STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165175	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical and hospital record reviews, interviews with staff, residents, family members of residents and a medical provider, the facility failed to ensure nursing competencies were maintained. This resulted in multiple significant medication errors for three of four residents reviewed (residents #2, #4, #6), lack of documentation regarding resident care, and concerns of failing to provide consistent, thorough personal assistance to the residents. Findings include:A review of hospital discharge orders for four residents revealed that three of these residents experienced significant medication errors (Res #2, #4, #6). 1. Following a February 2026 hospitalization, a reconciliation of Resident #2's discharge instructions against the Electronic Health Record (EHR) revealed the staff failed to implement a prescribed dosage increase for a blood pressure medication. Consequently, the resident experienced uncontrolled hypertension over the next three months. The facility additionally failed to process orders for corrective insulin and neglected to discontinue an oral diabetic medication that was noted by the hospital physician and contraindicated due to the resident's kidney function. The Administrator stated on 5/13/26 at 11:57 am via email that a further review was conducted regarding Res #2's readmission to the facility and it was identified that while his hospital discharge orders were largely consistent with his pre-discharge regimen, there was a frequency adjustment that was not identified during the reconciliation process. He added that these findings had been directly incorporated into the facility's process improvement actions. The email did not contain any information regarding the missed orders regarding his diabetic medications. 2. Following a February of 2025 hospitalization, a reconciliation of Resident #4's discharge orders against his EHR documentation revealed facility staff failed to notify the Advanced Registered Nurse Practitioner (ARNP) of hospital orders placing diabetes and other medications on hold pending provider review. Due to the transcription errors, the facility staff inadvertently discontinued three medications the resident took to aid in diabetes health, as well as an antihypertensive medication (blood pressure), an antihyperlipidemia medication (cholesterol) and an antidepressant. Additionally, laboratory results of Res #4 in December of 2025 indicated a significantly elevated blood glucose level of 352. The facility ARNP signed the lab results on 12/31/25 and indicated she would address the labs on her next visit. The facility was unable to provide any documentation of those labs being addressed. The resident experienced another hospitalization in May of 2026. At that time he had a life threatening blood glucose level of 1200. On 5/11/26 at 12:20 pm, the ARNP was interviewed regarding the error with Resident #4's medications. When asked about the monitoring of Res #4's diabetes, she stated she normally checks labs twice a year and more if needed and did not recall any concerns with his labs. She was unaware the resident had a blood sugar of 1200 when hospitalized on [DATE]. The ARNP was asked if she recalled any staff member informing her of his diabetic medications being placed on pause the prior year, and she stated she did not. She added she had been seeing this more often recently and said if staff does not tell her about these circumstances, then they can fall through the cracks but stated she also should have caught it herself. On 5/11/26 at 1:00 pm, the Director of Nursing (DON) was interviewed about Resident #4. She also was unaware of the resident's condition in the hospital and stated she (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	considered the situation to be a huge medication error. On 5/11/26 at 1:08 pm, Staff C, Licensed Practical Nurse (LPN) stated she had worked at the facility for almost two years. She stated she was not aware that his medications had changed after the hospitalization in February of 2025. She stated she does not know what medications the residents take because the Certified Medication Aides administer the medications and she would expect them to report any concerns to her. On 5/12/26 at 1:57 pm, Staff B, Registered Nurse (RN) stated she worked with the resident the night shift prior to him being admitted to the hospital. He experienced an unwitnessed fall and she stated he was weak and she felt he had a Urinary Tract Infection (UTI). She stated she did not think about checking a blood sugar on the resident because she felt his symptoms were related to having a UTI. She stated she did not recall ever having checked his blood sugar during her times