STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tweeten Lutheran Health Care Center	125 5th Avenue Southeast Spring Grove, MN 55974

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to investigate immediately a cause of hypoglycemia (low blood sugar) for 1 of 4 residents (R1) reviewed for insulin administration. Findings include:R1's face sheet dated 6/8/26, identified diagnoses of diabetes mellitus, sepsis, heart failure, hypertensive chronic kidney disease. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, had no behaviors, no rejection of care, required insulin injections and hypoglycemic medications (including insulin). R1 required supervision/touching assistance from staff for transfers. R1's care plan dated 5/1/26, identified R1 had a diagnosis of diabetes mellitus. R1's goal was to effectively manage health conditions along with nursing staff as evidenced by no acute exacerbation of condition. Corresponding interventions dated 5/13/26 included:Administer medications per physician orders. Nursing staff will dispense and administer all medications.Monitor blood sugars per physician orders. Notify provider of out-of-range blood sugars per facility policy. R1's physician orders with a start date of 5/13/26 directed the following:Check blood sugar four times a day at 7:00 a.m.; 11:00 a.m.; 4:00 p.m.; and 9:00 p.m.Insulin Glargine (long-acting) insulin 100 units/milliliter (ml): administer 15 units subcutaneously (under the skin) daily in the morning. Novolog (rapid acting) insulin U (units) 100 insulin: administer ten units every morning.Novolog insulin U-100 insulin: administer six units subcutaneous with lunch. Novolog insulin U-100: administer twelve units subcutaneously with evening meal. For signs/symptoms of hypoglycemic reaction initiate the 15/15 protocol. Check blood sugar, if less than 60, give 15 grams (g) of carbs (carbs only), 4 oz of orange juice; regular pop; glucose tablets; 1 tablespoon of jelly/jam/sugar/honey. Wait 15 minutes, then test again. If blood sugar does not increase repeat 15 g of carbs and wait 15 minutes and test again. If unable to consume a snack, provide oral glucose gel. If blood sugar does not show improvement after two rounds (30 minutes) or becomes unresponsive, seek medical help.If unable to administer oral glucose gel, administer Glucagon (emergency medication used to treat severe hypoglycemia) 1-unit subcutaneously/intramuscular (SQ/IM). Recheck blood sugar after administration. Notify provider of gel/glucose use. R1's progress note dated 5/15/26 at 2:01 p.m., identified R1's blood sugar reading had been extremely fluctuating and point of care testing (POCT) had to be completed twice so that insulin could be administered after meals (post prandial) when readings indicated better figures. R1's progress note dated 5/15/26 at 9:59 p.m., included R1 was taken to hospital at 9:40 p.m., after an unresponsive episode due to hypoglycemia. Writer went into R1's room to apply bedtime body creams and found R1 lying in bed unresponsive. POCT indicated, low, and there were no numerical numbers. Glucagon gel was applied and paramedics came and administered intramuscular (IM) glucagon and took R1 to the hospital. R1's hospital note dated 5/15/26 at 10:36 p.m., identified R1 presented in the emergency department (ED) from the nursing home with hypoglycemia. R1 reported recent episodes of low blood sugar, sweating, and difficulty eating at nursing home. R1 was admitted for ongoing hypoglycemia and borderline blood pressure, with concern that nursing home was insufficient for current acuity. Decision to admit was based on clinical instability and need for close monitoring and interventions, including intravenous glucose. ED course showed at 2:45 a.m., R1 developed recurrent hypoglycemia and had to be administered D50 (50% dextrose-sugar water) and had to be placed on a (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dextrose drip. R1 reported that earlier in the evening her blood sugar read 70, after she was advised to eat. R1 had consumed cottage cheese and attempted to eat melon but found it too hard to chew. Her last substantial meal was half a bacon, lettuce and tomato sandwich from the previous day. After returning to her room, she began to experience shaking and sweating, which she recognized as symptoms of hypoglycemia. R1 received 1 liter of intravenous fluids and a D50 injection in the ambulance prior to arrival. R1's blood glucose meter recorded on 5/15/26, blood sugars were reviewed on 6/5/26, in combination with record values in the electronic health record (EHR). The meter identified at 4:47 p.m., R1's blood sugar was 70 mg/dl, however the EHR did not identify this value. R1's record did not include an assessment for signs and symptoms of hypoglycemia after R1's meter identified the blood sugar of 70 nor evidence the physician was notified. R1's EHR identified the next recorded blood sugar was not obtained at 6:37 p.m. when her blood sugar was 97 mg/dl. R1's MAR identified at 6:38 p.m. R1 was administered 12 units of Novolog insulin even though post prandial blood sugar was only 97 mg/dl. R1's EHR at 9:20 p.m. documented the blood sugar as LOW. R1's meter identified LOW at 9:30 p.m. Review of R1's blood glucose monitor was not set to the correct date and time. On 6/5/26 at 2:07 p.m., Infection Control/Quality nurse (IC-QN) reviewed the meter, the actual date and time were determined and recorded blood sugars were validated. R1's meter identified at 12:04 p.m. R1's blood sugar was 55 mg/dl. Between 12:04 p.m. and 1:16 p.m. when the meter identified R1's blood sugar was 251 mg/dl there was no indication R1's blood sugar was rechecked every 15-minutes according to physician orders. In addition, review of R1's record did not include an assessment for signs and symptoms of hypoglycemia, no indication the 15/15 protocol was followed, and no indication the physician was notified. During an interview on 6/5/26 at 2:07 p.m., IC-QN verified R1's blood glucose monitor by comparing the EHR had two blood sugars taken on 5/15/26 at 12:04 p.m. with a value of 55 mg/dl and at 4:47 p.m., with a value of 70 mg/dl. IC-Q explained that neither of the values had been entered into R1's EHR and that R1 had received all of her doses of insulin that day. IC-QN stated R1 should not have received the noon or evening dose until the physician had been notified. During an interview on 6/8/26 at 3:53 p.m., former director of nursing (F-DON) stated she was the acting DON at the time of R1's hypoglycemic/unresponsive episode on 5/15/26, however, she had not been involved in the investigation to determine the cause of R1's