

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER The Laurels of Coldwater		STREET ADDRESS, CITY, STATE, ZIP CODE 90 N Michigan Avenue Coldwater, MI 49036	
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 0600 Level of Harm - Minimal harm or potential for actual harm 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** This citation pertains to intake #3051218Based on observations, interviews, record review, the facility failed to protect the resident's right to be free from physical abuse by a resident.Findings Include:Review of the medical record reflected R3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/18/26, reflected R3 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R4 was admitted to the facility on [DATE], with diagnosis that included Vascular dementia, moderate, with agitation and irritability and anger. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/8/26, reflected R4 scored 3 out of 15 (severe cognitively impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 7/29/26 at 3:20 pm, R3 was observed in her room, seated in a wheelchair, and reading a book. R3 recollected previous encounters with R4. R3 stated that she has never spoke to him before, however, R4 would enter R3's room uninvited on several occasions. On 6/8/26 around midnight, R4 entered R3's room and stepped over to her bedside. R3 told R4 that he needed to leave. R4 refused. R3 repeatedly told R4 to leave or she was going to call the police. R4 told R3 that he did not care of she called the police. Staff arrived to assist and removed R4 from the room. R3 stated that there had been several encounters similar to this which occurred on and off all day and all night. R3 reported feeling afraid, and therefore, filled out a Grievances form to express her concern regarding R4 entering her room without permission. R3 went on to explain that one day, on 6/14/26, R4 came into R3's room without permission, yet again. R3 told R4 that he needed to leave. R4 responded by repeatedly calling R3 a b*tch and an as*hole, R4 approached R3 and lifted his cane to hit R3/ R3 stated she put her arm up to avoid being hit in the face, resulting in R4's cane striking R3 on the outer portion of her palm. R3 stated that staff intervened and after a few moments of coaxing R4 to leave the room, R4 finally exited R3's room. R3 presented a photograph of her hand which had a deep purple bruise on the outer part of her hand and knuckle. R3 reported that after the incident, R4's room was moved to the front of the hall as opposed to the end which reduced the number of times that R4 was walking past her room. R3 stated that she felt relieved because she was getting more and more afraid for R4. When asked if there any interventions in place to keep R4 from entering her room, R3 stated she had a stop sign set across her doorway however, the time of the incident, she did not observe the sign in place across her doorway. R4 also stated that her stop sign was removed two or three days ago and a staff member put it back up today.Review of a handwritten Grievance form completed by R3 stated the guy that wanders came into my room Monday night 6/8/26. Was at end of curtains by bathroom and was walking up toward bed. Very scary. He did this 2-3 times. I called for help both times. The came 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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 235302	If continuation sheet Page 1 of 8

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	took him out. He is very scary. In the section which states who else knows about the problem or incident, R3's handwritten response stated man in charge of nurses . In the section that states how can we address your issues?, R3's handwritten response stated he is very scary. has been walking in hall most of day looking in rooms .I kept telling him to leave. He wouldn't. Called me names. On the Grievance form, R3 indicated that this was an ongoing problem, stating, about a week, off and on all day sometimes PM (night). Review of a Facility reported incident report dated 6/14/26 stated that on 6/14/26 at 3:20 PM, R4 entered R3's room and when R3 told R4 to leave, R4 made contact with R3 using a walking cane. According to the same report, Licensed Practical Nurse (LPN) C was interviewed LPN C stated I heard yelling down the hall. the CNA (certified nursing assistant) and I entered the room and [R4] sat down on B bed facing [R3]. [R4] said she's a b*tch. Why didn't she just say it was her room. [R3] said I came out of the bathroom and saw saw him and told him to leave now. He starting walking toward me swinging his cane. I put my hand up and he hit my hand with the cane. A staff interview conducted with CNA D stated I heard [R3] screaming, get out. When i entered the room, [R3] was at the end of her bed. [R4] was yelling, why bitch?. LPN C' took [R4] out of the room. R3 was rubbing her hand and I noticed a bruise. [R3] stated he was swinging his cane and I put my hand up and the cane hit my hand. Review of a Nurses Note dated 12/16/25 stated Due to increased aggression towards staff with cane, cane has been removed from residents room. A walker has been