of employment working with Resident #4. In a second interview with the ARNP on 5/12/26 at 12:54 pm, the ARNP stated the facility has had an issue with drawing labs in the past and she has had to order lab draws repeatedly before labs are drawn. She stated there have been times labs she orders are never completed. On 5/12/26 at 4:00 pm, Staff D, LPN stated she was unaware that Resident #4 was even diabetic. She stated she had worked at the facility for a few months and nobody had ever told her he was diabetic. Staff D verified she can read the diagnoses of the residents on the EHR but stated she felt someone should have directly informed her he was diabetic. Staff D stated she worked with Resident #4 the day he went to the hospital. He had been resistant to agreeing to provide a urine sample. She reported a urine sample was successfully obtained but staff then spilled it and they were unable to get a second sample. Upon the facility management being informed about the situation with Resident #4's medication errors, they began a plan to provide education to all nursing staff. This included a detailed email being sent to nursing staff who were not on duty that day (5/12/26). On 5/13/26 at 8:20 am, Staff C, LPN verified she had received the email. When asked to describe what was in the email, Staff C was unable to. She stated she would need to open it and read it again. She went through her phone and located the email and showed it to the State Surveyor. On 5/14/26 at 2:45 pm, an interview was conducted with a family member of Resident #4. The family member stated he was concerned because he found out the resident had been having high blood sugars since December and nobody had informed him. He stated he was told about this from a hospital employee. The family member also stated Resident #4 is very prone to having UTIs and every time he visits, he finds him with his pants needing changed and he (the family member) does it himself. The family member reported that he does not feel the facility changes the resident often enough or provides oral care. He reported he had bought personal care supplies several months earlier and they remained unopened including body spray and toothpaste. 3. Upon initial admission to the facility in April of 2026, Resident #6 admitted with diagnoses of necrotizing fasciitis (a rare but severe bacterial infection that destroys the tissue beneath the skin, including fat and the fascia covering muscles) along with sepsis (a life threatening emergency caused by bacteria entering the bloodstream). Staff G, a nurse manager, made four medication transcription errors when entering Res #6's medications into the EHR. Although the resident was stable upon transfer from the hospital to the facility, she required ongoing antibiotic therapy to treat her infections. Staff G erroneously entered orders that halved the prescribed antibiotic and doubled her prescribed narcotic pain medication. While two additional admission transcription errors were identified and corrected during a double-check by a second nurse, the incorrect antibiotic and narcotic orders were processed. On 5/12/26 at 11:51 am, Staff G, LPN stated Resident #6 had amoxicillin listed as an allergy and the hospital orders also had no stop date listed. She stated she called the ARNP to obtain orders. When the resident's allergies were reviewed during the interview, it was found that Res #6 had a listed allergy to piperacillin, not amoxicillin but the EHR software flagged this as the order was entered as a warning. Staff G stated she did not recall the order stating to take 1000 mg (the order read to take two 500 mg capsules) but she thought that the ARNP told her to just give one tab. She stated she was being very careful when she transcribed the orders. Staff G initially stated she thought she had called the ARNP prior to placing the orders in the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated this process reinforced expectations to ensure all external documentation is reviewed, reconciled, and uploaded into the EHRs within a defined and consistent time frame. On 5/14/26, three months worth of resident council notes were reviewed as well as grievances filed with the facility over the last three months. Several concerns of staff not being responsive to call lights were noted. The administrator stated the facility does not have the ability to run call light reports and call light times are monitored through oversight by nurse managers.