br>Based on record review, staff interviews, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure residents had an accurate Minimum Data Set (MDS) assessment for three of 36 sample residents (Resident (R) 24, R114, and R11) reviewed for MDS. Specifically, R24's Ozempic was coded as insulin, R114's therapy was not coded, and R11's insulin and antidepressant were coded incorrectly. These failures did not accurately represent the resident's health status.<br><br>Findings include:<br><br>Review of the RAI Manual, dated 10/01/19 and provided by the facility, indicated, .It is important to note here that information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment .<br><br>1. Review of R24's electronic medical record (EMR) Admission Record under the MDS tab revealed R24 was admitted to the facility on [DATE].<br><br>Review of the EMR quarterly MDS with an Assessment Reference Date (ARD) of 09/24/24 indicated R24 received insulin once a week.<br><br>During an interview on 12/03/24 at 4:50 PM, the MDS Coordinator (MDSC), stated R24's diabetes was controlled by diet and did not receive insulin. The MDSC stated Ozempic should not have been coded as insulin. The MDSC confirmed the R24 did not have orders for insulin.<br><br>During an interview on 12/04/24 at 2:01 PM, the Director of Nursing (DON) stated her expectation was for the MDS to be accurate.<br><br>43050<br><br>2. Review of the undated Admission Record located in the Profile tab of the EMR revealed, R114 was admitted to the facility on [DATE] with diagnoses that included a stroke and spondylolisthesis (a condition where a vertebra in the spine slips out of place and onto the bone below it.)<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the admission MDS located in the MDS tab of the EMR with an ARD of 09/22/24 revealed R114 had a BIMS score of 15 out of 15, which indicated she was cognitively intact. In addition, the assessment revealed R114 had received occupational therapy for only one day and physical therapy for only one day during the seven-day observation period.<br><br>During an interview on 12/05/24 at 7:36 AM, the Certified Occupational Therapy Assistant (COTA) was asked if R114 had received therapy during the seven-day observation period when she was admitted to the facility. The COTA stated, She received occupational therapy for six out of seven days.<br><br>During an interview on 12/05/24 at 7:37 AM, the Physical Therapy Assistant (PTA) was asked how many days R114 received physical therapy after admission. The PTA stated, R114 received five days of physical therapy during the seven-day observation period.<br><br>During an interview on 12/05/24 at 8:38 AM, the MDSC was asked why she coded only one day of occupational therapy and one day of physical therapy for R114 on the admission MDS. The MDSC stated, The therapy notes auto populate into the system daily and I am supposed to update it daily. I coded this section inaccurately as she has more than four days of therapy during the seven-day observation period.<br><br>46319<br><br>3. Review of R11's quarterly MDS located in the MDS tab of the EMR with an ARD of 10/08/24 revealed an original admitted [DATE] R11 had a BIMS score of 15 out of 15, which indicated she was cognitively intact. In addition, the assessment revealed the resident had diagnoses of anxiety disorder, depression, bipolar disorder, and morbid severe obesity due to excess calories received. The resident received insulin for only one day and antianxiety medication during the seven-day observation period.<br><br>Review of the physician orders located under the Orders tab of the EMR revealed that R11 received an order for trazodone 50 milligram (mg) by mouth every twelve hours for generalized anxiety disorder, dated 11/22/24 and an order for Ozempic 1mg dose subcutaneous one time a day every Saturday related to severe morbid obesity due to excess calories, dated 03/18/24.<br><br>During an interview on 12/04/24 at 10:15 AM, the MDSC was asked why she coded trazodone as an antianxiety and the Ozempic as an insulin. The MDSC stated the trazodone was used to help with anxiety and the Ozempic was an antidiabetic medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690<br><br>Based on interview, record review, and facility policy review, the facility failed to ensure one of five residents (Resident (R) 70) had an updated Level I Preadmission Admission Screening and Resident Review (PASARR) based on a newly acquired diagnosis of major depression of 36 sample residents. This failure has the potential to cause a negative psychosocial outcome for R70 by not receiving the treatment necessary for an individual with a diagnosis of major depressive disorder.