STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056317	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on interviews and record reviews, the facility failed to ensure the attending physician (Medical Doctor [MD] 1) included blood sugar monitoring [an intervention that is essential for managing diabetes that involves checking blood sugar levels using a device] and medications to manage Diabetes Mellitus [DM, a chronic disease where a person has high blood sugar levels because the body does not produce insulin (a hormone made by the pancreas- an organ in the body) normally] for one of three sampled residents (Resident 1) who was diabetic (a person with diagnosis of diabetes) by failing to: 1. Ensure the licensed staff reviewed Resident 1's general acute care hospital (GACH 1) records for all appropriate discharge orders and ensure admission orders from the facility and continuity of care for DM was verified with MD 1, upon admission to the facility, on [DATE]. 2. Ensure the licensed staff verified Resident 1's admission orders from the facility, by reviewing Resident 1's medical history from GACH 1 and addressed the resident's diagnoses of DM. There was no documented evidence diabetes management that included blood sugar monitoring, insulin administration and monitoring to prevent hyperglycemia (high blood sugar level) and hypoglycemia (low blood sugar level) was implemented while the resident resided in the facility from [DATE] to [DATE]. 3. Inform the physician that Resident 1 with DM did not have admission orders from the facility to monitor the resident's blood sugar and if the physician wanted to continue the orders for the resident to receive insulin to manage the resident's diabetes according to GACH 1's Discharge Documentation and in accordance with the facility's policy and procedure titled Admission Assessment. 4. Ensure the plan of care for Resident 1's DM was implemented by monitoring the resident for hypoglycemia and hyperglycemia while residing in the facility from [DATE] to [DATE] (a total of 61 days). As a result, Resident 1 was transferred to GACH 2 via 911 emergency services on [DATE] due to altered level of consciousness (a change in a patient's state of awareness [ability to relate to self and the environment]), oxygen desaturation (a decrease in the amount of oxygen in the blood) of 77% (blood oxygen levels drop below a normal range [normal levels are 96 to100 %]) and a blood sugar level of 500 (normal blood sugar levels are between 70 to 100). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident 1 arrived at GACH 2 Emergency Department (ED) with a blood sugar level of 810 (normal blood sugar levels are between 70 to 100) on [DATE]. Resident 1 was transferred to the Intensive Care Unit (ICU, a specialized unit in a hospital that caters to patients that are critically ill) for management of Diabetic Ketoacidosis (DKA - a serious complication of diabetes that happens when the body does not have enough of a hormone called insulin) and died on [DATE]. According to Resident 1's Certificate of Death (a legal document used by the state and federal government to prove someone has died), Resident 1's immediate cause of death (final disease or condition resulting in death) was Diabetic Ketoacidosis and the underlying cause of death (disease or injury that initiated the events resulting in death) was DM Type 2. On [DATE] at 7:33 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility's failure to ensure a resident with a diagnosis of DM Type 2 received the appropriate admission orders from the facility or diabetes care and management provided by a physician. The survey team notified the Administrator (ADM) and the Director of Nursing (DON) of an IJ situation on [DATE] at 7:33 PM, due to the facility's failure to ensure Resident 1 received the appropriate facility admission orders for diabetes care and management provided by a physician. On [DATE] at 3:02 PM, the ADM provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On [DATE] at 3:19 PM, while onsite and after the surveyor verified/confirmed the facility's full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. The IJ Removal Plan dated [DATE], included the following: - On [DATE], the DON provided an in-service (training program while staff are employed) with Licensed Vocational Nurse (LVN) 1 on diabetic medication order clarifications, facility admission orders, implementation of care plans, verification of physician orders, and signs and symptoms of hyperglycemia (high blood sugar levels) and hypoglycemia (low blood sugar levels). - LVN 1 was provided with additional in-service on Diabetic Care Policy and Procedure, diabetic patient management, order clarification, and care planning on escalation (to involve someone of higher position) of interventions if medication list is not provided for residents upon admission. - Starting [DATE], the Director of Nurses (DON)/Designee initiated monthly in-services for three months to reinforce best practices in the admission process, to review all inquiries for newly admitted residents. Registered Nurse [RN]/DON will input all medication orders for newly admitted residents. RN/DON will complete all admission assessments for newly admitted residents. RN/ DON will contact the transferring acute care hospital and primary care provider to clarify all medication orders and compare to the patient's diagnosis/medical condition to ensure that all of the correct medications are ordered for each resident upon admission to the facility and correct any potentially missed medication orders in real time. (continued on next page)

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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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- On [DATE] and [DATE], the DON provided all licensed nurses with an in-service regarding Diabetes Management including the review of facility admission diagnosis, diabetic medication order clarification, implementation of care plans, verification of physician orders, and proper documentation to ensure that all staff are updated on the current diabetic care policy and procedure. - On [DATE], the Pharmacist Consultant (provides facilities with expert advice and recommendations about resident's medications by performing medication reviews) completed a Medication Regimen Review (MRR, a process conducted by a pharmacist, to review a resident's medications) for all residents with diagnosis of DM at the facility and made recommendations. - On [DATE], the DON and Minimum Data Set (MDS- a comprehensive standardized assessment and screening tool) Nurse reviewed records for all current residents with the diagnosis of DM using a Diabetes Audit Log to identify other residents. All residents with diagnosis of DM were physically assessed, admission orders/documentation were reviewed, monitoring for signs and symptoms of hypoglycemia and hyperglycemia were reviewed, and care plans were reviewed/updated to address DM management. - On [DATE], the DON/MDS Nurse and the Medical Records Director (MRD), conducted an audit of medication administration records and treatment protocols for residents with a diagnosis of DM to ensure adherence to prescribed treatments. - Starting [DATE], the MDS Nurse will conduct an admission chart review audits for newly admitted residents the next day, after their admission to the facility to monitor compliance with diabetes management protocols, physician orders, blood sugar monitoring, and identify areas requiring corrective action. - Starting [DATE], the Interdisciplinary Team [IDT] will develop and implement comprehensive care plans for residents with DM, including regular monitoring, and preventive measures for complications. Care plans will be reviewed by IDT and updated during weekly meetings and as required by changes in the resident's condition by a licensed nurse. - Starting [DATE], the RN or DON will oversee documentation of care plans, assessments, medication orders, monitoring, and physician orders, ensuring that all interventions are properly recorded and that any issues or clarifications are addressed the same day that the residents are admitted . - On [DATE], the Medical Director provided an in-service with Resident 1's attending physician regarding admission orders, DM medication management, medication orders, order for blood sugar checks and monitoring for signs and symptoms of hypoglycemia and hyperglycemia. - On [DATE], the Medical Director provided an in service with the Pharmacist Consultant that reviewed Resident 1's medication regimen during the month of February 2024 to educate the consultant on reconciliation of all resident's diagnosis with medication orders concurrently. - On [DATE], the Medical Director educated the Pharmacist Consultant regarding medication recommendations regarding DM medication management, medication orders, and order for blood sugar checks and monitoring for signs and symptoms of hypoglycemia and hyperglycemia. - Starting [DATE], the DON/Designee will oversee the administration of diabetes-related medications and ensure that physician recommendations are followed daily. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Starting [DATE], the Medical Director will initiate an in-service of the facility's Primary Care Physicians, Nurse Practitioners, and Physicians Assistants on admission orders, DM medication management, medication orders, and order for blood sugar checks. Cross reference with F684, F711, F756 Findings: During a review of Resident 1's GACH 1 record, titled, Inpatient Progress Notes, dated [DATE], indicated Resident 1 had a diagnosis of DM . The GACH 1 record indicated a plan to continue Resident 1's insulin medication to maintain a blood sugar goal of less than 180. During a review of Resident 1's GACH 1 record titled Discharge Documentation dated [DATE], timed at 11:07 AM, indicated Issues to Address on Outpatient Follow Up/Discharge Action Plan which included Resident 1 to have continued diabetes management upon admission in the facility. The Discharge Documentation record indicated Resident 1 received insulin in GACH 1 and will need physician [follow up] for DM care. Further review of the Discharge Documentation indicated Resident 1's last blood sugar result in GACH 1 on [DATE] was 157. During a review of Resident 1's Facility Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included DM, encephalopathy (damage or disease that affects the brain), dementia (a syndrome that causes a decline in cognitive [thought process] abilities, such as thinking, remembering, and making decisions, that can interfere with daily activities), and hypertension (high blood pressure). During a review of Resident 1's Facility Nursing Admission Assessment, dated [DATE], timed at 6:03 PM, signed by LVN 1 and LVN 3, indicated the resident was admitted to the facility on [DATE] at around 5:10 P. M. The Nursing Admission Assessment indicated Resident 1 had a diagnosis of DM Type 2. During a review of Resident 1's care plan titled, The resident [Resident 1] has DM, initiated on [DATE] and revised on [DATE], indicated a goal for the resident is to not have complications related to diabetes. The care plan interventions included to monitor, document, and report signs and symptoms of hyperglycemia and hypoglycemia. During a review of Resident 1's Order Summary Report (OSR) for all orders during Resident 1's stay at the facility from [DATE] to [DATE], included a physician order to administer Insulin Lispro [a class of insulin hormone] Injection Solution 100 Unit/ML [Unit per milliliter, a unit of measure] Inject as per sliding scale (a guide use to determine how much insulin to give to correct an elevated blood sugar) on [DATE]. The OSR indicated the order for Insulin Lispro sliding scale was discontinued the same date, [DATE]. During a review of Resident 1's facility records titled, Discontinue Order, dated [DATE], timed at 11:17 PM, signed by LVN 1, indicated a telephone order from MD 1 for Insulin Lispro Sliding Scale to be discontinued on [DATE], timed at 11:16 PM. The record indicated the reason for discontinuing was Clarification of Order. During the review of the resident's physician orders, there was no additional orders or justification for Lispro insulin after it had been discontinued. (continued on next page)

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F 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's History and Physical (H&P), dated [DATE], signed by MD 1, indicated the resident did not have the capacity to understand and make decisions. The H&P indicated Resident 1 had a diagnosis of DM. During a review of Resident 1's Admission MDS, dated [DATE], indicated the resident had severely impaired [a condition that significantly limits an individual's physical or mental abilities] cognition (ability to remember and process information). The Admission MDS indicated Resident 1 did not have an order for insulin and did not include resident's diagnosis of DM. During a review of Resident 1's Change in Condition Evaluation (CIC), dated [DATE], timed at 7:04 PM, the CIC indicated Resident 1 was found to have labored breathing (a non-medical term used to describe when breathing is difficult or impaired) and with a blood sugar level of 500. The CIC indicated Resident 1 had signs and symptoms that included altered mental status, oxygen desaturation, and hyperglycemia. The CIC indicated MD 1 and Resident 1's family were notified. The CIC indicated Resident 1 was transferred via 911 emergency services to GACH 2 on [DATE]. During a review of Resident 1's Transfer Form, dated [DATE], the Transfer Form indicated Resident 1 was transferred to GACH 2 on [DATE]. The Transfer Form indicated the reason for the transfer was due to altered mental status. During a review of Resident 1's GACH 2 Emergency Department [ED] Reports dated [DATE], indicated the resident was admitted to the ED on [DATE] at 6:48 PM with a chief complaint of altered mental status and having a blood sugar of High [a glucometer (a portable device used to measure blood sugar levels) reading that means a very high blood sugar level above 600]. The GACH 2 ED Report indicated At around 5:50 PM, [Resident 1] refused her dinner and threw her juice on the floor and refused to eat. When [Resident 1] was reevaluated they [facility staff], noted that she [Resident 1] was breathing heavily [difficulty breathing] and not speaking. The GACH 2 ED Report indicated the facility staff tried to measure [Resident 1's] [blood] sugar, and the glucometer read as high. The GACH 2 ED Report indicated Resident 1's blood sugar level taken at the GACH 2 upon arrival to the ED was 810. During the same review of Resident 1's GACH 2 ED Report dated [DATE], indicated a diagnosis of DKA. The GACH 2 ED Report indicated the resident was started on insulin drip (insulin that is administered directly through a person's vein) and was admitted to the ICU for management of the DKA. During a review of Resident 1's GACH 2 Medication Administration Record [MAR], the GACH 2 MAR indicated GACH 2 started Resident 1 on insulin drip (insulin given through an intravenous [IV-thorough the vein] to get into the body more quickly to bring down high blood sugar) on [DATE]. During a review of Resident 1's GACH 2 records titled Discharge [DC] Summaries Notes, dated [DATE], timed at 3:11 PM, indicated Resident 1 coded [a medical term which means a person's heart stopped and basic life support was provided] and expired on [DATE] while in the ICU. The GACH 2 DC Summary indicated Resident 1's final diagnoses included DM Type 2, hyperosmolar hyperglycemic state (a serious complication of diabetes that happens when blood sugar levels are very high for a long period of time), DKA, sepsis (a serious condition in which the body responds improperly to an infection), and altered mental status . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Certificate of Death indicated Resident 1 expired on [DATE] in GACH 2. The Certificate of Death indicated the immediate cause of death (final disease or condition resulting in death) as Diabetic Ketoacidosis and underlying cause of death (disease or injury that initiated the events resulting in death) indicated Diabetes Mellitus Type 2. During a concurrent interview on [DATE] at 1:28 PM with the MDS Nurse and record review of Resident 1's clinical records and physician orders provided by the facility from [DATE] to [DATE], the MDS Nurse stated there were no documented evidence that the facility licensed staff called MD 1 to verify the reason for the Clarification of Order for Resident 1's Insulin Lispro Sliding Scale that was discontinued on [DATE]. The MDS Nurse stated there was no additional orders or justification for discontinuing the resident's order for Lispro insulin after it had been discontinued on ,d+[DATE].2024. The MDS Nurse stated there was no documented evidence that licensed staff notified MD 1 or other physicians that Resident 1 was receiving insulin while at GACH 1. The MDS Nurse stated there was no documented evidence that licensed staff verified if MD 1 would continue the order for insulin and blood sugar monitoring as a diabetic regimen [course of treatment] for Resident 1. The MDS Nurse stated residents that have a diagnosis of DM should have an order to have their blood sugar monitored. The MDS Nurse stated discontinuing a medication should have a valid reason. The MDS Nurse stated the reason indicated by LVN 1 on [DATE], which read clarification of order, was not a valid reason for discontinuing the Insulin Lispro Sliding Scale on [DATE]. The MDS Nurse stated she did not call or clarify with MD 1 to verify the insulin medication order and blood sugar monitoring, upon completion of the resident's Admission MDS [on [DATE]]. The MDS nurse stated there was no documented evidence that Resident 1 was monitored for signs and symptoms of hyperglycemia and hypoglycemia, as indicated in the resident care plan for DM developed on [DATE] and revised on [DATE]. During the same interview, on [DATE], at 1:28 PM, the MDS Nurse stated that she had reviewed the GACH 1 records provided to the facility upon Resident 1's admission on [DATE]. The MDS Nurse stated the GACH 1 records indicated Resident 1 was receiving insulin while at GACH 1. The MDS Nurse stated the facility should have continued Resident 1's blood sugar monitoring and insulin because it was the GACH 1's discharge plans for Resident 1, prior to facility admission. During a concurrent interview and record review of Resident 1's entire facility records, from [DATE] to [DATE], and the facility's policy and procedures on Admission Assessment and Admission and Orientation of Residents on [DATE] at 2:48 PM, LVN 2 stated there was no documented evidence that another licensed nurse, reviewed Resident 1's medication orders the next day after the resident's admission to the facility. LVN 2 reviewed the policy and procedures on Admission and Orientation of Residents, that indicated a registered nurse will conduct the initial assessment of the resident. LVN 2 stated when a resident is admitted during the evening or night shift by an LVN, an RN must re-assess the resident again the next day, which should include the verification of the resident's medication orders. LVN 2 stated there was no documented evidence that another licensed staff (RN or another LVN) conducted a drug review of Resident 1's medication orders and re-assess Resident 1 the next day, which should include verification of the resident's medication orders, as indicated in the facility's policy titled Admission Assessment and Admission and Orientation of Residents to ensure all the required orders were included. (continued on next page)

