STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Healthcare Center	3625 St Joseph Rd New Albany, IN 47150

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 15251 Based on record review and interview, the facility failed to ensure the Physician was notified when long acting insulin was held and when blood pressure, cardiac and blood thinner medications were refused for 1 of 3 residents reviewed for notification. (Resident 49) Findings include: The record for Resident 49 was reviewed on 5/5/25 at 1:12 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, other sequel of nontraumatic untraceable hemorrhage, cerebral edema with right hemicraniectomy, paroxysmal atrial fibrillation, congestive heart failure, hemiplegia and hemiparesis following cerebral infarction, history of venous thrombosis and embolism, and essential hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 4/9/25, indicated the resident had severe cognitive impairment. On 9/29/23, the physician's order indicated for the resident to receive Metoprolol Tartrate tablet 50 MG (milligram). One tablet by mouth every morning and at bedtime for hypertension. On 9/30/24, the physician's order indicated for the resident to receive Xarelto Oral tablet 20 MG (Rivaroxaban) - give one tablet by mouth in the morning for cerebral vascular accident, hemiplegia and atrial fibrillation. On 6/12/24, the physician's order indicated for the resident to receive Lisinopril tablet - give one tablet by mouth in the morning for hypertension. On 10/4/24, the physician's order indicated for the resident to receive Dilitazem HCl (hydrochloride) tablet 50 MG - give 1 tablet by mouth three times a day for atrial fibrillation. On 2/18/25, the physician's order indicated for the resident to receive Digoxin tablet 62.5 MCG (micrograms) - give one tablet by mouth in the morning for heart failure. The nurse's note, dated 1/21/25 between 12:48 p.m. and 1:02 p.m., indicated the resident refused to take all of his morning medications: Xarelto, Metoprolol Tartrate, Metformin, Lisinopril, Keppra, Dilitazem, and Digoxin, because he did not want his medications crushed. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The record lacked documentation of the physician being notified of the resident had refused all his medications, and did not want to have them crushed. On 8/7/24, the physician order indicated to monitor the resident for (s/s) signs and symptoms hypoglycemia/hyperglycemia (IE: sweating, tremor, pallor, tachychardia, palpitations, nervousness, h/a (headache), confusion, light headedness, slurred speech, lack of concentration, irritability, staggering gait etc.) every shift. Although the blood sugars were being monitored, The record lacked documentation of set parameters for when to hold the insulin. On 3/7/25, the physician order indicated to administer Tresiba FlexTouch 100 UNIT/(ML) milliter solution pen-injector - inject 50 unit subcutaneously at bedtime for diabetes. On 5/5/25, the physician order indicated to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector - inject 45 units subcutaneously once daily. The review of the nurse's notes, between December 2024 and April 2025, indicated the following: - On 12/2/24 at 8:37 p.m., the Medication Administration Record (eMar): indicated staff were to administerTresiba FlexTouch 100 UNIT/ML Solution pen-injector of 45 units subcutaneously to the resident at bedtime for diabetes. The insulin administration was held due to the resident's blood glucose being 147 (mg/dL) milligram/deciliter. No insulin coverage was required. - On 12/13/24 at 5:01 a.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 45 units subcutaneously to the resident at bedtime for diabetes. The insulin administration was held due to to the resident's blood glucose being 109. - On 12/16/24 at 9:17 p.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 45 units subcutaneously to the resident's at bedtime for diabetes. The insulin administration was held due to the resident's blood sugar being 97 mg/dL. - On 12/26/24 at 10:25 p.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 45 units subcutaneously to the resident at bedtime for diabetes. The insulin administration was held due to the resident's blood glucose being 119. No insulin coverage was required. - On 1/22/25 at 5:08 p.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 45 units subcutaneously to the resident at bedtime for diabetes. The insulin administration was held due to the resident's blood glucose being 115. No insulin coverage was required. - On 4/22/25 at 11:19 p.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 50 units subcutaneously to the resident at bedtime for diabetes. The insulin administration was held due to the resident's blood glucose being 89 and the resident indicated he did not eat supper. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 4/25/25 at 11:33 p.