STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105530	A. Building B. Wing	04/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Manor Healthcare and Rehabilitation Center	1550 Jess Parrish CT Titusville, FL 32796

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 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate, communicate, and document the change in diabetic treatment plan for a chronically ill resident who required a surrogate for decision making, (#1). This affected 1 out of 8 diabetic residents whose treatment plans were reviewed, out of 43 residents in the facility with a diagnosis of diabetes. Resident #1 and her representative were not informed of the risks associated with not receiving diabetic care and were not given the choice to make an informed decision on the treatment plan. The failure in care coordination resulted in lack of diabetes care and monitoring according to resident/family wishes for 48 days, during which the resident developed sepsis and Hyperosmolar Hyperglycemic State (HHS), a life-threatening condition that could lead to organ failure, coma or death. The resident required emergency 911 transfer to the hospital and admission to the Intensive Care Unit (ICU), for 3 days.HHS is a life-threatening complication of diabetes, mainly type II diabetes. HHS happens when your blood glucose (sugar) levels are too high for a long period, leading to severe dehydration and confusion. HHS requires immediate medical treatment, or it could be fatal. HHS involves a lack of insulin, but the person usually produces enough insulin to prevent the production of ketones. In addition, there's usually an underlying condition, such as an infection, that's also contributing to the high blood sugar. If you manage diabetes well, your risk for developing HHS is low but certain conditions and situations can trigger HHS to develop in people who aren't managing diabetes well. Common triggers of HHS include infections like pneumonia, urinary tract infections (UTI), and sepsis. Other triggers include stopping diabetes medications and cardiovascular issues such as stroke, pulmonary embolism or heart attacks. The risks factors for HHS include diagnosis of type II diabetes, having poorly managed diabetes, being 65 or older, and having a history of infections, illness or a heart condition. If untreated HHS could lead to seizures, coma, organ failure, or death, (retrieved from my.clevelandclinic.org on 04/23/26). On 3/17/26, resident #1 was found with severe hypoxia, cold, clammy skin, pallor, and a blood glucose finger stick reading high, that indicated it exceeded the device's measurement capabilities. Resident #1 had diagnosis of type II diabetes but had not been monitored or treated since her re-admission on [DATE]. She was transferred to the hospital via 911 and admitted to the Intensive Care Unit (ICU). She had a blood glucose level of 945 milligrams per deciliter (mg/dl), sepsis (infection) and HHS.The facility failed to ensure resident #1 and her representative were informed, in a timely manner, of the diabetic treatment options available and associated risks so they could make an informed decision. The facility made a choice for the resident that was not in alignment with her or her representative's healthcare goals which placed her and other residents at risk for serious injury, impairment, or death. This failure resulted in immediate Jeopardy which began on 1/28/26.Findings:Cross reference F684, F600, and F867Record review revealed resident #1, an [AGE] year-old female, was initially admitted to the facility on [DATE] for respite care (temporary care to give caregivers a break) with hospice services and re-admitted on [DATE] from an acute care hospital for skilled nursing care without hospice services. Her admitting diagnoses included type II diabetes mellitus with hyperglycemia (elevated blood sugar levels), sacral pressure ulcer stage 3, chronic kidney disease, heart failure, obesity, history of myocardial infarction (heart attack), and (continued on next page)

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

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

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	neuromuscular dysfunction of bladder (nerve damage that impairs bladder control).The Agency for Healthcare Administration (AHCA) Form 5000-3008 dated 1/28/26 documented resident #1 required a surrogate for decision making and listed the resident's husband as emergency contact but her cognitive status at transfer was alert, oriented, and able to follow instructions. Her primary diagnoses were UTI, and urinary retention with use of urinary catheter. The form directed the facility to review the Medication Administration Record (MAR) to review times when medications such as anticoagulants, antibiotics, and insulin were last administered.Review of the Minimum Data Set (MDS) admission Assessment with an Assessment Reference Date of 02/04/26 showed during the look back period, resident #1 scored 13 out 15 on the Brief Interview for Mental Status that indicated she was cognitively intact. No behavior or rejection of care were noted. It was noted the resident and family were active participants in the assessment process.Resident #1's hospital records for admission date 01/24/26 listed uncontrolled type II diabetes mellitus with hyperglycemia as one of her active diagnoses. She was treated with insulin Lispro 0-5 units subcutaneous (SQ) with meals and nightly. Her BG was monitored daily with her last one on being 239 mg/dl on 1/27/26, which was flagged as abnormal.On 04/13/26 at 4:43 PM, Licensed Practical Nurse (LPN) A stated in an interview she worked the 3 PM to 11 PM shift on 1/28/26 and was the admitting nurse for resident #1. She mentioned resident #1 had been previously admitted to the facility so she was familiar with her. She described the admission process. Resident #1 arrived with discharge paperwork from the hospital, which included clinical documents, discharge medication list, and discharge instructions. She said she completed the admission assessment, which included a head-to-toe assessment, blood glucose fingerstick, and interview with resident and/or representative. She claimed that it was standard to check blood glucose on newly admitted residents even if they were not diabetic. LPN A confirmed resident #1's blood glucose reading was 273 mg/dl, which was abnormal (high). She reviewed the hospital discharge medication list, which did not include diabetic medications, and called the attending physician to reconcile the medications. She said she did not receive any orders for diabetic medications or monitoring and did not report the abnormal blood glucose reading to the attending physician. She explained, it was the end of her shift when she spoke with the attending physician and was sure the resident would be discussed during morning clinical meeting. LPN A acknowledged she did not report the results of the fingerstick to resident #1 or her representative and did not ask how she managed her diabetes.On 4/13/26 at 2:49 PM, the Unit Manager (UM) for [NAME] 1 unit said she was part of the morning clinical meetings which included the Director of Nursing (DON), UM for [NAME] 2, and the Director of MDS. She explained that during clinical meetings the team discussed the previous night's admissions for each unit and clinical issues related to resident care. She said the team reviewed the medication orders entered by the admitting nurse and compared them to what was found in the clinical documents which included the 3008 form, discharge medication list, History and Physical (H&P), and Medication Administration Record (MAR). She said if there were discrepancies with the medications ordered they would call the attending to clarify. She recalled resident #1 was initially admitted on [DATE] for respite care and her blood glucose was managed with two oral antidiabetic medications by the same attending physician. She acknowledged the team reviewed resident #1's discharge documents and medications ordered but did not discuss her diabetes treatment plan. The UM said she was unsure how it was missed. On 4/13/26 at 3:13 PM, the UM for [NAME] 2 said resident #1 was transferred to her unit on 1/29/26 and remained there until she was transferred to the hospital on 3/17/26. She said she did not always attend the clinical meetings because she liked to stay involved in resident care along with her staff, but she would be briefed by the DON after the meeting. She recalled she did not attend the meeting on 1/29/26 and did not recall being informed that resident #1 did not have a diabetic treatment plan. She said as the UM, she reviewed admissions/re-admissions clinical documents and would audit charts sometimes. She did not recall reviewing resident #1's medical record or speaking with the resident or representative regarding her diabetic treatment plan.On 4/13/26 at 4:47 PM, resident #1's attending physician (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	confirmed he was also the facility's medical director. He stated he was familiar with resident #1 because he had been her attending since initial admission on [DATE]. He said the admission nurse called him on 1/28/26 (unsure of time) to reconcile resident #1's medications but there was a discrepancy with the paperwork the hospital sent and was unable to get clarification from them. He said he was aware resident #1 was a diabetic that had been previously treated with oral antidiabetic medications and was unsure why she was no longer taking them. He was aware she was treated with insulin at the hospital but decided not to continue that treatment plan. The attending physician explained resident #1 was a hospice resident with complex diagnoses so it was beneficial for her to stay hyperglycemic (elevated blood glucose) instead of hypoglycemic (low blood glucose) to prevent further complications. He was reminded that resident #1 was not receiving hospice services during her 1/28/26 admission and he said he was not aware. He confirmed he did not give orders for diabetic medications or monitoring, but staff knew to report if the resident showed physical signs and symptoms of hypo/hyperglycemia. In a later interview on 4/14/26 at 12:19 PM, the attending said via phone that he had a conversation with resident #1's representatives, her son and husband, (unable to provide date or time) about her diabetic treatment plan and they agreed with his plan. He said the representative wanted the resident to be treated with a palliative approach which he said meant they did not want her to be poked or prodded unnecessarily but the representative was not asked for clarification of what this meant. He was unable to provide documentation of the conversation but acknowledged it should have been documented.A palliative approach is holistic, compassionate care aimed at improving quality of life and relieving suffering for people living with serious or life-threatening illnesses, staring early in the course of illness rather than only at end of life. A palliate approach to