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, hospital record review, medical provider, staff, resident, and family interviews and facility policy review, the facility failed to accurately reconcile hospital discharge orders for three out of four residents reviewed (Res #2, #4, #6). The facility additionally failed to notify the medical provider of orders requiring follow-up upon a resident's return from a hospitalization. This resulted in harm due to the erroneous discontinuation of Res #4's diabetic medications, resulting in the resident experiencing 14.5 months of no diabetic treatment. Consequently, Resident #4 required hospitalization for a life-threatening blood sugar of 1200 mg/dL (milligrams per deciliter, the unit of measure for blood sugar).On May 12, 2026 at 9:30 am, the State Survey Agency informed the facility the staff's failure to accurately reconcile hospital discharge orders and notify the provider of the need to assess hospital instructions of re-starting diabetic medications created an Immediate Jeopardy situation resulting in a resident hospitalized with a blood sugar of 1200 being admitted to the Intensive Care Unit with potentially life threatening diagnoses which began on February 18, 2025. The facility removed the immediacy on May 13, 2026 at 2:05 pm when the facility staff implemented the following Corrective Actions: Immediate verbal education beginning on 5/12/26 regarding medication transcription expectations, hospital discharge medication reconciliation, and provider notification requirements. Formal in person education with return demonstration and competancy validation beginning on 5/12/26 for nursing staff.Education including monitoring of high risk conditionsRe-education beginning on 5/13/26 with additional focus on clarifying the required process for handling medications on hold or pause status and immediate provider notification for clarification of any discrepancies. Additional education on 5/13/26 to reinforce the education to address inconsistent staff understanding. The scope lowered from a K to a E (harm that is not immediate) at the time of the survey after ensuring the facility implemented their staff education and return demonstration, and competency validation.Findings include: 1. The Discharge Minimum Data Set (MDS) Assessment of Resident #4 dated 2/12/25 identified the resident as having modified independence for decision making, displayed an acute onset of mental status change, and fluctuating inattention. The MDS identified diagnoses which included diabetes, anxiety disorder, major depressive disorder, hyperlipidemia (high cholesterol) and aphasia following cerebral infarction (a communication disorder that affects a person's ability to speak, understand, read, and write following a stroke). The MDS documented the resident was taking medications which included antianxiety, antidepressant and hypoglycemic medications. The MDS documented the discharge was unplanned, and the resident was discharged to a hospital.A Nursing note dated 2/18/25 documented the resident's return to the facility at 3:00 pm.The medication list from the hospital dated 2/18/25 directed that the following medications be held upon the resident's return, pending further orders from the resident's physician or care provider:a. Dapagliflozin propanediol (Farxiga), used for diabetes.b. Lisinopril-hydrochlorothiazide, used for high blood pressure and as a diuretic.c. Metformin, used for diabetes.d. Semaglutide, used for reducing appetite and blood sugars.These hold orders required waiting for the resident's doctor or other care provider to authorize resumption. The resident's Electronic Health Record (EHR) failed to document that the medical director or other provider was at any time notified of these medications needing to be assessed. The medication orders from the hospital also included the following medications to resume upon readmission to the facility:a. Atorvastatin, used for cholesterol.b. Duloxetine, used for depression and/or anxiety.The Medication Administration Record (MAR) for Resident #4 for February of 2025 documented that none of the six above listed medications were given to the resident anytime after the discharge on [DATE].Laboratory results from labs resulted on 2/25/25 documented a Hemoglobin A1c of 5.6 (a blood test that measures average blood sugar levels over the past 2 to 3 months)A Condition Follow-up note dated 2/26/25 at 1:30 am documented the resident had been found on the floor at 8:00 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	pm the prior evening with injuries including a laceration above his right eyebrow and a broken tooth and had been sent back to the hospital. A Nursing note dated 2/26/25 at 2:37 pm documented the current facility medication list was faxed to the hospital. On 5/12/26 at 1:30 pm, an emergency room nurse at a local hospital was interviewed about the procedure for obtaining an accurate medication list when a resident is sent to the hospital from a nursing facility. She stated the ER staff will reach out to the facility for a current medication list for