provided. Resident has not used the cane consistently and ambulates frequently without it . Review of a Behavior Note dated 1/27/26 stated Resident attempted to enter female's room x 2. The first time he said he was lost. The second time he said she was his ex girlfriend . Review of a Progress Note dated 1/30/26 stated Nurse reports that his behaviors continue on second shift. He is still getting agitated with female residents and staff. He has been taking away food from other residents. When he is corrected or redirected, he gets verbally aggressive. Review of a Progress note dated 5/31/2026 revealed resident [R4] standing in the hallway arguing with [another resident], who accused him of being in her room. He said he did not know it was her room and [other resident] stated that he hit her in the left arm. He said that her would hit her again if she did not shut up. This nurse stepped between them and told him to go to his room . A nurses note dated 6/4/26 stated Guest [R4] came out of his room agitated that his roommate is accusing him of taking his stuff. Guest stated that he wanted a room change and he was done being blamed for everything going missing in that room. Guest also stated that if something does not change and his room mate goes off on him again he will hit him with his cane. DON (Director of Nursing) was called about situation. DON stated just to keep an eye on them and he will figure something out when he gets to facility. The follow up to the situation was to relocate R4 to a different room, at the end of the hallway. Review of the Care plan, Kardax, and Nurses Progress Notes revealed no indication of how R4 regained access to his cane that was removed from his possession in December 2025 or mention of any cane in any documentation. Review of a social services note dated 6/4/26 stated Resident wandering hallway and into other residents rooms throughout day. Resident easily redirected. Review of R4's Care plan revealed an absence of any Care Plan or any interventions related to R4's entering other residents' rooms. On 6/14/26, a nurses note stated At [3:20 PM] writer and CNA heard yelling down south hall. Writer and CNA entered [R3's room] and observed resident in front of TV (television) walking towards bed A, resident sat down on edge of bed facing female resident. Female resident observed sitting on the edge of her bed. [R4] stated She is mean, she is a b*tch. Writer and CNA encouraged resident to leave room that is not his. Resident stated why didn't she just say it was her room? Resident then began stating b*tch while pointing cane at female resident. Resident exited room with writer, writer escorted resident to his room. Resident then walked down south hall stating f*cking b*tch to writer. (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident placed on 1:1. Female resident stated I came out of the bathroom and saw him. I told him to leave now. He said no. I told him to leave and leave now or I was going to call the police. He said call them, call them now and started walking towards me swinging his cane. I put my hand up and he hit me with his cane right here. Purple bruise noted to female residents right hand. R4 was placed on one-to-one observation following the incident. Review of an Encounter note completed by a Physician dated 7/3/26 stated Resident (R4) reviewed regarding 1:1 status ? [sic] resident apparently has had some wandering tight [sic] behaviors and is going into other residence [sic] rooms. He has become aggressive with staff when attempted to be redirected. He also [sic] had a physical altercation with another resident. He was placed on 1:1 observation and since then seems to have done reasonably well as he is able to be immediately redirected instead of after he becomes involved with other residents. At this time, I do not think discontinuing one: one observation would be appropriate. In an interview on 7/30/28 at 11:09 AM, CNA D confirmed she was working the day of the incident between R3 and R4. CNA D stated she heard another resident yell [R3] needs help. CNA D went down to R3's room and observed R4 calling R3 a b*tch repeatedly. CNA D stated R4 sat on the roommate's bed in R3's room and continued to state that R3 was a b*tch. After some coaxing, staff were able to convince R4 to leave R3's room. In an interview on 7/30/26 at 11:18 am, LPN C stated that R4 is very forgetful, to the point that he will exit his room and immediately forget where his room is. LPN C stated she knew R3 was complaining prior to the incident between R3 and R4 regarding how R4 made her feel afraid. LPN C stated that R4's room was located at the end of the hall so despite having a sign on his door identifying R4's room as his room, R4 walked past several other rooms in the meantime and consistently attempted to enter them because he did not see the sign indicating which room was his until he got to the very end of the hallway and was able to locate his room. LPN C stated that on the day of the incident between R3 and R4, she heard yelling coming from R3's room and responded. R4 was observed seated on the roommate's bed, calling names to R3. R4 stated that he was in his room. In an interview