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 50 units subcutaneously to the resident at bedtime for diabetes. The insulin Administration was held due to the resident's blood glucose being 84. - On 4/27/25 9:33 p.m., the eMar indicated staff were to administer Tresiba FlexTouch 100 UNIT/ML Solution pen-injector of 50 units subcutaneously to the resident at bedtime for Diabetes. The insulin Administration was held due to the resident's blood glucose being 111. The record lacked documentation as to why the long lasting insulin was held and the physician being notified it was being held. The care plan, dated 10/25/21 and reviewed on 4/25/23, indicated the resident had a potential for alteration in mood and behavior related to diagnoses of depression and anxiety. Potential for yelling out, resisting care, hallucinations and refusing medications. The interventions included, but were not limited to, administer medications as ordered. Observe and document signs and symptoms of effectiveness and side effects. Educate the resident or the resident representative of the medication effectiveness and side effects. The care plan, dated 3/1/22, indicated the resident had altered cardiovascular status related to atrial fibrillation, chronic systolic heart failure and hypertension. The goal was for the resident to be free of signs and symptoms of complications of cardiac problems. The interventions included, but were not limited to, administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to medical provider, resident and the resident representative. Provide Digoxin as ordered. Check the pulse prior to administration, do not give if pulse was below 60 beats per minutes. Observe for s/sx of medication side effects: lack of appetite, vomiting, diarrhea, visual disturbances, fast heart rate, elevated Digoxin levels, fatigue, muscle weakness, anorexia, yellow halos around objects. Report any abnormal findings to the medical provider, resident or resident representative. A care plan, dated 3/1/22, indicated the resident had diabetic chronic kidney disease. The interventions included, but were not limited to, administer insulin injections per orders. Administer medications per medical provider's orders. Observe for side effects and effectiveness. Report abnormal findings to the medical provider, resident or the resident representative. Observe for signs and symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, kussmaul breathing, acetone breath, stupor, coma. Report any abnormal findings to medical provider, educate resident or the resident representative. Observe for signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, blurred speech, lack of coordination, staggering gait. Report any abnormal findings to medical provider, resident or the resident representative. Obtain blood sugars per orders. Report abnormal findings to the medical provider, resident or the resident representative. A care plan, dated 3/1/22, indicated the resident was at risk for abnormal bleeding or hemorrhage due to the anticoagulant related to the cerebral vascular accident; history of noncompliance with use of anticoagulant, atrial fibrillation. The interventions included, but were not limited to, educate the resident and the resident representative on the benefits and potential risks of the anticoagulant drug. Provide the anticoagulant and the antiplatelet medication per medical provider's order. Monitor for effectiveness, and side effects (bleeding, embolism). Report abnormal findings to the medical provider, resident or the resident representative. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Regional Director of Clinical Operations (RDCO), dated 5/8/25 at 9:15 a.m., she indicated there should be parameters for when to hold insulin, blood pressure and cardiac medications. At 9:24 a.m., the RDCO indicated because the resident had a long lasting insulin, there would be no set parameters. The resident should not have had his insulin medication held due to it being a long lasting insulin was not usually held except for a specific reason. The physician should have been notified of the resident's insulin being held and the resident's refusal of morning medications due to them being crushed. The review of the facility's current policy Notification of Change in Condition, included, but was not limited to, Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs of the residents .Compliance Guidelines: The center must inform the resident, consult with the resident's medical practitioner and/or notify the residents' representative, .when there is a change requiring such notification. Circumstances requiring notification included, but not limited to, .3. Circumstances that require a need to alter treatment which may include: a. new treatment; b. discontinuation of current treatment . 