STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide treatment and services in accordance with professional standards of practice (guidelines and expectations that define competent and ethical conduct within specific profession) for one of three sampled residents (Resident 1) who had a diagnosis of Type 2 Diabetes Mellitus ([DM] when a hormone called insulin does not work properly or there is not enough of it. This causes the level of glucose [sugar] in the blood to become too high) by failing to: 1.Ensre that its licensed nursing staff reviewed Resident 1's medical history of Type 2 Diabetes Mellitus (DM) and diabetes management prior to the readmission from the GACH on 1/11/2026. This medical history included Resident 1's diabetes management, such as checking and monitoring Resident 1's blood sugar levels by performing fingerstick tests. 2. Verify and document confirmation with Resident 1's attending physician (MD 1) and/or Nurse Practitioner (NP) 1 by transcribing the fingerstick blood glucose monitoring-before meals (AC) and at bedtime (HS)-as ordered in the GACH discharge instructions dated 1/11/2026, upon Resident 1 's readmission to the facility on 1/11/2026. 3.Implement Resident 1 's written care plan dated 12/11/2025 titled Risk for unstable blood glucose levels ([low blood sugar] and [high blood sugar]), which requires the facility's licensed nurses to monitor and observe Resident 1 for signs and symptoms of low and high blood sugar levels. The care plan did not address how licensed nurses would measure Resident 1's blood glucose levels to determine if the resident was experiencing low or high blood sugar levels. 4.Document verification of RN 4 with MD 1 whether fingerstick blood sugar monitoring should be performed when MD 1 ordered for Resident 1 to be on continuous infusion of Dextrose 5% in Water (D5W) (an intravenous [IV] fluid containing 5 grams of dextrose (sugar) dissolved in 100 mL of water) for poor appetite and hydration from 2/6/2026 to 2/8/2026. 5.Ensure effective communication (LVN 1, RN 1, RN 2, RN 3, RN 4) among the interdisciplinary team regarding Resident 1's change in condition, critical lab results, and ordered treatments. As a result of these deficient practices, Resident 1 did not receive required monitoring and timely intervention for hyperglycemia and was administered D5W IV fluids from 2/6/2026 to 2/8/2026 while in a hyperglycemic state. Resident 1 experienced a significant decline in condition, including altered level of consciousness and oxygen saturation of 85 percent (normal range 95-100 percent) on 2/8/2026. Emergency medical services were activated, and paramedics recorded a critically elevated blood glucose level of 530 mg/dL upon arrival. Resident 1 was transferred to the GACH Emergency Department for further evaluation and treatment of altered level of consciousness, hypoxia, and severe hyperglycemia. At the ED, additional blood glucose readings were 530 mg/dL at 4:35 PM and 434 mg/dL at 4:55 PM. The hospital diagnoses included severe sepsis, acute hypoxemic respiratory failure, and uncontrolled diabetes mellitus. Cross referenced to F711 Findings: During a review of Resident 1's diabetes care plan titled Risk for Unstable Blood Glucose Level (low and high blood sugar levels), initiated during Resident 1's initial admission at the facility dated 12/11/2025 with a goal date of 3/31/2026, the care plan (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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F 0684 Level of Harm - Actual harm Residents Affected - Few	indicated that Resident 1 should be checked for blood glucose (BG) if the level is below 70 mg/dL, and that if the resident is unconscious or vital signs are absent, staff should administer 1 milligram (mg) of Glucagon (a medication used to increase BG) intramuscularly (IM) and call 911. The care plan did not address how the licensed nurses would measure Resident 1's blood glucose levels to determine if they were below 70 mg/dL. The care plan interventions further indicated to observe for signs and symptoms (S/S) of high blood glucose levels and report observed S/S to the physician. During a review of Resident 1's General Acute Care Hospital (GACH) Records titled Orders Re-Cap (short for recapitulation that means to summarize the main points of something that has already been discussed or happened) dated 1/11/2026, the Recap indicated to renew (extend validity) Resident 1's fingerstick blood sugar before meals (AC-[ante-cebum which means before meals]) and at bedtime (HS -[hour of sleep]). The GACH records indicated that Resident 1 also had blood sugar checks as needed. The GACH records indicated to notify the physician when the blood sugar was greater than 250 mg/dL, and when the blood sugar was less than 70 mg/dL and to implement hypoglycemia protocol. During a review of Resident 1's admission Record (AR), the AR?indicated?Resident 1 was readmitted to the facility on [DATE], with diagnoses of Type 2 DM and sepsis (a life-threatening medical emergency from an infection). During a review of Resident 1's Nursing Progress Note dated 1/11/2026 at 6:30 PM, the Notes indicated that Resident 1 was readmitted from the GACH with a diagnosis of sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage, organ failure, and potential death). During a review of Resident 1's Physician Order Report from 1/11/2026 to 1/31/2026, the Report indicated that Resident 1 was to be monitored for signs and symptoms of hypoglycemia such as dizziness, confusion and restlessness three times a day starting on 1/11/2026. The physician's orders did not include instructions to monitor the resident's blood sugar levels by performing fingerstick tests AC and HS, nor did they include instructions to monitor for signs and symptoms of hyperglycemia as reflected in the resident's GACH records. The physician order further indicated Resident 1's oral diabetes medications including Alogliptin-metformin tablet, 