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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 0635 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 4:25 PM with LVN 1, LVN 1 stated when a resident is admitted to the facility, the admitting nurse calls the physician and asks if the attending physician would like to continue everything [medication orders from the GACH]. LVN 1 stated she does not verbally read over the resident's entire medication list to the physician. LVN 1 stated she could not remember if she spoke to MD 1 on [DATE], when she admitted Resident 1 to the facility. LVN 1 stated she could not remember discontinuing any insulin medications or blood sugar monitoring for Resident 1 on [DATE]. LVN 1 stated discontinuing an insulin order required a valid reason such as supporting the discontinuation with laboratory results such as a Hemoglobin [Hb] A1C [a common blood test used to diagnose type 1 (pancreas does not make insulin) and type 2 (the pancreas make less insulin) diabetes] laboratory result. LVN 1 stated the facility practice was for the MDS Nurse to review a newly admitted resident's GACH records and for the RN supervisor to review the admission orders for accuracy. LVN 1 stated she did not know if another licensed staff or an RN reviewed Resident 1's admission orders the next day following admission on [DATE]. During an interview on [DATE] at 6:45 PM with the DON, the DON stated when a resident is newly admitted to the facility, the licensed nurse should verify all the resident's medications with the physician. The DON stated it is the licensed nurse's responsibility to notify the physician if a resident's medical diagnosis was not addressed, such as not having medications for a resident's diagnosis of DM. The DON stated for a resident with a diagnosis of DM, the expectation is for the licensed nurse to ask the physician to add an order for blood sugar monitoring. The DON stated discontinuing insulin must be supported by enough justification such as blood sugar trends or laboratory values like the Hemoglobin A1C. During a review of the facility's P&P titled, Admission and Orientation of Residents, revised [DATE], indicated the following: 1. The resident's physician will provide medical orders, including a medical condition or problem associated with each medication. 2. The resident's physician will provide routine care orders to maintain or improve the resident's function. 3. A registered nurse will conduct the initial assessment of the resident. During a review of the facility's P&P titled, Admission Assessment, [DATE], indicated the licensed nurse will complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. During a review of the facility's policy and procedure titled Care Planning dated [DATE], indicated each resident should have a comprehensive person-centered care plan developed and implemented based on individual assessed needs.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 48854 Based on interviews and record reviews, the facility failed to ensure one of three sampled residents (Resident 1) who had a diagnosis of Diabetes Mellitus [DM, a chronic disease where a person has high blood sugar levels because the body does not produce insulin (a hormone made by the pancreas- an organ in the body) received treatment and services, in accordance with professional standards of practice, the care plan, physician orders, and the facility ' s policies and procedures, for the treatment and care of DM. The facility failed to: 1. Ensure a licensed staff reviewed Resident 1 ' s medical history of DM and discharge orders from GACH 1 that indicated Resident 1 was receiving insulin and blood sugar monitoring, prior to admission to the facility and verify with MD 1 if blood sugar monitoring and/or insulin should be continued while residing at the facility from [DATE] to [DATE]. 2. Implement the facility ' s policy and procedure titled Admission Assessment, when another licensed nurse did not complete a drug regimen review on or after Resident 1 ' s admission at the facility to identify any potential or actual clinically significant medication issues. 3. Implement the facility ' s policy and procedure titled Diabetic Care and Resident 1 ' s plan of care for DM, which indicated the facility ' s licensed nurses would monitor Resident 1 for signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar), and document in the resident ' s records, from the date of facility admission on [DATE]- [DATE] (a total of 61 days). 4. Ensure the facility ' s Interdisciplinary Team (IDT- a group of professionals with different areas of expertise who work together to achieve a common goal), that included the Director of Nursing (DON) was aware of Resident 1 ' s care plan for DM and reviewed the resident ' s records to ensure the care plan are being followed, in accordance with the DON ' s written job description. 5. Ensure that the facility ' s Pharmacist Consultant (PH) 1 have documented evidence in the facility ' s Medication Regimen Review (MRR, a process conducted by a pharmacist, to review a resident ' s medications) that pharmacy recommendations were provided to address concerns related to Resident 1 ' s diagnosis of DM, in accordance with the Pharmacist Consultant job description. The MRR did not indicate recommendations for blood sugar monitoring or insulin regimen to manage Resident 1 ' s DM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result, Resident 1 had a change in condition on [DATE], manifested by altered level of consciousness (a change in a patient's state of awareness [ability to relate to self and the environment]), oxygen desaturation (blood oxygen levels drop below a normal range [normal levels are 96 to100 %]) of 77% and a blood sugar of 500 (normal blood sugar levels are between 70 to 100). Resident 1 was transferred to the general acute care hospital (GACH) 2 via 911 emergency services. Resident 1 ' s blood sugar result from the GACH 2 indicated a blood sugar of 810 on [DATE]. Resident 1 died at the GACH 2 due to Diabetic Ketoacidosis (DKA - a serious complication of diabetes that happens when the body does not have enough of a hormone called insulin [a hormone made by the pancreas- an organ in the body)]) on [DATE]. Resident 1 ' s Certificate of Death (a legal document used by the state and federal government to prove someone has died) indicated the immediate cause of death (final disease or condition resulting in death) as Diabetic Ketoacidosis and underlying cause of death (disease or injury that initiated the events resulting in death) indicated DM Type 2 (a type of DM [chronic condition caused by not producing enough insulin in the body]) . On [DATE] at 7:43 PM, while onsite at the facility, the California Department of Public Health (CDPH) identified an Immediate Jeopardy situation (IJ, a situation in which the provider ' s noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) regarding the facility ' s failure to ensure a resident with a diagnosis of Diabetes Mellitus (DM, a chronic disease where a person has high blood sugar levels because the body does not produce insulin normally and required blood sugar monitoring and/or medications to lower blood sugar levels]) Type 2 received treatment and services for diabetes. The survey team notified the Administrator (ADM) and the Director of Nursing (DON) of an IJ situation on [DATE] at 7:43 PM, due to the facility ' s failure to ensure Resident 1 received the appropriate admission orders for diabetes care and management provided by a physician. On [DATE] at 3:02 PM, the Administrator (ADM) provided an acceptable IJ Removal Plan (a detailed plan to address the IJ findings). On [DATE] at 3:19 PM, while onsite and after the surveyor verified/confirmed the facility ' s full implementation of the IJ Removal Plan through observation, interview, and record review, and determined the IJ situation was no longer present, the IJ was removed onsite, in the presence of the ADM and the DON. The IJ Removal Plan dated [DATE], included the following: On [DATE], the DON provided an in-service (training program while staff are employed) with Licensed Vocational Nurse (LVN) 1 on diabetic medication order clarifications, admission orders, implementation of care plans, verification of physician orders, and signs and symptoms of hyperglycemia (high blood sugar levels) and hypoglycemia (low blood sugar levels). LVN 1 was provided with additional in-service on Diabetic Care Policy and Procedure, diabetic patient management, order clarification, and care planning on escalation (to involve someone of higher position) of interventions if medication list is not provided for residents upon admission. (continued on next page)

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	056317	A. Building B. Wing	08/10/2024

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Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Starting [DATE], the Director of Nurses (DON)/Designee initiated monthly in-services for three months to reinforce best practices in the admission process, to review all inquiries for newly admitted residents. Registered Nurse [RN]/DON will input all medication orders for newly admitted residents. RN/DON will complete all admission assessments for newly admitted residents. RN/ DON will contact the transferring acute care hospital and primary care provider to clarify all medication orders and compare to the patient's diagnosis/medical condition to ensure that all of the correct medications are ordered for each resident upon admission and correct any potentially missed medication orders in real time. On [DATE] and [DATE], the DON provided all licensed nurses with an in-service regarding Diabetes Management including the review of admission diagnosis, diabetic medication order clarification, implementation of care plans, verification of physician orders, and proper documentation to ensure that all staff are updated on the current diabetic care policy and procedure. On [DATE], the Pharmacist Consultant (provides facilities with expert advice and recommendations about resident ' s medications by performing medication reviews) completed a Medication Regimen Review for all residents with diagnosis of DM at the facility and made recommendations. On [DATE], the DON and Minimum Data Set (MDS- a comprehensive standardized assessment and screening tool) Nurse reviewed records for all current residents with the diagnosis of DM using a Diabetes Audit Log to identify other residents. All residents with diagnosis of DM were physically