3.1-5(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 35732 Based on record review and interview, the facility failed to ensure a resident received treatment and care in a timely manner for 1 of 5 residents reviewed for quality of care. (Resident 243) Findings Include: The record for Resident 243 was reviewed on 5/5/25 at 11:17 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, and sepsis due to methicillin susceptible staphylococcus aureus, and hyperglycemia. The physician's order, dated 4/9/25, indicated the resident was to receive Lispro 100 units per mg before meals for diabeties. The staff were to administer the rsident's insulin based on a sliding scale. The staff were to notifiy the physician if the resident's blood surgar level was less the 70 or grater than 400. If the resident's blood sugar level was 151 to 200 staff were to administer 2 units; 201 to 250 administer 4 units; 251 to 300 administer 6 units; 301 to 350 administer 8 units; 351 to 400 administer 10 units, and if the resident's blood sugar was greater than 400 administer 10 units, then recheck the resident's blood sugar in 30 minutes, and notify the physician. The physician's order, dated 4/29/25, indicated the resident was to receive Metformin extended release tablet 500 milligram (mg). Staff were to administer one tablet in the morning. The physician's order, dated 5/2/25, indicated the resident was to receive Tresiba FlexTouch Subcutaneous Solution Pen-injector 100 units/ml (Insulin Degludec). Staff were to administer 25 units subcutaneously to the resident every morning and at bedtime. The review of the residents' blood sugar indicated the following: - On 4/30/25 at 10:38 a.m., the residents' blood sugar was 400.0 (mg/dL) milligrams/deciliters - On 4/30/25 at 4:59 p.m., the residents' blood sugar was 502.0 mg/dL - On 4/30/25 at 5:31 p.m., the residents' blood sugar was 502.0 mg/dL - On 5/1/25 at 7:41 a.m., the residents' blood sugar was 430.0 mg/dL - On 5/1/25 at 9:13 a.m., the residents' blood sugar was 494.0 mg/dL - On 5/1/25 at 9:28 a.m., the residents' blood sugar was 494.0 mg/dL - On 5/1/25 at 12:06 p.m., the residents' blood sugar was 277.0 mg/dL - On 5/1/25 at 3:10 p.m., the resident's blood sugar was 400.0 mg/dL - On 5/2/25 at 10:58 a.m., the resident's blood sugar was 408.0 mg/dL (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 5/2/25 at 4:25 p.m., the resident's blood sugar was 279.0 mg/dL The nurse's note, dated 4/30/25 at 5:31 p.m., indicated the resident's blood sugar was 502 mg/dL at dinner time. The nurse tried to call the physician and left a message. The resident's blood sugar had been high all day. The nurse called the Director of Nursing (DON) and documented she was told by the DON to give 10 units of the sliding scale insulin and recheck the blood sugar in 30 minutes. The review of the resident's blood sugars, dated 4/30/25 at 5:31 p.m., indicated the resident's blood sugar was 502 mg/dL. The record indicated the resident's blood sugar wasn't rechecked again until 5/1/25 at 7:41 a.m., and his blood sugar was 430 mg/dL. The review of the resident's blood sugar, dated 5/1/25 at 3:10 p.m., indicated the resident's blood sugar was 400.0 mg/dL. The resident's blood sugar wasn't rechecked again until 5/2/25 at 10:58 a.m. The nurse's note, dated 5/2/25 at 10:58 a.m., indicated the resident's blood sugar was 408 mg/dL. The Nurse Practitioner (NP) was notified and gave orders to administer 10 units of sliding scale insulin and recheck. The resident's blood sugar wasn't rechecked again until 4:25 p.m. During an interview, on 5/7/25 at 10:15 a.m., the Regional Director of Clinical Operations (RDCO) indicated the DON told the RN to give the 10 units of the sliding scale insulin and call the NP. She indicated she had talked to the NP this morning and the NP indicated she was made aware of the resident's high blood sugars. The RDCO agreed the clinical record lacked documentation the NP was notified and the blood sugar was rechecked. During an interview, on 5/7/25 at 10:25 a.m., the DON indicated the RN called her and she instructed her to give the 10 units according to the sliding scale and call the NP. She indicated the night shift nurse called her later and told her the resident's blood sugar was down to 300 mg/dL. During an interview, on 5/8/25 at 8:37 a.m., the NP indicated she was made aware the resident's blood sugars were high on 4/30/25. She added a note on 5/1/25 that indicated she increased the resident's insulin. The NP contacted the pharmacy on 5/7/25 and requested the resident's (IV) intravenous antibiotics to be mixed with normal saline instead of dextrose (sugar) due to elevated blood sugars. The clinical documentation standards policy, dated 2014, included, but was not limited to, .Nurses will follow the basic standard of practice for documentation including but not limited to providing a timely and accurate account of resident information in the medical record . Cross reference F842 3.1-37