hypoglycemia. F-DON further explained that a consultant and the case manager did the investigation and the education with the staff. During a return phone call on 6/9/26 at 9:23 a.m., registered nurse case manager (RN)-CM stated she assisted in the investigation after R1's unresponsive/hypoglycemic episode on 5/15/26. RN-CM stated she was informed by RN-A on 5/18/26, that R1has episodes of hypoglycemia, but when she reviewed R1's vitals she had not identified any low blood sugars on 5/15/26 so she had instructed R1 to place the low values in the EHR. RN-CM did not review the values on the machine nor look at the administration history to see if RN-A had administered R1 insulin at the scheduled times and she should have completed this to determine if R1 received insulin when she was not supposed to. RN-CM was not aware R1 had blood sugar values of 55 mg/dl before lunch, nor a blood sugar of 70 mg/dl before supper and with values like that R1's insulin should have been held, and the physician should have been notified. Review of the facility's Abuse Potential/Vulnerable Adult/Quality Assurance and Performance Improvement (QAPI) Review Policy dated 3/26, identified the following:It is the policy of the facility that all incidents will be investigated even if not reportable and results of investigation will be documented. This included the following:-Taking steps to prevent further potential abuse.-Reporting the alleged violation and investigation within required time frames.-Conducting a thorough investigation of the alleged violation.-Revising the resident care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. Procedure:The investigation is the process used to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. This information gathered is given to administration.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to notify the physician of hypoglycemic (low blood sugar) episodes, ensure insulin was safely administered, and provide rescue medication per facility protocol during a severe hypoglycemic episode for 1 of 4 residents (R1). This resulted in immediate jeopardy (IJ) for R1 who had a severe hypoglycemic episode after repeated hypoglycemia episodes earlier in the day and was subsequently found unresponsive and required emergency medical care and hospitalization. In addition, the facility failed to notify the physician immediately of hypoglycemic episodes for 2 of 4 residents (R1, R2). The immediate jeopardy (IJ) began on 5/15/26 when it was identified that R1 had hypoglycemic episodes during the day, continued to receive insulin, proceeded to have a severe hypoglycemic episode, and needed to be hospitalized . On 6/5/26 at 4:32 p.m., the administrator and infection control/quality nurse (IC-Q) were notified of the IJ. The IJ was removed on 6/6/25 at 12 p.m., after it was verified the facility implemented an acceptable removal plan. However, non-compliance remained at a lower scope and severity of D, no actual harm, with a potential for more than minimal harm. Findings include: According to the Mayo Clinic a normal fasting (before eating) blood sugar reading would be 80-120 milligrams/deciliter (mg/dl). R1's face sheet dated 6/8/26, identified diagnoses of diabetes mellitus, sepsis, heart failure, hypertensive chronic kidney disease. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, no behaviors, no rejection of care, required insulin injections and hypoglycemic medications (including insulin). R1 required supervision/touching assistance from staff for transfers. R1's care plan dated 5/1/26, identified R1 had a diagnosis of diabetes mellitus. R1's goal was to effectively manage health conditions along with nursing staff as evidenced by no acute exacerbation of condition. Corresponding interventions dated 5/13/26 included: -Administer medications per physician orders. Nursing staff will dispense and administer all medications. -Monitor blood sugars per physician orders. Notify provider of out-of-range blood sugars per facility policy. R1's physician orders with a start date of 5/13/26 directed the following: -Check blood sugar four times a day at 7:00 a.m.; 11:00 a.m.; 4:00 p.m.; and 9:00 p.m. -Insulin Glargine (long-acting) insulin 100 units/milliliter (ml): administer 15 units subcutaneously (under the skin) daily in the morning. -Novolog (rapid acting) insulin U (units)-100 insulin: administer ten units every morning. -Novolog insulin U-100 insulin: administer six units subcutaneous with lunch. -Novolog insulin U-100: administer twelve units subcutaneously with evening meal. -For signs/symptoms of hypoglycemic reaction initiate the 15/15 protocol. Check blood sugar, if less than 60, give 15 grams (g) of carbs (carbs only), 4 oz of orange juice; regular pop; glucose tablets; 1 tablespoon of jelly/jam/sugar/honey. Wait 15 minutes, then test again. If blood sugar does not increase repeat 15 g of carbs and wait 15 minutes and test again. If unable to consume a snack, provide oral glucose gel. If blood sugar does not show improvement after two rounds (30 minutes) or becomes unresponsive, seek medical help. -If unable to administer oral glucose gel, administer Glucagon (emergency medication used to treat severe hypoglycemia) 1-unit subcutaneously/intramuscular (SQ/IM). Recheck blood sugar after administration. Notify provider of gel/glucose use. R1's progress note dated 5/15/26 at 2:01 p.m., identified R1's blood sugar reading had been extremely fluctuating and point of care testing (POCT) had to be done x2 so that insulin could be administered after meals (post prandial) when readings indicated better figures. Review of R1's record dated 5/15/26 between 6:00 a.m. and 3:00 p.m. identified recorded blood sugars did not reflect fluctuating blood sugars according to the progress note, instead the record noted at the following: -9:47 a.m. blood sugar reading was 181 milligram/deciliter (mg/dl). -1:17 p.m. blood sugar reading was 251 mg/dl. Review of R1's Medication Administration History for 5/15/26 identified the following administrations: -Glargine insulin: ten units administered at 9:47 a.m. (physician order was for fifteen units). R1's record did not identify a physician order for reduction of the insulin by 5 units nor a documented rationale for the lower dose. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Novolog insulin administered ten units at 9:47 a.m. -Novolog insulin: administered six units at 1:17 p.m. Review of R1's blood glucose monitor was not set to the correct date and time. On 6/5/26 at 2:07 p.m., Infection Control/Quality nurse (IC-QN) reviewed the meter, the actual date and time were determined and recorded blood sugars were validated. R1's meter identified at on 5/15/26 at 12:04 p.m. R1's blood sugar was 55 mg/dl. Between 12:04 p.m. and 1:17 p.m. when the meter identified R1's blood sugar was 251 mg/dl, there was no indication R1's blood sugar was rechecked every 15-minutes according to physician orders. In addition, review of R1's record did not include an assessment for signs and symptoms of hypoglycemia, no indication the 15/15 protocol was followed, and no indication the physician was notified. R1's physician assistant (PA) nursing home note dated 5/15/26 at 1:30 p.m. identified R1 had been seen for a new admission visit. Blood sugars were reviewed and there was no hypoglycemia documented. Insulin and semaglutide (a medication used to treat diabetes) will be continued as ordered. Blood sugar does not need to be checked at bedtime, and they can be checked three times per day before meals. R1's progress note dated 5/15/26 at 3:47 p.m., identified R1 had been seen by physician assistant (PA) for new admission. New orders to check blood sugar three times per day before meals. Bedtime blood sugar check was not necessary. In review of R1's record there was no indication the orders were transcribed into the medical record, nor notification to the provider of R1's blood sugar of 55 mg/dl. R1's afternoon blood glucose meter recorded on 5/15/26 blood sugars were reviewed on 6/5/26 in combination with record values in the electronic health record (EHR). The meter identified at 4:47 p.m. R1's blood sugar was 70 mg/dl, however the EHR did not identify this value. R1's record did not include an assessment for signs and symptoms of hypoglycemia after R1's meter identified the blood sugar of 70 nor evident the physician was notified. R1's EHR identified the next recorded blood sugar was obtained at 6:37 p.m. when her blood sugar was 97 mg/dl. R1's MAR identified at 6:38 p.m. R1 was administered 12 units of Novolog insulin even though post prandial blood sugar was only 97 mg/dl. R1's EHR at 9:20 p.m. documented the blood sugar as LOW. R1's meter identified LOW at 9:30 p.m. During an interview on 6/5/26 at 12:54 p.m., blood glucose monitor manufacturer (BGM)-A stated a reading of LOW on the monitor indicated the blood sugar reading was less than 20 mg/dl. During an interview on 6/5/26 at 2:07 p.m., IC-QN verified R1's blood glucose monitor by comparing the EHR had two blood sugars taken on 5/15/26 at 12:04 p.m. with a value of 55 mg/dl and at 4:47 p.m., with a value of 70 mg/dl. IC-QN explained that neither of the values had been entered into R1's EHR and that R1 had received all of her doses of insulin that day and should not have received the noon or evening dose until the physician had been notified first. R1's progress note dated 5/15/26 at 9:59 p.m., included that R1 was taken to (the hospital) at 9:40 p.m. after an unresponsive episode due to hypoglycemia. Writer went into R1's room to apply bedtime body creams and found R1 lying in bed unresponsive. Point of care testing (POCT) indicated R1's blood sugar was low and there were no numerical numbers. Glucagon gel was applied and paramedics came and administered intramuscular (IM) glucagon and took R1 to the hospital. R1's emergency department (ED) nursing note dated 5/15/26, identified R1 had been brought in via emergency management services (EMS) after an unresponsive episode. When EMS picked her up her blood pressures were in the 40's systolic, blood sugar was in the 60's. R1 did not eat much for dinner and was very diaphoretic (sweaty). Glucagon (emergency medicine used to treat severe hypoglycemia) was given via intramuscular on scene. Last blood sugar was 89. R1's hospital note dated 5/15/26 at 10:36 p.m., identified R1 presented in the ED from the nursing home with hypoglycemia. R1 reported recent episodes of low blood sugar, sweating, and difficulty eating at the nursing home. R1 was admitted for ongoing hypoglycemia and borderline blood pressure, with concern that nursing home was insufficient for current acuity. Decision to admit was based on clinical instability and need for close monitoring and interventions, including intravenous glucose. ED course showed at 2:45 a.m., R1 developed recurrent hypoglycemia and had to be administered D50 (50% dextrose-sugar water) and had to be placed on a dextrose drip. R1 reported that earlier in the evening her blood sugar read 70, after she was advised to eat. R1 had consumed cottage cheese and (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	attempted to eat melon but found it too hard to chew. Her last substantial meal was half a bacon, lettuce and tomato sandwich from the previous day. After returning to her room, she began to experience shaking and sweating, which she recognized as symptoms of hypoglycemia. R1 reported her daughter-in-law provided a nutritional drink, but symptoms worsened before she could consume it. R1 received 1 liter of intravenous fluids and a D50 injection in the ambulance prior to arrival. R1's hospital admission history and physical note dated 5/16/16, identified R1 was found unresponsive and diaphoretic at the facility and was found to be critically hypoglycemic, hypotensive, and anemic. R1 was admitted for management of hypoglycemia, hemoglobin monitoring, and acute kidney injury. Acute kidney injury suspected to be pre-renal (a medical condition occurring in the circulatory system before reaching the kidneys) etiology in setting of poor oral intake, blood loss anemia. R1 reported holding diuretics and blood pressure medication since her admission due to sepsis and acute kidney injury. During an interview on 6/4/26 at 1:36 p.m., R1 stated she had an episode a while ago where her blood sugar bottomed out and had to be sent to the hospital. R1 recalled being told around 5:00 p.m. that her blood sugar was around 70 mg/dl and the nurse told her to go and eat, and he would recheck it after she ate. R1 explained she then went to the dining room and really was not hungry, so she only ate a part of a sandwich and a little bit of cottage cheese. R1 then returned to her room after the meal but did not recall if the nurse came back to check on her or take her blood sugar. R1 stated she must have gone unresponsive and had to be taken to the ED, but it must have happened so fast, because she did not recall having any symptoms prior to that episode. R1 had heard the ambulance crew needed to give her glucose injection and she did not wake up until she got to the ED. R1 thought the nurse had given her less insulin on that day due to her blood sugar being low but did recall exactly. During an interview on 6/5/26 at 11:44 a.m., PA stated she had seen R1 for a new