assessed, admission orders/documentation were reviewed, monitoring for signs and symptoms of hypoglycemia and hyperglycemia were reviewed, and care plans were reviewed/updated to address DM management. On [DATE], the DON/MDS Nurse and the Medical Records Director (MRD), conducted an audit of medication administration records and treatment protocols (system of rules) for residents with a diagnosis of DM to ensure adherence to prescribed treatments. Starting [DATE], the MDS Nurse will conduct an admission chart review audits for newly admitted residents the next day, after their admission to the facility to monitor compliance with diabetes management protocols, physician orders, blood sugar monitoring, and identify areas requiring corrective action. Starting [DATE], the IDT will develop and implement comprehensive care plans for residents with DM, including regular monitoring, and preventive measures for complications. Care plans will be reviewed by IDT and updated during weekly meetings and as required by changes in the resident's condition by a licensed nurse. Starting [DATE], the RN or DON will oversee documentation of care plans, assessments, medication orders, monitoring, and physician orders, ensuring that all interventions are properly recorded and that any issues or clarifications are addressed the same day that the residents are admitted . On [DATE], the Medical Director provided an in-service with Resident 1 ' s attending physician regarding admission orders, DM medication management, medication orders, order for blood sugar checks and monitoring for signs and symptoms of hypoglycemia and hyperglycemia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the Medical Director provided an in service with the Pharmacist Consultant that reviewed Resident 1's medication regimen during the month of February 2024 to educate the consultant on reconciliation of all resident's diagnosis with medication orders concurrently. On [DATE], the Medical Director educated the Pharmacist Consultant regarding medication recommendations regarding DM medication management, medication orders, and order for blood sugar checks and monitoring for signs and symptoms of hypoglycemia and hyperglycemia. Starting [DATE], the DON/Designee will oversee the administration of diabetes-related medications and ensure that physician recommendations are followed daily. Starting [DATE], the Medical Director will initiate an in-service of the facility's Primary Care Physicians, Nurse Practitioners, and Physicians Assistants on admission orders, DM medication management, medication orders, and order for blood sugar checks. Cross reference to F635, F711, F756 Findings: During a review of Resident 1 ' s GACH 1 record, titled, Inpatient Progress Notes, dated [DATE], indicated Resident 1 had a diagnosis of DM . The GACH 1 record indicated a plan to continue Resident 1 ' s insulin medication to maintain a blood sugar goal of less than 180. During a review of Resident 1 ' s GACH 1 record titled Discharge Documentation dated [DATE], timed at 11:07 AM, indicated Issues to Address on Outpatient Follow Up/Discharge Action Plan which included Resident 1 to have continued diabetes management in the facility. The Discharge Documentation record indicated Resident 1 received insulin in GACH 1 and will need physician [follow up] for DM care. Further review of the Discharge Documentation indicated Resident 1 ' s last blood sugar result in GACH 1 on [DATE] was 157. During a review of Resident 1 ' s Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included DM, encephalopathy (damage or disease that affects the brain), dementia (a syndrome that causes a decline in cognitive [thought process]) abilities, such as thinking, remembering, and making decisions, that can interfere with daily activities), and hypertension (high blood pressure). During a review of Resident 1 ' s Nursing Admission Assessment, dated [DATE], timed at 6:03 PM, signed by LVN 1 and LVN 3, indicated the resident was admitted to the facility on [DATE] at around 5:10 P.M. The Nursing Admission Assessment indicated Resident 1 had a diagnosis of DM Type 2. During a review of Resident 1 ' s care plan titled, The resident [Resident 1] has DM, initiated on [DATE] and revised on [DATE], indicated a goal for the resident to not have complications related to diabetes. The care plan interventions included to monitor, document, and report signs and symptoms of hyperglycemia and hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s Order Summary Report (OSR) for all orders during Resident 1 ' s stay at the facility from [DATE] to [DATE], included a physician order to administer Insulin Lispro [a class of insulin hormone] Injection Solution 100 Unit/ML [Unit per milliliter, a unit of measure] Inject as per sliding scale (a guide use to determine how much insulin to give to correct an elevated blood sugar) on [DATE]. The OSR indicated the order for Insulin Lispro sliding scale was discontinued the same date, [DATE]. During a review of Resident 1 ' s facility records titled, Discontinue Order, dated [DATE], timed at 11:17 PM, signed by LVN 1, indicated a telephone order from MD 1, for Insulin Lispro Sliding Scale to discontinue on [DATE], timed at 11:16 PM. The record indicated the reason for discontinuing was Clarification of Order. During a review of Resident 1 ' s Admission MDS, dated [DATE], indicated the resident had severely impaired [a condition that significantly limits an individual's physical or mental abilities] cognition (ability to remember and process information). The Admission MDS indicated Resident 1 did not have an order for insulin and did not include resident ' s diagnosis of DM. During a review of Resident 1 ' s Admission MDS, dated [DATE], indicated the resident had severely impaired cognition (ability to remember and process information). The Admission MDS indicated Resident 1 did not have an order for insulin and did not include resident ' s diagnosis of DM. During a review of Resident 1 ' s IDT Conference Record, dated [DATE], signed by different members of the facility ' s IDT from the Nursing Department, Activities Department, and Social Services, participated by Resident 1 ' s family member (FM 1), the IDT Record indicated Resident 1 had a diagnosis that included dementia and DM Type 2. The IDT Record indicated Resident 1 ' s plan of care to receive physical therapy (a healthcare profession that helps an individual ' s body improve and perform physical movements) and occupational therapy (therapy based on engagement in meaningful activities of daily life) while residing at the facility and the discharge goals to go home with FM 1. The IDT Conference Record did not indicate information that IDT addressed Resident 1 ' s plan of care for management of DM. During a review of Resident 1 ' s Change in Condition Evaluation (CIC), dated [DATE], timed at 7:04 PM, the CIC indicated Resident 1 was found to have labored breathing (a non-medical term used to describe when breathing is difficult or impaired) and with a blood sugar level of 500. The CIC indicated Resident 1 had signs and symptoms that included altered mental status, oxygen desaturation, and hyperglycemia. The CIC indicated MD 1 and Resident 1 ' s family were notified. The CIC indicated Resident 1 was transferred via 911 emergency services to GACH 2 on [DATE]. During a review of Resident 1 ' s Transfer Form, dated [DATE], the Transfer Form indicated Resident 1 was transferred to GACH 2 on [DATE]. The Transfer Form indicated the reason for the transfer was due to altered mental status. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1 ' s GACH 2 Emergency Department [ED] Reports dated [DATE], indicated the resident was admitted to the ED on [DATE] at 6:48 PM with a chief complaint of altered mental status and having a blood sugar of High [a glucometer (a portable device used to measure blood sugar levels) reading that means a very high blood sugar level above 600]. The GACH 2 ED Report indicated At around 5:50 PM, [Resident 1] refused her dinner and threw her juice on the floor and refused to eat. When [Resident 1] was reevaluated they [facility staff], noted that she [Resident 1] was breathing heavily [difficulty breathing] and not speaking. The GACH 2 ED Report indicated the facility staff tried to measure [Resident 1 ' s] [blood] sugar, and the glucometer read as high. The GACH 2 ED Report indicated Resident 1 ' s blood sugar level taken at the GACH 2 upon arrival to the ED was 810. During the same review of Resident 1 ' s GACH 2 ED Report dated [DATE], indicated a diagnosis of DKA. The GACH 2 ED Report indicated the resident was started on insulin drip (insulin that is administered directly through a person ' s vein) and was admitted to the ICU for management of the DKA. During a review of Resident 1 ' s GACH 2 Medication Administration Records (MAR), the GACH 2 MAR indicated GACH 2 started Resident 1 on insulin drip (insulin given through an intravenous [IV-through the vein] to get into the body more quickly to bring down high blood sugar) on [DATE]. During a review of Resident 1 ' s GACH 2 records titled Discharge [DC] Summaries Notes, dated [DATE], timed at 3:11 PM, indicated Resident 1 coded [a medical term which means a person ' s heart stopped and basic life support was provided] and expired on [DATE] while in the ICU. The GACH 2 DC Summary indicated Resident 1 ' s final diagnoses included DM Type 2, hyperosmolar hyperglycemic state (a serious complication of diabetes that happens when blood sugar levels are very high for a long period of time), DKA, sepsis (a serious condition in which the body responds improperly to an infection), and altered mental status . During a review of Resident 1 ' s Certificate of Death indicated Resident 1 expired on [DATE] in GACH 2. The Certificate of Death indicated the immediate cause of death (final disease or condition resulting in death) as Diabetic Ketoacidosis and underlying cause of death (disease or injury that initiated the events resulting in death) indicated Diabetes Mellitus Type 2. (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview on [DATE] at 1:28 PM with the MDS Nurse and record review of Resident 1 ' s clinical records provided by the facility from [DATE] to [DATE], the MDS Nurse stated there were no documented evidence that any licensed staff called MD 1 to verify the reason for the Clarification of Order for Resident 1 ' s Insulin Lispro Sliding Scale that was discontinued on [DATE]. The MDS Nurse stated there was no documented evidence that licensed staff notified MD 1 or other physicians that Resident 1 was receiving insulin from GACH 1. The MDS Nurses stated there was no documented evidence that licensed staff verified if MD 1 would continue the order for insulin and blood sugar monitoring as a diabetic regimen [course of treatment] for Resident 1. The MDS Nurse stated residents that have a diagnosis of DM should have an order to have their blood sugar monitored. The MDS Nurse stated discontinuing a medication should have a valid reason. The MDS Nurse stated the reason indicated by LVN 1 on [DATE], which read clarification of order, was not a valid reason for discontinuing the Insulin Lispro Sliding Scale on [DATE]. The MDS Nurse stated she did not call or clarify with MD 1 to verify the insulin medication order and blood sugar monitoring, upon completion of the resident ' s Admission MDS [on [DATE]]. The MDS nurse stated there was no documented evidence that Resident 1 was monitored for signs and symptoms of hyperglycemia and hypoglycemia, as indicated in the resident care plan for DM developed on [DATE] and revised on [DATE]. During a concurrent interview on [DATE] at 1:28 PM with the MDS Nurse and record review of Resident 1 ' s clinical records provided by the facility from [DATE] to [DATE], the MDS Nurse stated there were no documented evidence that any licensed staff called MD 1 to verify the reason for the Clarification of Order for Resident 1 ' s Insulin Lispro Sliding Scale that was discontinued on [DATE]. The MDS Nurse stated there was no documented evidence that licensed staff notified MD 1 or other physicians that Resident 1 was receiving insulin from GACH 1. The MDS Nurses stated there was no documented evidence that licensed staff verified if MD 1 would continue the order for insulin and blood sugar monitoring as a diabetic regimen [course of treatment] for Resident 1. The MDS Nurse stated residents that have a diagnosis of DM should have an order to have their blood sugar monitored. The MDS Nurse stated discontinuing a medication should have a valid reason. The MDS Nurse stated the reason indicated by LVN 1 on [DATE], which read clarification of order, was not a valid reason for discontinuing the Insulin Lispro Sliding Scale on [DATE]. The MDS Nurse stated she did not call or clarify with MD 1 to verify the insulin medication order and blood sugar monitoring, upon completion of the resident ' s Admission MDS [on [DATE]]. The MDS nurse stated there was no documented evidence that Resident 1 was monitored for signs and symptoms of hyperglycemia and hypoglycemia, as indicated in the resident care plan for DM developed on [DATE] and revised on [DATE]. During the same interview, on [DATE], at 1:28 PM, the MDS Nurse stated that she had reviewed the GACH 1 records, provided to the facility upon Resident 1 ' s admission on [DATE]. The MDS Nurse stated the GACH 1 records indicated Resident 1 was receiving insulin from the GACH. The MDS Nurse stated the facility should have continued Resident 1 ' s blood sugar monitoring and insulin because it was the GACH 1 ' s discharge plans for Resident 1, prior to facility admission. The MDS Nurse stated there was no documented evidence the facility ' s licensed nurses monitored Resident ' s blood sugar from [DATE] to [DATE]. The MDS Nurse stated the only blood sugar result she found for Resident 1 was taken on [DATE], with a blood sugar result of 500. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/10/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review of Resident 1 ' s entire facility records, from [DATE] to [DATE], and the facility ' s policy and procedure on Admission Assessment and Admission and Orientation of Residents on [DATE] at 2:48 PM, LVN 2 stated there was no documented evidence that another licensed nurse, reviewed Resident 1 ' s medication orders the next day after the resident ' s admission to the facility. LVN 2 reviewed the policy and procedures on Admission and Orientation of Residents, that indicated a registered nurse will conduct the initial assessment of the resident. LVN 2 stated when a resident is admitted during the evening or night shift by an LVN, an RN must re-assess the resident again the next day, which should include the verification of the resident ' s medication orders. LVN 2 stated there was no documented evidence that another licensed staff (RN or another LVN) conducted a drug review of Resident 1 ' s medication orders and re-assess Resident 1 the next day, which should include verification of the resident ' s medication orders, as indicated in the facility ' s policy titled Admission Assessment and Admission and Orientation of Residents to ensure all the required orders were included. During a phone interview on [DATE] at 4:25 PM with LVN 1, LVN 1 stated when a resident is admitted to the facility, the admitting nurse calls the physician and asks if the attending physician would like to continue everything [medication orders from the GACH]. LVN 1 stated she does not verbally read over the resident ' s entire medication list to the physician. LVN 1 stated she could not remember if she spoke to MD 1 on [DATE], when she admitted Resident 1 to the facility. LVN 1 stated she could not remember discontinuing any insulin medications or blood sugar monitoring for Resident 1 on [DATE]. LVN 1 stated discontinuing an insulin order required a valid reason such as supporting the discontinuation with laboratory results such as a Hemoglobin [Hb] A1C (a common blood test used to diagnose type 1 and type 2 diabetes) laboratory result. LVN 1 stated the facility practice was for the MDS Nurse to review a newly admitted resident ' s GACH records and for the RN supervisor to review the admission orders for accuracy. During an interview on [DATE] at 6:45 PM with the DON, the DON stated it is the licensed nurse ' s responsibility to notify the physician if a resident ' s medical diagnosis was not addressed, such as not having medications for a resident ' s diagnosis of DM. The DON stated for a resident with a diagnosis of DM, the expectation is for the licensed nurse to ask the physician to add an order for blood sugar monitoring. The DON stated discontinuing insulin must be supported by enough justification such as blood sugar trends or laboratory values like the Hemoglobin A1C. During a concurrent interview and record review of Resident 1 ' s IDT Conference Record dated [DATE], and the resident ' s entire records from [DATE] to [DATE], on [DATE] at 9:55 AM with the DON, the DON stated the IDT Record did not show evidence that Resident 1 ' s DM was addressed. The DON stated the IDT record did not indicate a plan for Resident 1 ' s DM such as adding an order for insulin or blood sugar monitoring. The DON stated he could not find documented evidence the facility ' s IDT addressed Resident 1 ' s DM plan of care interventions on [DATE], to meet care plan goals to prevent complications related to diabetes that included monitoring, documenting, and reporting signs and symptoms of hyperglycemia and hypoglycemia. The DON stated the standard of practice for residents with DM should include blood sugar monitoring or a Hemoglobin A1C result and visual monitoring of signs and symptoms of DM. The DON stated there was no evidence in Resident 1 ' s records that the facility ' s licensed nurses monitored the resident for signs and symptoms of hypoglycemia, hyperglycemia and other signs and symptoms of DM such as frequent urination or increased thirst. The DON stated there was no laboratory order made by the physician (MD 1) that included Hb A1c during the resident ' s stay in the facility from [DATE] to [DATE]. The DON stated that Resident 1 ' s MAR from [DATE] to [DATE] did not indicate Resident 1 was monitored for blood sugar levels and DM signs and symptoms. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility ' s MRR for the months of ,d+[DATE], ,d+[DATE], and ,d+[DATE], the MRR did not have documented evidence that Pharmacist Consultant (PH) 1 addressed or provided pharmacy recommendations related to Resident 1 ' s diagnosis of DM. The MRR did not indicate recommendations for blood sugar monitoring or insulin regimen to manage Resident 1 ' s DM. During an interview, on [DATE] at 11:45 AM, PH 1 stated she comes to the facility on ce a month to review the facility residents ' medications. PH 1 stated she reviews the residents ' current medications only and does not look at a resident ' s diagnoses when making her recommendations. PH 1 stated, she was not part of the medication review when a resident gets admitted to the facility. PH 1 stated, she does not look at admission orders that were not current or had been discontinued. PH 1 stated she would only be able to recommend insulin medication for a resident, if the resident was getting their blood sugars checked and would base her recommendations on the results of the blood sugar checks. PH 1 stated she could not remember Resident 1 and did not check the resident ' s medication records why Resident 1 ' s insulin and blood sugar checks were discontinued on admission ([DATE]). PH 1 stated that if she knew Resident 1 had diabetes and did not have any blood sugar checks, she would have recommended for blood sugar checks or a Hemoglobin A1C laboratory test to be done and would have recommended insulin or oral diabetes medications (medications taken by mouth to manage blood sugar levels). During an interview on [DATE] at 1:19 PM, MD 1 stated that normally the current medications from the acute hospital are continued when a resident is admitted to the facility. MD 1 stated he could not remember Resident 1, but he signed and performed the resident ' s