care engages in advance care planning to support health care wishes, provides information, education, and community support. Conversations with the person or family are important to ensure wishes are followed and the person receives the care they want and need. (interiorhealth.ca, Palliative Approach to Care, retrieved 4/27/26).Resident #1's baseline care plan, started by LPN A on 1/28/26, documented she was on diabetic medications, and the goal was for resident to adhere to the prescribed individualized treatment plan for management of diabetes. The interventions included obtaining fingerstick blood glucose monitoring, diabetic medications, and monitoring for medication side effects. Resident #1 did not have physician's orders for blood glucose monitoring, medications, or a treatment plan. On 4/14/26 at 4:29 PM, the MDS Director confirmed she had worked at the facility for almost a year and had been a nurse for over 30 years. She explained the baseline care plan was generally started by the admission nurse and then she would complete it after the morning clinical meeting. She attended the clinical meeting on 1/29/26 but did not recall discussing resident #1's diabetic treatment plan. She said resident #1 was a re-admission on [DATE] so she pulled forward the care plan from the previous admission and continued the diabetic plan she had. She stated she was not aware resident #1 had no orders for diabetes management and did not discuss this with the clinical team or the attending physician. The MDS Director said a care plan meeting was held with the resident and representatives on 2/10/26. She explained they reviewed resident #1's medications and treatment plan and the representatives had no questions or concerns. She said the resident's representatives wanted a palliative approach to her care, which she agreed was not in the care plan so there was no clear explanation for what the resident or representative's wishes were.Review of the care conference record dated 2/10/26, revealed resident #1, her representatives, MDS Director, and Social Service Director (SSD) attended at the meeting. In the comment section it was noted the plan of care was reviewed and other areas such as medications, care, treatments, and therapies were discussed. There was no documentation to show the representatives were aware of resident #1's diabetic treatment plan.In a phone interview with one of resident #1's representatives, her husband, on 4/13/26 at 12:30 PM, he said she had been a diabetic for many years and had been managed with oral diabetic medications but during her 1/24/26 hospital admission, the hospital discontinued the oral medications and put her on insulin because of (continued on next page)

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F 0552 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hyperglycemia and uncontrolled diabetes. He said he was not aware resident #1's blood glucose was not being monitored or that she was not receiving insulin. He said he did not have any conversations with the attending physician about changing the treatment plan for diabetes and confirmed she was not receiving hospice services during her 1/28/26 admission.On 4/13/26 at 4:40 PM, resident #1's other representative, her son, said via phone interview that he was not aware the facility was not providing his mother with diabetic medications or daily fingerstick blood glucose monitoring until she was transferred to the hospital on 3/17/26. He said the facility called a meeting after the incident and their explanation for her not receiving diabetic care was that orders were transferred improperly into their system. He said they told him and his father that they were not aware of her not getting diabetic medicine or care until a nurse from the hospital called and made them aware she had not been receiving diabetic medication. He said the facility did not tell him the diabetic treatment plan had been changed, and he did not have any conversations with the attending physician. In a later phone interview on 4/18/26 at 12:16 PM, he said the facility did not tell him that his mother's blood sugar was high on 3/17/26, instead they told him she was being transferred due to low oxygen levels. He said he felt angry and upset when he learned the facility had not been giving her diabetic medications or care and said he never expected that. He said he absolutely expected the facility to provide diabetes care including medication and he would expect if facility or attending wanted to discontinue the diabetic treatments they would speak with him and discuss because he would not have agreed to that. On 4/13/26 at 5:24 PM, a meeting was held with the clinical team which included the DON, UMs for both units, Director of MDS, [NAME] Nurse Consultant (RNS), Regional [NAME] President of Clinical Services, and the attending physician (via phone). The DON stated she spoke with one of resident #1's representatives and he told her that he did not want his mother poked and prodded which she believed meant he did not want her to receive daily fingerstick for blood glucose checks or insulin injections, but she acknowledged she did not ask him to explain what he meant.Review of the Facility Assessment updated 8/2024, revealed they provided person centered care and encouraged staff to incorporate the resident in the care planning process, record and discuss treatment and care preferences, and offer/assist resident and family caregivers (or other proxy as appropriate) to be involved in person-centered care planning and advance care planning.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's Interdisciplinary Team (IDT) failed to protect the resident's right to be free from neglect by failing to identify the need for a diabetic treatment plan for a type II diabetic resident with a history of uncontrolled diabetes, chronic kidney disease, and recurrent urinary tract infections which placed her at a high risk for decline, (#1). This affected 1 out of 8 diabetic residents whose treatment plans were reviewed, out of 43 residents in the facility with a diagnosis of diabetes. This failure resulted in a lack of proper blood glucose monitoring and treatment for 48 days, during which resident #1 developed sepsis and Hyperosmolar Hyperglycemic State (HHS), a life-threatening condition that could lead to organ failure, coma or death. The resident required emergency 911 transfer to the hospital and admission to the Intensive Care Unit (ICU), for 3 days.On 3/17/26, resident #1 was found with severe hypoxia, cold, clammy skin, pallor, and a blood glucose finger stick reading high, that indicated it exceeded the device's measurement capabilities. Resident #1 had diagnosis of type II diabetes but had not been monitored or treated since her re-admission on [DATE]. She was transferred to the hospital via 911 and admitted to the Intensive Care Unit (ICU) with blood glucose level of 945 milligrams per deciliter (mg/dl), sepsis (infection) and HHS.HHS is a life-threatening complication of diabetes, mainly type II diabetes. HHS happens when your blood glucose (sugar) levels are too high for a long period, leading to severe dehydration and confusion. HHS requires immediate medical treatment, or it could be fatal. HHS involves a lack of insulin, but the person usually produces enough insulin to prevent the production of ketones. In addition, there's usually an underlying condition, such as an infection, that's also contributing to the high blood sugar. If you manage diabetes well, your risk for developing HHS is low but certain conditions and situations can trigger HHS to develop in people who aren't managing diabetes well. Common triggers of HHS include infections like pneumonia, urinary tract infections (UTI), and sepsis. Other triggers include stopping diabetes medications and cardiovascular issues such as stroke, pulmonary embolism or heart attacks. The risks factors for HHS include diagnosis of type II diabetes, having poorly managed diabetes, being 65 or older, and having a history of infections, illness or a heart condition. If untreated HHS could lead to seizures, coma, organ failure, or death, (retrieved from my.clevelandclinic.org on 04/23/26). The facility neglected to recognize resident #1 was not receiving diabetic care and failed to appropriately communicate within the interdisciplinary team (IDT) to ensure resident #1 received appropriate and timely diabetic care according to her goals and wishes. The lack of oversight by the IDT team led to resident #1 not having a diabetic treatment plan which placed her and all 42 diabetic residents at risk for serious injury, impairment, or death. This failure resulted in Immediate Jeopardy which began on 1/28/26.Findings:Cross reference F552, F684, and F867Resident #1, an [AGE] year-old female, was initially admitted to the facility on [DATE] for respite care (temporary care to give caregivers a break) with hospice services and re-admitted on [DATE] from an acute care hospital for skilled nursing care without hospice services. Her admitting diagnoses included Type II diabetes mellitus with hyperglycemia (elevated blood sugar levels), sacral pressure ulcer stage 3, chronic kidney disease, obesity, history of myocardial infarction (heart attack), atrial fibrillation, heart disease, and neuromuscular dysfunction of bladder (nerve damage that impairs bladder control).Review of resident #1's medical record revealed that during her 1/19/26 to 1/24/26 short term respite admission, she was on hospice and her diabetes was managed with two oral diabetic medications, daily blood glucose monitoring, and periodic lab tests. Her average daily fingerstick BG results averaged between 120 mg/dl to 240 mg/dl, while on medications, (average normal BG: 80-130 mg/dl before meals and less than 180 mg/dl 1-2 hours after meals). Review of progress notes revealed the medical team closely monitored her blood glucose levels and were focused on preventing hypoglycemia (low blood glucose levels). There was no evidence resident #1 had any episodes of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hypoglycemia during the respite admission.Hypoglycemia, or low blood sugar, occurs when blood glucose levels fall below normal, typically below 70 mg/dl. It is particularly prevalent in individuals with diabetes, especially those on insulin or certain medications. However, not taking diabetes medication for fear of low blood sugars could lead to uncontrolled diabetes, (retrieved from mayoclinic.org on 4/28/26).The medical record revealed resident #1 was discharged home on 1/24/26 but was admitted to the hospital a few hours later with complaints of chest pain.Resident #1's hospital records for admission date 01/24/26 noted resident presented with generalized weakness and urinary tract infection. Uncontrolled type II diabetes mellitus with hyperglycemia was listed as one of her active diagnoses and she was treated with insulin Lispro 0-5 units subcutaneous (SQ) sliding scale with meals and nightly. Blood glucose monitoring four times per day was also ordered. Her last blood