admission round on 5/15/26 and had not been notified of any hypoglycemic blood sugar readings during rounds. PA stated she had access to R1's electronic health record (EHR) and reviews blood sugars by looking at the documented vital signs. PA stated if she had been notified of R1's blood sugars of 55 mg/dl before lunch, she would have had the nurse hold the scheduled insulin and kept a close eye on R1's blood sugars that day. PA further explained when the nurse identified R1's low blood sugars but continued to administer R1's scheduled insulin without notification to a physician put R1 in harm's way and put her at risk for serious harm, impairment or even could have caused death. During an interview on 6/8/26 at 2:08 p.m., registered nurse (RN)-A stated he had checked R1's blood sugar on 5/15/26 before lunch and her reading was 55 mg/dl, however, could not recall if R1 had any hypoglycemic symptoms at that time. RN-A then instructed R1 to go and eat her noon meal due to her blood sugar being low. RN-A retook R1's blood sugars around 1:17 p.m. and found her blood sugar to be 251mg/dl, so RN-A stated he administered R1's insulin at that time. RN-A further explained before supper time R1's blood sugar reading was 70 mg/dl, so he also told R1 to go eat the meal, however, did not verify how much R1 ate during the meal, and he would check her blood sugar after she ate, which then he took a blood sugar at 6:37 p.m., which was 97 mg/dl. RN-A then administered R1 her 12 units of Novolog. RN-A explained R1's fasting blood sugar values before she ate would be considered hypoglycemic but believed he could base the insulin dosing on the after the meal blood sugar. RN-A explained that at around 9:30 p.m., he was notified by an aide that something was wrong with R1. RN-A went to R1's room immediately, where he found her lying in bed unresponsive. R1's blood sugar was taken and read LOW- there were no numbers registering on the glucose monitor. RN-A stated he immediately looked in the medication cart but could not find the rescue glucagon injection. Then licensed practical nurse (LPN)-B assisted him in trying to find the medication but was unable to locate the glucagon infection either. RN-A then went to find jam and honey and began to rub it on R1's oral mucosa (the mucous membranes lining the skin inside of the mouth, including cheeks and lips) to raise the blood sugar. LPN-B then found the oral glucose gel in the med room, so he then RN-A placed it in R1's oral mucosa also. RN-A reported that when the substances were applied in R1's mouth, R1 remained unresponsive and was unable to swallow. RN-A explained that is all I could do, since I could (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not find the medication, she needed. RN-A stated he was agency staff and had been working at the facility for the past 3 months but had never been shown where the location of the emergency kit and also was not aware of the hypoglycemic protocol. During an interview on 6/4/26 at 4:25 p.m., licensed practical nurse (LPN)-B stated she had worked at the facility on 5/15/26 when R1 was found unresponsive. LPN-B was passing medication when she heard a nursing assistant come out of R1's room and tell registered nurse (RN)-A that something was wrong with R1. RN-A then went into R1's room when LPN-B observed RN-A leaving and re-entering R1's room multiple times. When LPN-B entered R1's room she observed R1 to be pale and unresponsive. RN-A then informed LPN-B that R1's blood sugar was LOW and RN-A could not find the glucagon pen. LPN-B then called 911 and attempted to assist RN-A to find the glucagon pen, however, was unable to locate it. LPN-B explained she had not been shown during orientation of the location but knew it would be in the medication room however her badge did not work to enter the room. LPN-B then went to get RN-A to open the medication room door and both LPN-A and RN-A attempted to look for the glucagon injection but still was unable to locate it. LPN-B further explained she was finally able to locate the glucose gel and gave it to RN-A. When LPN-B heard R1's blood sugar was reading low and was unresponsive, she was aware she needed to have the glucagon injection quickly to avoid death. LPN-B stated when emergency management systems (EMS) arrived they had taken R1's blood sugar and continued to read LOW so they administered a glucagon injection and took her to the emergency department. LPN-B stated when EMS left the facility with R1, R1 remained unresponsive. During an interview on 6/5/26 at 12:08 p.m., nursing assistant (NA)-A stated she had been asked to sit with R1 on 5/15/26 because the nurses were having a tough time finding the glucose injection to give R1 because her blood sugar was too low. When NA-A entered R1's room she was pale and completely un-responsive. It was kind of scary to see her like that, I thought she might die. NA-A could not recall the exact time she sat with R1, but soon after RN-A returned to R1's room and applied some sort of gel on her gums then EMS arrived to take R1 to the hospital. Review of facility investigation notes dated 5/18/26 and 6/5/26 identified although the facility identified issues with licensed staff's awareness of the location of the glucagon there was no indication the facility completed an analysis of what led to R1's hypoglycemic event that had resulted in unconsciousness and hospital admission. The investigative notes dated 6/5/26 identified the facility met with RN-A to discuss R1's hypoglycemia episode. RN-A reported after R1 became unresponsive and her blood sugar reading was low, he was unable to locate the glucagon, so he located honey and rubbed it on her oral mucosa. Another nurse had already called 911 and when they arrived, they administered IM glucagon. Investigative notes on 6/5/26 identified an undated statement from RN-A that included R1 was found unresponsive when he went to administer bedtime body creams. R1's blood sugars had been extremely fluctuating blood sugar reading throughout the day. The writer searched and could not locate the glucagon. Two nurse managers were called to assist in its location and there was no solution. The writer rubbed honey and jam in R1's oral mucosa. A few minutes later the oral glucagon gel was found and administered to the resident. 