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 51675 Based on observation, interview and record review the facility failed to ensure interventions and treatments were completed for 1 of 4 residents reviewed for pressure ulcers. (Resident 53). Findings included: The record for Resident 53 was reviewed on 5/7/25 at 12:29 p.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus, morbid obesity, osteomyelitis of vertebra, sacral and sacrococcygeal region, and chronic embolism and thrombosis. A physician's order, dated 1/13/25, indicated staff were to obtain the resident vitals every shift for 72 hours and then daily to establish baselines. The record lacked documentation to indicate the resident's vital signs were being completed. The last recorded blood pressure was on 1/28/25 at 95/66 (mm/hg) millimeters of mercury. Vital sign monitoring was an intervention in the care plans of actual skin impairment and osteomyelitis. The care plan, dated 1/14/25, indicated the resident had actual impaired skin integrity that included, a Stage 4 pressure ulcer to the sacrum and unstageable wound to right hip. On 3/17/25, the area to the right hip was classified as stage 4 pressure ulcer. The interventions included, but were not limited to, low air loss mattress to bed per manufacturer guidelines, monitor the area for signs of infection, monitor the area for signs of progression, encourage turning and repositioning, and provide wound care per treatment orders. The Wound Assessment report, dated 1/14/25, indicated the resident had a stage 4 pressure injury to the sacrum, measuring 5 cm (centimeters) in length, by 2 cm in width by 3 cm in depth with serosanguineous drainage with subcutaneous tissue, bone and adipose tissue present. The wound was not acquired in house. The treatment was to cleanse the wound with NS (Normal Saline) cleanser, then apply NS wet to moist rolled gauze to the wound bed, and cover with a bordered gauze dressing every 12 hours and as needed until resolved On 2/4/25, the wound assessment indicated the sacrum wound measured 5 cm in length, by 1 cm in width by 2.7 cm in depth. On 3/6/25, the wound assessment indicated the wound measured 4.8 cm in length, by 1 cm in width, by 2 cm in depth. On 4/22/25, the wound assessment indicate wound measured 4.6 cm in length, by 1.2 cm in width by 2 cm in depth. The resident was on antibiotics to treat a wound infection, and the status indicated the wound was improving with complications. On 5/6/25, the wound assessment indicated the wound measured 4.5 cm in length, by 1.2 cm in width by 2 cm in depth. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order, dated 1/14/25, indicated that a low air loss mattress should be applied, which should be checked every shift for proper placement and function. The care plan, dated 1/22/25, indicated that the resident had a history of osteomyelitis. The interventions included, but were not limited to, observe the resident for any signs of infection, monitoring of vital signs, and administer antibiotics per the medical provider's orders. A nurse's note, dated 2/28/25, indicated during wound care on the sacrum the resident alerted the nurse that a previously scabbed area to the side of her right thigh was bothering her. The nurse observed the right thigh had an open area with a small amount of drainage. The nurse notified the provider and received an order for wound care. The resident was encouraged not to sit in her wheelchair as frequently to promote healing of both wounds. The Wound Assessment report, dated 3/6/25, indicated the resident had an unstageable pressure injury to the right hip, measuring 3 cm in length, by 2.5 cm in width by 0.1 cm in depth with no drainage and subcutaneous tissue exposed. The wound was in house acquired. Treatment included to cleanse the wound with NS cleanser, apply medical grade honey to the wound bed, and cover with a bordered gauze dressing until resolved daily and as needed. On 3/13/25, the wound assessment indicated the resident had an unstageable pressure injury to the right hip, measuring 2.8 cm in length, by 2.2 cm in width by 0.1 cm in depth with no drainage and subcutaneous tissue was exposed. On 4/1/25, the wound assessment indicated that the resident had a Stage 3 pressure injury to the right hip, measured 2 cm in length, by 1.7 cm in width by 2.4 cm in depth with a moderate amount of serosanguineous drainage and subcutaneous tissue and the dermis were exposed. On 4/22/25, the wound assessment indicated the resident had a Stage 3 pressure injury to the right hip measured 1.1 cm in length, by 1.6 cm in width by 2.4 cm in depth with a moderate amount of serosanguineous drainage and subcutaneous tissue and dermis were exposed. On 5/6/25, the wound assessment indicated the resident had a Stage 3 pressure injury to the right hip measured 1.1 cm in length, by 1.6 cm in width by 1.7 cm in depth with a moderate amount of serosanguineous drainage and subcutaneous tissue and dermis were exposed. The peri-wound was