STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056322	A. Building B. Wing	05/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave Montrose, CA 91020

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 - Actual harm 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 interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one of three sampled residents (Resident 1) with diagnosis of Diabetes Mellitus (DM, a chronic disease where a person has high blood sugar [glucose] levels because the body does not produce or use insulin [a type of hormone] normally and required blood sugar monitoring and/or medications to lower blood sugar levels) by failing to ensure to: 1. All appropriate discharge orders for diabetes management from the General Acute Care Hospital (GACH 1) were verified with the attending physician/Medical Doctor (MD) 1 upon admission to the skilled nursing facility on [DATE]. 2. The Director of Nursing (DON) or designee thoroughly reviewed Resident 1's medical history of DM and discharge orders from the General Acute Care Hospital (GACH) 1 that indicated resident was receiving Insulin (medication given by injection to lower blood sugar level) prior to admission to the facility and verified with the physician if blood sugar monitoring and/or Insulin should be continued to be administered to the resident while residing in the facility. 3. The licensed staff verified Resident 1's admission orders and notified the physician that resident with DM did not have orders to monitor the resident's blood sugar or if the resident needed to continue insulin to prevent hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar). 4. Ensure plan of care was implemented by ensuring Resident 1 was monitored for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) from the date of admission to the facility on [DATE] and discharged from the facility on [DATE] (a total of six days). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	As a result of this deficient practice Resident 1 was transferred to the GACH 1 via 911 (an emergency number for medical assistance) due to altered level of consciousness and was admitted to the emergency room (ER) and with blood sugar of 823 (normal blood sugar level is between 70 to 100) mg/dL (milligrams per deciliter, a unit of measurement). The resident was transferred to ICU (intensive Care Unit- a unit in the hospital for residents with life threatening condition) where resident received vasopressin (medications given into the vein to increase blood pressure which then increases the blood flow to the body) and continuous insulin drip (a hormone therapy continuously given directly into vein and enters the bloodstream to lower and/or control high blood sugar level) was started due to critical high blood sugar and was diagnosed with Diabetic Ketoacidosis (DKA, a serious complication of diabetes and occurs when the body starts breaking down fat at a rate that is much too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic). Resident 1 required ICU care from [DATE] until Resident 1 expired on [DATE] at 8:07 PM (a total of 6 days after Resident 1 was admitted to the GACH 1). Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses that included DM. A review of Resident 1's Clinical Admission Evaluation indicated Resident 1 was admitted to the facility on [DATE] at 8:20 PM. The Clinical Evaluation indicated Resident 1 had a diagnosis of DM. During a review of Resident 1's clinical record titled, Hospital Discharge Instructions, indicated Resident 1 was admitted to the GACH 1 on [DATE] with diagnosis that included DM and was discharged on [DATE] from the GACH 1 to the facility. The record indicated Resident 1 received 6 units of Novolog (a medication that lowers the blood sugar given via injection under the skin) on [DATE] at 12 PM for the blood sugar level of 241 mg/dL (eight hours prior to admission of the resident in the facility). A review of Resident 1's History and Physical (H&P) from the facility dated [DATE], indicated Resident 1 had fluctuating capacity to understand and make decisions. The H&P indicated Resident 1 had a diagnosis of DM. 