911 had already been called for assistance. Vital signs were taken and blood sugar readings indicated low on the glucometer. When emergency personnel came, they administered IM glucagon and left to take R1 to the hospital. R1 was still unresponsive at the time she was taken to hospital around 9:45 p.m. As a result of the facility investigation that identified staff being unable to locate emergency medications used to treat a severe hypoglycemia reaction, the following education was provided to staff beginning 5/18/26: -Staff provided the Management of Hypoglycemia Policy to read; instructed staff that nurses should respond to blood sugars less than 70 mg/dl according to the policy; instruction on the location of the glucagon injection (located in the medication room in an emergency kit). -Instructed staff that providers should be notified whenever glucagon is administered and/or 911 is called for appropriate follow up care. -Instructed staff that if residents are unresponsive or responding poorly, they should not be given anything orally to prevent choking, During an interview on 6/4/26 at 2:14 p.m., LPN-A stated she was agency nursing staff, and it had only been her 3rd or 4th (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	day working at the facility. LPN-A was unable to articulate the facility protocol for a resident with a hypoglycemic episode. LPN-A stated if she identified a diabetic resident unresponsive, she would first check the blood sugar, and if the reading showed a reading of low, she would quickly give oral glucose gel to bring the blood sugar up. LPN- A stated she would give the glucose oral gel, even if the resident could not swallow, because the oral glucose gel would just absorb in their oral mucosa. LPN-A explained she would not give the unconscious resident the glucagon injection, because she believed it would be above her scope of practice as an LPN to administer this medication. During an interview on 6/5/26 at 11:20 a.m., LPN-D stated after R1's hypoglycemic episode the facility printed off the policy and wanted the staff to read it and then sign the paper that they read it. LPN-D stated she did not receive any education on the policy for treatment of hypoglycemia or been shown the exact location of the emergency glucose injection and believed this medication is kept in the refrigerator but was not exactly sure. During a return phone call on 6/9/26 at 9:23 a.m., case manager RN-B stated she had assisted in the investigation after R1's unresponsive/hypoglycemic episode on 5/15/26. RN-B stated she had been informed by RN-A on 5/18/26 that R1has episodes of hypoglycemia, but when she reviewed R1's vitals she had not identified any low blood sugars on 5/15/26 so she had instructed R1 to place the low values in the EHR. RN-B did not review the values on the machine nor look at the administration history to see if RN-A had administered R1 insulin at the appropriate time and she should have completed this to determine if R1 received insulin when she was not supposed to. RN-B was not aware R1 had blood sugar values of 55 mg/dl before lunch, nor a blood sugar of 70 mg/dl before supper and with values like that R1's insulin should have been held, and the physician should have been notified. During an interview on 6/5/26 at 4:16 p.m., medical director (MD) stated she had not been notified of the hypoglycemic event that happened with R1 on 5/15/26. MD explained if she had been notified of the event, she would have worked with the facility to determine a root cause of the hypoglycemic event and assisted with the education of staff. MD explained that oral glucose gel or anything orally should have never been given to an unconscious resident due to the risk of choking. MD also explained the facility should have ensured all staff had been trained in the location of any emergency medication to ensure that there was not a delay in administration. R2 R2's face sheet dated 6/8/26, identified diagnoses of diabetes mellitus and long-term use of insulin. R2's Annual MDS dated [DATE], identified moderate cognitive impairment, had no behaviors, no rejection of cares, took insulin injections 7 out of 7 days during the assessment. R2's health condition focus care plan dated 2/18/20, identified R2 had a diagnosis of diabetes mellitus type 2. Goal to effectively manage health conditions along with nursing staff as evidenced by no acute exacerbation of condition. Interventions as follows:-Monitor blood sugars per provider orders. Notify provider of out-of-range blood sugars per facility policy. Dated 4/8/24.-Administer medications per providers orders. Dated 4/8/24. R2's physician orders identified the following orders:-Check blood sugar three times per day. Notify physician on next business day on blood sugars less than 50 mg/dl or greater than 450 mg/dl. -Lantus (long-acting insulin): administer 7 units with meals. Hold for blood sugars less than 90 mg/dl three times per before meals. -Lantus insulin: administer 7 units every morning. Dated 8/29/25.-Lantus insulin: admininster17 units every evening. Dated 3/6/26 with a stop date of 6/5/26. -Lispro insulin (rapid acting): administer 5 units with meals (three times per day). Dated 5/15/26.-Lispro insulin per sliding scale (a method used to manage blood glucose levels by adjusting the insulin dose based off blood glucose levels) three times per day before meals: If blood sugar is 200 to 249-give 2 units; if blood sugar is 250-299-give 4 units; if blood sugar is 300-349-give 6 units; if blood sugar is greater than 349-give 8 units. Dated 10/22/25. -Give glass of orange juice halfway through night shift to help blood sugars from dropping prior to breakfast. Dated 6/29/25.-Give resident toast with peanut butter at bedtime. Dated 6/23/23. Review of R2's Medication Administration Record (MAR), identified on 5/12/26, and 5/15/26 R2 did not receive the orange juice during the night shift. R2's progress note dated 5/11/26, identified R2 verbalized to another staff that she was not feeling good. Blood sugars were checked at 9:05 p.m., and the 15/15 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245429	A. Building B. Wing	06/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tweeten Lutheran Health Care Center	125 5th Avenue Southeast Spring Grove, MN 55974