glucose at the hospital on [DATE] was 239 mg/dl, which was flagged as abnormal.The Agency for Healthcare Administration (AHCA) Form 5000-3008 dated 1/28/26 revealed resident #1's primary diagnoses were generalized weakness, UTI, and urinary retention with use of urinary catheter. The form directed the facility to review the Medication Administration Record (MAR) for review of times when medications such as anticoagulants, antibiotics, and insulin were last administered.According to resident #1's medical record her blood glucose fingerstick reading on 1/28/26 was 273 mg/dl, which was abnormal. Her blood glucose was not monitored after 1/29/26 to 3/17/26 when she was transferred to the hospital.Review of resident #1's progress notes on 1/28/26 revealed the abnormal blood glucose reading had not been reported to the attending physician immediately. There were no new orders. Review of resident #1's Order Summary Report dated 4/11/26 revealed there were no orders for diabetic treatment or monitoring from 1/28/26 to 3/17/26. The resident had diet order for Consistent Carbohydrates Diabetic (CCD) diet that started on 1/28/26. A Comprehensive Metabolic Panel (CMP) was ordered by the attending physician on 3/11/26 and the on-call provider on 3/17/26.In an interview on 4/13/26 at 4:43 PM, Licensed Practical Nurse (LPN) A said she reviewed resident #1's medication list and Agency for Healthcare Administration (AHCA) form 3008 on 1/28/26 but did not see orders for diabetic medications or monitoring. She reconciled the medications with the attending physician but neglected to make him aware the resident's blood glucose reading was abnormal. She indicated there were no orders for diabetic medications or monitoring. LPN A's rationale was that the clinical team would discuss the resident's diabetic care during the morning clinical meetings. Resident #1's abnormal blood glucose level was neglected by staff during the 3 PM to 11 PM shift and there was no documentation to show it was addressed during the 11 PM to 7 AM shift.On 4/13/26 at 2:49 PM, the Unit Manager (UM) for [NAME] 1 unit confirmed she had attended the morning clinical meeting on 1/29/26. She said the team did not discuss resident #1's diabetes or abnormal blood glucose reading. She agreed LPN A should have reported the abnormal blood glucose result to the attending right away and should have reviewed the clinical notes.On 4/13/26 at 3:13 PM, the UM for [NAME] 2 unit confirmed resident #2 was transferred to her unit sometime after 1/29/26. She said she did not attend morning clinical meeting on 1/29/26 because she was assisting with resident care, which she did often. She was not aware resident #1's diabetes was not being managed and said neither the resident nor the family complained of anything. She said she did not understand how LPN A missed the diabetic orders on admission or how they were missed when resident #1 was transferred to her unit. She agreed the attending physician should have been made aware by staff that the resident was diabetic and had no diabetic orders. The UM for [NAME] 2 said, I would not like to say that it was neglect, but it was a lack of care.In a telephone interview with resident #1's representative, her son, on 4/18/26 at 1:04 PM, he said he was concerned with resident #1's blood glucose because he would see staff providing her regular sugar packets on her meal tray. He complained to the staff and put up a sign in her room to alert staff not to give her sugar.Resident #1's progress notes were reviewed from 1/28/26 to 3/17/26 and revealed several providers had mentioned the need for diabetes monitoring including the attending physician and Advanced Practice Registered Nurse (APRN) but there were no new orders or documentation to (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	show recommendations were discussed amongst the Interdisciplinary team (IDT) to ensure resident #1 was provided the care she needed and as per her wishes.The following were some of the progress notes:1/29/26 APRN initial progress note: BG 273 mg/dl on 1/28/26 and recommended to continue management of hypertension and diabetes.02/02/26 attending physician note: type II DM condition unstable as blood glucose readings remain persistently elevated (273 on 1/29 and 240 on 1/19) most recent A1c ([DATE]) is 8.1% indicating poor glycemic control. Monitor BG, A1c, renal function, and symptoms of hypo/hyperglycemia.On 4/15/26 at 5:21 PM, in a telephone interview, the APRN who evaluated resident #1 on 1/29/26 confirmed she had cared for resident #1 under the supervision of the attending physician since her initial admission on [DATE]. She said she could not access the resident's medical record to provide clarification on her notes. She asserted resident #1 was on hospice but was informed she was not during the 1/28/26 admission. She said diabetic care depended on what the resident's wishes were so she would not order labs or treat a diabetic resident who was on hospice and wished not to be poked or prodded. Her progress note dated 1/29/26 was reviewed and there was no documentation to show the resident or representatives declined diabetes care.On 4/13/26 at 4:47 PM, in a telephone interview with the attending physician, who was also the Medical Director, provided several versions of why resident #1 did not have diabetes care. He stated the hospital had neglected to send the appropriate medication list and instead sent a Medication Administration Record (MAR), which he did not consider to be a discharge medication list. He attempted to contact the hospital but was unsuccessful. He asserted the hospital should not have taken her off the oral diabetic medication she was taking during her initial admission on [DATE]. He said he preferred for the resident not to take medication due to her medical complexity and hospice status. He explained, resident #1 had a complex medical history and he wanted to prevent her from being hypoglycemic, which was contradictory to what he noted on his progress note on 2/2/26. He was reminded that his progress note mentioned resident #1's diabetes was unstable and she had poor glycemic control based on her blood glucose reading on 1/28/26. He contended that although he recommended blood glucose monitoring, he did not order it because he spoke with the family and they did not want her to be poked and prodded. He acknowledged there was no documentation to show he spoke with the family and that they agreed with his treatment plan. He agreed that a blood glucose level of over 900 mg/dl could cause severe injury.On 4/13/26 at 5:24 PM, the Director of Nursing (DON) confirmed that on 1/28/26 there might have been confusion on whether the discharge medication list for resident #1 had been provided by the hospital but she agreed that there was a list of medications, which the nurse reconciled with the attending. She said during the morning clinical meeting the team did not call the attending to clarify orders even though it was part of their process. She believed the facility did not neglect resident #1 because she did not exhibit symptoms of hyperglycemia prior to 3/17/26 and she was transferred to the hospital due to low oxygen levels. She said the facility became aware of resident #1's elevated blood glucose from the hospital after she had been transferred. However, the DON acknowledged that the discharge nurse on 3/17/26 had told her that the resident's BG was high when she performed a fingerstick at approximately 5:30 AM prior to EMS being called. Also, a CMP had been ordered by the on-call provider at 6:30 AM, which showed the resident's BG was 899 mg/dl. The DON said the results were reviewed by the APRN after resident #1 had been transferred to the hospital. She sustained that resident #1's elevated BG could not have been prevented and therefore it was not neglect.On 4/14/26 at 12:19 PM, a meeting was held with the clinical team (DON, ADON, Director of MDS, and UMs for both units), Nursing Home Administrator (NHA), Regional Nurse Consultant (RNC), Senior [NAME] President (VP) of Operations, and Attending Physician/Medical Director (via phone). The DON stated that resident #1 had a medication list from the hospital which the admission nurse reconciled with the attending. She said insulin was not listed on the medication list. The Regional VP of Operations confirmed the AHCA 3008 form noted the MAR was attached for review of medication times which included insulin; however, it was not best practice to use the MAR to reconcile medications because it could have been inaccurate. She confirmed the (continued on next page)

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Vista Manor Healthcare and Rehabilitation Center	1550 Jess Parrish CT Titusville, FL 32796

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	APRN was aware resident #1's BG was 273 on admission, however there was no documentation to show any actions were taken by the APRN or that she communicated with the IDT. The Attending/Medical Director said he could not recall if he was made aware of the BG reading but said the whole IDT was aware resident #1 was diabetic. He agreed that resident #1's poor glycemic control was not ideal but due to her comorbidities and to prevent further kidney injury, he preferred to not put her on diabetic medications. He said her family preferred a palliative approach, but he was unable to provide documentation that this was discussed with the family.The NHA stated the team had a discussion related to the incident and given the fact that resident #1 had not been transferred to the hospital due to low oxygen not hyperglycemia, they did not feel the facility neglected resident #1's diabetes care. She said she became aware resident #1's BG was elevated when the hospital called her to say the resident's son did not want the resident to return to the facility. She said she called the resident's son for a meeting at the facility to discuss his concerns, but he never told them he had an issue during the meeting and was fine with his mother returning to the facility. She said they did not discuss why the resident was not receiving diabetic care during the meeting.Review of resident #1's medical record revealed she was re-admitted to the facility on [DATE] under the same attending physician with orders for insulin before meals, at bedtime, and on a sliding scale as well as daily BG monitoring.In a telephone interview with resident #1's son on 04/13/26, 4/16/26 and 4/18/26, he maintained the facility told him they had made a mistake when they transcribed the orders from the hospital and his mother did not receive diabetic medications. He said the doctors that treated her at the facility were the only ones responsible for her care. He expressed feeling angry and upset when he learned the facility had not provided his mother diabetic care which ultimately contributed to her decline and hospitalization.The Centers for Medicare and Medicaid Services defines Neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish or emotional distress, (retrieved on 5/01/26 from www.eCFR.gov).