12.5-1,000 mg to be given twice daily for DM - 9 AM and 5 PM, and Jardiance tablet 25 mg, to give one tablet once a day for DM - 9 AM. During a review of Resident 1's Nursing Progress Note dated 1/11/2026 at 6:35PM, the Note indicated that Registered Nurse (RN) 4 notified Resident 1's attending physician Medical Doctor (MD 1) regarding Resident 1's readmission to the facility on 1/11/2026. The Note indicated Resident 1's Physician Orders were verified and carried out. There is no documented evidence that RN 4 verified with MD 1 whether Resident 1 required continued fingerstick testing to establish baseline blood sugar levels in order to manage the resident's diabetes. During a review of Resident 1's History and Physical (H&P) signed and dated on 1/26/2026 signed by NP 1 indicated Resident 1 did not have the capacity to understand and make decisions. The H&P indicated that Resident 1's Type 2 DM required monitoring. During a review of a physician order dated 2/5/2026, the order indicated to perform a stat laboratory work for comprehensive metabolic panel (CMP). During a review Resident 1's Comprehensive Metabolic Panel (CMP - Blood test) dated 2/5/2026, the Panel indicated that Resident 1 blood sugar was 351 mg/dL. During a review of Resident 1's Nursing Progress Note dated 2/5/2026 at 10:11 PM, the Note indicated Licensed Vocational Nurse (LVN) 1 communicated the CMP results to MD 1. The documentation further indicated that no new orders were given by MD 1 following this notification. During a review of Resident 1's physician order dated 2/5/2026, from NP 1, the order indicated to give 0.9 % Normal Saline (NS) via IV 1 liter bolus (a single, concentrated dose of medication or fluid given rapidly to achieve a quick effect) one time. During a review of the MAR dated 2/5/2026, the MAR indicated Resident 1 received the 0.9 % NS bolus via IV one time. During a review of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Resident 1's physician order dated 2/6/2026 timed at 7:12 AM, from MD 1, the order indicated to give Dextrose 5% Water (D5W) via IV at 60 cc per hour for a total of 3 liters. During a review of the MAR dated 2/5/2026 to 2/8/2026, the MAR indicated Resident 1 received (D5W) via IV at 60 cc per hour. During a review of a facility cell phone communication with the physician, dated 2/6/2026 at 5:29 AM, showed that a screenshot of Resident 1's CMP results was texted to MD 1. The text message indicated that MD 1 ordered a change in the resident's intravenous fluids to dextrose 5% in water (D5W) at a rate of 60 cc/hr, with a total of 3 liters to be administered to Resident 1. During a review of Resident 1's Nursing Progress Note dated 2/6/2026 at 7:20 AM, the Note indicated MD 1 ordered intravenous (IV-in the vein) hydration for Resident 1 due to poor appetite. The order indicated to infuse D5W via IV at 60 cc/hr times, with a total infusion of 3L's. During a review of Resident 1' Nursing Progress Note dated 2/8/2026 at 3:55 PM, the Note indicated that Resident 1 had a change of condition (COC - a significant change in residents health) that Resident 1 was non-verbal, respirations were shallow, oxygen saturation was 87% (% - unit of measurement - normal range 95 - 100%), respiratory rate was 33 breaths per minute (bpm - unit of measurement - normal range 12 - 20 bpm), temperature was 100.7 ? (? - unit of measurement - normal range 97? to 99?), heart rate (HR) was 133 beats per minute (bpm - unit of measurement - normal range 60 - 100 bpm), BG level was 463 mg/dL, Resident 1 was administered oxygen at 15 L via non-rebreather (Face-mask for oxygen delivery) and the oxygen saturation (measures the percentage of hemoglobin in red blood cells carrying oxygen, indicating how well blood is transporting oxygen throughout the body) was at 95%. During a review of Resident 1's clinical record indicated no documented evidence that Resident 1's blood sugar levels were being checked or that the resident was being monitored for signs and symptoms of high and low blood sugars in accordance with the resident's care plan titled Risk For Unstable blood glucose. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR - a communication tool to relay health information) dated 2/8/2026, the SBAR indicated that Resident 1 was non-verbal, respirations were shallow, oxygen saturation was 87%, respiratory rate was 33 beats per minute, temperature was 100.7 Fahrenheit (?), heart rate was 133 bpm, BG level was 463 mg/dL. The SBAR indicated Resident 1 was administered oxygen at 15 L via non-rebreather, head of bed was elevated, and the oxygen saturation was at 95%. During a review of Resident 1' Nursing Progress Note dated 2/8/2026 at 4:10 PM, the Note indicated that the paramedic's (emergency responders)/911 (emergency services) was called. During a review of Resident 1's Paramedic Run Report dated 2/8/2026, the Report indicated that Paramedic's arrive at the facility at 4:16 PM and Resident 1 had an altered level of consciousness (ALOC), was not responding to his name. The Report indicated D5W IVF was discontinued due to Resident 1's high BG level of 530 mg/dL, and the electrocardiogram (devise to measure heart rhythm) indicated Resident 1 had sinus tachycardia regular, rapid heartrate) at 130 bpm, respiratory rate was 32 with labored breathing and Resident 1 was hot to touch with a temperature of 101?. During a review of Resident 1's GACH Records title Emergency (ED) Department Notes dated 2/8/2026, authored by the ED Physician the GACH record indicated that Resident 1 was admitted for altered level of consciousness, fever and hyperglycemia on 2/8/2026. The ED Notes indicated Also notably patient had a blood sugar of 350 [mg/dL] which they [facility licensed nurses] treated with dextrose. EMS [emergency medical services] decided to bring him [Resident 1] here [GACH] for further evaluation and management . The ED report indicated Resident 1's fingerstick blood sugar result taken at 4:35 PM was 530 mg/dL and 