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 indicated Resident 1 had a diagnosis of DM. A review of Resident 1's Order Summary Report for ,d+[DATE], included to administer Sitagliptin Phosphate (Januvia is the brand-name of an oral medication that control the blood sugar) an oral tablet 100 mg and give 1 tablet by mouth in the morning for DM with meal. A review of Resident 1's care plan for Potential for injury related to hypoglycemia secondary to the use of oral hypoglycemic agents or insulin therapy, initiated on [DATE], created by Registed Nurse (RN) 1 indicated Resident 1 the facility staff are to monitor for [signs and symptoms] of hypoglycemia/hyperglycemia such as changes on [level of consciousness], skin [temperature], change in mood, thirst and notify MD. (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 - Actual harm Residents Affected - Few	A review of Resident 1's Medication Administration Record (MAR) for ,d+[DATE] indicated Resident 1 was administered Sitagliptin daily from [DATE] to [DATE]. The MAR had no documented evidence that Resident 1's blood sugar was monitored. The MAR also did not show documented evidence that staff monitored Resident 1 for signs and symptoms of hypoglycemia or hyperglycemia, as indicated in the resident's care plan. A review of Resident 1's Skilled Evaluation form for the dates of [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] (a total of six days) did not have documented evidence that the licensed nurse verified with the Nurse Practitioner (NP) or MD 1 if the resident needed an order to check the blood sugar or to administer insulin based on the resident's history of diabetes and receiving insulin while in the GACH 1 prior to admission to the facility. A review of Resident 1's Change in Condition Evaluation (CIC), dated [DATE], timed at 6:45 PM, indicated Resident 1 was found unresponsive on [DATE] at 6:30 P.M. The CIC report indicated Resident 1 had a pertinent diagnosis of diabetes. The CIC had no documented evidence Resident 1's blood sugar was checked when Resident 1 had a change of condition. The CIC indicated Resident 1's physician and family was notified. The CIC indicated Resident 1 was transferred via 911 to GACH 1. A review of Resident 1's Transfer Form, dated [DATE], timed at 7:15 PM, indicated Resident 1 was transferred back to GACH 1 for the loss of consciousness. The Transfer Form also indicated DM as a relevant diagnosis. The Transfer Form indicated 911 was called on [DATE] at 7 P.M. A review of Resident 1's Emergency Documentation Notes from GACH, dated [DATE], indicated the resident admitted to the emergency department on [DATE] at 7:54 PM with chief complaint of hyperglycemia. The notes indicated the blood sugar was 400+ on scene (in the facility from the 911 call). The notes indicated Resident 1 will need ICU admit and was started on insulin drip at 6 units/h (units per hour). A review of Resident 1's Critical Care IP (in Patient) Progress Notes from GACH, dated [DATE], timed at 10:57 PM, indicated Resident 1 was admitted to the emergency department with a blood sugar of 823 mg/dL and the resident's condition was critical. A review of Resident 1's Progress Notes from GACH 1, dated [DATE], indicated Resident 1 was admitted back to GACH 1 due to altered mental status, elevated blood sugar levels and was diagnosed with DKA. A review of Resident 1's Procedure Note from GACH 1, dated [DATE], indicated an endotracheal intubation (a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth to provide artificial breathing and life support) procedure was performed on Resident 1 on [DATE] at 12:16 PM. A review of Resident 1's Critical Care IP Progress Notes from GACH, dated [DATE], indicated Resident 1 was intubated and placed on mechanical ventilation (a machine that provides artificial breathing to a person). A review of Resident 1's Physician Orders- Medication from GACH 1 indicated Resident 1 received the following medications between [DATE] to [DATE]: (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 - Actual harm Residents Affected - Few	a. Insulin drip: Insulin regular IV (intavenous-given into the vein) additive 100 Unit(s) + NS [Normal Saline] 0. 9% (base) 100 mL (milliliter-a unit of measurement). The order was started on [DATE] at 11:12 PM and was discontinued on [DATE] at 12:15 PM and physician order for insulin was changed to ISS (insulin sliding scale-insulin dose given based on the blood sugar level) on [DATE]. b. Vasopressin Vasopressin IV additive 40 Unit(s) + NS 0.9% 100 mL. The physician order indicated to start on [DATE] at 8:30 PM. A review of Resident 1's Critical Care IP Progress Notes from GACH 1, dated [DATE], indicated Resident 1 was pronounced brain dead (when a person no longer has any brain functions) on [DATE] at 6 PM (five days after admitted back in GACH 1). A review of Resident 1's Certificate of Death, indicated Resident 1 died on [DATE] at 8:07 PM due to cardiac arrest (when the heart stops beating suddenly) as the primary cause of death. During a concurrent interview and record review of Resident 1's clinical records that included the physician orders, Order Summary report, Nursing Progress notes and MAR on [DATE] at 11:41 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had no physicians' order to receive insulin or to monitor for blood sugar. LVN 1 stated there was no evidence that Resident 1 was administered any insulin or had her blood sugars monitored during the resident's stay in the facility. LVN 1 stated Resident 1 had a diagnosis of DM and included insulin as one of the medications