History and Physical assessment on [DATE]. MD 1 stated, generally, unless the discharging physician in the GACH discontinued the GACH medications, the expectation is for current medications to be continued at the facility. MD 1 stated, he reviewed the medications of Resident 1 from GACH 1 and stated that all current medications was supposed to be continued. MD 1 stated Resident 1 ' s insulin medications should not have been discontinued. MD 1 stated Resident 1 ' s insulin should have been continued at the upon admission to the facility on [DATE]. MD 1 stated, he does not discontinue insulin medications, once admitted to the facility, but would review for any dosage changes. MD 1 stated, he was not aware Resident 1 ' s insulin was not continued in the facility and that there was no blood sugar monitoring ordered for the resident. MD 1 stated, if insulin is discontinued, the resident could get hyperglycemic [increase blood sugar levels]. MD 1 stated, Resident 1 should have received insulin while in the facility. MD 1 stated, Resident 1's blood sugar levels could go high if not monitored and complication such as DKA could happen and result in death. MD 1 stated, he was not aware Resident 1 did not have an order for blood sugar monitoring, and if he knew that Resident 1 had a diagnosis of diabetes, he would have placed an order for blood sugar monitoring. MD 1 stated he expected the facility ' s licensed nurses to let him know that Resident 1 did not have blood sugar monitoring for the management of DM. MD 1 stated, discontinuing insulin needs documented justification and could not recall if the facility ' s licensed nurses informed him of Resident 1 ' s blood sugar monitoring. During an interview on [DATE] at 5:25 PM, the DON stated that PH 1 did not have any pharmacy recommendations for Resident 1 for the months of ,d+[DATE], ,d+[DATE], and ,d+[DATE]. During a review of the facility ' s policy and procedure (P&P) titled, Diabetic Care, revised [DATE], indicated the following: 1. The purpose of the P&P is to provide a protocol for the immediate treatment of hypoglycemia in residents diagnosed with diabetes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. The Licensed Nurse will monitor residents for signs and symptoms (of) hypoglycemia and hyperglycemia. Signs and symptoms will be documented in the resident ' s medical record and the Attending Physician will be notified. 3. Notify the Attending Physician of treatment and results and for any possible changes in insulin or oral diabetes medications. During a review of the facility ' s P&P titled, Admission and Orientation of Residents, revised [DATE], indicated the following: 1. The resident ' s physician will provide medical orders, including a medical condition or problem associated with each medication. 2. The resident ' s physician will provide routine care orders to maintain or improve the resident ' s function. 3. A registered nurse will conduct the initial assessment of the resident. During a review of the facility ' s P&P titled, Admission Assessment, [DATE], indicated the the licensed nurse will complete a drug regimen review upon admission or as close to the actual time of admission as possible to identify any potential or actual clinically significant medication issues. During a review of the facility ' s policy and procedure titled Care Planning dated [DATE], indicated each resident should have a comprehensive person-centered care plan developed and implemented based on individual assessed needs. During a review of the facility ' s job description titled, Consultant Pharmacist, (undated) indicated the pharmacist is to: 1. Provide physicians, nurses, and patients with therapeutic recommendations and/or medication information. 2. Report any drug regimen irregularities to the attending physician and Director of Nursing. During a review of the facility ' s job description titled, Charge Nurse (oversee the operations of their specific nursing unit) dated Year 2003, indicated the Charge Nurse ' s duties and responsibilities include: 1. Report all discrepancies noted concerning physician ' s orders, diet change, charting error, etc. to the Nurse Supervisor. 2. Consult with the resident ' s physician in providing resident ' s care, treatment, rehabilitation etc, as necessary. 3. Review the resident ' s chart for specific treatments, medication orders, diet,[TRUNCATED]

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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** 48854 Based on interviews and record reviews, the facility failed to ensure the attending physician (Medical Doctor [MD] 1) assessed and evaluated the total program of care for one of three sampled residents (Resident 1) who was diabetic (a person with diagnosis of diabetes) by ensuring the resident ' s blood sugar was monitored [an intervention that is essential for managing diabetes that involves checking blood sugar levels using a device] and Lispro (a medication that lowers the blood sugar level) to manage Diabetes Mellitus [DM, a chronic disease where a person has high blood sugar levels because the body does not produce insulin (a hormone made by the pancreas- an organ in the body) was not administered while under the physician ' s care in the facility from [DATE] to [DATE] (a total of 61 days). As a result of this failure, Resident 1 ' s blood sugar was not monitored and did not receive any medication to control Resident 1 ' s blood sugar from [DATE] to [DATE]. On [DATE] at 6:42 PM, Resident 1 was transferred to General Acute Care Hospital (GACH) 2 via 911 emergency services (an emergency number for any police, fire, or medic) due to altered mental status and with a blood sugar reading of 500 (normal levels are between 70 to 100), oxygen desaturation (low oxygen blood level), and hyperglycemia. Resident 1 was admitted to GACH 2 with a diagnosis of Diabetic Ketoacidosis (DKA, a life-threatening problem related to DM in which the body starts breaking down fat too fast) and expired 2 days after admission to GACH 2 on [DATE]. Cross reference to F684, F756 and F635 Findings: During a review of Resident 1 ' s GACH 1 record, titled, Inpatient Progress Notes, dated [DATE], indicated Resident 1 had a diagnosis of DM. The GACH 1 record indicated a plan to continue Resident 1 ' s insulin medication to maintain a blood sugar goal of less than 180. During a review of Resident 1 ' s GACH 1 record titled Discharge Documentation dated [DATE], timed at 11:07 AM, indicated Issues to Address on Outpatient Follow Up/Discharge Action Plan which included Resident 1 to have continued diabetes management upon admission in the facility. The Discharge Documentation record indicated Resident 1 received insulin in GACH 1 and will need physician [follow up] for DM care. Further review of the Discharge Documentation indicated Resident 1 ' s last blood sugar result in GACH 1 on [DATE] was 157. During a review of Resident 1 ' s Facility Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included DM, encephalopathy (damage or disease that affects the brain), dementia (a syndrome that causes a decline in cognitive [thought process] abilities, such as thinking, remembering, and making decisions, that can interfere with daily activities), and hypertension (high blood pressure). (continued on next page)

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	056317	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Facility Nursing Admission Assessment, dated [DATE], timed at 6:03 PM, signed by LVN 1 and LVN 3, indicated the resident was admitted to the facility on [DATE] at around 5:10 P. M. The Nursing Admission Assessment indicated Resident 1 had a diagnosis of DM Type 2. During a review of Resident 1 ' s care plan titled, initiated on [DATE] and revised on [DATE], indicated to prevent complications related to diabetes, Resident 1 will be monitored and will document, and report signs and symptoms of hyperglycemia and hypoglycemia to the physician. During review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated [DATE], indicated the resident had severely impaired cognition (ability to remember and process information). The MDS also did not indicate that Resident 1 had a diagnosis of DM. The MDS also indicated Resident 1 did not have an order for insulin (a type of hormone that is used as an injectable medication to control the blood sugar for a person with DM). During a review of Resident 1 ' s History and Physical (H&P), dated [DATE], signed by MD, indicated the resident did not have the capacity to understand and make decisions. The H&P indicated Resident 1 had a diagnosis of DM. The H&P did not indicate to administer insulin to the resident or to monitor blood sugar level. During a review of Resident 1 ' s, Order Summary Report (a list of physician ' s orders), dated [DATE] included an order to administer Insulin Lispro (medication that lowers blood sugar) Injection Solution 100 Unit/ML [Unit per milliliter, a unit of measure] (Insulin Lispro) Inject as per sliding scale. The report indicated the order for Insulin Lispro was discontinued on [DATE]. The record indicated the reason for discontinuing was clarification of order. There was no documented evidence in Resident 1 ' s physician orders the reason to discontinue Lispro and the clarification needed. During a review of Resident 1 ' s clinical record titled, Discontinue Order, dated [DATE], timed at 11:17 PM, indicated Insulin Lispro was discontinued on [DATE], timed at 11:16 PM. The record indicated the reason for discontinuing was clarification of order, but did not indicate what was clarified with the physician. The record also indicated the discontinuation was ordered by MD and there was indication for the reason the insulin was discontinued or not ordered. During a review of Resident 1 ' s Interdisciplinary Team Conference Record (IDT, a multidisciplinary meeting), dated [DATE], indicated Resident 1 had a diagnosis of DM. The IDT did not have documented evidence that Resident 1 ' s DM was discussed during the IDT and did not discuss that the MD ordered the resident to receive insulin and blood sugar to be monitored. During a review of Resident 1 ' s Medication Administration Record (MAR) for February 2024, [DATE], and [DATE], did not have documented evidence that Resident 1 was administered Insulin Lispro, the blood sugar level was monitored. and that staff monitored Resident 1 for signs and symptoms of hypoglycemia or hyperglycemia, as indicated in the resident ' s care plan. During a review of Resident 1 ' s Transfer Form, dated [DATE], timed at 6:42 PM, indicated Resident 1 was transferred to GACH 2, due to altered mental status. (continued on next page)