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	protocol initiated. 15 grams of carbs, orange juice and peanut butter jelly toast given. Blood sugar rechecked and was 85 at 9:20 p.m. R2 stated she felt better. R2's blood glucose readings with low values for the month of 5/26 included:-5/11/26 at 9:05 p.m. was 47 mg/dl.-5/11/26 at 9:20 p.m. was 85 mg/dl.-5/12/26 at 5:15 p.m. was 60 mg/dl. Review of R2's medical record from 5/11/26 through 5/14/26, did not indicate the physician had been notified of R2's low blood sugar readings. R2's progress note dated 5/15/26, identified R2 was seen by physician assistant and gave new orders to reduce Lispro insulin to 5 units three times per day and hold for blood sugars less than 90 mg/dl or not going to eat. Follow up if any blood sugars are low. R2's PA progress note dated 5/15/26, identified R2 had some recent hypoglycemia with one blood sugar of 47 at the time of the evening meal and one blood sugar of 60 at bedtime. Plan was for type 2 diabetes was her last hemoglobin A1C was probably too well controlled too well controlled for her age and comorbidities [sic]. Long-acting insulin was reduced with the A1C of 6.0 and still having some hypoglycemia. New orders to reduce Lispro insulin to from 7 units to 5 units three times per day with meals and hold for blood sugars less than 90 mg/dl or if she is not going to eat. Insulin glargine and sliding scale left as ordered. Follow up if there is recurrent hypoglycemia. Review of R2's MAR for month of May 2026, identified R2's Lispro insulin was held on 5/18/26 at 4:45 p.m.; 5/20/26 at 7:30 a.m.; 5/31/26 at 11:30 a.m. R2's medical record reviewed from 5/18/26 through 6/5/26, identified the following low blood sugar readings:-5/18/26 at 4:55 p.m. was 85 mg/dl. -5/20/26 at 8:09 a.m. was 77 mg/dl.-5/20/26 at 4:55 p.m. was 85 mg/dl.-5/31/26 at 11:32 a.m. was 79 mg/dl. -5/31/26 at 5:07 p.m. 191 mg/dl. -6/5/26 at 3:37 a.m. was 65 mg/dl. Review of R2's record from 5/18/26 through 5/31/26 did not identify the physician had been updated on R2's low blood sugar readings. R2's progress note dated 5/31/26 at 10:58 a.m., identified R2 was extremely tired today. When in to get blood sugar resident stated she was ready to get up staff was told resident fell back asleep [sic]. Asked resident why she was so tired and her response was I think they gave me too many sleeping pills. Resident was up in wheelchair. Glucose check was 79 before lunch and was sent to dining room for lunch. Although R2's record showed symptoms of hypoglycemia of feeling tired, a recheck blood sugar was not identified in R2's chart until 5/31/26 at 5:07 p.m. During an interview and observation on 6/5/26 at 9:46 a.m., LPN-C stated she had been informed during report from LPN-B that R2 had a low blood sugar in the middle of the night around 3:37 a.m., with a value of 65 mg/dl. LPN-C reviewed R2's progress notes and did not identify any documentation of any symptoms during the low blood sugar and also reviewed R2's vitals and did not identify a recheck R2's blood sugar 15 minutes later. LPN-C stated LPN-B told her she gave R2 orange juice and a half a peanut butter sandwich when she identified the low blood sugar. LPN-C verified on R2's blood glucose monitor that a blood sugar had been rechecked 30 minutes after the value of 65 mg/dl and was listed as 110 mg/dl. LPN-C explained R2's blood sugar should have been checked 15 minutes after the snack had been given and the physician should have been notified, however, did not see any notification in the progress notes. During an interview on 6/8/26 at 10:05 a.m., LPN-B stated on 6/5/26 at around 3:37 a.m., R1 had reported she was not feeling well and wanted her blood sugar taken. LPN-B explained when she had taken R2's blood sugar at that time she got a result of 65 mg/dl, she gave R2 some orange juice and a half of a peanut butter sandwich and rechecked R2's blood sugar about 30 minutes after giving the carbohydrates and the result was 110 mg/dl. LPN-B explained she had not documented R2 symptoms, the re-check of R2's blood sugar, nor notified the physician of R2's hypoglycemic reaction and was not aware of the facility protocol of notifying physician. LPN-B believed since R2's blood sugar improved she did not need to notify the physician. R2's progress note dated 6/5/26 at 4:21 p.m., identified a new order for glargine insulin to reduce evening dose to 16 units and continue 7 units in the morning. Follow up on blood sugar on Tuesday 6/9/26. R2's physician orders identified an order for Lantus insulin: give 16 units every evening. Dated 6/5/26. During an interview on 6/5/25 at 9:46 a.m., LPN-C stated it was reported to her that in the middle of the night R2 had a low blood sugar. LPN-C reviewed R2's record and identified R2 had a blood sugar of 68 mg/dl. LPN-C then reviewed R2's blood glucose monitor and (continued on next page)

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	245429	A. Building B. Wing	06/08/2026

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	identified a blood glucose was obtained (with an incorrect date of 4/8/26 at 4:03 a.m. reading on the monitor) of 68 mg/dl. LPN-C stated the blood glucose machine showed another reading 30 minutes later at 4:33 a.m. (30 minutes later, incorrect time) of 110 mg/dl. LPN-C stated per the facility protocol R2's blood sugar should have been rechecked 15 minutes later to ensure it did not drop any lower, however, according to the glucose monitor it did not appear to be done per protocol. During an interview on 6/5/26 at 9:54 a.m., R1 stated she had woken up in the middle of the night and did not feel well. R2 explained she felt shaky and just off. R2 stated she called for the nurse, and she came in and took her blood sugar and told her it was low and proceeded to give her a peanut butter sandwich and some orange juice. During an interview on 6/5/26 at 11:44 a.m., PA stated she was on-call last night and had not been notified of R2's hypoglycemic episode on 6/5/26 and should have been notified to review R2's blood sugars to possibly make an adjustment in her insulin dosing. PA will review R2's blood sugars during rounds today and make the adjustments. PA further explained by the facility not contacting her to inform of her blood sugars being low had the possibility of causing a severe hypoglycemic reaction. During an interview on 6/5/26 at 4:16 p.m., MD stated when R2 had a hypoglycemic reaction in the middle of the night, the physician should have been notified immediately to possibly make adjustments to her insulin order to attempt to prevent future hypoglycemic reactions. Review of facility Standing Orders dated 6/25/24, identified under blood sugars the following:-Nurse may check blood glucose on any resident at any time if they feel it is indicated.-If resident is having nausea/vomiting or decreased nutritional intake, nurse may hold oral diabetic medications and/or insulin until oral intake is tolerated. Notify provider immediately if medication is held.