434 mg/dL at 4:55 PM. Resident 1's urine glucose level indicated high taken at 2/8/2026 timed at 6:22 PM. During a review of the GACH H&P dated 2/9/2026, authored by MD 1, the GACH H&P indicated Resident 1 was brought in the GACH for evaluation and was hyponatremic and hyperglycemic and in Acute Kidney Injury (AKI (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- the sudden, temporary loss of kidney function occurring over hours or days, leading to waste buildup in the blood). The H&P indicated Resident 1' diagnosis included Uncontrolled DM 2. During a telephone interview on 2/10/2026 at 7:58 AM with the local fire department Fire Chief (FC) 1, FC 1 stated that on 2/8/2026 at approximately 4:15 PM, Engine 25 responded to a 911 call regarding Resident 1 who was experiencing oxygen desaturation (a significant, temporary drop in blood oxygen saturation levels, generally falling below 90%) , ALOC, fever, tachycardia (rapid heart rate), and tachypnea (rapid breathing). FC 1 stated that he had received report from RN 1, who stated that Resident 1 had a change in condition with abnormal laboratory results. FC 1 stated that Paramedic (PM) 1, reviewed the laboratory report and noted an elevated fasting blood glucose level of 351 mg/dL dated 2/5/2026. FC 1 stated that he requested RN 1 to check Resident 1's blood sugar at that moment, which resulted in a level of 530 mg/dL. FC 1 stated Resident 1 was observed receiving IV fluids containing D5W infusing at 60 cc/hr. FC 1 stated that RN 1 reported to him that the IV D5W was ordered by MD 1. FC 1 stated that after the paramedics' assessment, PM 1 and PM 2 requested RN 1 to discontinue the IV D5W infusion. FC 1 stated they observed RN 1 to stop the IV infusion at that time. RN 1 responded and informed PM 1, PM 2, and FC 1 that the IV D5W infusion was already stopped but FC 1, PM 1, PM 2 all observed that the D5W IV was still infusing when they arrived and RN 1 only discontinued the IV infusion after RN 1 was asked to check the blood sugar and was told to discontinue the IVF. During a telephone interview on 2/10/2026 at 10:30 AM with PM 2, PM 2 stated on 2/8/2026 at approximately 4:15 PM, the 911 emergency services responded to a 911 call from the facility regarding a resident with oxygen desaturation. PM 2 stated upon arrival to Resident 1's room, Resident 1 was on high-flow oxygen at 15 L, non-responsive, and experiencing shortness of breath and an IV of D5W was observed infusing. PM 2 stated RN 1 reported to him that Resident 1 had abnormal laboratory results but could not recall which lab was result was abnormal. PM 2 stated that PM 1 reviewed Resident 1's lab results which indicated Resident 1's fasting blood glucose level was 351 mg/dL on 2/5/2026. PM 2 stated they instructed RN 1 to discontinue the D5W infusion. PM 2 stated RN 1 stopped the IV. PM 2 stated that PM 1, and FC 1 witnessed RN 1 stopping the IV when requested. PM 2 stated Resident 1 exhibited signs and symptoms consistent with hyperglycemia, including tachycardia, rapid respirations, and non-responsiveness. PM 2 stated Resident 1 was transported to GACH for a higher level of care at 4:38 PM. During an interview on 2/10/2026 at 12:14 PM with Registered Nurse (RN 2), RN 2 stated that Resident 1 had an IV infusing D5W at 60cc/hr per MD 1orders. RN 2 stated she was aware that Resident 1 had a history of type 2 DM and that Resident 1 BG were not being monitored because MD 1's orders did not indicate to monitor BG, and that Resident 1, and other residents who had a diagnosis of DM should be monitored. During a concurrent interview and record review on 2/10/2026 at 12:25 PM with RN 2, Resident 1 Nursing Notes dated 2/5/2026 at 10:11 AM was reviewed. RN 2 stated that LVN 1 had documented that Resident 1's stat (an abbreviation meaning immediately in medical context) laboratory (lab) result, which was a complete blood count (CBC) and comprehensive metabolic panel (CMP) dated 2/5/2026, were reported to MD 1 via text message using the facility's designated cellphone on 2/6/2026 during the 11 PM to 7 AM shift. RN 2 stated that the lab results dated 2/5/2026 had an abnormal lab value but could not recall which lab result it was since RN 2 had not reviewed the CBC and CMP lab results prior to sending the text message to MD 1 on 2/5/2026. RN 2 stated after she reviewed the Stat lab results, the results indicated Resident 1's fast blood glucose (a blood test measuring glucose levels after at least 8 hours without eating, usually in the morning) was 351 mg/dL. During the same interview on 2/10/2026 at 12:25 PM, RN 2 stated that on 2/8/2026, Resident 1 was awake and alert with an IV of D5W infusing at 60 cc per hour. RN 2 stated that she failed to identify or act upon Resident 1's (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	elevated blood sugar level lab result of 351 mg/dL dated 2/5/2026 while the D5W infusion was ongoing since 2/6/2026 because she did not review the stat lab results indicating a high fasting blood glucose level of 351 mg/dL. RN 2 further stated that RN 1 later observed that day on 2/8/2026, a change in Resident 1's condition, noting droopy eyes, non-responsiveness, and nonverbal behavior, but did not stop the D5W infusion or notify MD 1 at that time. During an interview on 2/10/2026 at 1 PM with RN 3, RN 3 stated that Licensed Vocational Nurse (LVN) 2, who was the night shift charge nurse did not endorse that Resident 1's fasting blood glucose lab result take on 2/5/2026 was high at 351 mg/dL prior to starting the IV infusion of D5W on 2/6/2026. RN 3 stated she was the nurse who received and reviewed the telephone order from MD 1 to start one of the 3 liters of D5W at 60 cc/hr for Resident 1 due to poor appetite. RN 3 stated that she started the IV D5W at around 7:30 AM on 2/6/2026. RN 3 stated she did not review Resident 1 abnormal fasting blood glucose lab result dated 2/5/2026. RN 3 stated she should have reviewed the stat lab results dated 2/5/2026 to see