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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** Based on observation, interview, and record review, the facility failed to coordinate and communicate effectively among the interdisciplinary team to ensure diabetic residents received continuity of care in accordance with professional standards of practice, the care plan, and resident choice to attain or maintain their highest practicable physical, mental and psychosocial wellbeing, (#1). This failure in care coordination resulted in a lack of proper blood glucose monitoring and treatment for 48 days, during which resident #1 developed sepsis and Hyperosmolar Hyperglycemic State (HHS), a life-threatening condition that could lead to organ failure, coma or death. The resident required emergency 911 transfer to the hospital and admission to the Intensive Care Unit (ICU), for 3 days. This affected 1 out of 8 diabetic residents whose treatment plans were reviewed, out of 43 residents in the facility with a diagnosis of diabetes.On 3/17/26, resident #1 was found with severe hypoxia, cold, clammy skin, pallor, and a blood glucose finger stick reading high, that indicated it exceeded the device's measurement capabilities. Resident #1 had a diagnosis of type II diabetes but had not been ordered any finger stick glucose monitoring or medications for diabetes since her re-admission on [DATE]. She was transferred to the hospital via 911 and admitted to the Intensive Care Unit (ICU). She was admitted with sepsis (infection) and HHS with blood glucose level of 945 milligrams per deciliter (mg/dl).HHS is a life-threatening complication of diabetes, mainly type II diabetes. HHS happens when your blood glucose (sugar) levels are too high for a long period, leading to severe dehydration and confusion. HHS requires immediate medical treatment, or it could be fatal. HHS involves a lack of insulin, but the person usually produces enough insulin to prevent the production of ketones. In addition, there's usually an underlying condition, such as an infection, that's also contributing to the high blood sugar. If you manage diabetes well, your risk for developing HHS is low but certain conditions and situations can trigger HHS to develop in people who aren't managing diabetes well. Common triggers of HHS include infections like pneumonia, urinary tract infections (UTI), and sepsis. Other triggers include stopping diabetes medications and cardiovascular issues such as stroke, pulmonary embolism or heart attacks. The risks factors for HHS include diagnosis of type II diabetes, having poorly managed diabetes, being 65 or older, and having a history of infections, illness or a heart condition. If untreated HHS could lead to seizures, coma, organ failure, or death, (retrieved from my.clevelandclinic.org on 04/23/26). The facility failed to recognize resident #1 was not receiving diabetic care and failed to appropriately communicate within the interdisciplinary team (IDT) to ensure resident #1 received appropriate and timely diabetic care according to her goals and wishes. The lack of oversight by the IDT team led to resident #1 not having a diabetic treatment plan which placed her and all diabetic residents at risk for serious injury, impairment, or death. This failure resulted in Immediate Jeopardy which began on 1/28/26.Findings:Cross reference F552, F600, and F867Resident #1, an [AGE] year-old female, was initially admitted to the facility on [DATE] for respite care (temporary care to give caregivers a break) with hospice services and re-admitted on [DATE] from an acute care hospital for skilled nursing care without hospice services. Her admitting diagnoses included type II diabetes mellitus with hyperglycemia (elevated blood sugar levels), sacral pressure ulcer stage 3, chronic kidney disease, obesity, history of myocardial infarction (heart attack), atrial fibrillation, heart disease, and neuromuscular dysfunction of bladder (nerve damage that impairs bladder control).The Agency for Healthcare Administration (AHCA) Form 5000-3008 dated 1/28/26 documented resident #1 required a surrogate for decision making and listed the resident's husband as emergency contact but her cognitive status at transfer was alert, oriented, and able to follow instructions. Her primary diagnoses were UTI, and urinary retention with use of urinary catheter. The form directed the facility to review the Medication Administration Record (MAR) to review times when medications such as anticoagulants, antibiotics, and insulin were last administered.Resident #1's hospital records for admission date 01/24/26 listed uncontrolled type II (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	diabetes mellitus with hyperglycemia as one of her active diagnoses and insulin Lispro 0-5 units subcutaneous (SQ) with meals and nightly was part of her medication list for diabetes management along with finger stick blood glucose monitoring. Her last blood glucose at the hospital on [DATE] was 239 mg/dl, which was flagged as abnormal.On 04/13/26 at 4:43 PM, Licensed Practical Nurse (LPN) A said she was familiar with resident #1 because she was a re-admit. She explained that when a resident was admitted from the hospital, they arrived with an admission packet which included the discharge medication list, AHCA form 3008, and the clinical documents. She explained resident #1's discharge medication list from the hospital did not look like what she was used to. She recalled that on 1/28/26 she had several admissions, so she was unable to look through all the documents that came in resident #1's admission packet. LPN A said she did not have time that night to look at any other documents that arrived with the resident, so she called the attending physician and reconciled the medications based on the medication list that was provided. As part of the admission process, LPN A said she did a blood glucose finger stick on resident #1 and the result was 273 mg/dl, which she acknowledged was abnormal. She said she documented the result but did not check to see if the resident had orders for diabetic medications and did not report the result to the attending physician because it was the end of her shift. LPN A said she figured the clinical team would discuss the resident's abnormal blood glucose during the morning clinical meeting.For reference, individuals with type II diabetes are recommended to keep fasting blood sugars between 80 mg/dl and 130 mg/dl and less than 180 mg/dl 2 hours after meals (medicalnewstoday.com, retrieved 4/28/26).On 4/13/26 at 2:49 PM, the Unit Manager (UM) for [NAME] 1 unit said she attended the morning clinical meeting on 1/29/26. She explained that during clinical meetings the 24-hour report was usually reviewed which included admissions/re-admissions, changes in condition, resident assessments, new physician orders, and progress notes. She could not recall if the team reviewed resident #1's clinical documents but they did review her orders to ensure they were in the system. She said if there had been any concerns with her orders, they would have called the attending physician to clarify. She said this was resident #1's second admission so the clinical team knew about her. The UM said resident #1 was transferred to another unit, [NAME] 2 unit on 1/29/26 and then she did not recall hearing about her during clinical meetings until she was transferred to the hospital on 3/17/26. She said LPN A should have reported the abnormal blood glucose result to the attending.On 4/13/26 at 3:13 PM, the UM for [NAME] 2 unit said she did not attend the morning clinical meeting on 1/29/26 as she was assisting with resident care. She explained she liked to work alongside the staff so sometimes she did not attend the meetings, but the Director of Nursing (DON) or other Unit Manager communicated with her after the meetings. She could not recall on which day resident #1 was transferred to her unit from [NAME] 1 unit but she believed it was on the weekend and not when it was documented, 1/29/26. She explained her expectation was for the nurses to review the clinical documents to ensure they didn't miss anything and if they had question, they should clarify with the physician, hospital, resident, or family. She said if there were no orders for diabetic management, the nurses should have made the attending physician aware. She said the clinical team did not discuss resident #1's diabetic management until after she was transferred to the hospital on 3/17/26. She recalled the DON held a meeting with LPN A to discuss how diabetic management orders were missed during admission. She said resident #1's family never had concerns related to her diabetes management and did not make any complaints. She added that resident #1 was being followed closely by several physicians.Review of resident #1's progress notes, revealed a note from the Advanced Practice Nurse Practitioner (APRN) on 1/29/26 which listed resident #1's diagnoses, medical history, current and past medications, labs, vital signs, and plan of care. It noted resident #1 was a type II diabetic, on Metformin, received respite care, and was followed by hospice. Last fingerstick blood glucose level on 1/28/26 at 11:34 PM was 273. The plan was to continue hypertension