accuracy. She added that if the ER does not obtain the list then the hospital pharmacist would obtain the list from the facility. When asked if the hospital would look at medications from a prior hospitalization, she stated they would not. She clarified that it was important for the medication list to be the most recent and accurate so therefore, if the resident came from a facility, they would use that list provided by the facility. A Condition Follow-up note dated 2/28/25 at 3:42 pm documented the resident returned back to the facility. The facility Advanced Registered Nurse Practitioner (ARNP) performed a routine visit for Resident #4 on 3/11/2025. The visit summary failed to reflect that the ARNP had been notified of the need to address the held hypertensive and diabetic medications following the first hospitalization.The MDS section of the EHR reflected that the resident remained in the facility from 2/28/25 until 5/5/26. Subsequent laboratory results collected several months later on 12/24/25 documented a significant increase in blood sugar levels. The lab results revealed glucose of 352, compared to the reading from three months earlier of 135, and the Hemoglobin A1c increased from 7.2, up from 6.4 three months prior. Hemoglobin A1c history per facility records (indicating a rising average blood sugar trend):5.6 February of 2025 (average glucose of 114)6.4 September of 2025 (average glucose of 137)7.2 December of 2025 (average glucose of 160)The ARNP noted the 12/24/25 results with her signature on 12/31/25 and documented she would address them on the next visit. The facility was unable to show any documentation of the resident being seen by the ARNP again until 2/12/26. The visit note dated 2/12/26 failed to document the rising trend of the A1c or the glucose reading of 352 (random blood sugars, not fasting, are typically 125-140).A Nursing note dated 5/4/26 at 6:20 pm authored by Staff C, Licensed Practical Nurse (LPN) documented Resident #4's son visited the facility and took the resident outdoors to smoke. The son reported to the nurse the resident was weak, was unable to hold his cigarette properly and had general pain. The note documented Staff C checked the resident's vital signs of blood pressure, pulse, temperature and oxygen. The note failed to document the checking of blood sugar. The note documented Staff C asked the resident of burning sensation, flank pain or back pain with urination with the resident denied. Staff C offered to send Resident #4 to the emergency room (ER) for evaluation. Both Res #4 and his son declined. An SBAR (Situation, Background, Assessment, and Recommendation) note authored by Staff B, Registered Nurse (RN) dated 5/5/26 at 3:43 am documented a change of condition of falls. Blood pressure, pulse, respirations, temperature, weight and oxygen levels were documented on this assessment. No blood sugar level was documented. The note documented an on-call ARNP was notified of the resident being weaker and questioning if the resident had a Urinary Tract Infection (UTI). The resident had refused to have a urine specimen collection completed. A nursing note dated 5/5/26 at 4:36 pm authored by Staff D, LPN documented an order received to obtain a urinalysis with culture and sensitivity and labs.A nursing note dated 5/5/26 at 5:18 pm authored by Staff D, LPN documented the resident was educated on the need to collect a urinalysis sample. Several attempts were made and the resident refused. The family was present and requested to take the resident to the hospital. The ARNP was notified and orders received and the family took the resident to the ER via private vehicle. The History of Present Illness summary from the emergency room physician documented the resident presented at the ER for altered mental status. Increased lethargy, slurred speech, disorientation. The note added he had been repeatedly asking for drinks, expressing increased thirst (a symptom of high blood sugar). The note documented the resident's son was unsure when the symptoms started and that they asked staff how long this had been happening and they were unsure. The ED Course note documented at 5/5/26 Res #4's white blood cell count was 15.75 (normal 4.5-11). At 7:00 pm, it was documented (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	at 1:57 pm, Staff B, RN stated she was passing medications (the night shift prior to the resident being sent to the hospital) and Resident #4 had attempted to transfer himself out of bed and into his wheelchair to go out for a smoke break. He had an unwitnessed fall. She stated she assessed him and found no injuries. She had been told about his change of status from the prior nurse but had not yet been in to see him. When she spoke to him, she felt he was having symptoms of a UTI but said it is