

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055662	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Bethany Home Society San Joaquin County		STREET ADDRESS, CITY, STATE, ZIP CODE 930 West Main Street Ripon, CA 95366	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an environment free of accident hazards and adequate supervision for 2 of 22 sampled residents (Resident 17 and Resident 22) when: 1. A fall (floor) mat remained on the floor next to Resident 17's bed while Resident 17 was up in a wheelchair; and, 2. On 7/8/26 Resident 43 approached Resident 22 and touched Resident 22's personal blanket wrapped around her shoulders. Resident 22 then swatted at Resident 43's hand to remove Resident 43's hand, and Resident 43 picked up a box of gloves and hit Resident 22 on the right shoulder with the box of gloves. These failures created an obstacle that interfered with Resident 17's ability to self-propel the wheelchair close to the bed and increased the risk of a fall while attempting to propel over or around the fall mat and had the potential to cause physical injury and psychosocial distress to Resident 22. Findings: 1. Review of Resident 17's admission RECORD indicated Resident 17 was admitted to the facility with dementia (memory loss and problems with thinking), abnormalities of gait and mobility (difficulty walking and moving), weakness, and lumbar spinal stenosis with neurogenic claudication (narrowing of the lower spine that caused leg pain and weakness with walking). Review of Resident 17's Brief Interview for Mental Status, (BIMS - to assess a resident's thinking and memory) dated 6/19/26 indicated Resident 17's BIMS score was 6, which reflected severe cognitive impairment (13 through 15 = Intact, 8 through 12 = Moderate Impairment, 0 through 7 = Severe Impairment). During a concurrent observation and interview on 7/15/26 at 8:48 AM in Resident 17's room, Resident 17 sat in a wheelchair while a fall mat remained on the floor next to the left side of the bed. The right side of the bed was against the wall. Resident 17 self-propelled the wheelchair in the room and stated he did not want the fall mat on the floor next to his bed because it made it hard to move around the room and get close to the bed. During a concurrent observation and interview on 7/15/26 at 8:55 AM with Certified Nursing Assistant (CNA) 5 in Resident 17's room, Resident 17 remained in the wheelchair while the fall mat remained on the floor next to the bed. CNA 5 confirmed Resident 17 was a fall risk and that the fall mat was on the floor while Resident 17 was not in bed. During a concurrent observation and interview on 7/15/26 at 11:00 AM with the Assistant Director of Nursing (ADON) in the hallway, Resident 17 self-propelled the wheelchair about 150 feet from Resident 17's room without assistance while the fall mat remained on the floor in Resident 17's room next to Resident 17's bed. The ADON confirmed Resident 17 was not in bed and the fall mat remained on the floor next to Resident 17's bed. During a concurrent interview and record review on 7/16/26 at 8:45 AM with ADON, Resident 17's fall care plan, initiated on 11/22/22 and FALL RISK FORM V [version] 5.2, dated 3/13/26, were reviewed. Resident 17's fall care plan, in the section titled, Problem, indicated, . [Resident 17] AT RISK FOR FALLS. In the section titled Interventions, indicated, .place floor mat by bedside when in bed, monitor q [every] shift for placement. The ADON (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated staff did not implement the care plan intervention to place the fall mat by the bedside only while Resident 17 was in bed because the fall mat remained on the floor while Resident 17 was not in bed. The ADON stated there was no monitoring process that was documented on paper, rather the nursing staff would do visual checks. Resident 17's FALL RISK FORM V [version] 5.2, indicated Resident 17 was at high risk for falls. The ADON stated leaving the fall mat on the floor while Resident 17 was in the wheelchair and not in bed created a safety hazard, especially because Resident 17 was assessed as being at high risk for falls. The ADON stated Resident 17 could push against the fall mat while trying to move closer to the bed, slide out of the wheelchair, and fall. The ADON further stated staff were expected to implement the interventions in the care plan to maintain resident safety. Review of the facility's policy and procedure (P&P) titled, Fall Prevention Program Policy and Procedure, revised in 11/2023, indicated .to increase staff awareness and sensitivity to the potential for accidents within the facility through an ongoing education program addressing hazards in the environment [things in the surroundings that could cause injury]. Factors taken into consideration for evaluating and preventing falls may include. Hazards in the environment. Arrhythmias [irregular heartbeats]. Lack of conditioning [poor physical strength]. Gait disturbance [difficulty walking]. History of falls. Cognition [thinking and memory]. Fall risk screening tools, such as the Morse Fall Risk [fall risk assessment tool], BIMS score. Safety measures will be included in the plan of care for residents identified as having fall risks. 