and diabetes management with a palliative focus. There were no new orders documented for diabetes management. A second progress note on 02/02/26 with date of service 1/30/26 from the attending physician noted: type II (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DM (diabetes mellitus) condition unstable as blood glucose readings remain persistently elevated (273 on 1/29 (done 1/28) and 240 on 1/19) most recent A1c ([DATE]) is 8.2%indicating poor glycemic control. Episodes of chronic kidney disease and advanced age are risk factors that increase the risk for diabetes-related complications. The plan was to monitor BG (blood glucose), A1c, renal function, and symptoms of hypo/hyperglycemia. The attending physician did not give any new orders for diabetes management.A1c is a test that measures average blood sugar levels over the past 2-3 months. For most adults with diabetes, an A1c of less than 7% is generally recommended, but individual targets may vary based on personal health conditions (healthline.com, retrieved 4/28/26).On 4/13/26 at 4:47 PM, in a telephone interview with the attending physician, it was revealed that he did not mean to say resident #1's diabetes was unstable but instead meant to say it was stable. He did not answer when asked if the rest of his note was also a mistake. The attending stated that he was aware resident #1 was diabetic and his treatment plan was appropriate based on her complex medical history. He said the recommendations to monitor BG (blood glucose), A1c, renal function, and symptoms of hypo/hyperglycemia were not orders. He expected staff to know the physical signs and symptoms of hypo/hyperglycemia and that they would report changes in condition. The attending stated that it was difficult to say if resident #1's increased blood glucose caused her to have sepsis or if the sepsis caused her blood glucose to rise but he acknowledged there was a possibility that her blood glucose could have been lower with proper blood glucose monitoring and medications, but it was hard to say. He agreed that a blood glucose level of over 900 mg/dl could cause severe injury.Review of resident #1's Order Summary Report dated 4/11/26 revealed there were no orders for diabetic treatment or monitoring from 1/28/26 to 3/17/26. The resident had a diet order for Consistent Carbohydrates Diabetic (CCD) diet that started on 1/28/26. There was a Comprehensive Metabolic Panel (CMP) ordered by the attending physician on 3/11/26.Results of resident's #1 CMP on 3/12/26 per the medical record, revealed her blood glucose level was 285 mg/dl.On 4/17/26 at 4:58 PM, a phone interview was conducted with the prior Dietician, who was a consultant for the facility. He was unable to access resident #1's record as he no longer worked with the facility but stated that when he evaluated residents, he looked at hospital records, physician orders, progress notes, and the AHCA 3000 form to create the dietary plan. He said if the resident was diabetic, he would recommend the CCD diet and monitor labs and blood sugar levels during follow ups to ensure the dietary plan was working. He explained that if the resident had no orders for diabetic medications or monitoring but had diagnosis of diabetes, he would clarify the plan with the DON.Review of resident #1's assessments revealed she had been evaluated by the dietician on 02/05/26. The note listed her diagnoses including type II diabetes and noted she had pressure sores to her sacrum. There were no diabetic medications listed or labs. The plan was for a CCD diet and to follow up with labs. There was no evidence resident #1's diabetes was being controlled or monitored via diet since there was no mention of her abnormal fingerstick blood glucose result on 1/28/26 or the diabetic plan based on review of her clinical documents from the hospital.Review of resident #1's progress notes from 3/12/26 to 3/17/26 revealed the Nurse Practitioner reviewed the blood glucose result from the CMP and there were no new orders for diabetic management from any of the multiple providers who assessed her from 1/28/26 to 3/17/26.Resident #1 had a care plan for diabetes management initiated on 1/19/26 and revised 2/10/26 by the Director of Minimum Data Set (MDS). The goal was for the resident to have no complications related to diabetes through next review date with target date 4/21/26. The interventions included:(Initiated 1/19/26)- diabetes medication as ordered by doctor, monitor for medication effectiveness, routine skin inspections, and notify provider of abnormal observations.(Initiated 2/10/26)- fasting blood sugars as ordered, monitoring for s/s (signs and symptoms) of hypo/hyperglycemia.On 4/14/26 at 4:29 PM, the Director of MDS acknowledged resident #1's diabetic care plan had been pulled from her previous admission on [DATE] which was created based on the diabetic plan she had at that time, which included medications and daily blood glucose monitoring. She said the care plan was created based on the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident's orders, diagnoses, assessments, and clinical history which was obtained from hospital records. She confirmed resident #1 did not have any orders for diabetes management but the care plan was standard for a diabetic resident. She explained that some care plans were created with the expectation that orders would be put in at some point based on their diagnosis and diabetes was one of them because most diabetic residents had orders for either medications, labs, and/or monitoring. The Director of MDS said she had a care plan meeting with resident #1's family on 2/10/26 but there were no concerns related to her diabetes management. She said she pulled resident orders every morning and updated the care plan as needed and if there were concerns, they would talk about it during morning clinical meetings. She was unable to explain why resident #1 had interventions initiated on 2/10/26 for obtaining fasting blood sugars as ordered and monitoring for s/s of hypo/hyperglycemia when there were no new orders.On 4/18/26 at 1:04 PM, resident #1's representative (son), stated he did not recall speaking about his mother's diabetic care plan during the care plan meeting on 2/10/26 with the Director of MDS. He explained he expected the facility to provide his mother with diabetic medications and monitoring like they had during her previous admission on [DATE]. He said he had concerns with her BG because he would visit the facility every day and would see staff giving her sugar on her meal trays even though she was supposed to be on a diabetic diet. He kept finding sugar packets all over the resident's room, so he posted signs in her room for staff to not give her regular sugar. On 4/15/26 at 2:17 PM, LPN B confirmed she was the assigned nurse for resident #1 on 3/17/26. She said it was her first time being assigned to resident #1 so she was not familiar with her. She recalled that at 5:30 PM when she noticed the resident was having difficulty breathing, she did a head-to-toe assessment including a BG. She said she was not aware resident #1 was diabetic but it was standard practice to test the person's glucose level during a change in condition. She said resident #1's BG read ?high on the machine which meant it was too high for the machine to read it. She called and reported the resident's condition to the on-call Nurse Practitioner (NP) including the high BG reading but there were no orders related to BG control just related to her low oxygen levels. She was instructed by the NP to provide oxygen and call back if s/s did not resolve. LPN B told the DON (unsure of date) that she had reported the BG results to the NP but did not document it. She confirmed she did not tell the resident's family about resident #1's BG levels being elevated, she said the resident was transferred due to low oxygen.Review of resident #1's hospital records for date 3/17/26, revealed the report from Emergency Medical Services (EMS) which showed their primary impression was diabetic hyperglycemia and secondary impression was shortness of breath. They arrived at the facility at 7:05 PM and did a BG at 7:29 PM which was noted to be high.On 4/13/26 at 5:24 PM, the DON stated resident #1 did not show any s/s of hyperglycemia so there was no indication for the clinical team to look at her diabetic management. She said LPN A entered the medications that were listed on the medication list from the hospital and there were no diabetic medications. She confirmed the clinical team reviewed resident #1's hospital records on 1/29/26, during clinical meeting and there were no orders for diabetes management. She acknowledged the LPN A should have reported the elevated BG reading on 1/28/26 to the attending physician.According to the Facility Assessment updated 8/2024, the facility is able to care for residents with metabolic disorders such as Diabetes. The facility is able to manage medical conditions by performing assessments, early identification of problems/deterioration, and management of certain conditions such as diabetes.