STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235484	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Sterling Skilled Rehabilitation	34643 Ketsin Drive Sterling Heights, MI 48310

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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2647910Based on interview and record review, the facility failed to implement medication pass guidelines for safe medication administration for one resident (R701) of four residents reviewed for medication administration. Findings include:Review of Intake 2647910 revealed an allegation that R701, who was not diabetic and did not have physician orders to receive insulin, had been administered an injection of 12 units of insulin on 09/09/25.A review of the facility record revealed R701 was originally admitted to the facility on [DATE] and was most recently admitted on [DATE] with diagnoses including Dementia and Congestive Heart Failure. It was noted R701 did not have a diagnosis of Diabetes Mellitus. R701 was discharged from the facility on 09/18/25 per family request.On 10/22/25 at 11:57 AM, Unit Manager (UM) B was interviewed in their office. UM B reported they did recall the reported incident and indicated on 09/09/25 around lunch time Licensed Practical Nurse (LPN) A came to them and reported they had administered 12 units of Lispro/Humalog (a fast-acting insulin often used at mealtime to control blood sugar) to R701 in error after mistaking them for another resident. UM B reported they called R701's physician and were advised to complete blood sugar checks every 30 minutes and to monitor the resident for any signs/symptoms of hypoglycemia (low blood sugar).Further review of R701's facility record revealed no physician orders for insulin. A physician's progress note dated 09/10/25 authored by Medical Doctor (MD) D stated Patient is being seen due to an incident that occurred. [R701] was given 12 units of Humalog which was intended for another resident. [R701] did not have any reactions to the medication. When queried regarding any further documentation of the incident UM B produced a Medication Error Report that documented the incident had occurred on 09/09/25 at 11:50 AM and that the physician was notified at 11:55 AM. The report included additional information pertaining to resident monitoring and staff education. The report was signed by LPN A, the Director of Nursing (DON), the Medical Director, and the facility Administrator.On 10/22/25 at 2:03 PM, LPN A was interviewed via phone call and reported they did recall the incident of administering insulin to R701. They reported multiple residents had returned from outside appointments and were in the dining room prior to lunch. LPN A reported they saw R701 beginning to eat some fast food they must have brought in from outside and they thought R701 was a different resident who required a standard dose of 12 units of insulin at meals. LPN A reported they completed a blood sugar check then administered the insulin to R701. When asked if R701 questioned them or tried to stop them LPN A indicated R701 started to ask about the injection once it was being administered. LPN A reported once the resident questioned them, they checked further and realized the insulin had been given to the wrong resident. They reported they immediately reported the error to UM B. When queried how they would normally verify a resident's identity for medication administration they stated, The five rights . right patient, right drug, right dose, right route, right time. When asked to describe that process LPN A reported they would refer to the resident's electronic medical record (EMR) to view their picture, ask the resident their name and date of birth , and check their wrist band if one was present. LPN A acknowledged that in this situation they did not do any of those things prior to the administration of the insulin. Review of the facility policy Med Pass Guidelines dated 08/2011 revealed the Purpose (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement To assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy for each resident by providing the administration of drugs in an accurate, safe, timely, and sanitary manner and to systematically distribute medications to residents in accordance with state and federal guidelines.