<br><br>Findings include:<br><br>Review of facility's policy, titled, Resident Assessment-Coordination with PASARR Program implemented 03/01/22, revealed This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs . The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status.<br><br>Review of R70's electronic medical record (EMR) Admission Record located under the Profile tab revealed the resident was admitted to the facility on [DATE]. R70 had a diagnosis that included major depressive disorder.<br><br>Review of R70's EMR quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/21/24 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which revealed the resident was cognitively intact. The assessment did not identify the resident with a depression diagnosis.<br><br>Review of a document provided by the facility titled, Preadmission Screening and Resident Review (PASARR) Level I Assessment (Form: DMA-613), dated 01/08/24, indicated R70 did not have a diagnosis of major depressive disorder.<br><br>Review of a document provided by the facility titled, Psychiatric Diagnostic Evaluation, dated 01/16/24, indicated the psychiatric provider diagnosed R70 with major depressive disorder.<br><br>During an interview on 12/05/24 at 3:41 PM, the Social Services Director (SSD) and the Administrator said if a resident had a diagnosis change, the PASARR should be updated. Upon review, the Administrator confirmed the PASARR should have been updated. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513<br><br>Based on interviews, record review, and review of the facility policy titled Comprehensive Care Plan, the facility failed to ensure a comprehensive care plan was developed for two of 36 sampled residents (Resident (R) 65 and R97) reviewed for care plans. The failure had the potential to lead to unmet care needs.<br><br>Findings include:<br><br>Review of the facility's policy titled, Comprehensive Care Plan reviewed 01/01/23, revealed It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.<br><br>1.Review of R65's electronic medical record (EMR) Admission Record under the Profile tab, revealed R65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of quadriplegia and type two diabetes mellitus.<br><br>Review of R65's EMR quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R65 was cognitively intact. The MDS revealed R65 received insulin seven of the last seven days prior to the ARD.<br><br>Review of R65's EMR Care Plan under the Care Plan tab, revealed the Diabetes Mellitus Management Care Plan had been initiated on 10/20/21 and most recently revised on 02/21/24. There was nothing on the care plan that indicated the doctor should be notified if R65 did not receive his physician ordered insulin or if blood sugars were not obtained.<br><br>Review of the EMR Medication Administration Record (MAR) under the Orders tab, dated 10/24, revealed R65 was ordered Humalog Solution 100 Unit/mL (insulin Lispro) Injects as per sliding scale if 0-200 = 0 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401+ = 12 Units, Call MD (Medical Director) . call MD/NP (Medical Doctor/Nurse Practitioner) if BBG (Bedside Blood Glucose) > (greater than) with a start date of 09/26/24.<br><br>Review of R65's Progress Notes located in the EMR, under the progress notes tab revealed the physician was not notified anytime the facility failed to provide the medication.<br><br>Review of the EMR MAR under the Orders tab, dated 11/2024, revealed R65 was ordered Humalog Solution 100 Unit/mL (insulin Lispro) Injects as per sliding scale if 0-200 = 0 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401+ = 12 Units, Call MD, call MD/NP if BBG > (greater than) with a start date of 09/26/24.<br><br>Review of R65's Progress Notes located in the EMR, under the progress notes tab revealed the physician was not notified anytime the facility failed to provide the medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/05/24 at 8:00 AM, the Staff Development Coordinator (SDC) said R65's physician should be notified anytime the resident did not receive their medication or the resident's blood sugars were not obtained.<br><br>During an interview on 12/05/24 at 1:20 PM, the Director of Nursing (DON) said that notifying the physician should also be included in the resident's care plan.<br><br>35690<br><br>2. Review of R97's Admission Record located in the Profile tab of the EMR revealed R97 was admitted to the facility on [DATE] with diagnoses that included a stroke and osteoarthritis.