2. A review of Resident 22's minimum data set (MDS -a resident assessment and screening tool which identifies care needs) dated 7/22/26, under section titled, .Section C: Cognitive Patterns, - (an assessment of the mental abilities and functions the brain uses to think, learn, remember, pay attention, process information and solve problems) indicated Resident 22's Brief Interview for Mental Status (BIMS - a screening tool used in long-term care to assess a resident's cognitive function [the mental processes like thinking, memory, and perception, that a person uses to understand and respond to their environment]) was 03 out of 15 which indicated Resident 22 had severe cognitive impairment (a significant decline in mental abilities including memory). A review of Resident 22's Care Plan (a roadmap that details an individual's health needs, goals, and steps required by healthcare to achieve the goals) titled, .[Resident 22] I HAVE DX [diagnosis] OF DEMENTIA., revised 10/30/25, indicated, .I WILL REMAIN COMFORTABLE AND SECURE IN MY ENVIRONMENT. I AND MY FAMILY HAVE BEEN SCREENED FOR PAST TRAUMATIC EVENTS THAT MAY STILL AFFECT ME. I HAVE EXPERIENCED SOME TRAUMATIC EVENTS. STAFF WILL OBSERVE FOR AND REPORT ANY SIGNS OF DEPRESSION OR ANXIETY. During an interview on 7/14/26 at 10:03 AM, in Resident 22's room, when asked if Resident 22 recalled the incident with another resident last week, Resident 22 stated she had an encounter with a lady that was undone in the brain. Resident 22 further stated she had to swat Resident 43's hand away from her belongings. Resident 22 was unable to recall any other events related to the incident. Resident 22 was unable to answer whether she felt safe in the facility. During an interview on 7/17/26 at 9:32 AM, with Activities Assistant (AA), the AA stated that on 7/8/26 around 6:30 PM in the evening, she left the residents alone in the East dining room, including Resident 22 and Resident 43, who were gathered for an activity, to retrieve another resident. The AA further stated upon return she observed that Resident 43 had roamed in her wheelchair over to where Resident 22 sat and was observed touching Resident 22's blanket that was draped around Resident 22's shoulders. The AA explained she observed Resident 22 swat Resident 43's hand away. The AA added Resident 43 picked up the box of gloves that was in her lap and hit Resident 22 with the box on Resident 22's right shoulder. The AA stated that there were no other witnesses since the other residents were watching television and faced a different direction. The AA stated immediately after Resident 22 was smacked on the shoulder, Resident 22 became (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	upset and grabbed her mouth with her hands. The AA explained Resident 22 calmed down after Resident 43 was removed from the room. The AA stated she was the only staff in the East Dining room. The AA further stated Resident 43 had previously hit another resident in the same East Dining room on 4/1/26 that the AA had also witnessed. The AA stated Resident 43 needed to be watched closely because she was unpredictable, fast, and roamed in her wheelchair. The AA added that Resident 43 was known to invade the space of other residents. The AA explained that Resident 43 was known to be up close and personal by touching staff and residents, usually in an innocent way, but added that sometimes other residents did not like having their personal space invaded. The AA stated the incident could have possibly been prevented if another staff member was in the room and the residents had not been left alone. During an interview on 7/16/26 at 9:25 AM, with Licensed Nurse (LN) 1, LN 1 confirmed the AA reported the physical abuse to her after it occurred on 7/8/26. LN 1 stated after the residents were separated both Resident 22 and Resident 43 were checked for injuries. LN 1 stated Resident 43 was agitated after the incident and Resident 22 was upset after the incident occurred. LN 1 explained when she attempted to interview the residents after the incident neither resident was able to verbalize what happened. LN 1 explained Resident 43 had previous aggressive behaviors with other residents, but that Resident 22 had not. During a concurrent observation and interview on 7/16/26 at 4:24 PM at the East Dining Room with Licensed Nurse (LN) 2, LN 2 stated Resident 43 was currently being monitored for aggression and irritability. LN 2 added that sometimes Resident 43 could become tearful and refuse care and had more aggressive behaviors in the evenings. LN 2 explained Resident 43 was very mobile in her wheelchair