intact, but fragile. A skin note, dated 3/6/25, indicated that the resident was seen for wound rounds. The sacrum was stable at that time. The wound to the right hip was noted to be a pressure ulcer. The area was suspected of being caused by the resident's previous wheelchair, and the wheelchair had been replaced. A physician's order, dated 3/6/25, indicated to cleanse the area to the side of the right thigh with wound cleanser and pat dry. The order read to apply silver collagen to the wound bed and place saline wet to moist gauze over the wound and cover it with a dry dressing daily and as needed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note, dated 4/2/25, indicated that during a dressing change the nurse observed the wound to resident's sacrum had green drainage along with a very strong foul odor. Neither drainage or odor was documentated previously during the dressing changes. The NP was notified and gave orders for Doxycycline 100 mg twice daily for 7 days, probiotic twice daily for 10 days and for a wound culture to be obtained on next dressing change. A nurse's note, dated 4/7/25, the resident was seen by the wound care center. The wound center obtained a wound culture during the visit. The nurse then called the wound center to notify the physician that the resident was currently on an antibiotic for wound infection. A nurse's note, dated 4/14/25, indicated the wound center ordered amoxicillin for 10 days and for the resident to return to the wound center on 4/28/25. A nurse's note, dated 4/22/25, indicated that the resident had refused further use the low air loss mattress, and the resident was encouraged to turn and reposition while in bed. The intervention was not removed from the resident care plans. The May 25 (EMAR/ETAR) Electronic Administration Record/Electronic Treatment Administration Record indicated that the order was still on the EMAR/ETAR and was to be checked every shift for proper placement and function. This was completed by nursing staff every shift despite the removal of the mattress on 4/22/25. A physician's order, dated 4/29/25, indicated to cleanse the area to the sacrum with wound cleanser and pat dry, apply silver collagen to the wound bed, place a fluffed normal saline, wringing out the excess saline, collagen in place, and cover the area with a bordered gauze daily for wound care. The April and May 25 EMAR/ETAR indicated the resident record lacked documentation of the daily wound assessment to the right thigh wound on 4/7/25, 4/11/25, 4/23/25, 5/2/25, and 5/3/25. The record lacked documentation of wound care and dressing changes on the right thigh on 4/9/25 and 5/2/25. The record lacked docunentation of wound care and dressing changes to the sacrum on 4/9/25, 4/28/25, and 5/2/25. The record lacked documentation of a daily assessments to the sacral wound on 5/2/29. The Braden Assessment scores completed for the resident included a low-risk score for skin breakdown 1/27/25, 2/3/25, and 5/4/25. For the month of May 2025, the resident consistently rated her pain at 4 to 5 out of 10. The pain scale indicated 10 being severe. The resident received pain medication twice daily. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, 5/8/25 at 10:00 a.m., Licensed Practical Nurse (LPN) 10 performed hand hygiene. The resident stood up with assistance and bent over the chair for completion of the wound care. The right hip wound had redness on the tissue surrounding the wound, The wound was tunneling with a small amount of slough and a moderate amount of serosanguineous exudate. The wound was cleaned with wound cleanser, packed with prism collagen, a wrung out 4 x 4 was placed on top of the wound and covered with bordered gauze. The nurse removed her gloves and performed hand hygiene. The nurse completed wound care to the sacrum. A dressing was then removed, cleaned with wound cleanser, packed the prism collagen and packed a normal saline soaked gauze. The wound was then covered with bordered gauze. Neither dressing to the right hip or sacrum was dated. During an interview, 5/8/25 at 10:15 a.m., the resident indicated that she does not have any pain due to having routine pain medication. She had a pressure cushion on the wheelchair. The pressure reducing mattress was removed due to the resident was not comfortable on the mattress. She went to bed 2 to 3 times per day, and turned and repositioned herself while in bed. She reported that she was finished with the antibiotics for a sacrum wound infection. During an interview, on 5/8/25 at 10:20 a.m., LPN 10 indicated the resident was not comfortable on the air loss mattress, so it was removed. The resident did have an air loss cushion on her wheelchair. The resident was good at turning and repositioning herself every 2 hours while in bed. If a resident refused any intervention, the physician or the NP would be notified. A wound care policy was not received from the facility. 3.1-40