on 7/30/26 at 11:55 am, Resident #6 (R6) was interviewed regarding R4. R6 resided on the same hallway as R3 and R4. R6 stated that R4 had wandered into her room several times. During on occasion, R4 was aggressive and told R4 that he owns this building, so she needed to get out. R6 responded by telling R4 that she pays rent and had no intentions of leaving. R4 proceeded to bawl his fists up and call R6 a b*tch. R6 reported the incidents as scary and felt disrespected. Per R6, this was reported to the DON who took down the information. and told R6 that this was an ongoing issue with R4. R6 stated that staff placed a stop sign across her doorway however, it had been removed and she was not sure why. In an interview on 7/30/26 at 12:30 pm, Social Worker (SW) J stated that she spoke with R3 regarding the grievance she filed. The solution was to put a stop sign across R3's door. In an interview on 7/30/26 at 12:42 PM, Unit Manager (UM) E stated that R4 used to reside on her unit. When residing on that unit, R4 entered other residents' rooms. When asked about the walking cane, UM E stated that it was removed and could not locate any information regarding a cane on R4's care plan, only ambulation using a walker. In an interview on 7/30/26 at 1:29 PM, DON B stated that he was aware of R4's cane being removed, however, was not sure how he regained access to the walking cane. After the first incident when R4 allegedly entered a room and struck a resident, he was moved to another unit. DON B stated that R4's room was moved to the front of the hall but acknowledged that was an intervention that was taken after the incident with R3 occurred. DON B could not speak much to interventions in place to eliminate R4 entering other residents' rooms. On 7/30/26 at 2:33 pm Nursing Home Administrator (NHA) A stated that abuse is described as any willful verbal and/or physical act. NHA A acknowledged that swinging a cane to hit another resident was a willful act.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3051218 Based on observation, interview, and record review the facility failed to develop an individualized care plan addressing behaviors and appropriate ambulatory device for one (Resident #4) out of 6 reviewed for care plans. Finding include: Review of the medical record reflected R3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included anxiety disorder. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/18/26, reflected R3 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R4 was admitted to the facility on [DATE], with diagnosis that included Vascular dementia, moderate, with agitation and irritability and anger. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 6/8/26, reflected R4 scored 3 out of 15 (severe cognitively impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 7/29/26 at 3:20 pm, R3 was observed in her room, seated in a wheelchair, and reading a book. R3 recollected previous encounters with R4. R3 stated that she has never spoke to him before, however, R4 would enter R3's room uninvited on several occasions. On 6/8/26 around midnight, R4 entered R3's room and stepped over to her bedside. R3 told R4 that he needed to leave. R4 refused. R3 repeatedly told R4 to leave or she was going to call the police. R4 told R3 that he did not care of she called the police. Staff arrived to assist and removed R4 from the room. R3 stated that there had been several encounters similar to this which occurred on and off all day and all night. R3 reported feeling afraid, and therefore, filled out a Grievances form to express her concern regarding R4 entering her room without permission. R3 went on to explain that one day, on 6/14/26, R4 came into R3's room without permission, yet again. R3 told R4 that he needed to leave. R4 responded by repeatedly calling R3 a b*tch and an as*hole, R4 approached R3 and lifted his cane to hit R3/ R3 stated she put her arm up to avoid being hit in the face, resulting in R4's cane striking R3 on the outer portion of her palm. R3 stated that staff intervened and after a few moments of coaxing R4 to leave the room, R4 finally exited R3's room. R3 presented a photograph of her hand which had a deep purple bruise on the outer part of her hand and knuckle. R3 reported that after the incident, R4's room was moved to the front of the hall as opposed to the end which reduced the number of times that R4 was walking past her room. R3 stated that she felt relieved because she was getting more and more afraid for R4. When asked if there any interventions in place to keep R4 from entering her room, R3 stated she had a stop sign set across her doorway however, the time of the incident, she did not observe the sign in place across her doorway. R4 also stated that her stop sign was removed two or three days ago and a staff member put it back up today. Review of a handwritten Grievance form completed by R3 stated the guy that wanders came into my room Monday night 6/8/26. Was at end of curtains by bathroom and was walking up toward bed. Very scary. He did this 2-3 times. I called for help both times. The came and took him out. He is very scary. In the section which states who else knows