and was known to swat at other residents. LN 2 added that Resident 43 was known to be touchy feely and the staff were supposed to monitor Resident 43 closely when she was with other residents. At 4:34 PM LN 2 and this writer observed Resident 43 move quickly towards another resident in the East dining room. LN 2 stated she needed to intervene because she knew this resident did not like to be touched by Resident 43. Resident 43 was observed moving her wheelchair as close to this resident as possible. At that time, LN 2 intervened and redirected Resident 43 back to her table in the East dining room. During an interview on 7/17/26 at 9:21 AM, with the Social Services Director (SSD), the SSD confirmed she was aware of the incident between Resident 22 and Resident 43 and completed the investigation. The SSD stated that Resident 43 was known to have behaviors of aggression and the incident on 7/8/26 was not her first one. The SSD added that Resident 43 likes to be comforted by touching when she was upset. The SSD also added that Resident 22 liked her personal space and was very emotional at times. The SSD stated the incident could have been prevented if staff were present and kept a closer eye on Resident 43 when she was in the East dining room. During an interview with the Administrator (ADM) on 7/17/26 at 3 PM, the ADM confirmed that the incident that occurred between Resident 43 and Resident 22 physically hit each other, leading their facility to report it to the Department per Federal and State guidelines. A review of Resident 43's admission RECORD, indicated Resident 43 was admitted to the facility with diagnoses including encephalopathy (an umbrella term for any disease, damage, or malfunction that affects the brain function), dementia, depression, and anxiety (an emotional state that includes feelings of tension, worried thoughts, and physical changes). A review of Resident 43's MDS dated [DATE], under section titled, .Section C: Cognitive Patterns, indicated Resident 22's BIMS was 01 out of 15 which indicated Resident 22 had severe cognitive impairment. A review of Resident 43's Order Summary Report, dated 7/17/26, an order from Resident 43's physician dated, 12/3/25, indicated, .monitor [Resident 43] for aggressive behaviors such as: yelling, striking out, hitting and punching. every shift. A review of Resident 43's BEHAVIORS, monitoring schedule for May 2026 revealed out of 93 opportunities, Resident 43 had 21 documented (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed behaviors related to aggression, with 5 blank/undocumented boxes.A review of Resident 43's BEHAVIORS, monitoring schedule for June 2026 revealed out of 90 opportunities, Resident 43 had 30 documented observed behaviors related to aggression, with 7 blank/undocumented boxes.A review of Resident 43's BEHAVIORS, monitoring schedule for July 1, 2026, through July 16, 2026, revealed out of 48 opportunities, Resident 43 had 10 documented observed behaviors related to aggression, with 2 blank/undocumented boxes.A review of Resident 43's Progress Notes, dated 4/2/26 at 3:09 PM, by the Assistant Director of Nursing (ADON), indicated, .On 4/1/26 [Resident 43] was noted tearful in her usual spot in the East dining room. Resident suddenly propelled her wheelchair toward another resident and started yelling at the resident. When the Activity Staff attempted to remove her, [Resident 43] slapped the other resident on his left shoulder.IDT recommendations: monitor resident for aggressive behaviors.A review of Resident 43's care plan titled, I have increased behaviors in the evening. I have potential to be physically/verbally aggressive r/t [related to] Poor impulse control. dated 1/16/26, indicated under the section titled, Goal, .I will demonstrate effective coping skills through the review date.I will not harm self or others.Interventions.Analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document.Assess and anticipate [Resident 43's] needs: food, thirst, toileting needs, comfort level, body positioning.My triggers for physical aggression are being overly tired.A review of the facility provided policy and procedure titled, Freedom from Abuse, Neglect, Exploitation., revised 1/28/2019, indicated, .Each resident has the right to be free from abuse.Residents must not be subjected to abuse by anyone including.other residents.Physical abuse means assault, battery.this includes.hitting, slapping, punching, biting, or kicking.pinching, spanking, slapping of hands, flicking, or hitting with an object.All residents of [name of facility] shall be free from verbal, mental, sexual, physical abuse, and corporal punishment.staff will identify, correct and intervene in situations in which abuse.is likely to occur. This also includes the identification, ongoing assessment, care planning for appropriate intervention and monitoring of residents with needs and behaviors which might lead to conflict.