<br><br>Review of the admission MDS located in the MDS tab of the EMR with an ARD of 08/03/24 revealed, R97 had a BIMS score of 15 out 15, which indicated she was cognitively intact. In addition, the assessment revealed R97 required substantial assistance with most activities of daily living (ADLs). Review of Section V Care Area Assessment (CAA) on the admission MDS revealed that Functional Abilities (self-care and mobility) triggered as care area and a care plan would be developed.<br><br>Review of R97's 07/29/24 ADL Care Plan located in the Care Plan tab of the EMR revealed, ADL assistance r/t [related to] decreased/impaired mobility, new environment. Interventions included the following: Assist with bath/shower as needed; Assist with dressing and choosing appropriate clothes for the season, if needed; Assist with mobility devices as needed; and Enhanced Barrier Precautions as ordered.<br><br>During an interview on 12/05/24 at 9:52 AM, the MDS Coordinator (MDSC) was asked if she was responsible for developing the Care Plan. The MDSC stated, for R97, the person who developed her 'Care Plan' is no longer here. She does have an ADL Care Plan dated 07/29/24. The MDSC was asked what the interventions listed on the ADL Care Plan were regarding needing assistance and how do staff know how to care for her when it did not list information regarding toileting assistance, transfers etc. The MDSC stated, You will have to ask the DON about that information.<br><br>During an interview on 12/05/24 at 1:00 PM, the DON stated, When a resident is admitted , the unit manager will do a huddle with staff regarding what they need as far as assistance. The DON further stated, The ADL Care Plan needs to be more specific as to the needs of the residents so staff are aware of transfer status, if the resident is given showers or bed baths and on what days, including how many staff should be assisting her. The DON confirmed R97's ADL Care Plan was not fully developed. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32513<br><br>Based on interviews, record review, and review of the facility policy titled, Change in Resident's Condition or Status, the facility failed to identify a resident's need to transfer to the hospital for one of five residents (Residents (R) 171) reviewed of 36 sampled residents, who had experienced a change in condition with altered mental status. This failure placed the residents at risk for increased complications and unmet care needs.<br><br>Findings include:<br><br>Review of a facility's policy titled, Change in Resident's Condition or Status, revised May 2022, revealed .The nurse will notify the resident's Attending Physician or physician on call when there has been a(an) accident or incident involving the resident .Significant change in the resident's physical/emotional/mental condition . Need to alter the resident's medical treatment significantly .Need to transfer the resident to a hospital/treatment center .<br><br>In addition, the facility policy revealed, .A 'significant change' of condition is a major decline or improvement in the resident's status that .Will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions .<br><br>Review of the Admission Record located in the Profile tab of the electronic medical record (EMR) revealed, R171 was originally admitted on [DATE] and readmitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (a change in how the brain works due to an underlying condition), chronic pain, end-stage renal disease (ESRD), and dependence on hemodialysis.<br><br>Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 10/05/24 revealed R171 had a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated R171 was severely impaired in cognition and received dialysis during the seven-day observation period.<br><br>Review of the Care Plan, dated 09/11/24 and located in the Care Plan tab of the EMR revealed, Diagnosis of ESRD- receives dialysis and is at risk for complications and potential for occlusion of shunt [a passage that is made to allow blood to move from one part of the body to another.] Signs/Symptoms of complications of renal failure will be identified and appropriate interventions initiated on an ongoing basis.<br><br>Review of a Nursing Progress Note, dated 10/15/24 at 7:41 PM and located in the Progress Notes tab of the EMR, revealed .[R171] readmitted from [name withheld] hospital. He was admitted to the hospital with AMS [altered mental status.]