about the problem or incident, R3's handwritten response stated man in charge of nurses . In the section that states how can we address your issues?, R3's handwritten response stated he is very scary. has been walking in hall most of day looking in rooms .I kept telling him to leave. He wouldn't. Called me names. On the Grievance form, R3 indicated that this was an ongoing problem, stating, about a week, off and on all day sometimes PM (night). Review of a Facility reported incident report dated 6/14/26 stated that on 6/14/26 at 3:20 PM, R4 entered R3's room and when R3 told R4 to leave, R4 made contact with R3 using a walking cane. According to the same (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report, Licensed Practical Nurse (LPN) C was interviewed LPN C stated I heard yelling down the hall. the CNA (certified nursing assistant) and I entered the room and [R4] sat down on B bed facing [R3]. [R4] said she's a b*tch. Why didn't she just say it was her room. [R3] said I came out of the bathroom and saw saw him and told him to leave now. He starting walking toward me swinging his cane. I put my hand up and he hit my hand with the cane. A staff interview conducted with CNA D stated I heard [R3] screaming, get out. When i entered the room, [R3] was at the end of her bed. [R4] was yelling, why bitch?. LPN C' took [R4] out of the room. R3 was rubbing her hand and I noticed a bruise. [R3] stated he was swinging his cane and I put my hand up and the cane hit my hand. Review of a Nurses Note dated 12/16/25 stated Due to increased aggression towards staff with cane, cane has been removed from residents room. A walker has been provided. Resident has not used the cane consistently and ambulates frequently without it . Review of a Behavior Note dated 1/27/26 stated Resident attempted to enter female's room x 2. The first time he said he was lost. The second time he said she was his ex girlfriend . Review of a Progress Note dated 1/30/26 stated Nurse reports that his behaviors continue on second shift. He is still getting agitated with female residents and staff. He has been taking away food from other residents. When he is corrected or redirected, he gets verbally aggressive. Review of a Progress note dated 5/31/2026 revealed resident [R4] standing in the hallway arguing with [another resident], who accused him of being in her room. He said he did not know it was her room and [other resident] stated that he hit her in the left arm. He said that her would hit her again if she did not shut up. This nurse stepped between them and told him to go to his room . A nurses note dated 6/4/26 stated Guest [R4] came out of his room agitated that his roommate is accusing him of taking his stuff. Guest stated that he wanted a room change and he was done being blamed for everything going missing in that room. Guest also stated that if something does not change and his room mate goes off on him again he will hit him with his cane. DON (Director of Nursing) was called about situation. DON stated just to keep an eye on them and he will figure something out when he gets to facility. The follow up to the situation was to relocate R4 to a different room, at the end of the hallway. Review of the Care plan, Kardax, and Nurses Progress Notes revealed no indication of how R4 regained access to his cane that was removed from his possession in December 2025 or mention of any cane in any documentation. Review of a social services note dated 6/4/26 stated Resident wandering hallway and into other residents rooms throughout day. Resident easily redirected. Review of R4's Care plan revealed an absence of any Care Plan or any interventions related to R4's entering other residents' rooms. R4's Care plan spoke to using a walker for ambulation, however, nothing was noted on his Care Plan about using a walking cane. In an interview on 7/30/26 at 11:55 am, Resident #6 (R6) was interviewed regarding R4. R6 resided on the same hallway as R3 and R4. R6 stated that R4 had wandered into her room several times. During on occasion, R4 was aggressive and told R4 that he owns this building, so she needed to get out. R6 responded by telling R4 that she pays rent and had no intentions of leaving. R4 proceeded to bawl his fists up and call R6 a b*tch. R6 reported the incidents as scary and felt disrespected. Per R6, this was reported to the DON who took down the information. and told R6 that this was an ongoing issue with R4. R6 stated that staff placed a stop sign across her doorway however, it had been removed and she was not sure why. In an interview on 7/30/26 at 12:42 PM, Unit Manager (UM) E stated that R4 used to reside on her unit. When residing on that unit, R4 entered other residents' rooms. When asked about the walking cane, UM E stated that it was removed and could not locate any information regarding a cane on R4's care plan, only ambulation using a walker. UM E denied seeing any interventions regarding entering other residents' rooms. In an interview on 7/30/26 at 1:29 PM, DON B stated that he was aware of R4's cane being removed, however, was not sure how he regained access to the walking cane. After (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the first incident when R4 allegedly entered a room and struck a resident, he was moved to another unit. DON B stated that R4's room was moved to the front of the hall but acknowledged that was an intervention that was taken after the incident with R3 occurred. DON B could not speak much to interventions in place to eliminate R4 entering other residents' rooms or notifying staff that he was not to have access to a cane.