Resident 1 was ordered to receive in GACH. During an interview on [DATE] at 11:08 AM with MD 1, MD 1 stated most oral diabetic medications like Sitagliptin do not drastically lower the blood sugar. MD 1 stated putting an order to monitor the resident's blood sugar would depend on the orders sent by the transferring hospital. MD 1 stated continuation of insulin and blood sugar monitor would depend on the discharge paperwork provided by the hospital to the facility. MD 1 stated the transition from the hospital to the facility is critical and stated if what was happening in the hospital was working so the orders should be the same. During an interview on [DATE] at 11:30 AM with LVN 2, LVN 2 stated prior to admission to the facility, the facility was contacted by the hospital via phone call to inform the facility about the resident. LVN 2 stated if a newly admitted resident has a diagnosis of DM, she expected the physician to order blood sugar monitor. LVN 2 stated when admitting residents to the facility, the physician was usually contacted to verify the resident's medication orders which was part of the admission process. During a concurrent interview and record review of Resident 1's medical records that included the physician orders, Order Summary report, Nursing Progress notes and MAR with Registered Nurse (RN) 1 on [DATE] at 1PM, RN 1 stated communications with the physician were documented on Skilled Evaluation. RN 1 stated there was no documented evidence that the facility staff communicated to MD 1 that Resident 1, with diagnosis of DM, did not have an order for insulin or to check or monitor the blood sugar. RN 1 stated if blood sugar was not monitored for residents with DM, the residents could suffer from hyperglycemia (high blood sugar levels) or hypoglycemia (low blood sugar levels). RN 1 stated a resident that is experiencing hyperglycemia or hypoglycemia could have altered mental status or go into a comatose state (coma, a stated of deep sleep and cannot be awakened). (continued on next page)

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F 0635 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 9:45 AM with the DON, the DON stated, on [DATE] there was no physician's order to check for blood sugar when the physician ordered Resident 1 to start Januvia and the Metformin (medication taken by mouth to lower blood sugar level) was discontinued. The DON also indicated if a resident with the DM was admitted without an order for blood sugar monitoring, it was beyond his scope of practice to ask and verify with the MD if the blood sugar of the resident should be checked. A review of the facility's job description titled, Director of Nursing Services, undated, indicated the DON assumes ultimate responsibility for coordinating plans for the total care of each resident. The document also indicated the DON participates in admission of residents. A review of the facility's policy and procedure (P&P) titled, Admission and Orientation of Residents, revised , d+[DATE], indicated the attending physician will provide medication orders, including a medical condition or problem associated with each medication. The P&P also indicated the physician will provide routine care orders to maintain or improve the resident's function. The P&P indicated eligibility for admission will be determined by facility staff, including the DON. A review of the facility's P&P titled, Progress Notes, revised ,d+[DATE], indicated the resident's progress notes will reflect the resident's current status, progress or lack of progress, changes in condition, adjustment to the facility, and other relevant information. A review of the facility's P&P titled, Physician Orders, revised ,d+[DATE], indicated the licensed nurse will confirm that physician orders are clear, complete, and accurate as needed. A review of the facility's P&P titled, Diabetic Care, revised ,d+[DATE], indicated the following: 1. The facility will provide the necessary care and services to permit each diabetic resident to attain or maintain optimal well-being while monitoring their care in accordance with their individualized Comprehensive Assessment and Care Plan. 2. The Attending Physician will write parameters for notification for blood sugar that is out of control. 3. A Licensed Nurse will document clearly and consistently all diabetic monitoring. 4. Nursing Staff will monitor the resident for signs and symptom of hypoglycemia or hyperglycemia, initiate interventions if necessary, and notify the Attending Physician and responsible party if signs and symptoms are present. 5. The Interdisciplinary Team (IDT) will ensure the Care Plan addresses the resident's diabetes, goals, and interventions, and update the Care Plan as necessary. 6. All documentation related to the resident's diabetic condition will be maintained in the resident's medical record.