<br><br>Review of a Nursing Progress Note, dated 10/16/24 at 3:02 PM and located in the Progress Notes tab of the EMR, revealed Received resident alert and responsive able to make needs known. Resident refused dialysis, stating I am not feeling well.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of a Medical Practitioner Note, 10/17/24 at 3:12 PM and located in the Progress Notes tab of the EMR, revealed [R171] was seen for routine f/u [follow up] for rehab services 2/2 [secondary to] debility. He is laying in bed at time of rounds. Awake, alert, talkative. He refused HD [hemodialysis] yesterday r/t [related to] 'not feeling well.' He is able to report that he is experiencing pain. He has a h/o [history of] chronic pain, has been followed by physiatry [a medical specialty that deals with the treatment of people who have a disability, chronic pain, or some other physical problem] at the facility .Educated on importance of going to HD. He shares that he will go to his next HD session as scheduled. Support given .Reviewed chronic conditions and POC [plan of care]. No acute issues reported by staff.<br><br>Review of an eMAR [electronic Medication Administration Record] note, dated 10/18/24 at 5:55 PM and located in the Progress Notes tab of the EMR, revealed R171 went to dialysis.<br><br>Review of a Medical Practitioner Note, dated 10/19/24 at 10:29 AM and located in the Progress Notes tab of the EMR, revealed .admitted from [name withheld] 2/2 to AMS [altered mental status]. He had initially been hospitalized in August. He had been at HD clinic when he had decreased responsiveness. Upon EMS [emergency medical support] arrival his GCS [Glasgow coma scale-a clinical scale that measures a person's level of consciousness] was 7 [the highest score is 15 and the lowest is 3. A score of 15 means you're fully awake, responsive and have no problems with thinking ability or memory. Having a score of 8 or fewer means you're in a coma] and had a temp of 102.1. At that time, EMS witnessed seizure activity. He was intubated [tube inserted into trachea] for airway protection and hypoxemia [low levels of oxygen in the blood] . He (sic) medically stabilized and transferred .<br><br>Review of a SBAR (situation, background, assessment, and recommendation) for Providers dated 10/21/24 at 12:00 PM and located in the Progress Notes tab of the EMR, revealed Situation: The Change In Condition/s reported on the CIC [change in condition] evaluation are/were: Altered mental status Edema (swelling) Pain (uncontrolled) .Vital signs at 8:20 AM were: Blood Pressure: 108/62, Pulse 83 regular, Respirations 20, Temperature 97.8 and pulse ox (measure the amount of oxygen in the blood) at 92% on room air.<br><br>Review of a Nurses Progress Note, dated 10/21/24 at 3:31 PM and located in the Progress Note tab of the EMR, revealed Resident noted with edema and pain to left upper extremity, 3x3 (cm) blister noted. Provider aware, new order confirmed for Xray and venous doppler, both complete. Negative results of Xray. Awaiting on results from doppler. Resident declining, unable to feed self. Unable to verbalize pain scale, however resident was moaning and noted with facial grimacing while being turned and repositioned. Staff will continue to monitor resident for distress and further decline. Provider is aware and will assess.<br><br>Review of a Nursing Progress Note, dated 10/21/24 at 3:39 PM and located in the Progress Notes tab of the EMR, revealed Resident left facility to attend dialysis. Resident left via stretch accompanied by transport and CNA [Certified Nurse Aide]. Resident alert visibly seen groaning facial grimacing present.<br><br>Review of a Nursing Progress Note, dated 10/21/24 at 4:01 PM and located in the Progress Notes tab of the EMR, revealed Spoke with [name withheld] and it was reported that resident arrived at the dialysis center unresponsive. [name withheld] explained that she was not going to call 911 for [R171] because that is the way he arrived, and she did not want to assume responsibility. I informed transportation driver to take resident to ER [emergency room ] for eval and treatment .Provider is aware.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the discharge MDS located in the MDS tab of the EMR with an ARD of 10/21/24 revealed, R171 had a staff assessed BIMS score of moderately impaired, was on opioid pain medications and had received hemodialysis.