the abnormal lab findings of high blood glucose of 351 mg/dL. RN 3 stated Resident 1's signs and symptoms of hyperglycemia and blood sugar levels should have been monitored while at the facility, especially when the D5W started infusing on 2/6/2026. RN 3 stated that the IV D5W caused Resident 1's blood sugar level to increase. RN 3 stated that Resident 1 did not have any orders for blood sugar fingerstick monitoring since being admitted to the facility even when Resident 1 had a diagnosis of Type 2 DM. RN 3 stated that Resident 1 should have been monitored for fingerstick blood sugar levels and she should have clarified the DM monitoring parameters with MD 1. RN 3 stated she did not clarify the monitoring parameters for Resident 1's DM to ask how hypoglycemia and hyperglycemia would be monitored for Resident 1's Type 2 DM. During a concurrent interview and record review with the DON on 2/10/2026 at 2 PM, it was identified that Resident 1's facility cell phone communication to MD 1 on Friday, 2/6/2026 at 5:29 AM showed a screenshot of the STAT lab results, including the abnormal blood glucose level. The message was sent by RN 2 to MD 1 that read, MD 1, here are the STAT results of Resident 1's labs. The DON stated that MD 1 had responded on 2/6/2026 and texted an order to change Resident 1's IVF to D5W to infuse at 60cc/hr with a total of 3 Liters. The DON stated that the licensed nurses were following MD 1's order, but the order should have been clarified since Resident 1's fasting blood glucose lab result was high at 351 mg/dL. The DON stated that licensed nurses should have monitored Resident 1 for hyperglycemia while infusing D5W because the IVF D5W would cause Resident 1 to be hyperglycemic (a condition in which the level of glucose in the blood is higher than normal). The DON stated that the licensed nurses should have asked MD 1 or NP 1 for clarification as to why Resident 1 did not have fingerstick blood sugar monitoring for the diagnosis of Type 2 DM and documented the rationale (reason). The DON stated that there was no documentation on Resident 1's H&P, MD 1's or NP 1's progress notes from admission to readmission dates to indicate why Resident 1 did not receive blood sugar fingerstick monitoring at the facility and when the resident was receiving the D5W. The DON stated that by not monitoring Resident 1's blood sugar, the resident's glucose levels increased, resulting in the need for transfer to the GACH. During an interview on 2/10/2026 at 3:29 PM, LVN 1 stated that she received Resident 1's STAT CBC and CMP lab results, which included an abnormal value, on 2/5/2026. LVN 1 stated that she reported the abnormal lab result to MD 1 via a text message to MD 1's cell phone and also left a voicemail message on 2/6/2026. LVN 1 stated that she additionally faxed the lab results to MD 1's office. LVN 1 stated she documented that MD 1 was notified; however, she did not document indicating which lab result was abnormal or the specific abnormal value that was reported to MD 1. During a telephone interview on 2/11/2026 at 12 PM with RN 4, RN 4 stated that Resident 1 was readmitted from the GACH on 1/11/2026 at around 6 PM with diagnosis of Type 2 DM. RN 4 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	stated that he had spoken to MD 1 at 6:35 PM and verified all of Resident 1's GACH discharge orders. RN 4 stated MD 1 did not want to reorder Resident 1's fingerstick blood sugar monitoring before meals (AC) and at bedtime (HS), indicated in the GACH discharge instructions. RN 4 stated that MD 1 told RN 4 he would come to the facility on 1/12/2026 and assess and review the orders. RN 4 stated that he did not document in the nursing notes regarding the blood sugar monitoring not being reordered by MD 1 and the reason why it was not reordered. RN 4 stated he only documented that all the orders for Resident 1 were verified and carried out. RN 4 stated he did not know if MD 1 came and visited Resident 1 on 1/12/2026. During the same telephone interview on 2/11/2026 at 12 PM with MD 1, MD 1 stated that Resident 1's health was declining and had poor oral intake with weight loss. MD 1 stated Resident 1 had Type 2 DM but was controlled with oral medications and did not require blood sugar monitoring. MD 1 stated that when Resident 1 was readmitted to the facility on [DATE], MD 1 spoke with RN 3 and reviewed Resident 1's medication list and orders. MD 1 stated that he told RN 3 not to renew the fingerstick blood sugar monitoring for AC and HS and that he would assess and review Resident 1's the following day on 1/12/2026. MD 1 stated Resident 1's blood sugar level were at an acceptable level when Resident 1 was readmitted and did not require monitoring. MD 1 stated he did not document this plan in Resident 1's progress notes. MD 1 stated that the facility informed MD 1 on 2/6/2026 at 5:29 AM that Resident 1 STAT lab results had indicated that Resident 1's fasting blood glucose level was 351 mg/dL and he was in a hyperglycemic state. MD 1 stated that he ordered Resident 1 to receive 3 liters of D5W at 60cc/hr. MD 1 stated that Resident 1 needed nutrition because of his poor oral intake and the D5W was to provide nutrition. MD 1 stated he wanted to treat the poor nutrition with the D5W for comfort because Resident 1 was declining. MD 1 stated he was aware of the complications and what could happen while Resident 1 received D5W while in a hyperglycemic state, but MD 1 stated the priority for Resident 1 was nutrition and making Resident 1 comfortable. During a telephone interview on 2/11/2026 at 1:35 PM with NP 1, NP 1 stated that she worked with MD 1 and was managing the care of Resident 1. NP 1 stated that Resident 1 had a history of Type 2 DM. NP 1 stated that Resident 1 was not being monitored for fingerstick blood sugars and Resident 1's DM was being treated with oral hypoglycemic medications. NP 1 stated Resident 1's DM was monitored with random blood works such as the CBC and BMP but