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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 interview and record review, the facility failed to ensure the physician visits included an evaluation of the resident's condition and total program of care and the appropriateness of the resident's current medication regimen for one of three sampled residents (Resident 1) with a diagnosis of Diabetes Mellitus (DM, a chronic disease where a person has sustained high blood sugar levels) with high blood sugar levels while in the General Acute Care Hospital (GACH) had no physician order for blood sugar monitoring. As a result of this deficient practice, Resident 1 blood sugar was not monitored for high blood sugar and not evaluated for the need for administration of insulin from ,d+[DATE]- ,d+[DATE] (a total of 6 days at the facility). On [DATE] at 7:15 PM, Resident 1 was transferred to the GACH via 911 (an emergency number for any police, fire or medic) due to altered level of consciousness and admitted in ER with a blood sugar of 823 mg/dL [milligrams per deciliter] (a normal blood sugar range is ,d+[DATE] mg/dL) and was transferred to ICU where resident received insulin continuous drip (a hormone therapy continuously given directly into vein and enters the bloodstream to lower and/or control high blood sugar level) and diagnosed with DKA (is a life-threatening problem related to DM in which the body starts breaking down fat too fast. The liver processes the fat into a fuel called ketones, which causes the blood to become acidic). Cross reference to F635 Findings: A review of Resident 1's Admission Record indicated Resident 1 was originally admitted to the facility on [DATE] with diagnoses that included DM. A review of Resident 1's Clinical Admission Evaluation indicated Resident 1 was admitted to the facility on [DATE] at 8:20 PM. The Clinical Evaluation indicated Resident 1 had a diagnosis of DM. During a review of Resident 1's clinical record titled, Hospital Discharge Instructions, indicated Resident 1 was admitted to the GACH 1 on [DATE] with diagnosis that included DM and was discharged on [DATE] from the GACH 1 to the facility. The record indicated Resident 1 received 6 units of Novolog on [DATE] at 12 PM for the blood sugar level of 241 mg/dL (eight hours prior to admission of the resident in the facility). A review of Resident 1's History and Physical (H&P) from the facility dated [DATE], indicated Resident 1 had fluctuating capacity to understand and make decisions. The H&P indicated Resident 1 had a diagnosis of DM. 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 indicated Resident 1 had a diagnosis of DM. (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	A review of Resident 1's Order Summary Report for ,d+[DATE], included to administer Sitagliptin Phosphate (Januvia is the brand-name of an oral medication that control the blood sugar) an oral tablet 100 mg and give 1 tablet by mouth in the morning for DM with meal. A review of Resident 1's Medication Administration Record (MAR) for ,d+[DATE] indicated Resident 1 was administered Sitagliptin daily from [DATE] to [DATE]. The MAR had no documented evidence that Resident 1's blood sugar was monitored. The MAR also did not show documented evidence that staff monitored Resident 1 for signs and symptoms of hypoglycemia or hyperglycemia, as indicated in the resident's care plan. A review of Resident 1's Skilled Evaluation form for the dates of [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] (a total of six days) did not have documented evidence that the licensed nurse verified with the Nurse Practitioner (NP) or MD 1 if the resident needed an order to check the blood sugar or to administer insulin based on the resident's history of diabetes and receiving insulin while in the GACH 1 prior to admission to the facility. A review of Resident 1's discharge record, dated [DATE], indicated Resident 1 had a diagnosis of DM. with a blood sugar level of 231 mg/dL on [DATE] and 536 mg/dL (critical) on [DATE]. A review of Resident 1's Clinical Physician Orders, dated [DATE] to [DATE] indicated no documented evidence that the physician ordered Resident 1's blood sugar to be monitored or to receive insulin. During a concurrent interview