<br><br>During an interview on 12/04/24 at 12:04 PM, Unit Manager (UM) 1 stated, [R171] was responding but he wasn't himself that day. When he arrived at dialysis, they called and told me he was unresponsive. UM1 was asked if the facility had taken vital signs prior to leaving for dialysis. She stated, Yes, they were taken at 1:30 PM. UM1 reviewed the vital signs and stated, His blood pressure was 171/91, temperature was 97.1, pulse was 72, respirations were 20 and his oxygen saturation level was 92%. UM1 was asked if the provider had been made aware of R171's condition prior to leaving the facility. She stated, I did contact the physician, but the Nurse Practitioner (NP) was aware of everything. UM1 further stated, It was [R171's] norm to go in and out of mental status changes and after dialysis he would return to baseline. It was a progressive change in him, but the NP wanted to monitor him. UM1 was asked if she had communicated with dialysis regarding R171's condition when he left the facility to ensure continuity of care. UM1 stated, To be honest with you, there is probably not a note. The van driver did voice concerns about him, and I told him (the driver) that the NP was aware and wanted him to go to dialysis.<br><br>During an interview on 12/04/24 at 12:39 PM, the NP was asked about R171's change in condition. The NP stated, I saw him last on 10/17/24. At that time, he was awake, alert and talkative. The NP was asked if refusing dialysis was a common issue for R171. She stated, I don't recall. He was not feeling well, he has chronic pain at baseline. The NP further stated, I would have put a note in if I was aware of the situation. The NP was asked, per the Nursing Progress Notes you were notified. The NP stated, They must have notified the physician.<br><br>During an interview on 12/04/24 at 12:54 PM, the Director of Nursing (DON) stated, The order to go ahead and send R171 to dialysis on 10/12/24 at 3:31 PM was the from the NP. She was here at the facility. The DON further stated, If the NP was in the building and was aware of the situation, then the physician would not have been made aware.<br><br>During a follow-up interview on 12/04/24 at 1:09 PM, the NP was asked if she had been aware of R171's decline and went ahead and sent him to dialysis. The NP stated, I don't recall this, it was October.<br><br>During an interview on 12/04/24 at 5:29 PM, the Medical Director was asked if he had been made aware of R171's decline by either the nursing staff or the NP. The Medical Director stated, If anything is going on at the facility before 5:00 PM, then it would have been the NP, during the week. They notify me if after 5:00 PM and on weekends. The Medical Director further stated, The mental status changes are the main concern with him, the nurses were concerned also. I saw him over the weekend, and he was fine. He goes back and forth to the ER. When he showed up his mental status improved, they would send him back. When you see him one time, he is fine and the next time it will change. The Medical Director was given the information regarding the change in condition for R171 from the nurses' notes. The Medical Director stated, I did not know about this issue. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>35690<br><br>Based on resident and staff interviews, record review, and facility policy review, the facility failed to ensure that narcotics were signed out for one of 36 sampled residents (Resident (R) 99). The deficient practice had the potential for drug diversion.<br><br>Findings include:<br><br>Review of the facility's policy titled, Pharmacy Services, reviewed 03/01/24, revealed The facility will provide pharmaceutical services to include procedures that assure the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals to meet the needs of each resident, are consistent with state and federal requirements . The pharmacist is responsible for helping the facility obtain and maintain timely and appropriate pharmaceutical services that support residents' healthcare needs, goals and quality of life that are consistent with current standards of practice and meet state and federal requirements reflect current standards of practice.<br><br>Review of the facility's policy titled, Controlled Substance Administration and Accountability, dated 08/01/23 revealed, .The Controlled Drug Record (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration .The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR [Medication Administration Record] is the source for documenting any patient-specific narcotic dispensed from the pharmacy .