Resident 1 should have had a fingerstick blood sugar monitoring for AC & HS while at the facility because of his Type 2 DM. NP 1 stated she did not know that Resident 1's readmission orders on 1/11/2026 for fingerstick blood sugar monitoring for AC and HS was not reordered as indicated in the GACH discharge orders. NP 1 stated she had written an order for Normal Saline (NS) IV fluids 1 liter on 2/5/26 at around 11:30 AM for Resident 1's poor oral intake and hyponatremia (low sodium level) and did not know if that was carried out by licensed staff. NP 1 stated that she was unaware that Resident 1's fasting blood glucose level was 351 mg/dL from the STAT lab result on 2/5/2026 because no one informed her. NP 1 stated the licensed staff did not communicate to her that Resident 1 was receiving D5W IV fluids instead of the NS IV fluids she ordered on 2/5/2026. NP 1 stated that she would not have ordered D5W while Resident 1 was in a hyperglycemic state. NP 1 stated that the D5W would have caused Resident 1 to experience hyperglycemic shock (a life-threatening emergency marked by severely high blood sugar, extreme dehydration, and altered mental status) such as loss of consciousness, fast heart rate, and rapid breathing. NP 1 stated she was unaware that Resident 1 had a change in condition on 2/8/2026 and was hospitalized for altered level of consciousness (ALOC), oxygen desaturation and high blood sugar of 520 mg/dL. During an interview on 2/12/2026 at 1:07 PM with the facility's Medical Director (MD 2), MD 2 stated if a resident was left in a hyperglycemic state it would lead to a resident getting dehydrated (loss of bodily water), electrolyte (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	imbalance, ALOC, diabetic ketoacidosis (DKA - life threatening complication from high blood sugar) and acute renal failure (kidneys stop working). MD 2 stated that it is never a sound medical decision to keep any residents in a hyperglycemic state because the outcome would not benefit the resident and would lead to other serious medical issues. MD 2 stated that infusing D5W to Resident 1 while experiencing hyperglycemia would not provide nutritional value but further elevate Resident 1's blood glucose level and cause hyperglycemic shock. MD 2 stated that any resident with Type I or 2 DM needs to be monitored for fingerstick blood sugar AC and HS. During a review of the facility P&P titled Blood Glucose Monitoring for Diabetic Residents Experiencing COC undated, the P&P indicated that it is the policy of the facility to ensure safe monitoring and management of blood glucose levels for residents with diabetes mellitus who are experiencing a change of condition that may affect glycemic control. The P&P indicated blood glucose monitoring shall be performed via fingerstick in accordance with physician orders, nursing assessment, and recognized standards of nursing practice. The P&P indicated the facility recognizes that IV fluids containing dextrose, infections, decreased oral intake, medication changes, and other clinical conditions may significantly alter blood glucose levels and require increased monitoring. The P&P indicated the failure to monitor blood glucose in these situations may place residents at risk for hyperglycemia, hypoglycemia, dehydration, and hospitalization. The P&P indicated IV Therapy (Relevant to Glucose Monitoring) Includes but is not limited to: D5W and any dextrose-containing solution. The P&P indicated that the licensed nurse shall identify residents requiring blood glucose monitoring when the resident: Has a diagnosis of DM, is receiving IV therapy (especially dextrose-containing fluids), has a change of appetite or poor oral intake, has an active infection, has medication changes affecting glucose levels, exhibits symptoms of hypo or hyperglycemia and is NPO or has reduced nutritional intake. The P&P indicated that unless otherwise ordered by the physician. the licensed nurse shall initiate blood glucose monitoring when indicated by clinical condition, recommended monitoring frequency, Before meals and at bedtime (AC, HS), or Every 6 hours if not eating, or as ordered by physician. During a review of the facility P&P titled Diabetic Management undated, the P&P indicated that the facility will provide both preventive measures and treatment of complications pertaining to the management of residents with Diabetes Mellitus. The P&P indicated the facility will provide an overview of diabetes in the older adult, its symptoms and complications, and the principles of glucose monitoring. The P&P indicated that upon admission, physician's orders are received, which include blood glucose monitoring and anti-diabetic agents. The P&P indicated that blood glucose orders will include parameters of when to call the physician if the glucose is too low or too high. The P&P indicated that hyperglycemia, uncontrolled diabetes from lack of insulin or inadequate insulin results in hyperglycemia. The P&P indicated that the facility would follow the provider orders for blood glucose monitoring. Examples for various situations may include: for the resident on oral medication(s) who is well controlled, monitor blood glucose levels at least twice weekly (or more frequently if there is a change in drugs or drug dosages) for the resident receiving oral medication(s) who is poorly controlled: monitor blood glucose levels twice to four times daily as needed.

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	055288	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Health Care Center	430 N.Glendale Ave Glendale, CA 91206