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on observation, interview, and record review, the facility failed to implement trauma-informed care (a framework that recognizes the widespread impact of trauma and actively avoids re-traumatization) for 1 of 22 sampled residents (Resident 71), when Resident 71's trauma history and trauma triggers were not reassessed and staff failed to collaborate with Resident 71, her family, friends, and/or any other health care professionals (such as psychologists, mental health professionals) to develop and implement individualized interventions to avoid re-traumatization after the staff learned that her bed alarm triggered memories of the resident's childhood house fire. This failure resulted in repeated episodes of re-traumatization, fear, emotional distress, anxiety, agitation, and aggressive behaviors for Resident 71. Findings: A review of Resident 71's admission RECORD, indicated Resident 71 was admitted to the facility with diagnoses including dementia (memory loss and problems with thinking, and decision making), anxiety disorder, disorientation (confusion about time, place, or person), and need for assistance with personal care. Review of Resident 71's Brief Interview for Mental Status, (BIMS - an assessment of thinking and memory) dated 6/18/26, indicated Resident 71 had a BIMS score of 4, which reflected severe cognitive impairment (13 through 15 = Intact, 8 through 12 = Moderate Impairment, 0 through 7 = Severe Impairment). A review of Resident 71's Progress Notes, dated 4/21/26 through 6/19/26 were reviewed as follows: -The progress notes dated 4/21/26, at 2:50 PM, indicated Resident 71 returned to the facility from the hospital at approximately 2:08 PM following a left femur (thigh bone) surgery on 4/19/26. Resident 71's daughter requested a personal safety alarm on the bed for the resident's safety. The notes indicated Resident 71's mood was pleasant with some agitation observed. -The progress notes dated 4/22/26, at 5:30 PM, indicated that during dinner, Resident 71 was removing the hospital gown, safety alarm, and brief, and Resident 71 attempted to hit staff. -The progress notes dated 4/22/26, at 6:48 PM, indicated that at approximately 5:10 PM the same day, Resident 71 yelled for help, stated she was on fire, removed her personal alarm and gown, and struck staff while staff attempted to calm her. -The progress notes dated 4/23/26, at 8 AM, indicated Resident 71 refused to participate in the BIMS assessment and exhibited increased confusion. -The progress notes dated 4/23/26, at 2:58 PM, indicated that while staff were providing care, the bed alarm was activated and Resident 71 became agitated and yelled, Fire, and yelled for staff to call her daughter because it was hot. -The progress notes dated 4/23/26, at 5:43 PM, indicated Resident 71 removed the bed alarm and became agitated when it sounded. Resident 71's daughter informed staff that Resident 71's childhood home burned down when Resident 71 was a child and that the sound of the bed alarm reminded Resident 71 of the fire alarm heard during the childhood fire. -The progress notes dated 5/11/26, at 7:45 PM, indicated Resident 71 yelled, Fire, fire, help me, call the fire department. Resident 71 was inconsolable and became aggressive towards staff. -The progress notes dated 6/1/26, at 10:13 PM, indicated that at approximately 8 PM the same day, Resident 71 opened the door at the end of the hallway, attempted to leave, and expressed concern that there was a fire. Resident 71 was not consolable. -The progress notes dated 6/19/26, at 9:26 AM, indicated Resident 71 stated she occasionally felt down and depressed while staff were assessing Resident 71 for discharge. During an interview on 7/17/26, at 9:18 AM, with Resident 71's Responsible Party (RP), the RP stated Resident 71's childhood home burned down when Resident 71 was 3 years old. The RP stated the sound of the bed alarm reminded Resident 71 of the childhood fire and that the RP had shared this information with staff. During a concurrent interview and record review on 7/15/26, at 9:48 AM, with the Social Services Director/Activities Director (SSD/AD), Resident 71's TRAUMA INFORMED SOCIAL HISTORY FORM, dated 4/22/26, completed at [hospital (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	name] was reviewed. Resident 71's TRAUMA INFORMED SOCIAL HISTORY FORM, indicated Resident 71 had no history of an adverse childhood event, no history of post-traumatic stress disorder (PTSD, a mental health condition that develops after experiencing or witnessing a terrifying life-threatening event), and no additional information shared by the Responsible Party. The SSD/AD confirmed the TRAUMA INFORMED SOCIAL HISTORY FORM, inaccurately documented that Resident 71 had no history of childhood trauma or PTSD despite Resident 71 exhibiting agitation, anxiety, and aggression related to the childhood house fire, which could indicate