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent an avoidable fall with fracture for 1 of 3 residents reviewed for falls, of a total sample of 8 residents, (#1). Findings:Record review revealed resident #1 was an [AGE] year-old female, admitted to the facility on 1/19/26 for hospice respite care and discharged [DATE]. On 1/28/26, resident #1 was admitted to the facility for long term care. On 3/17/26 resident #1 was admitted to the hospital's Intensive Care Unit with diagnoses of critically high blood sugar, sepsis, pneumonia and a heart attack. On 3/20/26, resident #1 was readmitted to the facility for long term care. The 5 Day Medicare Minimum Data Set (MDS) dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident's cognition was intact. Review of the Activities of Daily Living (ADL) section of the assessment indicated the resident had no impairment of her arms or legs and needed set-up and clean-up assistance for eating and oral hygiene. The assessment showed the resident required assistance of one staff person for bed mobility and had a urinary catheter and was incontinent of bowel. The Discharge Rehab Functional Assessment for the End of Medicare Stay dated 4/3/16 indicated resident #1 needed set-up and clean-up assistance for eating and oral hygiene and was dependent for toileting and bathing. The resident required the assistance of one staff person for bed mobility and dressing of the upper and lower body. Review of the resident's medical record revealed a care plan for falls related to decreased mobility, weakness, cardiac conditions, nerve pain, and spinal stenosis. A nursing care plan for ADL self-care performance was initiated 1/19/26 and revised 4/6/26. The interventions noted the resident required meal tray set up and the resident could feed self after set-up. Dressing, hygiene, oral care and bed mobility required the assistance of one staff. On 4/17/26 at 3:20 PM, the Director of Rehabilitation stated he was familiar with resident #1 as she had physical therapy from 1/28/26 to 3/16/26. He reported the resident's functionality was a maximum assist (1 person) for bed mobility, turning and repositioning. Her lower body had minimal movement. He stated she was dependent for lower body ADLs and maximum assist for upper body. He stated that transfers required a mechanical lift requiring two staff to assist. Review of nursing progress notes dated 4/11/26 at 10:12 PM, by Licensed Practical Nurse (LPN) C noted the resident had a fall. The note read, S/P (status post) fall. New orders for pain management, X-Rays for right shoulder and arm. TX (treatment) order for right shin skin tear. 3cm (centimeter) by 3cm.< (less than) 0.1. V/S (vital signs) B/P (blood pressure) 126/78 P (pulse) 78 R (respirations) 22 T (temperature) 97.6 02 (oxygen) sat (saturation) 97%. Blood glucose 151. Spoke with husband R/T (related to) new TX orders. Son came to facility to see her. Hospice arrived at 8:30(PM) and wrote new orders. Included x-rays, labs including U/A (urinalysis). Resident and staff stated the head did not hit anything. NEURO (neurological) check completed and no concerns noted. Review of physician orders on 4/11/26 showed an order for right forearm and right shoulder x-ray and pain medication every six hours as needed. Review of the right shoulder and right forearm radiology report dated 4/12/26 at 2:09 PM for the right shoulder revealed, No clearly displaced fracture by AP (Anteroposterior) view. The right forearm showed no fracture. An AP projection means the x-ray beam passes from the front of the patient to the back, (retrieved from www.NIH.gov on 4/27/26). Review of the rehabilitation post fall note dated 4/14/26 at 6:54 AM, revealed resident #1 on 4/11/26 at 8:15 PM, was rolled out of bed during care. The notes included, Education to staff per nursing to roll patient towards staff member during care. Review of the nursing post fall note on 4/12/26 at 3:10 AM, revealed resident #1 had a Numeric Pain Rating Scale (NPRS) of 2 out of 10 and two staff members to assist for repositioning was added to the care plan. The Numeric Pain Rating Scale (NPRS) is a validated, self-reported measure in which 0 indicates no pain and 10 indicates the worst pain, (retrieved from www.AHRQ.gov on 4/27/26). Review of the nursing post fall note dated 4/13/26 at 3:40 PM, indicated resident #1 had (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a pain level of 6/10 and the resident received pain medication. On 4/15/26 at 12:45 PM, resident #1 was observed sitting upright in her bed with the head of the bed elevated. The quarter-length side rails at the head of the bed were in the up position. The bed was in a high position. Her upper body was slightly leaning towards the right side of the bed. Her left hand was on her right forearm. The resident said she had pain all over. She stated, I was pushed and rolled out of bed to the floor, on Saturday when I was getting a bath. She revealed she was in pain most of the time since the fall and sometimes received pain medication. Review of the orders on the day of the fall, 4/11/26 showed the resident was ordered Hydrocodone-Acetaminophen tablet 5-325 milligrams (mg) 1 tablet by mouth every 6 hours, as needed for pain by the hospice provider. On 4/13/26 an order for Oxycodone HCl Oral Tablet 5 mg by mouth every 2 hours as needed for severe breakthrough pain, call if 3 doses in 24 hours. On 4/14/26 an order for Dexamethasone (steroid) 4 mg oral was obtained for right shoulder pain for 5 days. Review of the medication administration record (MAR) from 4/11/26 through 4/15/26 indicated resident #1 received pain medication as needed on 4/12/26 at 3:34 PM, 4/13/26 at 12:42 AM and 6:45 AM. The resident received scheduled pain medications on 4/13/26 at 6:00 PM and 4/14/26 at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Break through medication was given on 4/15/26 at 3:29 PM. Review of nursing progress note for 4/15/26 at 7:07 PM, by the Director of Nursing (DON), read, This writer was notified by CNA (Certified Nursing Assistant) A that assistance was needed in resident's room. Upon entering the resident's room, she was alert and looking towards the door. This writer observed the resident had tremors to her left arm. When asked how she was feeling, the resident stated not good in a low voice. As the interview with the resident continued, the resident was only able to answer yes and no questions. The resident was unable to follow commands such as to smile, raise arms, and squeeze hands. This writer notified assigned nurses to bring vital sign equipment to room, as well as glucometer to check her glucose level. The nurse stated that her dinner glucose test was in the 200 range. When checked by the additional nurse in room, the resident's glucose level had risen to 381. The MD (Medical Doctor) was present in the facility and came to assess resident. Resident's baseline was reported to MD and showed resident with a change in condition. Temp was 98.5, B/P was unable to be obtained due to tremors to left arm as resident was guarding her right arm due to discomfort from previous fall. O2 in place via NC (nasal canula). Another nurse assigned to the resident entered the room to report that 911 had been called. EMS (Emergency Medical Services) arrived a few minutes later and transported the resident to (name of hospital) ER (Emergency Room) for further eval (evaluation). Assessment of resident shortly after lunch by this writer showed vital signs of B/P 156/58, Pulse 72, Resp 17, Temp 98.7, O2 sats 98% on O2 via NC. Glucose level was 121 at lunch. Resident was alert and oriented and could hold a conversation and answer questions appropriately. Lung sounds were clear, resident able to perform hand grips, abdomen was soft with no distention or c/o (complaints of) tenderness. Bowel sounds present and normoactive. Resident has a foley catheter that was draining straw colored urine without sediment. Skin was warm and dry to touch. Resident was able to state that she was on a diabetic diet and used pink sweetener packets. Resident was observed drinking from water cup at bedside and able to grip cup without difficulty. Resident was at baseline during this prior assessment but had a noted decline during this episode resulting in transfer to ER. A review of the acute care hospital records dated 4/15/26 noted that upon arrival to the Emergency Department (ED), resident #1's chief complaint was altered mental status and fever. A right shoulder x-ray was completed due to the resident's complaint of pain and a recent fall. The x-ray result revealed an Acute comminuted impacted fracture of the right humerus head and surgical neck. A comminuted impacted fracture of the humeral head and surgical neck is a severe, multi-fragmentary break (comminuted) in which the upper ball-shaped part of the shoulder (humeral head) is forced into the shaft (impacted) at the neck, usually shattering into 3 or 4 pieces, (retrieved on 4/27/26 from NIH.gov). On 4/16/26 at 4:50 PM, in a telephone interview with hospice Registered Nurse (RN) K, he stated he was aware the resident had a fall on the previous Saturday. He said he was aware the resident was in the hospital with a shoulder (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fracture. The nurse explained the resident was not a candidate for surgery and the family was placing her with hospice. He further stated the family only wanted to treat her shoulder fracture medically. On 4/16/26 