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that the resident's authorized practitioners (Medical Doctor [MD] 1 and Nurse Practitioner [NP] 1) adequately supervised and managed the medical care of Resident?1 as required under physician services for one of three sampled residents. The facility failed to: 1. Ensure licensed nursing staff and MD 1 reviewed and addressed the General Acute Care Hospital (GACH) discharge orders, including the need to reorder fingerstick blood sugar monitoring (AC & HS) upon readmission for Resident 1 with Type 2 Diabetes Mellitus (DM) at the facility on 1/11/2026. 2. Ensure that MD?1's verbal decision to the licensed nursing staff to discontinue the GACH discharge order for blood sugar monitoring for Resident?1 upon readmission on [DATE]-despite the resident's uncontrolled diabetes and risk for unstable blood glucose levels-and the rationale for this decision were documented in the medical record and communicated to NP 1. 3. Ensure the physician or practitioner responsible for the resident's care (MD?1 and NP?1) documented all assessments, clinical reasoning, treatment decisions, and licensed staff communications throughout the resident's stay, in accordance with the facility's policy and procedure titled Physician Services. 4. Ensure effective communication occurred among MD 1, NP 1, and licensed nursing staff regarding Resident?1's DM management, DM care plan titled Risk for unstable blood glucose levels ([low blood sugar] and [high blood sugar]), change in condition, critical laboratory results, and ordered treatments (from NP 1 and MD 1). 5. Ensure MD?1 communicate to NP?1 his treatment plan that Resident?1 was intentionally left without blood sugar monitoring while in a hyperglycemic state on 2/6/2026 to 2/8/2026, upon ordering D5W to be administered intravenously for nutrition, leaving NP 1 unaware of the resident's condition and treatment needs. These failures resulted in Resident?1 not receiving required monitoring and timely intervention for hyperglycemia, being administered D5W IV fluids while in a hyperglycemic state, and experiencing a significant decline in condition, including altered level of consciousness, oxygen desaturation, and critically elevated blood glucose levels requiring hospitalization. Findings: During a review of Resident 1's diabetes care plan titled Risk for Unstable Blood Glucose Level (low and high blood sugar levels), initiated during Resident 1's initial admission at the facility dated 12/11/2025 with a goal date of 3/31/2026, the care plan indicated that Resident 1 should be checked for blood glucose (BG) if the level is below 70 mg/dL, and that if the resident is unconscious or vital signs are absent, staff should administer 1 milligram (mg) of Glucagon (a medication used to increase BG) intramuscularly (IM) and call 911. The care plan did not address how the licensed nurses would measure Resident 1's blood glucose levels to determine if they were below 70 mg/dL. The care plan interventions further indicated to observe for signs and symptoms (S/S) of high blood glucose levels and report observed S/S to the physician. During a review of Resident 1's General Acute Care Hospital (GACH) Records titled Orders Re-Cap (short for recapitulation that means to summarize the main points of something that has already been discussed or happened) dated 1/11/2026, the Recap indicated to renew (extend validity) Resident 1's fingerstick blood sugar before meals (AC-[ante-cebum which means before meals]) and at bedtime (HS -[hour of sleep]). The GACH records indicated that Resident 1 also had blood sugar checks as needed. The GACH records indicated to notify the physician when the blood sugar was greater than 250 mg/dL, and when the blood sugar was less than 70 mg/dL and to implement hypoglycemia protocol. During a review of Resident 1's admission Record (AR), the AR?indicated?Resident 1 was readmitted to the facility on [DATE], with diagnoses of Type 2 DM and sepsis (a life-threatening medical emergency from an infection). During a review of Resident 1's History and Physical (H&P) signed and dated on 1/26/2026 signed by NP 1 indicated (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1 did not have the capacity to understand and make decisions. The H&P indicated that Resident 1's Type 2 DM required monitoring. During a review of Resident 1's Physician Order Report dated 1/1/2026 to 1/31/2026, indicated that Resident 1 was to be monitored for signs and symptoms of hypoglycemia such as dizziness, confusion and restlessness 3 times a day starting on 1/11/2026. The order report did not indicate to monitor Resident 1 BG level with fingerstick AC & HS or to monitor for hyperglycemia. During a review of Resident 1's Nursing Progress Note dated 1/11/2026 at 6:35 PM, the Note indicated that Registered Nurse (RN) 4 notified Resident 1's attending physician Medical Doctor (MD 1) regarding Resident 1's readmission to the facility on 1/11/2026. The Note indicated Resident 1's Physician Orders were verified and carried out. There is no documented evidence that RN 4 verified with MD 1 whether Resident 1 required continued fingerstick testing to establish baseline blood sugar levels in order to manage the resident's diabetes. During a review of Resident 1's Physician Order Report from 1/11/2026 to 1/31/2026, the Report indicated that Resident 1 was to be monitored for signs and symptoms of hypoglycemia such as dizziness, confusion and restlessness three times a day starting on 1/11/2026. The physician's orders did not include instructions to monitor the resident's blood sugar levels by performing fingerstick tests AC and HS, nor did they include instructions to monitor for signs and symptoms of hyperglycemia as reflected in the resident's GACH records. During a review of Resident 1's Physiatry (physical medicine and rehabilitation) Progress Note dated 1/14/2026 at 1:41 PM, The Note indicated to monitor and evaluate obstacles to therapy including hypoglycemia. During a review of Resident 1' Nursing Progress Note dated 2/8/2026 at 3:55 PM, the Note indicated that Resident 1 had a change of condition (COC - a significant change in residents health) that Resident 1 was non-verbal, respirations were shallow, oxygen saturation was 87% (% - unit of measurement - normal range 95 - 100%), respiratory rate was 33 breaths