PTSD. The SSD/AD stated staff were expected to report trauma-related behaviors so the TRAUMA INFORMED SOCIAL HISTORY FORM, could be updated by the facility and appropriate trauma-informed interventions added to the resident's care plan. The SSD/AD further stated that an inaccurate TRAUMA INFORMED SOCIAL HISTORY FORM, could affect the resident's emotional well-being, sense of safety, and psychosocial needs (emotional and social needs). During a concurrent interview and record review on 7/15/26, at 10:05 AM, with the Assistant Director of Nursing (ADON), Resident 71's current care plan and progress notes, dated 4/2026 through 6/2026 were reviewed. The ADON stated the care plan did not include interventions addressing Resident 71's childhood house fire or the bed alarm as the identified trauma trigger. The ADON confirmed Resident 71's progress notes dated 4/21/26 through 6/19/26 documented repeated episodes of agitation, anxiety, and aggression triggered by the bed alarm after staff learned of Resident 71's childhood house fire. The ADON stated staff failed to reassess the resident's trauma history and develop trauma-informed care plan interventions, resulting in repeated trauma-triggered behaviors. The ADON further stated staff were expected to notify the SSD/AD so the trauma history could be reassessed to prevent recurrent behaviors, emotional distress, re-traumatization, and potential safety risks, including falls. Review of the facility's policy and procedure titled, Trauma Informed Care, revised on 11/18/19, indicated .[Facility Name] shall continue to improve systems for ensuring person-centered care for each resident by including trauma informed care principles in to each individualized plan of care.to provide comprehensive, person-centered care to assess each resident during pre-admission, admission and post admission time periods for history of any type of trauma as well as triggers which may cause re-traumatization.For those residents already in the care of [Facility Name], staff will make a good-faith effort to interview residents and or their representatives, regarding history of trauma, known triggers and historically effective methods of de-escalation for the individual.Care plans may be updated at such time that other information is made available.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview, and record review, the facility failed to ensure 1 of 22 sampled residents (Resident 37) was free of significant medication errors (one which could jeopardize the residents health and safety) when on 7/4/26, Resident 37 was administered a short acting insulin (insulin, a hormone produced by the pancreas that acts like a key so the body can absorb sugar [glucose] from the blood) instead of a long acting insulin. (Short acting insulin's onset occurs within one hour, peaks between two to four hours and has a duration of action up to eight hours. Long-acting insulin provides a steady, consistent release of insulin into the bloodstream for 24 hours or longer and maintains stable blood sugar levels between meals and overnight). This failure contributed to Resident 37 being sent out to a hospital for treatment and monitoring. In addition, this failure had the potential to result in seizures (a sudden, uncontrolled surge of electrical activity in the brain), aspiration (choking), altered mental status (confusion), and/or symptomatic hypoglycemia (when blood sugar drops below 70 mg/dL [mg/dL, a unit of measurement]) which includes, shakiness, sweating, rapid heartbeat, blurred vision, loss of consciousness, or coma (a deep, prolonged state of unconsciousness). Findings: A review of Resident 37's admission RECORD, indicated Resident 37 was admitted to the facility with diagnoses including type 2 diabetes mellitus (chronic condition where the body resists insulin or fails to produce enough). A review of Resident 37's Order Summary Report, dated 7/15/26, indicated, .Insulin lispro [short acting insulin] .inject per sliding scale: if 0-60 [blood glucose level] call MD [Medical Doctor, MDR]; 61-130 = 0 [units of insulin], 131-180 = 2 [units of insulin], 181-240 = 4 [units of insulin]; 241-300 = 6 units of insulin]; 301-350 = 8 [units of insulin]; 351-300 = 10 [units of insulin]; 401-999 notify MD .one time a day for DM2 [diabetes mellitus type 2] . Further review of the document indicated, .insulin glargine [long-acting insulin] .inject 25 unit .at bedtime for DM 2 .A review of Resident 37's Medication Administration Record, (MAR, official legal document used by healthcare professionals to track and record every medication administered to a resident) dated 7/2026, indicated Resident 37 was on the following daily medications to manage type 2 diabetes mellitus: insulin lispro (fast acting insulin used to lower blood sugar quickly around meal time) and insulin glargine (long-acting insulin used to treat diabetes by keeping blood sugar levels steady over time). Further