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Change in Condition Evaluation (CIC), dated [DATE], indicated Resident 1 was found with labored breathing and blood sugar level of 500 (mg/dL). The CIC also indicated Resident 1 had signs and symptoms that included altered mental status, oxygen desaturation, and hyperglycemia. The CIC also indicated Resident 1 was transferred via 911 to GACH 2. During a review of Resident 1 ' s Emergency Department Reports from GACH 2, dated [DATE], indicated the resident was admitted to the Emergency Department (ED) on [DATE] at 6:48 PM with chief complaint of altered mental status and the blood sugar was high. The report indicated on [DATE] at around 5:50 PM, [Resident 1] refused her dinner and threw her juice on the floor and refused to eat. When [Resident 1] was reevaluated by [facility staff], they noted that she was breathing heavily and not speaking. The report also indicated the facility staff tried to measure [Resident 1 ' s] sugar, their glucometer (a device used to measure the blood sugar) read as high. Additionally, the laboratory blood test conducted in the ED indicated the following: 1. Arterial Blood Gas (ABG)- pCO2 level of 17.0 (pCO2, partial pressure of carbon dioxide, the measure of carbon dioxide within the blood, normal levels fall between 35 to 45) a sign indicating ketoacidosis. 2. ABG- pO2 level of 306 (pO2, partial pressure oxygen level, the amount of oxygen gas dissolved in the blood, normal levels fall between 75 to 100) high pressure of oxygen in the lungs that could cause lungs to collapse. 3. ABG- HCO3 level of 9.6 (HCO3, bicarbonate, concentration of bicarbonate in arterial blood, normal levels fall between 22 to 26) indication of metabolic acidosis (the body produces too much acid that could be caused by ketoacidosis). 4. Blood Sugar of 810 mg/dL (Normal levels fall between 70 to 100) During a review of the Emergency Department Reports from GACH 2, dated [DATE], indicated the resident had a diagnosis of DKA. The ED report also indicated the resident was started on insulin drip (insulin that is administered directly through a person ' s vein) and was admitted to the Intensive Care Unit (ICU, a specialized unit in a hospital that caters to patients that are critically ill) for DKA. During a review of Resident 1 ' s Discharge Summaries Notes from GACH 2, dated [DATE], timed at 3:11 PM, indicated Resident 1 coded [a medical term which means a person ' s heart stopped and basic life support was provided] and expired on ,d+[DATE] while in the ICU. The notes indicated the final diagnoses of: 1. Diabetes Mellitus Type 2 2. Hyperosmolar hyperglycemic state (a serious complication of diabetes that happens when blood sugar levels are very high for a long period of time) 3. Diabetic Ketoacidosis 4. Sepsis (a serious condition in which the body responds improperly to an infection) (continued on next page)

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Certificate of Death indicated Resident 1 expired on [DATE] at 6:45 AM in GACH 2. The certificate indicated the immediate cause of death as Diabetic Ketoacidosis and sequentially, Diabetes Mellitus Type 2. During a concurrent interview and record review on [DATE] at 1:28 PM with MDS Nurse, Resident 1 ' s clinical records, including the progress notes, were reviewed. The MDS Nurse stated there is no documented evidence in Resident 1 ' s clinical record that the physician ordered insulin or to monitor the Resident 1 ' s blood sugar. The MDS Nurse also indicated there was no documented evidence that the staff administered insulin to Resident 1 and monitored Resident 1 ' s blood sugar. The MDS Nurse stated residents that have a diagnosis of DM should have an order to have their blood sugar monitored. During the same concurrent interview and record review of Resident 1's Order Summary Report, dated [DATE] on [DATE] at 1:28 PM, the MDS Nurse stated the report had a signature but did not indicate who signed it and when it was signed. The MDS Nurse stated there should be a name and a date along with the signature. The MDS Nurse stated the signature is an indication that Resident 1 ' s medications were reviewed by the physician who signed it. The MDS Nurse stated the Order Summary Report did not have an order for insulin or blood sugar monitoring. During a phone interview on [DATE] at 1:19 PM with MD 1, MD 1 stated he does not recall Resident 1 but he was the primary physician for the resident since admitted to the facility. MD 1 stated residents admitted to the facility from a hospital usually continues medications at the facility because the medications had been reviewed and optimized for the resident. MD 1 stated Resident 1 ' s insulin should have been continued to be administered in the facility and there should have been an order for blood sugar monitoring because if sugar is not checked the resident could develop hyperglycemia and DKA could lead to septic induced hyperglycemia. MD 1 stated the DKA cause Resident 1 to become dehydrated, acidotic, ketosis and death if the resident does not get immediate help. MD 1 stated he was not sure why Resident 1 ' s insulin was discontinued and why there was no order for the blood sugar to be monitored. MD 1 stated he was not aware that the blood sugar of Resident 1 was not being checked. MD 1 stated the doctors have the final say and oversee discontinuing the medications. During a review of the facility ' s policy and procedure (P&P) titled, Diabetic Care, revised [DATE], indicated blood [sugar] levels will be monitored at specific intervals as ordered by the attending physician. During a review of the facility ' s P&P titled, Admission and Orientation of Residents, revised [DATE], indicated the following: 1. The resident ' s physician will provide medical orders, including a medical condition or problem associated with each medication. 2. The resident ' s physician will provide routine care orders to maintain or improve the resident ' s function. (continued on next page)

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s P&P titled, Physician Services & Visits, revised [DATE], indicated the physician is to provide advice, treatment, and determination of appropriate level of care needed for each [resident]. The P&P also indicated for the physician ' s participation in the resident ' s assessment and care planning and monitoring changes in resident ' s medical status. The P&P also indicated for the physician to participate in an evaluation of the [resident] and review of orders for care and treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48854 Based on interview and record review, the facility failed to ensure the facility ' s pharmacy consultant thoroughly reviewed and reported irregularities to the attending physician and the facility ' s medical director and Director of Nursing (DON) during Medication Regimen Review (MRR-a structured, critical examination of a person's medicines of the residents to ensure they receive the right medications and monitoring needed to optimize the impact of medicines) for one of one sampled residents (Resident 1) who was admitted to the facility from [DATE] to [DATE] (total 2 months), with diagnosis of Diabetes Mellitus Type 2 (DM, a chronic disease where a person has high blood sugar [glucose] levels) and did not receive insulin that was discontinued without clear indication and blood sugar was not monitored. As a result of this failure, Resident 1 ' s blood sugar level was not monitored and did not receive any Lispro (medication to control blood sugar level) from [DATE] to [DATE]. On [DATE] at 6:42 PM, Resident 1 was transferred to General Acute Care Hospital (GACH) 2 via 911 (an emergency number for any police, fire, or medic) due to altered mental status and with a blood sugar reading of 500 (normal levels are between 70 to 100). Resident 1 was admitted to GACH 2 with a diagnosis of Diabetic Ketoacidosis (DKA, a life-threatening problem related to DM in which the body starts breaking down fat too fast) and expired 2 days after on [DATE]. Cross reference to F635, F684, and F711 Findings: During a review of Resident 1 ' s GACH 1 record, titled, Inpatient Progress Notes, dated [DATE], indicated Resident 1 had a diagnosis of DM . The GACH 1 record indicated a plan to continue Resident 1 ' s insulin medication to maintain a blood sugar goal of less than 180. During a review of Resident 1 ' s GACH 1 record titled Discharge Documentation dated [DATE], timed at 11:07 AM, indicated Issues to Address on Outpatient Follow Up/Discharge Action Plan which included Resident 1 to have continued diabetes management upon admission in the facility. The Discharge Documentation record indicated Resident 1 received insulin in GACH 1 and will need physician [follow up] for DM care. Further review of the Discharge Documentation indicated Resident 1 ' s last blood sugar result in GACH 1 on [DATE] was 157. During a review of Resident 1 ' s Facility Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses that included DM, encephalopathy (damage or disease that affects the brain), dementia (a syndrome that causes a decline in cognitive [thought process] abilities, such as thinking, remembering, and making decisions, that can interfere with daily activities), and hypertension (high blood pressure). During a review of Resident 1 ' s Facility Nursing Admission Assessment, dated [DATE], timed at 6:03 PM, signed by LVN 1 and LVN 3, indicated the resident was admitted to the facility on [DATE] at around 5:10 P. M. The Nursing