per minute (bpm - unit of measurement - normal range 12 - 20 bpm), temperature was 100.7 ? (? - unit of measurement - normal range 97? to 99?), heart rate (HR) was 133 beats per minute (bpm - unit of measurement - normal range 60 - 100 bpm), BG level was 463 mg/dL, Resident 1 was administered oxygen at 15 L via non-rebreather (Face-mask for oxygen delivery) and the oxygen saturation (measures the percentage of hemoglobin in red blood cells carrying oxygen, indicating how well blood is transporting oxygen throughout the body) was at 95%. During a review of Resident 1's entire records and validated with the Medical records supervisor and administrator, there were only three documented provider visits for the resident's stay at the facility from 12/11/2025 to 2/8/2026. The documented visits were identified as one H&P signed and dated by NP 1 on 12/14/2025 and another H&P signed and dated by NP 1 again, as well as one handwritten progress note authored and signed by NP 1 dated 2/5/2026. NP 1's H&Ps and Progress Notes with date that included 2/5/2026 indicated there was no documentation about how Resident 1's blood sugar monitoring should be performed by the licensed nurses, including a coordination with MD 1 about the plan not to monitor Resident 1's blood sugar via fingerstick as indicated in the GACH Discharge Instructions dated 1/11/2026. During a review of Resident 1's Situation, Background, Assessment, Recommendation (SBAR - a communication tool to relay health information) dated 2/8/2026, the SBAR indicated that Resident 1 was non-verbal, respirations were shallow, oxygen saturation was 87%, respiratory rate was 33 beats per minute, temperature was 100.7 Fahrenheit (?), heart rate was 133 bpm, BG level was 463 mg/dL. The SBAR indicated Resident 1 was administered oxygen at 15 L via non-rebreather, head of bed was elevated, and the oxygen saturation was at 95%. During a review of Resident 1' Nursing Progress Note dated 2/8/2026 at 4:10 PM, the Note indicated that the paramedic's (emergency responders)/911 (emergency services) was called. During a review of Resident 1's Paramedic Run Report dated 2/8/2026, the Report indicated that Paramedic's arrive at the facility at 4:16 PM and Resident 1 (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had an altered level of consciousness (ALOC), was not responding to his name. The Report indicated D5W IVF was discontinued due to Resident 1's high BG level of 530 mg/dL, and the electrocardiogram (devise to measure heart rhythm) indicated Resident 1 had sinus tachycardia regular, rapid heartrate) at 130 bpm, respiratory rate was 32 with labored breathing and Resident 1 was hot to touch with a temperature of 101?. During a review of Resident 1's GACH Records title Emergency (ED) Department Notes dated 2/8/2026, authored by the ED Physician the GACH record indicated that Resident 1 was admitted for altered level of consciousness, fever and hyperglycemia on 2/8/2026. The ED Notes indicated Also notably patient had a blood sugar of 350 [mg/dL] which they [facility licensed nurses] treated with dextrose. EMS [emergency medical services] decided to bring him [Resident 1] here [GACH] for further evaluation and management . The ED report indicated Resident 1's fingerstick blood sugar result taken at 4:35 PM was 530 mg/dL and 434 mg/dL at 4:55 PM. Resident 1's urine glucose level indicated high taken at 2/8/2026 timed at 6:22 PM. During an interview on 2/10/2026 at 12:14 PM with Registered Nurse (RN 2), RN 2 stated that Resident 1 had an IV infusing D5W at 60cc/hr per MD 1orders. RN 2 stated she was aware that Resident 1 had a history of type 2 DM and that Resident 1 BG were not being monitored because MD 1's orders did not indicate to monitor BG, and that Resident 1, and other residents who had a diagnosis of DM should be monitored. During a concurrent interview and record review with the DON on 2/10/2026 at 2 PM, the DON stated that MD 1 had responded on 2/6/2026 and texted an order to change Resident 1's IVF to D5W to infuse at 60cc/hr with a total of 3 Liters. The DON stated that the licensed nurses were following MD 1's order, but the order should have been clarified since Resident 1's fasting blood glucose lab result was high at 351 mg/dL . The DON stated that the licensed nurses should have asked MD 1 or NP 1 for clarification as to why Resident 1 did not have fingerstick blood sugar monitoring for the diagnosis of Type 2 DM and documented the rationale (reason). The DON stated that there was no documentation on Resident 1's H&P, MD 1's or NP 1's progress notes from admission to readmission dates to indicate why Resident 1 did not receive blood sugar fingerstick monitoring at the facility and when the resident was receiving the D5W. The DON stated that by not monitoring Resident 1's blood sugar, the resident's glucose levels increased, resulting in the need for transfer to the GACH. During a telephone interview on 2/11/2026 at 12 PM with RN 4, RN 4 stated that Resident 1 was readmitted from the GACH on 1/11/2026 at around 6 PM with diagnosis of Type 2 DM. RN 4 stated that he had spoken to MD 1 at 6:35 PM and verified all of Resident 1's GACH discharge orders. RN 4 stated MD 1 did not want to reorder Resident 1's fingerstick blood sugar monitoring before meals (AC) and at bedtime (HS), indicated in the GACH discharge instructions. RN 4 stated that MD 1 told RN 4 he would come to the facility on 1/12/2026 and assess and review the orders. RN 4 stated that he did not document in the nursing notes regarding the blood sugar monitoring not being reordered by MD 1 and the reason why it was not reordered. RN 4 stated he only documented that all the orders for Resident 1 were verified and carried out. RN 4 stated he did not know if MD 1 came and visited Resident 1 on 1/12/2026. During the same telephone interview on 2/11/2026 at 12 PM with MD 1, MD 1 stated that Resident 1's health was declining and had poor oral intake with weight loss. MD 1 stated