-For signs/symptoms of hypoglycemia (low blood sugar) reaction, initiate the following protocol: check blood sugar; If blood sugar is less than 60, provide resident with snack (such as 4 ounces of milk, 4 oz. of orange juice; 2 graham crackers). If unable to consume a snack, provide oral glucose gel; If unable to consume oral glucose gel, administer Glucagon 1 unit subcutaneously/intramuscular. Recheck blood sugar after administration. Notify the provider of gel/glucagon use. Review of the facility's Management of Hypoglycemia Policy/Protocol dated 2/26, identified the following are symptoms of hypoglycemia:Weakness; restlessness; tachycardia (fast heartrate); pale/cool/moist skin; excessive perspiration; irritability/bizarre behavior; blurred vision; headaches; numbness of the tongue; more severe (stupor, unconscious and or convulsions) and coma. Management of Hypoglycemia:The following is a suggested protocol that should not be implemented without the approval of the Medical Director and Director of Nursing. If there is already a protocol in place, disregard this and follow the existing approved protocol instead.Classification of hypoglycemia:Level 1 hypoglycemia: blood glucose is less than 70 mg/dl but greater than 54 mg/dl.Level 2 hypoglycemia: blood glucose less than 54 mg/dlLevel 3 hypoglycemia: blood glucose: altered mental status and/or physical status requiring assistance for treatment of hypoglycemia.For Level 1 hypoglycemia (less than 70 mg/dl)Give the resident an oral form of rapidly absorbed glucose (15-20 grams).Notify the provider immediately.Remain with the resident.Recheck blood glucose in 15 minutes.If blood glucose is within established reference range, provide the resident with a meal or snack. If blood glucose is greater than established reference range administer diabetic me[TRUNCATED]

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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 - Few	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 interview and document review the facility failed to ensure nurses were competent in their skill level to identify a hypoglycemic (low blood sugar) episode and safely administer insulin for 1 of 1 resident (R1) reviewed for insulin administration. Findings include: R1's face sheet dated 6/8/26, identified diagnoses of diabetes mellitus, sepsis, heart failure, hypertensive chronic kidney disease. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, no behaviors, no rejection of care, required insulin injections and hypoglycemic medications (including insulin). R1 required supervision/touching assistance from staff for transfers. R1's care plan dated 5/1/26, identified R1 had a diagnosis of diabetes mellitus. R1's goal was to effectively manage health conditions along with nursing staff as evidenced by no acute exacerbation of condition. Corresponding interventions dated 5/13/26 included: Administer medications per physician orders. Nursing staff will dispense and administer all medications. Monitor blood sugars per physician orders. Notify provider of out-of-range blood sugars per facility policy. R1's progress note dated 5/15/26 at 2:01 p.m., identified R1's blood sugar reading had been extremely fluctuating and point of care testing (POCT) had to be done x2 so that insulin could be administered after meals (post prandial) when readings indicated better figures. R1's afternoon blood glucose meter recorded on 5/15/26, blood sugars were reviewed on 6/5/26, in combination with record values in the electronic health record (EHR). The meter identified at 4:47 p.m. R1's blood sugar was 70 mg/dl, however the EHR did not identify this value. R1's record did not include an assessment for signs and symptoms of hypoglycemia after R1's meter identified the blood sugar of 70 nor evident the physician was notified. R1's EHR identified the next recorded blood sugar was not obtained at 6:37 p.m., when her blood sugar was 97 mg/dl. R1's MAR identified at 6:38 p.m. R1 was administered 12 units of Novolog insulin even though post prandial blood sugar was only 97 mg/dl. R1's EHR at 9:20 p.m. documented the blood sugar as LOW. R1's meter identified LOW at 9:30 p.m. During an interview on 6/5/26 at 2:07 p.m., IC-QN verified R1's blood glucose monitor by comparing the EHR had two blood sugars taken on 5/15/26 at 12:04 p.m., with a value of 55 mg/dl and at 4:47 p.m., with a value of 70 mg/dl. IC-Q explained that neither of the values had been entered into R1's EHR and that R1 had received all of her scheduled doses of insulin that day and should not have received the noon or evening dose until the physician had been notified first. R1's progress note dated 5/15/26 at 9:59 p.m., included R1 was taken to hospital at 9:40 p.m. after an unresponsive episode due to hypoglycemia. Writer went into R1's room to apply bedtime body creams and found R1 lying in bed unresponsive. POCT indicated R1's blood sugan was LOW and there were no numerical numbers. Glucagon gel was applied and paramedics came and administered intramuscular (IM) glucagon and took R1 to the hospital.During an interview on 6/8/26 at 2:08 p.m., registered nurse (RN)-A stated he had checked R1's blood sugar on 5/15/26, before lunch and her reading was 55 mg/dl. RN-A could not recall if R1 had any hypoglycemic symptoms at that time. RN-A then instructed R1 to eat her noon meal due to her blood sugar being low. RN-A retook R1's blood sugars around 1:17 p.m., R1's blood sugar was 251mg/dl, so RN-A stated he administered R1's insulin at that time. RN-A further explained before supper R1's blood sugar reading was 70 mg/dl, so he also told R1 to eat the meal and he would re-check her blood sugar after she ate. RN-A checked R1's blood sugar at 6:37 p.m., which was 97 mg/dl. RN-A then administered 12 units of Novolog to R1. RN-A explained, R1's fasting blood sugar values before she ate would be considered hypoglycemic but believed he could base the insulin dosing on the after the meal blood sugar. RN-A explained, at approximately 9:30 p.m., he was notified by an aide that something was wrong with R1. RN-A went to R1's room immediately, where he found her lying in bed unresponsive. R1's blood sugar was taken and read LOW- there were no numbers registering on the glucose monitor. RN-A stated he immediately looked in the medication cart but could not find the rescue glucagon injection. Then licensed practical (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse (LPN)-B assisted him in trying to find the medication but was unable to locate the glucagon injection either. RN-A then went to find jam and honey and began to rub it on R1's oral mucosa (the mucous membranes lining the skin inside of the mouth, including cheeks and lips)to raise the blood sugar. LPN-B then found the oral glucose gel in the medication room, so he then placed it in R1's oral mucosa also. RN-A reported, when the substances were applied in R1's mouth, R1 remained unresponsive and was unable to swallow. RN-A explained, that