review of the document indicated on 7/4/26, the insulin glargine documentation noted the ordered medication was not administered at 8 PM and to review the progress note. During a concurrent interview and record review on 7/16/26, at 5:28 PM, with licensed nurse (LN) 4, Resident 37's record titled, Progress Notes dated 7/4/26, at 10:01 PM, was reviewed. LN 4 confirmed she wrote the progress note in Resident 4's electronic health record (EHR) and the progress note indicated on 7/4/26 at 7 PM, LN 5 administered 25 units of insulin lispro, instead of the ordered 25 units of insulin glargine to Resident 37. LN 4 stated she rechecked Resident 37's blood sugar level and got 170 mg/d L (high result, normal glucose range 72-99) before she notified the Medical Doctor (MDR) and received the order to send Resident 37 to the hospital for evaluation and treatment. LN 4 further stated the medication error was preventable, LN 5 stated she should have read the insulin bottle and verified it to Resident 37's physician order listed on the MAR. During an interview on 7/17/26, at 11:09 AM, with LN 5, LN 5 stated on 7/4/26, during the evening medication pass she accidentally administered Resident 37's short acting insulin instead of the long-acting insulin. LN 5 further stated she should have double checked Resident 37's orders and compared it to the insulin bottle she was holding at the time. LN 5 stated Resident 37 did not show signs of hypoglycemia (low blood sugar) and was at her baseline, but was at risk of experiencing hypoglycemia symptoms, such as altered level of consciousness. During an interview on 7/17/26, at 9:19 AM, with Resident 37's (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician (MDR), MDR stated he was notified on 7/4/26 that Resident 37 had received 25 units of short acting insulin instead of the scheduled long-acting insulin. MDR further stated Resident 37 was at risk of becoming very hypoglycemic due to receiving the wrong insulin. MDR stated Resident 37 had to be transferred to an acute care setting for heavy monitoring and to treat Resident 37's blood sugar levels intravenously (medications given through the vein) if required. A review of Resident 2's, [Hospital Name] medical record document titled, Emergency/Urgent Care, dated 7/5/26, at 5:21 PM, indicated, .admission date: 07/24/26 .20:47 .[8:47 PM] .presenting from [Facility Name] after a medication error in which she was given 25 units of subcutaneous [located, used, or introduced under the skin, specifically in the fatty layer found between the skin and the muscles] Humalog [Humalog, short acting insulin also known as insulin lispro] instead of her usual 25 units of subcutaneous glargine at bedtime. She was brought in by ambulance for monitoring .blood sugar with EMS [Emergency Medical Services] and on arrival has been stable, with a fingerstick of 114 [blood sugar testing result] .07/04/26 21:50: [9:50 PM] Glucose 47 mg/dL [low- out of the normal range], patient asymptomatic [no symptoms], D50 [a concentrated 50% (percent) sugar solution used primarily to treat severe low blood sugar] administered IV [IV, intravenous, through the vein] .07/04/26 22:23 [10:23 PM]: Glucose 166/mg/dL [high- out of range], patient asymptomatic .07/04/26 23:36 [11:36 PM] Glucose 90 mg/dL [within normal range], no symptoms, neurologically at baseline .07/05/26 00:32=[12:30 AM] Glucose 92 mg/dL [within normal range], patient awake, alert, no new complaints .07/05/26 01:54 [1:54 AM] Glucose 105 mg/dL [slightly high] .07/05/26 03:57 [3:57 AM] Glucose 116 mg/dL [slightly high] .Discharge Time: 07/05/26 04:50:00 [4:50 AM] .Further review of Resident 2's same (Hospital Name) medical record document titled, Emergency/Urgent Care, dated 7/5/26, at 5:21 PM, under the medical decision-making section indicated, .I considered life-threatening complications, altered mental status, seizures, and aspiration. The patient was placed on continuous monitoring with hourly glucose checks for the expected duration of Humalog action .After prolonged observation period with stable glucose levels, absence of symptoms, and return to baseline, the patient was deemed safe for discharge back to her facility .During an interview on 7/17/26, at 10:46 AM, with the Assistant Director of Nursing (ADON), the ADON stated it was his expectation for licensed nursing staff to administer the five rights of medication administration (right resident, right medication, right dose, right time, right route). The ADON further stated the medication error was preventable and placed Resident 37 at risk of hypoglycemia.A review of the facilities policy and procedure titled, MEDICATION ADMINISTRATION, dated 11/25, indicated, .Medication shall be administered by Licensed Nursing staff according to.and good nursing procedure to limit error and to assure optimum desired effect from administered medications.Medications and treatment shall be administered as prescribed.		