<br><br>During a medication administration observation on 12/04/24 at 7:44 AM LPN1 obtained pregabalin oxycodone (a narcotic pain medication) from the locked controlled substance lock box from the Unit Medication Cart. LPN1 placed the medications in a medication cup with the remainder of R99's scheduled medications. LPN1 then closed the lid on the control substance lock box, locked it, and then proceeded to enter R99's room to administer the medications. LPN1 was not observed to have verified the remaining amount of the pregabalin on the medication card against the controlled substance book or sign the medications out prior to administering the medications to indicate the count was correct and to document she was the nurse who had obtained the controlled medication from the control substance lock box.<br><br>During an interview on 12/04/24 at 7:44 AM, LPN1 was asked why she did not sign out the narcotic medication she obtained from the controlled substance lock box prior to administering the medication to R99. LPN1 stated, I give the medications first and then come back to the cart and sign them out. I do this because if she refuses them, I can then destroy them. I don't sign them out until after I give the medication.<br><br>During a medication administration observation on 12/04/24 at 9:34 AM, on the 400 Hall Medication Cart, LPN2 opened the controlled substance lock box and removed pregabalin, oxycodone and trazadone (an antidepressant medication). LPN2 was not observed to have signed out the medications after obtaining them from the controlled substance lock box, nor verified the number of medications left in the medication cards, prior to entering R11's room.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 10/04/24 at 9:36 AM, LPN2 was asked why she did not sign out the medications at the time she removed them from the medication cart and controlled substance lock box to verify that the count was correct. LPN2 stated, I give the medications first and then come back, so if she refuses, I can destroy them.<br><br>During an interview on 12/04/24 at 9:56 AM, the DON was asked what her expectation was regarding signing out narcotic and controlled substance medications. The DON stated, They are to look at the MAR and the label to ensure it is the right drug and the right patient. When they punch out the medication, they are to sign the narcotic book [controlled substance logbook], at the same time. This is a standard of nursing practice. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35690<br><br>Based on record review, resident and staff interviews, and facility policy review, the facility failed to administer physician ordered insulin for one resident (Resident (R) 65) reviewed for insulin administration of 36 sample residents. This failure had the potential to cause hyperglycemia episodes in insulin dependent residents.<br><br>Findings include:<br><br>Review of the facility's policy titled, Medication Administration, reviewed 06/01/24, revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice.<br><br>Review of the facility's policy titled, Medication Errors, reviewed 03/01/24, revealed Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety.<br><br>Review of R65's electronic medical record (EMR) Admission Record under the Profile tab, revealed R65 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of quadriplegia and type two diabetes mellitus.<br><br>Review of R65's EMR quarterly Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 08/24/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that R65 was cognitively intact. The MDS revealed R65 received insulin seven of the last seven days prior to the ARD.<br><br>Review of R65's EMR Care Plan under the Care Plan tab, revealed the Diabetes Mellitus Management Care Plan had been initiated on 10/20/21 and most recently revised on 02/21/24. The goal for R65 was to not have complications related to diabetes through the review date. Interventions included R65 was to receive diabetes medications as ordered, obtain blood sugar as ordered, and monitor for any signs and symptoms of hyperglycemia and/or hypoglycemia. There was nothing on the care plan that indicated the doctor should be notified if R65 did not receive his physician ordered insulin or if blood sugars were not obtained.<br><br>Review of the EMR Medication Administration Record (MAR) under the Orders tab, dated 10/24, revealed R65 was ordered Humulin 70/30 Kwik Pen Subcutaneous Suspension Pen-Injector (70-30) 100 Unit/milliliters (mL) Inject 45 Units Subcutaneously two times a day related to Type 2 Diabetes Mellitus with mild Non-proliferative diabetic retinopathy without macular edema, bilateral with a start date of 07/09/24 and discontinued on 10/29/24. Review of the MAR revealed the resident did not receive the 5:00 PM medication on 10/04/24, 10/09/24, 10/22/24, 10/26/24, and 10/28/24.