at 7:00 PM, CNA A stated she had been with the facility for the entire six months she had been a CNA. She explained she was completing peri-care on resident #1 and standing on the resident's left side of the bed and the resident was lying on her left side. She stated while she was still on the left side of the bed, when she completed cleaning the resident's back side, she told the resident to roll over to the right side. She described that the resident rolled to her right side and moved her right leg over and then slid off the right side of the bed. CNA A stated she had her hand on the resident's lower hip and upper leg while she attempted to move around the foot of the bed to the right side, to prevent the resident from falling but the resident's legs fell off the bed, followed by her right hip and right shoulder. CNA A noted the resident was on her right side when she landed on the floor. She reported the resident did not hit her head. The CNA explained she called out for help and stayed with the resident. She recalled two nurses came to the resident's room and assessed the resident, who complained of right knee pain and had a skin tear to the right shin. CNA A explained that once the nurse completed the assessment, they used a mechanical lift to get the resident back in bed. She recalled at that time the resident complained of whole right-sided pain. CNA A stated she met with the DON and Assistant DON after the fall who educated her on bed mobility for residents. She said she was told, I should always roll the resident towards the side I am on. On 4/17/26 at 3:55 PM, LPN C explained she responded to the resident's room when she heard CNA A calling for help. She recalled the resident was lying on the floor parallel to her bed on her right side. She stated, I was shocked because the resident doesn't move. She remembered she assessed her neurological function, and she was ok and didn't hit her head. The nurse explained they rolled her onto her back and LPN C assessed her range of motion. She was able to move all of her extremities. She stated they obtained a mechanical lift and put her back in bed with the assistance of two staff. LPN C stated CNA A reported she went to roll the resident, the resident's leg went over the bed and she slid off. LPN C notified the on-call physician and family, then completed an incident report while on-shift. On 4/17/26 at 1:45 PM, the DON explained she had completed the fall investigation and met with the Interdisciplinary Team on Monday 4/13/26. She stated she was notified at the time of the occurrence by LPN C who reported the resident had slid off the bed during peri-care. She explained LPN C had assessed resident #1, notified hospice and her family, and immediately put a two staff assist care plan in for resident #1's bed mobility. The DON recalled LPN C completed a post fall huddle, which included the circumstances of the fall, medications prior to the fall, and interventions needed post fall. She indicated she obtained a statement from CNA A and provided education to her. The DON confirmed her expectation was for CNAs to roll residents towards them instead of away. Review of the One-on-One Inservice Record provided to CNA A on 4/13/26 included, Safe resident turning. Pull, don't push, and always roll residents toward you, not away. On 4/17/26 at 2:00 PM, the ADON explained the orientation for CNAs required a skills demonstration for bed mobility. She stated CNAs must demonstrate the proper procedure for bed mobility and the CNA will keep demonstrating until the proper procedure is acceptable. She stated that CNA A had passed the skills demonstration for bed mobility at orientation. She did not explain why CNA A did not follow the protocol when turning resident #1 in bed. Review of the facility's Orientation Competency, Bed Mobility - Turning and Positioning Competency Validation, under the section of Side Lying Position, the first step validated the resident was to be rolled towards the caregiver. On 4/17/26 at 5:00 PM, CNA D explained when she had a resident that required the assist of one staff for turning in bed, I always roll the resident towards me, so the resident doesn't roll out of bed. On 4/17/26 at 5:04 PM, CNA E stated when she completed bed baths, she rolled the resident towards herself, or else they could fall out of the bed. She stated if she needed to change sides, she would keep the resident on their back until she was on the other side and then roll the resident to her. On 4/17/26 at 5:12 PM, CNA F explained when she performed peri-care or bathing, she always rolled the resident to the side she was on, so they don't roll out of bed. She stated, I will (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	not roll a resident until I am on the side the resident is rolling to. On 4/17/26 at 5:15 PM, the Unit Manager (UM) explained the bed should be in low position and the resident should be rolled to the side the CNA is on, or else the resident could roll out of bed and get hurt. She stated, My priority is resident safety, and the expectation is the team follow safety processes to keep the residents safe. On 4/18/26 at 12:16 PM, in a telephone interview with resident #1's husband, he stated he was at the facility until 5:00 PM on the evening his wife fell. He stated he had just gotten home when the facility called to tell him she had fallen. He stated the facility had taken an X-ray done and it looked, okay. He explained when his wife went to the hospital, she complained of shoulder pain, and they took another X-ray which showed a fracture. He stated she had never had a fracture of the shoulder before. He said the strength in her upper body had gone down recently so she couldn't roll herself in bed. On 4/18/26 at 1:04 PM, in a telephone interview with resident #1's son, he stated his mother had never had a previous fall at the facility and had not had any falls in several years because she was bedridden. He explained she had never had a previous right shoulder fracture and could use that hand and arm to feed herself before the fall. The son further stated she could not fall out of bed herself because she could barely move her legs. He recalled his mother told him when the staff were changing her, the small staff pushed her, and she went over the side when her legs went over. He said she hit her hip and shoulder but not her head. The son recalled she told him, The staff pushed her too far. He stated she was sent to the hospital because she had a urinary tract infection and was unresponsive. While she was there, she again complained of right shoulder pain, so they did an X-ray that showed a fracture. He stated she didn't have any old injury to her shoulder. Resident #1's son conveyed his mother was no longer able to eat by herself because she was right-handed and couldn't use that arm. He explained she was able to feed herself and do simple things with her right arm before the fall. He stated now he had to be with her to feed her three times a day because he did not trust the facility to feed her. He stated he visited his mother every day before the fall and usually had pain levels between two and three from sitting and lying in bed for long periods. The son said after the fall, his mother's pain levels were between nine and ten and she required narcotic medications for pain. He stated she was in extreme pain after the fall and noted she was not a candidate for surgery because of her age and condition. On 4/18/26 at 2:25 PM, CNA G said she worked the 7 AM to 3 PM shift and had cared for resident #1 on almost every shift as she was on her usual assignment. She explained prior to the resident's fall, the resident was able to eat independently and brush her own teeth. She said she would help cut her meat into smaller pieces, but the resident always fed herself. She noted the resident would brush her own teeth. CNA G stated, after the fall she was ?weak handed' and needed help to eat and to brush her teeth. On 4/18/26 at 2:30 PM, CNA A stated her usual assignment included resident #1 on the 3 PM to 11 PM shift. She explained prior to resident #1 s fall, the resident was able to use both arms and hands to eat. She stated after the fall, she became weak in her arms and hands and needed help eating and drinking. On 4/18/26 at 2:35 PM, LPN H said she was very familiar with resident #1. She noted prior to resident #1's fall, the resident took her medications and drank from a cup without assistance. The nurse said after the fall, she had to put the resident's medication in her mouth and had to hold the water cup, for her. On 4/18/26 at 12:15 PM, in a joint interview, the Nursing Home Administrator (NHA) and DON discussed the residents' fall on 4/11/26. The DON stated that CNA A yelled out to a nurse for help when the resident fell out of bed. The nurse arrived and assessed the resident then completed the incident report while on shift. The DON stated hospice arrived about 45 minutes later and also assessed the resident. Hospice ordered an x-ray of right shoulder and right forearm, labs, and pain medication. The x-ray results were received on 4/12/26 and revealed no fracture. On 4/15/26, 4 days after the fall, the resident had a change in condition, was only able to answer yes and no questions and her