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34309 Based on observation, record review, and interview, the facility failed to ensure the food was disposed of once expired, the vents were cleaned and repaired, the refrigerator thermostat and drip pan under the stove top were repaired. This had the potential to affect 93 of 95 residents who consume meals from the facility. Findings include: During the initial tour of the kitchen on [DATE] at 9:10 a.m., the following concerns were observed: - On a stand-alone refrigerator, the external temperature was at 38 degrees Fahrenheit (F). No internal thermometer was located. A gallon container of whole milk, which was ,d+[DATE] full, had an expiration date of [DATE]. - The second stand-alone refrigerator, had an external temperature of 37 degrees F. No internal thermometer was located. There was a container of leftover fish, with a use by date of [DATE]. There was another container of tuna, with a use by date of [DATE]. There was a container of lettuce with brown edges, but no serve date or use by date. - The third stand-alone refrigerator, the external temperature read 50 degrees F. There was no internal thermometer. There were 16 prepared glasses of cranberry juice and lemonade on the trays. There were 9 glasses of lemonade and tea on the other side of the stand-alone refrigerator. There were 5 pitchers of orange juice, tea, lemonade, water and cranberry juice, which were half full. [NAME] 3 indicated the drinks were still in use. - Dust was observed on the two vents over the serving counter. The vent over the preparation table had 3 screws holding the vent to the ceiling. The fourth corner of the vent was hanging loose. [NAME] 3 indicated when it rained, the vent would hang down. - The Dietary Manager was observed placing a tray of dessert bars into the trash can from the freezer. The same dessert bars were also on a tray in the stand-alone refrigerator with no date. - One of the 3 drip pans under the cook top had a drip pan stuck with food debris and grease build up, almost up to the underside of the cook top panel, visible through the opening of the pan. The review of the Menu, indicated the fish had last been served on [DATE] for dinner and [DATE] for lunch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. Building B. Wing	05/08/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a second kitchen observation, on [DATE] at 10:45 a.m., the instant mashed potatoes were being prepared. [NAME] 3 obtained the gallon container of whole milk, which was ,d+[DATE] full, with a use by date of [DATE], and began pouring it into the instant mashed potatoes. When asked about the date, [NAME] 3 stopped pouring, checked the date and indicated the milk was bad and that it was her fault that she hadn't looked at the use by date. She thought she had grabbed the whole milk with the use by date of [DATE]. She would discard the mashed potatoes and she took it away. [NAME] 3 indicated that the gallon containers were used for cooking and the small containers were for the residents to drink. During a third observation in the kitchen, on [DATE] at 9:18 a.m., the same fish in the container had been re-dated to read a serve date of [DATE] and use by date of [DATE]. The vent over the serving table still had a coating of dust. The vent over the preparation table was still pulled away from the ceiling. The lettuce with the brown edges had been removed from the refrigerator. The tuna in a container had been removed. During an interview, on [DATE] at 9:19 a.m., the Dietary Regional Director of Operation (RDCO) indicated the fish would have been on the menu, on Friday, [DATE]. The Dietary RDCO checked the refrigerators bi-weekly for expired dates. During an interview, on [DATE] at 9:24 a.m., the Dietary Manager indicated she was responsible for monitoring the expiration dates on food items, but all staff should monitor the dates. The Maintenance Director was responsible for cleaning the vents and doing repairs in the kitchen, such as repairing the drip pan and the vent being attached to the ceiling. The current Food Storage and Retention Guide, included, but was not limited to, . Raw Meat/Poultry/Seafood Fish, seafood, ground meat and all poultry Once thawed ,d+[DATE] days . The current Labeling and Dating Inservice, included, but was not limited to, . Purpose: To educate all new hires and current employees on the importance of and guidelines for proper labeling and dating . Guidelines for Labeling and Dating . The use by date as outlined in the attached guidelines . Leftovers must be labeled and dated with the date they are prepared and the use by date . The Maintenance Supervisor Position Description, dated [DATE], included, but was not limited to, . Plan, develop and schedule preventive maintenance for the center. Establish standards for preventive maintenance and cleaning . 