<br><br>Review of R65's Progress Notes located in the EMR, under the Progress Notes tab revealed the physician was not notified anytime the facility failed to provide the medication.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the EMR MAR under the Orders tab, dated 10/24, revealed R65 was ordered Humalog Solution 100 Unit/mL (insulin Lispro) Injects as per sliding scale if 0-200 = 0 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401+ = 12 Units, Call MD (Medical Director), Subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with mild Non-proliferative diabetic retinopathy without macular edema, bilateral, call MD/NP (nurse practitioner) if BBG (Bedside Blood Glucose) >(greater than) with a start date of 09/26/24. Review of the MAR revealed R65 did not receive the medication on 10/04/24, 10/09/24, 10/22/24, and 10/26/24 at 4:30 PM and his blood sugars were not obtained.<br><br>Review of R65's Progress Notes located in the EMR, under the Progress Notes tab revealed the physician was not notified anytime the facility failed to provide the medication.<br><br>Review of R65's EMR MAR under the Orders tab, dated 11/24, revealed R65 was ordered Humulin 70/30 Kwik Pen Subcutaneous Suspension Pen-Injector (70-30) 100 Unit/milliliters (mL) Inject 47 Units Subcutaneously two times a day related to Type 2 Diabetes Mellitus with mile Non-proliferative diabetic retinopathy without macular edema, bilateral with a start date of 11/01/24. Review of the MAR revealed the resident did not receive the medication on 11/15/24 at 9:00 AM or 5:00 PM.<br><br>Review of R65's Progress Notes located in the EMR, under the Progress Notes tab revealed the physician was not notified anytime the facility failed to provide the medication.<br><br>Review of the EMR MAR under the Orders tab, dated 11/24, revealed R65 was ordered Humalog Solution 100 Unit/mL (insulin Lispro) Injects as per sliding scale if 0-200 = 0 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 10 Units; 401+ = 12 Units, Call MD (Medical Director), Subcutaneously before meals and at bedtime related to Type 2 Diabetes Mellitus with mild Non-proliferative diabetic retinopathy without macular edema, bilateral, call MD/NP (nurse practitioner) if BBG (Bedside Blood Glucose) >(greater than) with a start date of 09/26/24. Review of the MAR revealed R65 did not receive the medication on 11/13/24 at 9:00 PM, 11/15/24 at 7:40 AM or 4:30 PM, and 11/30/24 at 9:00 PM.<br><br>Review of R65's Progress Notes located in the EMR, under the Progress Notes tab revealed the physician was not notified anytime the facility failed to provide the medication.<br><br>During an interview on 12/02/24 08:30 AM, R65 stated the facility ran out of insulin because they don't order meds (medications), and insulin is a problem. He stated the nurses know he used two or three pens a week but no one orders, and no one cares.<br><br>During an interview on 12/05/24 at 8:00 AM, Licensed Practical Nurse (LPN) 1 and Staff Development Coordinator (SDC) said if the medication the resident needed was not available, they would call the pharmacy to order more. They said that R65 would run out of insulin occasionally because of the amount he received every day. The SDC said that in the insulin pen there was only 100 mL, and he required 47 units twice per day, so it wasn't uncommon to run out. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050<br><br>Based on observation, staff interviews , and review of the facility policy, the facility failed to ensure all food in the freezer, refrigerator, and dry storage was labeled, dated, and not expired. These failures had the potential to affect all 116 residents in the facility who consumed food from the kitchen.<br><br>Findings include:<br><br>Review of the facility's policy titled, Date Marking for Food Safety, dated [DATE], revealed The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. The discard day or date may not exceed the manufacturer's use-by-date, or four days, whichever is earliest. The date of opening of preparation counts as day one. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly. The dietary manager, or designee, shall spot check refrigerators weekly for compliance .<br><br>During an observation on [DATE] at 9:43 AM, the following observations in the kitchen were identified and verified by the Dietary Manager (DM).