responses were delayed. The DON indicated the facility called 911 for transport to the hospital emergency department and the resident was admitted to the hospital for sepsis. They said on 4/16/26, the facility received the ED report which noted the resident had complained about shoulder pain and an x-ray was taken which showed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	an acute shoulder fracture. The NHA stated on 4/16/26, she was notified that resident #1 had a fracture and they contacted the facility's contracted mobile x-ray company for a re-read of the x-ray taken on 4/11/26. She said the report came back showing an old shoulder fracture. The NHA stated they contacted the Risk Manager (RM) at the hospital and told her there were conflicting x-ray results and asked if their x-ray department could re-read their x-ray and the RM agreed. The NHA said they received a call from the RM on 4/17/26 who said the x-ray re-read showed a chronic fracture. The NHA requested a copy of the re-read results, but the hospital RM told them she could not provide the information requested because the hospital wanted to do a CT (computerized tomography) Scan to age the fracture. The NHA said the hospital could not do a CT scan as the resident had been discharged from the hospital. The RM told them they would not be able to provide the re-read and were leaving the reading as an acute fracture.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program effectively identified and addressed a systemic process failure related to coordination, communication, and continuity of care for a resident requiring diabetes management. Following a resident's hospitalization for complications related to not receiving diabetic treatments for 48 days, the facility failed to immediately identify the factors that contributed to the resident's decline. Approximately three months later, after the survey team identified the incident, the QAPI committee initiated a Performance Improvement Plan (PIP) that lacked documentation and root cause.On 3/17/26, resident #1 was found with severe hypoxia, cold, clammy skin, pallor, and a blood glucose finger stick reading high, that indicated it exceeded the device's measurement capabilities. Resident #1 had a diagnosis of type II diabetes but had not been monitored or treated since her re-admission on [DATE]. She was transferred to the hospital via 911 and admitted to the Intensive Care Unit (ICU). She had a blood glucose level of 945 mg/dl, sepsis (infection) and HHS.HHS is a life-threatening complication of diabetes, mainly type II diabetes. HHS happens when your blood glucose (sugar) levels are too high for a long period, leading to severe dehydration and confusion. HHS requires immediate medical treatment, or it could be fatal. HHS involves a lack of insulin, but the person usually produces enough insulin to prevent the production of ketones. In addition, there's usually an underlying condition, such as an infection, that's also contributing to the high blood sugar. If you manage diabetes well, your risk for developing HHS is low but certain conditions and situations can trigger HHS to develop in people who aren't managing diabetes well. Common triggers of HHS include infections like pneumonia, urinary tract infections (UTI), and sepsis. Other triggers include stopping diabetes medications and cardiovascular issues such as stroke, pulmonary embolism or heart attacks. The risks factors for HHS include diagnosis of type II diabetes, having poorly managed diabetes, being 65 or older, and having a history of infections, illness or a heart condition. If untreated HHS could lead to seizures, coma, organ failure, or death, (retrieved from my.clevelandclinic.org on 04/23/26). Findings:Cross reference F552, F600 and F684 Review of the facility's Policy and Procedure titled, Quality Assurance and Performance Improvement (QAPI), revised 12/08/25 defined an adverse event as, an untoward, undesirable and usually unanticipated event that causes death or serious injury, or the risk thereof. High risk areas referred to care and service areas associated with significant risk to the health or safety of residents and errors in these care areas had the potential to cause adverse events resulting in pain, suffering, and/or death. Examples provided included administration of high-risk medications such as insulin. The policy detailed Performance Improvement (PI) identified areas of opportunity and underlying causes and provided approaches to correct systemic problems or barriers to improvement. QAPI was defined as taking a systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve safety and quality. The program's purpose was to prevent deviation from care processes to the extent possible, focus on indicators of outcomes of care, quality of life, and resident choice, and developing and implementing plans to correct and/or improve identified areas. On 4/09/25 at 9:17 AM, the Director of Nursing (DON) acknowledged an incident where resident #1 did not receive their diabetic medications or monitoring which led to her being hospitalized . The DON said when resident #1 was re-admitted to the facility from the hospital on 1/28/26, the hospital had taken her off the oral diabetic medications and put her on insulin, but the admitting nurse never entered the order so resident #1 went without diabetic care until she was transferred to the hospital on 3/17/26, around 48 days later. The DON stated the facility had not taken the incident to QAPI or created a PIP. She said the facility conducted audits of all diabetic residents in the facility after the resident returned on 3/20/26 but she was unable to provide documentation of the audits or of any review of the audit results by the QAPI (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	committee to determine if the facility needed to take action. On 4/13/26 at 5:24 PM, the DON stated statement was that they did not receive a discharge medication list for resident #1 from the hospital on 1/28/26. She said the facility did not hold any QAPI meetings related to the incident after they realized her BG was elevated when she arrived at the hospital. The DON said that after the resident returned to the facility on 3/20/26 there were no new processes implemented. She said the medical director was made aware of the incident after the resident had been transferred to the hospital, but he did not call for an Ad Hoc or bring it to QAPI. The DON conveyed that issues were usually brought to the Interdisciplinary team (IDT) meeting, every morning, and they determined if the incident/issue was a reportable. She confirmed resident #1's incident was not discussed in IDT or QAPI until after the concerns were brought up during the recertification survey of 4/06/26 to 4/09/26, even after identifying the resident was sent to the hospital on 3/17/26 with hyperglycemia. Further review showed the facility failed to initiate a PIP to investigate the underlying causes of the breakdown in medication administration, physician order transcription, and/or medication reconciliation processes. There was no evidence of a structured root cause analysis, interdisciplinary involvement, measurable improvement goals, or ongoing monitoring for effectiveness. On 4/13/26 at 4:47 PM, in a telephone interview, the Medical Director confirmed there had been no Ad Hoc or QAPI meeting after he found out resident #1's BG was elevated and she was admitted to the ICU. He was unable to provide an explanation of why the incident had not been investigated or brought to QAPI but said resident #1 had been treated by multiple providers while she was at the facility and was unsure of what their recommendations were. The physician said resident #1 had been followed by hospice during her initial admission on [DATE] and they were managing her diabetic medications, but he was not aware the resident was no longer on hospice services when she returned on 1/28/26. He said resident #1 was transferred to the hospital because she had hypoxia and not because she was hyperglycemic. He said it was hard to determine if hyperglycemia could have been prevented by the facility, had she been on diabetic medications, because she had a urinary tract infection which could increase the BG level for diabetic residents.In people with diabetes, infections can trigger or worsen hyperglycemia, and uncontrolled high blood sugar can make infections more severe and harder to treat, (retrieved from pmc.ncbi.nlm.nih.gov on 4/30/26). In a joint interview with the Director of Nursing (DON), Nursing Home Administrator (NHA), and Medical Director (via phone) on 4/14/26 at 12:19 PM, the DON, NHA, and Medical Director confirmed there was no formal performance improvement project or review by QAPI after resident #1 was found on 3/17/26 with an unreadable (high) blood glucose level and she was hospitalized in the ICU with sepsis and HHS, until the concern was brought to the facility's attention during the previous recertification survey. The NHA explained the facility felt they did not need to investigate the incident of resident #1's rehospitalization and related hyperglycemia because they felt resident #1's elevated BG could not have been prevented, and she was transferred to the hospital due to hypoxia.