

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
NAME OF PROVIDER OR SUPPLIER Menifee Lakes Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 27600 Encanto Drive Sun City, CA 92586	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37536</p> <p>Based on observation, interview, and record review, the facility failed to ensure, for one of four residents reviewed (Resident 1), to monitor blood sugar level, assess meal intake percentage, or ensure proper communication among staff for a resident admitted with diabetes (abnormal blood sugar level).</p> <p>This failure had the potential to cause adverse health effects.</p> <p>Findings:</p> <p>On April 3, 2025, Resident 1's record was reviewed. Resident 1 was admitted to the facility with a diagnosis which included, type 2 diabetes mellitus with ketoacidosis (uncontrolled blood glucose levels in the body), chronic kidney disease, stage 3 (weakened kidney function), and acquired absence of left leg below knee.</p> <p>A further review of Resident 1's clinical admission form dated April 3, 2025, indicated, there was no documentation of Resident 1's baseline blood glucose level and oral intake upon admission.</p> <p>A review of Resident 1's physician order dated April 4, 2025, indicated, .Humulin R U-500 KwikPen subcutaneous Solution Pen-injector 500 unit/ml (insulin regular [human]) inject 110 unit subcutaneously in the morning for DM .before breakfast .</p> <p>A review of the Medication Administration Record (MAR) for the month of April 2025, indicated Resident 1 received insulin at 7:00 a.m. with a blood glucose level of 99.</p> <p>A review of Resident 1's change of condition notice dated April 4, 2025, at 8:47 a.m. indicated, .At 7:45am resident found unresponsive. Opened eyes but no verbal response when stimulated with sternal rub. V/S (vital signs) 144/76 PR (pulse rate) 105 o2 (oxygen saturation - how much oxygen the blood is transporting throughout the body) at 92% T 97.6 RR 18 BS (blood sugar) 25. Given glucagon (medical glucose) shot at 7:55 and BS was 32 after 15 minutes. Before the 2nd dose of glucagon shot as ordered by MD at 8:05am, resident started to respond and verbally responsive, able to say name when asked. After 15 minutes of 2nd glucagon shot BS went up to 53. Resident more alert and responsive and able to drink orange juice. Continue to give OJ (orange juice) and given Breakfast. At 8:35am BS checked again and went up to 82. MD (physician) ordered to hold all insulin at this time and continue to monitor .</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On April 24, 2025, at 3:06 p.m., an interview was conducted with the Licensed Vocational Nurse (LVN) 1. LVN 1 stated he was informed Resident 1 had diabetes and was alert, as reported by the Registered Nurse (RN 1). LVN 1 stated he was unsure whether Resident 1 had received nourishment before admission or what his baseline blood glucose level was. LVN 1 stated he administered insulin to Resident 1 as per the physician's order.</p> <p>On April 24, 2025, at 3:30 p.m., an interview was conducted with the Registered Nurse (RN) 1. RN 1 stated she did not document Resident 1's last meal or blood glucose level and did not communicate the information to LVN 1. RN 1 stated according to admission protocol, it was necessary to record the last meal, check blood glucose levles, offer a snack to diabetic resident during admission, and relay this information to the assigned LVN. RN 1 stated, she should have done so.</p> <p>On April 24, 2025, at 4:03 p.m., an interview was conducted with RN 2. RN 2 stated blood glucose levels should always be checked upon admission for diabetic residents. RN 2 stated, the facility practice includes assessing if the resident has eaten, offering a snack, and documenting the intake. RN 2 stated, she could not recall receiving any blood glucose information from the hospital and remembered that Resident 1 was an unstable diabetic. RN 2 stated, administering insulin without prior food intake increases the risk of hypoglycemia (low blood glucose).</p> <p>On April 24, 2025, at 4:34 p.m. a concurrent interview and record review was conducted with Director of Nursing (DON). The DON stated, the admission assessment should include documentation of blood glucose levels and the last meal intake for diabetic residents. The DON stated, the clinical admission form dated April 3, 2025, had no documented blood glucose level and meal intake. The DON stated, there was a potential risk for hypoglycemia and hyperglycemia (high blood glucose) for diabetic residents and there should have been documentation and communication regarding the intake and blood glucose levels for Resident 1.</p> <p>On April 29, 2025, at 11:06 a.m. an interview was conducted with LVN 2. LVN 2 stated, during the endorsement rounds for Resident 1, she was informed by LVN 1 that Resident 1 was alert, diabetic, and had no overnight issues. LVN 2 stated Resident 1 was sleeping and unresponsive during the endorsement when both LVNs 1 and 2 entered the room on April 4, 2025. LVN 2 stated, she was not informed about Resident 1's last meal or blood glucose levels. LVN 2 stated, if she had been aware of the resident's sensitivity to insulin, she would have checked the blood glucose before the morning medication pass. LVN 2 stated, administering insulin without prior food intake poses a risk of hypoglycemia.</p> <p>A review of the facility policy and procedure titled, Nursing Care of the Resident with Diabetes Mellitus, dated 2022, indicated, .Recognize, manage, and document the treatment of complications commonly associated with diabetes .Hypoglycemia .many of these symptoms can also be caused by other conditions, for example adverse consequences due to medications or fluid and electrolyte imbalance .it should not just be assumed that these symptoms are related to diabetes, without carefully investigating and reporting other potential causes .kidney disease .nerve damage .foot complications .Glucose Monitoring .the physician will order the frequency of glucose monitoring .residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation .Documentation .percentage of meals consumed .blood sugar results and other pertinent laboratory studies .</p> <p>(continued on next page)</p>		

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