Resident 1 had Type 2 DM but was controlled with oral medications and did not require blood sugar monitoring. MD 1 stated that when Resident 1 was readmitted to the facility on [DATE], MD 1 spoke with RN 3 and reviewed Resident 1's medication list and orders. MD 1 stated that he told RN 3 not to renew the fingerstick blood sugar monitoring for AC and HS and that he would assess and review Resident 1's the following day on 1/12/2026. MD 1 stated Resident 1's blood sugar level were at an acceptable level when Resident 1 was readmitted and did not require monitoring. MD 1 stated he did not document this plan in Resident 1's progress notes. MD 1 stated that the facility informed MD (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 on 2/6/2026 at 5:29 AM that Resident 1 STAT lab results had indicated that Resident 1's fasting blood glucose level was 351 mg/dL and he was in a hyperglycemic state. MD 1 stated that he ordered Resident 1 to receive 3 liters of D5W at 60cc/hr. MD 1 stated that Resident 1 needed nutrition because of his poor oral intake and the D5W was to provide nutrition. MD 1 stated he wanted to treat the poor nutrition with the D5W for comfort because Resident 1 was declining. MD 1 stated he was aware of the complications and what could happen while Resident 1 received D5W while in a hyperglycemic state, but MD 1 stated the priority for Resident 1 was nutrition and making Resident 1 comfortable. During a review of Resident 1's physician progress notes. There was no progress notes found written by MD 1 during Resident 1's stay at the facility from 1/11/2026 to 2/8/2026. There was no progress note documented on MD 1 on 1/12/2026 as indicated in the above interview that Resident 1 would be visited by MD 1 and assessed on 1/12/2026. During a phone interview on 2/11/2026 at 1:35 PM with Nurse Practitioner (NP) 1, NP stated that she worked with MD 1 and was managing the care of Resident 1. NP stated that Resident 1 had a history of type 2 DM. NP stated that Resident 1 was not being monitored for BG with fingerstick and Resident 1 DM was being treated with oral hypoglycemic medication. NP stated Resident 1 DM was monitored with random blood work such as the CBC and BMP but Resident 1 should have had BG monitoring for AC & HS because of his type 2 DM. NP stated she was unaware of Resident 1 readmission order for BS monitoring for AC and at bedtime was not reordered. Mg/dL. During a telephone interview on 2/11/2026 at 1:35 PM with NP 1, NP 1 stated Resident 1's DM was monitored with random blood works such as the CBC and BMP but Resident 1 should have had a fingerstick blood sugar monitoring for AC & HS while at the facility because of his Type 2 DM. NP 1 stated she did not know that Resident 1's readmission orders on 1/11/2026 for fingerstick blood sugar monitoring for AC and HS was not reordered as indicated in the GACH discharge orders. NP 1 stated she had written an order for Normal Saline (NS) IV fluids 1 liter on 2/5/26 at around 11:30 AM for Resident 1's poor oral intake and hyponatremia (low sodium level) and did not know if that was carried out by licensed staff. NP 1 stated that she was unaware that Resident 1's fasting blood glucose level was 351 mg/dL from the STAT lab result on 2/5/2026 because no one informed her. NP 1 stated the licensed staff did not communicate to her that Resident 1 was receiving D5W IV fluids instead of the NS IV fluids she ordered on 2/5/2026. NP 1 stated that she would not have ordered D5W while Resident 1 was in a hyperglycemic state. NP 1 stated that the D5W would have caused Resident 1 to experience hyperglycemic shock (a life-threatening emergency marked by severely high blood sugar, extreme dehydration, and altered mental status) such as loss of consciousness, fast heart rate, and rapid breathing. NP 1 stated she was unaware that Resident 1 had a change in condition on 2/8/2026 and was hospitalized for altered level of consciousness (ALOC), oxygen desaturation and high blood sugar of 520 mg/dL. During an interview on 2/12/2026 at 1:07 PM with the Medical Director (MD 2), MD 2 stated that it is never a sound medical decision to keep any residents in a hyperglycemic state because the outcome would not benefit the resident and would lead to other serious medical issues. MD 2 stated that infusing D5W to Resident 1 while experiencing hyperglycemia would not provide nutritional value but further elevate Resident 1's blood glucose level and cause hyperglycemic shock. MD 2 stated that any resident with type I or 2 DM needs to be monitored for BG AC & HS. During a review of the facility's P&P titled Physician Services (undated), the P&P indicated physician services included but not limited to the following: A medical evaluation of the resident and review of orders for care and treatment, resident diagnoses and plan of care, advice, treatment, and determination of appropriate level of care needed for each resident, progress notes and other appropriate entries in the resident's medical record. The P& P further indicated that the resident's plan of care (including medication and treatments) must be (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed at each required visit. The P& P further indicated that the physician who uses the services of an NP . agrees to ensure the physician make the initial visit and may alternate subsequent required visits with the delegate (NP) ad agrees to be bound by all policies, procedures, rules, and regulations covering physician services During a review of the facility P&P titled Physician Order (undated), indicated that the physician orders are obtained to provide a clear direction in the care of the resident. The P&P indicated upon receipt of a discontinuation order, the licensed nurse must transcribe the order (This applies to discontinuation of medication and/or treatment) and the licensed nurse makes notation of discontinuation by writing the following on the MAR, TAR, and any other pertinent document.