Admission Assessment indicated Resident 1 had a diagnosis of DM Type 2. (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s facility records titled, Discontinue Order, dated [DATE], timed at 11:17 PM, signed by LVN 1, indicated a telephone order from MD 1 for Insulin Lispro Sliding Scale to be discontinued on [DATE], timed at 11:16 PM. The record indicated the reason for discontinuing was Clarification of Order. During the review of the resident ' s physician orders, there was no additional orders or justification for Lispro insulin after it had been discontinued. During a review of Resident 1 ' s History and Physical (H&P), dated [DATE], signed by MD 1, indicated the resident did not have the capacity to understand and make decisions. The H&P indicated Resident 1 had a diagnosis of DM. During a review of Resident 1 ' s Minimum Data Set (MDS, a comprehensive standardized assessment and screening tool), dated [DATE], indicated the resident had severely impaired cognition (ability to remember and process information). The MDS also did not indicate that Resident 1 had a diagnosis of DM. The MDS also indicated Resident 1 did not have an order for insulin (a type of hormone that is used as an injectable medication to control the blood sugar for a person with DM). During a review of Resident 1 ' s clinical record from General Acute Care Hospital (GACH) 1 that was provided by the facility titled, Inpatient Progress Notes, dated [DATE], timed at 8:51 PM, indicated Resident 1 had DM. The GACH 1 record indicated a plan to continue Resident 1 ' s insulin. During a review of Resident 1 ' s Order Summary Report (OSR) for all orders during Resident 1 ' s stay at the facility from [DATE] to [DATE], included a physician order to administer Insulin Lispro [a class of insulin hormone] Injection Solution 100 Unit/ML [Unit per milliliter, a unit of measure] Inject as per sliding scale (a guide use to determine how much insulin to give to correct an elevated blood sugar) on [DATE]. The OSR indicated the order for Insulin Lispro sliding scale was discontinued the same date, [DATE]. During a review of Resident 1 ' s Order Summary Report, dated [DATE], did not include an order for insulin or blood sugar monitoring. The report was signed but does not indicate the person who the signed the report on the section right next to the signature. The report did not indicate the date when the report was signed. During a review of Resident 1 ' s facility records titled, Discontinue Order, dated [DATE], timed at 11:17 PM, signed by LVN 1, indicated a telephone order from MD 1, for Insulin Lispro Sliding Scale to discontinue on [DATE], timed at 11:16 PM. The record indicated the reason for discontinuing was Clarification of Order. During a review of Resident 1 ' s clinical record titled, Discontinue Order, dated [DATE], timed at 11:17 PM, signed by LVN 1, indicated the order for Insulin Lispro was discontinued on [DATE], timed at 11:16 PM. The record indicated the reason for discontinuing was clarification of order. The record also indicated the discontinuation was ordered by MD. During a review of Resident 1 ' s Medication Administration Record (MAR) for February 2024, [DATE], and [DATE], did not have documented evidence that Resident 1 was administered Insulin Lispro. The MAR also did not have documented evidence that Resident 1 ' s blood sugar level was monitored. The MAR also did not have documented evidence that staff monitored Resident 1 for signs and symptoms of hypoglycemia or hyperglycemia, as indicated in the resident ' s care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056317	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenoaks Convalescent Hospital	409 W. Glenoaks Blvd. Glendale, CA 91202

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Interdisciplinary Team Conference Record (IDT, a multidisciplinary meeting), dated [DATE], indicated Resident 1 had a diagnosis of DM. The IDT did not have documented evidence that Resident 1 ' s DM was discussed during the IDT. During a review of the facility ' s Medication Regimen Review (MRR, process conducted, usually by a pharmacist , to review a resident ' s medication regimen) MRR for the months of ,d+[DATE], ,d+[DATE], and , d+[DATE], the MRR did not have documented evidence that Pharmacist Consultant (PH) 1 addressed or provided pharmacy recommendations related to Resident 1 ' s diagnosis of DM. The MRR did not indicate recommendations for blood sugar monitoring or insulin regimen to manage Resident 1 ' s DM. The MRR did not have documented evidence that PH 1 informed the DON or MD 1 to recommend to check the blood sugar level of Resident 1 to determine if the resident required DM management. During a review of Resident 1 ' s Change in Condition Evaluation (CIC), dated [DATE], timed at 7:04 PM, indicated Resident 1 was found to have labored breathing and with a blood sugar level of 500 (mg/dL). The CIC also indicated Resident 1 had signs and symptoms that included altered mental status, oxygen desaturation, and hyperglycemia. The CIC indicated MD and family were notified. The CIC also indicated Resident 1 was transferred via 911 to GACH 2. During a review of Resident 1 ' s Emergency Department Reports from GACH 2, dated [DATE], indicated the resident was admitted to the Emergency Department (ED) on [DATE] at 6:48 PM with chief complaint of altered mental status and the blood sugar was high with laboratory blood test conducted in the ED indicated Resident 1 ' s blood Sugar level of 810 (Normal levels fall between 70 to 100). During a review of the Emergency Department Reports from GACH 2, dated [DATE], indicated the resident had a diagnosis of DKA. The ED report also indicated the resident was started on insulin drip (insulin that is administered directly through a person ' s vein) and was admitted to the Intensive Care Unit (ICU, a specialized unit in a hospital that caters to patients that are critically ill) for DKA. The report also indicated Resident 1 ' s condition as critical. During a review of Resident 1 ' s MAR from GACH 2 indicated the resident received the following medication between [DATE] to [DATE]: 1. Insulin drip: Insulin regular 100 units [units, a unit of measure] (1 units/hour) + manufacturer premix 100 mL. The order was started on [DATE] at 11:39 PM. 2. Vasopressin: Vasopressin 20 units (0.03 units/min) + manufacturer premix 100 mL. The order was started on [DATE] at 3:00 PM. During a review of Resident 1 ' s H&P from GACH 2, dated [DATE], timed at 1:05 AM, indicated Resident 1 intubated (a person that is intubated underwent a process in which a plastic tube is inserted through the mouth and into the person ' s airway for the purpose of providing artificial breaths) with During a review of Resident 1 ' s H&P from GACH 2, dated [DATE], times at 1:07 AM, indicated Resident 1 ' s MAR from the facility did not include any medications for Resident 1 ' s DM. The notes indicated Resident 1 had a diagnosis of DM and was receiving insulin during a recent hospitalization . (continued on next page)

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	056317	A. Building B. Wing	08/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1 ' s Discharge Summaries Notes from GACH 2, dated [DATE], timed at 3:11 PM, indicated Resident 1 coded [a medical term which means a person ' s heart stopped and basic life support was provided] and expired on ,d+[DATE] while in the ICU with the primary diagnosis of DKA and sepsis. During a review of Resident 1 ' s Certificate of Death indicated Resident 1 expired on [DATE] at 6:45 AM in GACH 2. The certificate indicated the immediate cause of death as Diabetic Ketoacidosis and sequentially, Diabetes Mellitus Type 2. During a concurrent interview and record review on [DATE] at 1:28 PM with the MDS Nurse, Resident 1 ' s entire medical records, including the progress notes, were reviewed. The MDS Nurse stated there is no documented evidence that licensed staff administered insulin to Resident 1 and monitored Resident 1 ' s blood sugar. The MDS Nurse stated residents that have a diagnosis of DM should have an order to have their blood sugar monitored. During a phone interview on [DATE] at 11:45 AM with PH 1, PH 1 stated she only reviews the residents ' current medications and not discontinued medications or the resident ' s diagnoses when making recommendations. PH 1 added she would not have known if a resident was taking insulin if the insulin was discontinued. PH 1 stated if she was aware that Resident 1 had a diagnosis of DM, she would have recommended for the resident to have the blood sugar monitored and for the resident to start receiving medications to control the blood sugar. During a phone interview on [DATE] at 1:19 PM with MD 1, MD 1 stated Resident 1 ' s insulin should have been continued and Resident 1 ' s blood sugar should have been monitored. MD 1 stated a resident who has a diagnosis of DM and who was not receiving insulin could suffer DKA. MD 1 stated DKA could cause death. During a concurrent interview and record review on [DATE] at 5:25 PM with Director of Nursing (DON), the facility ' s Medication Regiment Review (MRR) for February 2024, [DATE], and [DATE], was reviewed. The DON stated the MRR does not have any recommendations, such as adding insulin to Resident 1 ' s medication regimen or blood sugar monitoring, from PH 1 to address Resident 1 ' s diagnosis of DM. During a review of the facility ' s job description titled, Consultant Pharmacist, undated, indicated the pharmacist is to: 1. Provide physicians, nurses, and patients with therapeutic recommendations and/or medication information. 2. Report any drug regimen irregularities to the attending physician and Director of Nursing. During a review of the facility ' s P&P titled, Drug Regimen Review, revised [DATE], indicated the following: 1. The pharmacist will review each resident ' s medication regimen at least once a month to identify irregularities. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Irregularity refers to identification of conditions that may warrant initiation of medication therapy.