and record review of Resident 1's clinical records on [DATE] at 11:41 AM with LVN 1, LVN 1 stated Resident 1 had no physicians' order to receive insulin or to monitor for blood sugar. LVN 1 stated there was no evidence that Resident 1 was administered any insulin or had her blood sugars monitored during the resident's stay in the facility. During a review of Resident 1's H&P from GACH with LVN 1, LVN 1 stated Resident 1 had a diagnosis of DM and included insulin as one of the medications Resident 1 was ordered to receive in GACH. During a concurrent interview and record review of Resident 1's clinical records with Registered Nurse (RN) 1 on [DATE] at 1PM, RN 1 stated there is no order to administer insulin or to monitor Resident 1's blood sugar. RN 1 stated if blood sugar was not monitored for residents with DM, the residents could suffer from hyperglycemia (high blood sugar levels) or hypoglycemia (low blood sugar levels). RN 1 stated a resident that is experiencing hyperglycemia or hypoglycemia could have altered mental status or go into a comatose state (coma, a stated of deep sleep and cannot be awakened). During an interview on [DATE] at 11:08 AM with MD 1, MD 1 stated most oral diabetic medications like Sitagliptin do not drastically lower the blood sugar. MD 1 stated putting an order to monitor the resident's blood sugar would depend on the orders sent by the transferring hospital. MD 1 stated continuation of insulin and blood sugar monitor would depend on the discharge paperwork provided by the hospital to the facility. MD stated the transition from the hospital to the facility is critical and stated if what was happening in the hospital was working so the orders should be the same. A review of Resident 1's Change in Condition Evaluation (CIC), dated [DATE], timed at 6:45 PM, indicated Resident 1 was found unresponsive on [DATE] at 6:30 P.M. The CIC report indicated Resident 1 had a pertinent diagnosis of diabetes. The CIC had no documented evidence Resident 1's blood sugar was monitored during the change of condition. The CIC indicated Resident 1 was transferred via 911 to GACH. (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	A review of Resident 1's Transfer Form, dated [DATE], timed at 7:15 PM, indicated Resident 1 was transferred to GACH for the loss of consciousness. The Transfer Form also indicated DM as a relevant diagnosis. The Transfer Form indicated 911 was called on [DATE] at 7 P.M. A review of Resident 1's Progress Notes from GACH, dated [DATE], indicated Resident 1 and was admitted to GACH 1 due to altered mental status and elevated blood sugar levels. The notes indicated Resident 1 had a critical blood sugar level of 823mg/dL. The notes indicated Resident 1 was diagnosed with diabetic ketoacidosis. A review of Resident 1's Progress Notes from GACH, dated [DATE], indicated Resident 1 was intubated (a process in which a plastic tube is inserted through a person's airway to provide artificial breathing and life support) and placed on mechanical ventilation (a machine that provides artificial breathing to a person). A review of Resident 1's Certificate of Death, dated [DATE], indicated Resident 1 died on [DATE] at 8:07 PM. The document indicated cardiac arrest (when the heart stops beating suddenly) as the cause of death. A review of the facility's Policy and Procedure (P&P) titled, Physician Services & Visits, revised [DATE], indicated physician services include an evaluation of the patient and review of orders for care and treatment. The P&P also indicated physician services include supervising follow-up visits from Nurse Practitioners or Physician Assistants, etc., to ensure that the resident receives quality care and medical treatments. A review of the facility's P&P titled, Diabetic Care, revised [DATE], indicated the attending physician will write parameters for notification for blood sugar. A review of the facility's policy and procedure (P&P) titled, Admission and Orientation of Residents, revised , d+[DATE], indicated the attending physician will provide medication orders, including a medical condition or problem associated with each medication. The P&P also indicated the physician will provide routine care orders to maintain or improve the resident's function.