very challenging to get urine samples from him. She said she was doing frequent neuro checks on him from the unwitnessed fall so had a lot of interaction with him. She said she did not check a blood sugar because she had never checked a blood sugar on him. She was unaware of him ever taking medications for diabetes. She said she would consider it to be best practice to check blood sugars on diabetic residents but she did not recall ever checking blood sugars on Res #4. She described the resident as being weaker than his baseline and that she spent one on one time with him. She felt he was alert and oriented to his normal baseline. She spoke to both of his sons and had a conversation about how the resident is very hard headed about not wanting to do labs or go to the hospital. He didn't go to the hospital that shift. She reported she pushed a lot of fluids and he took all the fluids fine. She did not feel he took an abnormal amount of water. She said he was a bit disoriented and tired and she had to wake him up a few times (during fall follow up checks). In a follow up interview, the ARNP stated on 5/12/26 at 12:54 pm, that in her professional opinion, the primary cause of Resident #4's blood sugar reaching 1200 was It was that he was not on his medications, obviously. She initially stated she had ordered labs in February and in March and the facility failed to draw them. She then corrected herself and stated the notes she was reading were February and March of 2025. She felt the labs that had been drawn in December of 2025 were unremarkable. On 5/12/26 at 4:00 pm, Staff D, LPN stated when a resident returns from the hospital to check the five rights of medications and to make sure orders are transcribed correctly. She stated to clarify any orders you question and a nurse is never to change orders on their own without a provider order. Staff D stated the family had noticed when Resident #4 had changes, and his transfer status was weak. She said the facility staff felt it was a UTI. She said the resident was not agreeable to giving a urine sample but said the did finally get one but then staff spilled it. She said the ARNP had ordered the urine sample and labs. She had been told about his son coming in and him not being able to hold his cigarette. She said his vitals were stable. The only symptom he had was weakness which normally for this resident meant he was having a UTI. She stated when she checked his vital signs, this did not include a blood sugar. She said she was unaware he was a diabetic. She reported she had been employed at the facility since January of 2026 and nobody had ever advised her he was diabetic. She verified she had access to see the resident's EHR and a list of his diagnoses but felt someone should have told her he was diabetic. She said on the day he went to the hospital, she had called the ARNP several times and kept her advised of his status but she didn't think of it being blood sugar related and she and his family both thought it was a UTI. On 5/12/26 at 4:16, Staff E, Certified Medication Aide (CMA) stated he had worked with Resident #4 for approximately one and a half years. Stated he had never seen him with symptoms of high blood sugar. He did not remember prior medications he was on. He said Res #4 has days of not feeling well, and thought he may have seen him last the day prior to his hospitalization but said he floated between the two floors frequently. He didn't notice any particular symptoms but said he had been working downstairs (Resident #4's room was upstairs) more often the week he was sent to the hospital. On 5/12/26 at 4:20 pm, Staff F, LPN stated the nurse managers are the ones who put orders in. She said the floor nurses do not do anything with any medications until the managers have put the orders in then the floor nurses do another check. She said usually another manager does a second check and the floor nurse does a triple check. She said if medications are paused, then it's held until there is a follow up from the doctor. She said one of them can notify the doctor, and said she would call the doctor who discharged the resident from the hospital but normally it would be the nurse managers who would do that. She said the floor nurses can call or fax the facility providers but would not administer a medication until it was verified. On 5/14/26 at 2:45 pm, (continued on next page)

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	165175	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greater Southside Health and Rehabilitation	5608 SW 9th Street Des Moines, IA 50315