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3072680. Based on observation, interview and record review, the facility failed to ensure adequate blood glucose (sugar) monitoring for one (R2) of three reviewed. Findings include: Review of the medical record reflected R2 admitted to the facility on [DATE], with diagnoses that included type 1 diabetes mellitus with ketoacidosis, without coma. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 7/9/26, reflected R2 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 7/29/26 at 3:20 PM, R2 was observed in bed. R2 reported the amount of insulin that had been ordered for them was too high and had been decreased. On 7/30/26 at 10:35 AM, R2 was observed in bed. R2 reported monitoring their own blood glucose multiple times daily, at home. R2 reported their blood glucose was not being monitored daily at the facility. A Physician History and Physical Progress Note, dated 7/3/26, reflected R2 was seen for an admission visit, after hospitalization for hyperglycemia (high blood sugar). According to the note, R2 had a history of poorly controlled type one diabetes. R2's medical record reflected a Physician Order, dated 7/2/26 to 7/9/26, for nine units of insulin glargine (long-acting insulin to help maintain stable blood glucose levels) to be administered twice daily. R2's medical record reflected a Physician Order, dated 7/10/26 to 7/20/26, for 15 units of insulin glargine to be administered daily. R2's medical record reflected a Physician Order, with a start date of 7/22/26, for 10 units of Lantus (long-acting insulin) to be administered daily. R2's medical record did not reflect routine monitoring of blood glucose levels. A Physician Order, with a start date of 7/5/26, reflected R2 was to have a FreeStyle Libre device (blood glucose monitor with a sensor that is placed in the arm, which can monitor blood glucose levels continuously) that was to be changed every 14 days. The July 2026 Medication Administration Record (MAR) reflected FreeStyle Libre device changes were ordered for 7/5/26 and 7/19/26 but were not documentation as being administered. Documentation for 7/5/26 reflected the device was not placed/changed due to R2 being absent from the facility. A Medication Administration Progress Note for 7/19/26 reflected the FreeStyle Libre device was on order. R2's July MAR reflected their blood glucose was documented as being checked on 7/4/26, 7/6/26, 7/7/26, 7/8/26, 7/16/26, and 7/19/26. The vital signs section of R2's medical record reflected additional documentation which included blood glucose checks on 7/3/26, 7/4/26, 7/6/26, 7/7/26, 7/8/26, 7/9/26, 7/16/26, 7/19/26 and 7/25/26. On 7/4/26, R2's blood glucose levels were documented ten times, with results ranging from 39 mg/dL (milligrams per deciliter/unit of measurement) to 273 mg/dL. A Progress Note for 7/5/26 at 9:32 AM reflected R2 was transferred to the emergency room after being observed in bed, unresponsive to verbal stimuli. R2's oxygen saturation level was 70 percent, and their blood glucose level was 40 mg/dL. A Progress Note for 7/5/26 at 6:29 PM reflected R2 returned to the facility. A Progress Note for 7/16/26 reflected a nurse entered R2's room and noted that R2 appeared unresponsive and was snoring loudly. R2's blood glucose was 53 mg/dL at that time. A Glucagon injection (medication used for emergency treatment of low blood sugar) was administered. Recheck blood glucose levels were 63 mg/dL and 120 mg/dL. In an interview on 7/30/26 at 11:18 PM, Licensed Practical Nurse (LPN) C reported residents that were receiving long-acting did not typically have their blood glucose levels checked after they were deemed stable. After they were deemed stable, blood glucose levels were checked if a resident exhibited signs of hypoglycemia (low blood sugar). In an interview on 7/30/26 at 1:29 PM, Director of Nursing (DON) B reported if a resident was on long-acting insulin, they typically did not monitor blood glucose levels. DON B reported if there (continued on next page)		

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were complications with blood glucose or they had to send a resident to the hospital, they may monitor blood glucose for residents receiving long-acting insulin. DON B reported R2 had a FreeStyle Libre device. After discussion pertaining to FreeStyle Libre documentation for R2, DON B then stated he did not know if R2 had a FreeStyle Libre device. DON B reported if R2 did not have a FreeStyle Libre device, the expectation was that R2's blood glucose would be monitored daily while on Lantus insulin. R2's medical record, including the 7/2026 MAR, Progress Notes and vital signs documentation did not reflect daily blood glucose level monitoring.		