3XXX,d+[DATE](i)(3)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 35732 Based on record review and interview, the facility failed to ensure sufficient information related to a resident's blood sugar was rechecked; and physician notification and verbal orders were documented in the resident's clinical record for 1 of 21 residents reviewed for Documentation. (Resident 243) Findings include: The record for Resident 243 was reviewed on 5/5/25 at 11:17 a.m. The resident's diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene, and sepsis due to methicillin susceptible staphylococcus aureus, and hyperglycemia. The physician's order, dated 4/9/25, indicated the resident was to receive Lispro 100 units per mg before meals for diabeties. The staff were to administer the rsident's insulin based on a sliding scale. The staff were to notifiy the physician if the resident's blood surgar level was less the 70 or grater than 400. If the resident's blood sugar level was 151 to 200 staff were to administer 2 units; 201 to 250 administer 4 units; 251 to 300 administer 6 units; 301 to 350 administer 8 units; 351 to 400 administer 10 units, and if the resident's blood sugar was greater than 400 administer 10 units, then recheck the resident's blood sugar in 30 minutes, and notify the physician. The review of the residents' blood sugar indicated the following: - On 4/30/25 at 10:38 a.m., the residents' blood sugar was 400.0 mg/dL(milligrams/deciliters) - On 4/30/25 at 4:59 p.m., the residents' blood sugar was 502.0 mg/dL - On 4/30/25 at 5:31 p.m., the residents' blood sugar was 502.0 mg/dL - On 5/1/25 at 7:41 a.m., the residents' blood sugar was 430.0 mg/dL - On 5/1/25 at 9:13 a.m., the residents' blood sugar was 494.0 mg/dL - On 5/1/25 at 9:28 a.m., the residents' blood sugar was 494.0 mg/dL - On 5/1/25 at 12:06 p.m., the residents' blood sugar was 277.0 mg/dL - On 5/1/25 at 3:10 p.m., the resident's blood sugar was 400.0 mg/dL The nurse's note, dated 4/30/25, at 4:59 p.m., indicated the physician was called for a blood sugar of 502 mg/dL. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note, dated 4/30/25, at 5:31 p.m., indicated the resident's blood sugar was 502 mg/dL at dinner time. The nurse tried to call the physician and left a message. The resident's blood sugar had been high all day. The nurse called the Director of Nursing (DON) and documented she was told by the DON to give 10 units of the sliding scale insulin and recheck the blood sugar in 30 minutes. The record lacked documentation indicating the physiucian/Nurse Practitioner (NP) received the left message, a recheck of the resident's blood sugar was completed, or any verbal NP orders were received. During an interview, on 5/7/25 at 9:55 a.m., RN 8 indicated the resident's blood sugar was 502 mg/dL and she tried to call the physician without success. She called the DON and was told to call the NP on call because she would probably order 10 units of insulin. She indicated she took a verbal order from the NP to give the insulin. The RN was unable to locate a verbal order from the NP in the resident's medical record. During an interview, on 5/7/25 at 10:15 a.m., the Regional Director of Clinical Operations (RDCO) indicated the DON told the RN to give the 10 units of the sliding scale insulin and call the NP. She indicated she had talked to the NP this morning and the NP indicated she was made aware of the resident's high blood sugars. The RDCO agreed that the record lacked documentation the NP was notified, and the blood sugar was rechecked. During an interview, on 5/7/25 at 10:25 a.m., the DON indicated the RN called her and she instructed her to give the 10 units according to the sliding scale and call the NP. She indicated the night shift nurse called her later and told her the resident's blood sugar was down to 300 mg/dL. During an interview, on 5/8/25 at 8:37 a.m., NP indicated she was made aware the resident's blood sugars were high. She added a note on 5/1/25 that indicated she increased the resident's insulin. The NP indicated on 5/7/25 she called the pharmacy and requested the resident's Intravenous (IV) antibiotics be mixed with normal saline instead of dextrose (sugar). During an interview, on 5/8/25 at 8:50 a.m., the RDCO indicated the nurse had given the 10 units according to the sliding scale and his blood sugar came down to 300 mg/dL. She indicated there should have been documentation the nurse called the NP and documented the blood sugar and what time it was taken. The clinical documentation standards policy dated 2014, included, but was not limited to, .a. The primary purpose of the medical record (s) is to provide continuity of care 1. Clinical evidence of care and treatment records as evidence of care iv. Document the status of the resident including changes i. The medical record will reflect the current status of the resident a. Chart in [real time] when an event is occurring or shortly thereafter, as is practicable . 3.1-3(o)(r)