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #4's son reported learning from the hospital that his father's blood sugar levels had been elevated since December 2025 and that facility staff had failed to notify him of this five-month elevation. He stated that he was only informed after receiving a call from a hospital employee. The son noted his father was initially diagnosed as borderline diabetic and expressed serious concern that the facility had not called him regarding the significant increase in his blood sugars. He said he just wanted to know that staff are performing their duties, specifically citing the correct administration of insulin and medications, and ensuring appropriate hygiene practices given his father's predisposition to UTI's. 2. Clinical records from a local hospital documented Resident #2 had been hospitalized from [DATE] until 2/7/26, having arrived from the facility. The reason for being sent to the ER was shortness of breath with his family expressing concerns of pneumonia. Prior to the hospitalization, the Medication Administration Record (MAR) for Resident #2 for documented medications including the following: Hydralazine, 50 mg, give twice a day (blood pressure medication). The order had a start date of 4/2/25, being on hold during his hospitalization. The order resumed with no changes on the morning of 2/8/26.The MAR additionally documented Metformin, a diabetic medication (1000 mg twice a day, start date 4/2/25), was held during hospitalization. The medication resumed on the morning of 2/8/26 and was given through the morning dose of 2/16/26 when it was then discontinued.The blood sugar administration record for February 2026 reflects the following insulin orders upon the resident's return from the hospital:a. An order for 35 units of long-acting insulin at bedtime was continued after the hospitalization, then discontinued on 2/22/26.b. A new order for 40 units of long-acting insulin each night was ordered with a start date of 2/25/26.c. A new order for short-acting sliding scale insulin, twice a day, start date 2/23/26.The discharge orders from the hospital dated 2/7/26 included these medications:a. Hydralazine: 100 mg total (two 50 mg tablets) by mouth three times dailyb. Insulin Aspart: 0 to 12 unit injected into the skin three times daily after meals. The resident's Metformin was not included as an active medication on the hospital discharge list.The Hospital Course Note in the hospital clinical records (page 41) noted the residents blood pressures and blood sugars were significantly elevated so medication was uptitrated. Correctional insulin was added and metformin was not restarted at discharge given Stage 4 chronic kidney disease. The facility failed to increase the hydralazine as ordered, failed to discontinue the metformin as ordered and failed to begin the short acting sliding scale medication as ordered. On 5/13/26 at 11:57 am the Administrator, via email, stated that upon further review of Res #2's readmission from the hospitalization of 1/29/26 - 2/7/26, it was identified that while the hospital discharge orders were largely consistent with the resident's pre-discharge regimen, there was a frequency adjustment that was not identified during the reconciliation process. He added that at the time of readmission, the nursing staff reconciled medications and re-entered the orders into PCC (EHR software), however, the reconciliation process did not include a sufficiently detailed line-by-line comparison between the hospital discharge MAR and the facility MAR, which contributed to the missed frequency change. The Administrator added the findings were incorporated into process improvement actions.The email did not address the new order for short acting insulin or the discontinuation order of metformin. Review of facility blood pressure documentation reflected the resident had a systolic blood pressure of greater than 180 on:2/9/262/10/262/12/262/13/262/27/263/7/26 (over 200) 3/8/26 (over 200) 3/9/26 (over 200) 3/11/263/17/263/19/26 (over 200) 3/26/26 (over 200) 3/28/263/29/263/30/263/31/264/1/264/7/264/14/264/18/264/20/264/21/265/13/26A progress note dated 2/23/26 documented the ARNP rounded and placed orders to increase Coreg (blood pressure medication), increase long acting insulin and begin sliding scale short acting insulin. 3. The MDS of Resident #6 dated 5/1/26 documented an admission date to the facility of 4/24/26, entering from an acute care hospital. The MDS recorded a Brief Interview for Mental Status score of 15, indicating cognition intact. The MDS recorded diagnoses including necrotizing fasciitis (a rare but severe bacterial infection that destroys the tissue beneath the skin, including fat and the fascia covering muscles) and sepsis. The MDS recorded the presence of a Stage 4 pressure ulcer, which (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was present at the time of admission to the facility. The Medication List from the hospital, received by the facility upon admission included the following orders:a. Amoxicillin, 500 mg capsule. Take 2 (two) capsules (1,000 mg total) by mouth 3 (three) times daily. b. Hydromorphone 2 mg tablet. Take 0.5 (1 mg total) by mouth 3 (three) times daily as needed for pain. 20 minutes prior to dressing changes. c. Docusate sodium. 