<br><br>1. The walk-in freezer contained one bag of turkey that had been opened on [DATE] with no use-by-date. It also contained one bag of hot dogs opened on [DATE] with no use-by-date.<br><br>2. The walk-in refrigerator contained one bag of pork that had an expiration date of [DATE].<br><br>3. The dry Storage room contained two bowls of cereal covered with cellophane with no labeling or dating. There was also one bag of cake mix that had been opened with no labeling or dating. An opened bag of Jell-O had an expiration date of [DATE].<br><br>During an interview on [DATE] at 9:43 AM, the DM revealed, These things should have been caught. They were just overlooked.<br><br>During an interview on [DATE] at 10:06 AM, the Administrator revealed, My expectation for the kitchen is that all items in the kitchen need to be labeled and dated and not expired. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>43050<br><br>Based on observations and staff interview, the facility failed to ensure garbage was properly disposed of for two out of three facility dumpsters. This had the potential for pests and rodents to enter the dumpsters.<br><br>Findings include:<br><br>During observation of the dumpster area behind the kitchen with the Dietary Manager (DM) on 12/02/24 at 10:20 AM, a small amount of trash was revealed on the ground by the first of three dumpsters. Dumpster number one's side door was open, and dumpster number two did not have a drain plug to close off the opening.<br><br>During an interview on 12/02/24 at 10:20 AM, the DM revealed, I did not know that the plug was missing from the dumpster and that the door was open. I understand that pests can get into these dumpsters, and we do not want that. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 12/05/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43050<br><br>Based on observations, interviews and review of facility policy, the facility failed to ensure that a glucometer was cleaned properly after blood glucose testing for one of three residents (R) 39) observed for glucometer use of 36 sample residents. This had the potential for cross contamination.<br><br>Findings include:<br><br>Review of the facility's policy titled, Blood Glucose Monitoring, dated 11/22/24, revealed Clean and disinfect the glucometer as per manufacturer's instructions .<br><br>Review of the undated glucometer handbook provided by the facility, revealed .To disinfect your meter, clean the meter surface with one of the approved disinfecting wipes. Other EPA [Environmental Protection Agency] registered wipes may be used for disinfecting the glucometer system, however, these wipes have not been validated and could affect the performance of the meter. Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use.<br><br>Review of the facility's germicidal wipes on 12/05/24 at 10:05 AM with the Director of Nursing (DON) revealed the facility used germicidal wipes to disinfect glucometers that met the EPA standards for the glucometer.<br><br>Observation and interview on 12/02/24 at 4:14 PM revealed R39 receiving blood glucose monitoring by Licensed Practical Nurse (LPN) 4. LPN4 stated, Every diabetic resident has their own glucometer that is kept in the medication cart. After completing the blood glucose monitoring, LPN4 stated, I do not have the wipes on my cart to clean the glucometer and I will use an alcohol wipe. When asked what type of wipe was to be used, LPN4 stated, The purple top, but I would have to go to Central Supply to get them.<br><br>Review of the electronic medical record (EMR) Admission Record under the Admission Record tab revealed R39 was admitted to the facility on [DATE].<br><br>Review of the EMR Orders Record under the Orders Record tab, dated 11/19/24, revealed R39 was to receive Fiasp Flex Touch 100 UNIT/ML (milliliters) Solution pen-injector Insulin per sliding scale subcutaneously before meals and at bedtime related to type two diabetes mellitus without complications.<br><br>Interview with Unit Manager (UM) 1 on 12/02/24 at 4:25 PM revealed Each diabetic resident has their own glucometer. Alcohol wipes cannot be used. Germicidal wipes (purple top) are to be used according to manufacturer instructions. [LPN4] should have had the wipes on her cart.<br><br>During an interview on 12/05/24 at 9:54 AM, the DON revealed I heard about the incident, and we educated immediately. All medication carts are to have the proper cleaning supplies. Nurses should notify their managers if they do not have what is needed and carts can be restocked. |