100 mg capsule. Take 100 mg by mouth 2(two) times daily. d. Oxycodone 5 mg immediate release tablet. Take 0.5-1 tablets (2.5-5 mg total) by mouth every six (6) hours for 20 days. (Also known as Roxicodone)A review of the Medication Administration Record (MAR) for Res #6 for April of 2026 included the following entries:a. Amoxicillin, 500 mg capsule. Take 1 capsule 3 (three) times daily for sepsis for 10 days, start date 4/24/26. b. Hydromorphone 2 mg tablet. Give 1 tablet by mouth every 8 hours as needed for pain 2-10 and/or 20 minutes prior to dressing changes, start date 4/24/26. c. Docusate sodium. 100 mg. Give 2 capsules by mouth two times a day for constipation, start date 4/24/26. (This error was caught on double check and corrected, the resident did not receive the wrong order) d. Roxicodone 5 mg. Give 0.5 tablet by mouth every 6 hours as needed for pain for 20 days, start date 4/24/26. (This error of being written for as needed rather than scheduled was caught on double check and corrected)In April of 2026, Resident #6 received 10 doses of the incorrect dosage of Hydromorphone (Dilaudid). She did not receive any of the Dilaudid in May, and it was discontinued on 5/11/26.On 5/12/26 at 11:51 am, Staff G, LPN stated Resident #6 had Amoxicillin listed as an allergy and the hospital orders also had no stop date listed. She stated she called the ARNP to obtain orders. When the resident's allergies were reviewed during the interview, it was found that Res #6 had a listed allergy to Piperacillin, not Amoxicillin but the EHR software flagged this as the order was entered as a warning. Staff G stated she did not recall the order stating to take 1000 mg for the Amoxicillin but she thought that the ARNP told her to just give one tab. She stated she was being very careful when she transcribed the orders. Staff G initially stated she thought she had called the ARNP prior to placing the orders in the EHR, but then said she must have called her when she placed the order and it flagged it as a warning due to her allergies. When asked if she documented the phone call anywhere, she stated when there is a medication warning, a box comes up on the screen and she normally documents it there. She was unable to provide this documentation. In a second interview with Staff G on 5/12/26 at 12:38 pm regarding the Dilaudid order, Staff G verified that order was also placed incorrectly. She acknowledged the order from the hospital was for 1 mg and the resident had received multiple doses of 2 mg.On 5/12/26 at 12:54 pm, the ARNP was asked if she recalled Staff G calling her on 4/24/26 regarding the allergy warning for Resident #6 as well as having no end date on the order. The ARNP verified she remembered the phone call and was able to verify the resident had received the medication with no allergic reactions during the hospitalization and ordered an end date of 10 days. She stated she did not change the dosage amount. She added that she was aware of Infectious Disease physicians having extended the end date since that time. She verified she only discussed the allergy listing and the length of the order with Staff G and the dosage was not discussed. Staff A, RN was the nurse who performed the double check of Resident #6's orders after they had been entered into the EHR by Staff G.On 5/12/26 at 1:40 pm, Staff A, RN stated his process is to use the original copies from the hospital and check if the nurse who entered the orders placed the orders correctly. He recalled he did call the hospital to get a clarification on the Oxycodone as it was labeled 0.5 - 1.0 tablets. He stated he also clarified the order for the docusate. He did not recall finding errors with the Amoxicillin or the Hydromorphone/Dilaudid. The facility policy/procedure titled Diabetes Mellitus Resident, Nursing Care of, revision date 11/2007 documented the policy as follows:1. Assist the resident to establish a balance between diet, exercise, and insulin. 2. Restore carbohydrate utilization, correct electrolyte imbalance and prevent recurrence in the resident with diabetic ketoacidosis. 3. Quickly restore normal cerebral function and prevent recurrence of hypoglycemia. 4. Recognize and assist in the treatment of complications commonly associated with diabetes. 5. Individualize teaching according to carefully assessed resident and family needs. The facility policy/procedure titled - Nursing Clinical, reviewed (continued on next page)

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