is all I could do, since I could not find the medication, she needed. RN-A stated he was agency staff and had been working at the facility for the past three months but had never been shown where the location of the emergency kit and also was not aware of the hypoglycemic protocol. RN-A explained he was unaware that a blood sugar of 55 indicated hypoglycemia nor that the facility protocol indicated a specific treatment for a blood sugar of this value. RN-A explained any medication had a window of an hour before and an hour after, so when he had R1 eat her meal and he re-checked R1's blood sugar, he thought he could give the scheduled dose because her blood glucose value was in the normal range. RN-A stated he thought R1 would be just fine. RN-A stated he had not had any training on how to safely administer insulin nor had any competencies on this skill from the facility. RN-A further explained, when he first started working at the facility he had only been showed a basic layout of the facility, but not had any competencies completed by the facility. Review of RN-A's supplemental nursing staffing agency employee form dated 11/11/25, identified RN-A was able to perform blood glucose monitoring, performing fingerstick, use of blood glucose meter device, and use of visual blood glucose strips independently. Although RN-A's employee file identified RN-A was able to perform independently, had knowledge of diabetes and hypoglycemia, there was no competency completed by the facility to identify RN-A was deemed to be competent in those skills. During an interview on 6/8/26 at 2:45 p.m., IC-QN stated she was responsible to complete any competency of the nurses in the facility, however, had not completed a competency on RN-A because she believed an agency nurse had these competencies completed by the agency before being allowed to work in the facility, however, had not reviewed any documentation of competency the agency had completed. IC-QN explained she should have completed the competency on all staff and not relied on the competency documentation the agency completed. Review of the facility's Building Competency Evaluations Policy dated 2/26, identified the purpose of the policy was to define and set expectations regarding a system to evaluate and verify competency of nursing service personnel in the facility to assure resident safety and to attain the highest practicable physical, [NAME], and psychosocial well-being of each resident. Competency needs will be identified based on resident assessments, individualized plan of care, resident acuity, resident diagnoses and unique resident needs. The competency process will assess the knowledge and skills of the nursing staff in the specific skill being assessed. This process will include verification of education and competence for certification or licensure upon hire and on an ongoing basis to substantiate evidence of proficiency and skill for quality resident care. Orientation: New employee orientation, in-service education and verification of skills will be completed upon hire for all nursing services personnel. Follow up evaluation of understanding and competency will be obtained with post-test skills check list.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to maintain a complete, accurate and readily accessible medical record for 2 of 3 residents (R1, R2) who were noted to have missing blood sugar values in their record. Findings include:R1R1's face sheet dated 6/8/26, identified diagnoses of diabetes mellitus, sepsis, heart failure, and hypertensive chronic kidney disease. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had intact cognition, had no behaviors, no rejection of care, required insulin injections and hypoglycemic medications (including insulin). R1 required supervision/touching assistance from staff for transfers. R1's care plan dated 5/1/26, identified R1 had a diagnosis of diabetes mellitus. R1's goal was to effectively manage health conditions along with nursing staff as evidenced by no acute exacerbation of condition. Corresponding interventions dated 5/13/26 included: -Administer medications per physician orders. Nursing staff will dispense and administer all medications.-Monitor blood sugars per physician orders. Notify provider of out-of-range blood sugars per facility policy. R1's physician orders with a start date of 5/13/26 directed the following: -Check blood sugar four times a day at 7:00 a.m.; 11:00 a.m.; 4:00 p.m.; and 9:00 p.m. R1's progress note dated 5/15/26 at 2:01 p.m., identified R1's blood sugar reading had been extremely fluctuating and point of care testing (POCT) had to be done x2 so that insulin could be administered after meals (post prandial) when readings indicated better figures. Review of R1's record dated 5/15/26 between 6:00 a.m. and 3:00 p.m., identified recorded blood sugars did not reflect fluctuating blood sugars according to the progress note, instead the record noted at the following: 9:47 a.m. blood sugar reading was 181 milligram/deciliter (mg/dl). 1:17 p.m. blood sugar reading was 251 mg/dl. R1's physician assistant (PA) nursing home note dated 5/15/26 at 1:30 p.m., identified R1 had been seen for a new admission visit. Blood sugars were reviewed and there was no hypoglycemia (low blood sugar) documented. Insulin and semaglutide (a medication used to treat diabetes) will be continued as ordered. Blood sugar does not need to be checked at bedtime, and they can be checked three times per day before meals. R1's progress note dated 5/15/26 at 9:59 p.m., included R1 was taken to hospital at 9:40 p.m. after an unresponsive episode due to hypoglycemia. Writer went into R1's room to apply bedtime body creams and found R1 lying in bed unresponsive. Point of care testing (POCT) indicated low and there were no numerical numbers. Glucagon gel was applied and paramedics came and administered intramuscular (IM) glucagon and took R1 to the hospital. Review of R1's record dated 5/15/26 between 6:00 p.m. and 9:30 p.m., indicated:6:38 p.m. blood sugar reading was 97 mg/dl. 9:20 p.m. blood sugar reading was LOW. During an observation and interview on 6/5/26 at 2:07 p.m., Infection Control/Quality nurse (IC-QN) verified on R1's blood glucose monitor (which was not set to the correct date and time) by comparing R1's meter along with the electronic health record (EHR) that R1's blood sugar recorded in the meter on 5/15/26 at 12:04 p.m. of 55 mg/dl and at 4:47 p.m., with a value of 70 mg/dl. was not recorded in R1's EHR. During an interview on 6/8/26 at 2:08 p.m., registered nurse (RN)-A stated on 5/15/26 he had checked R1's blood sugar before lunch and got a value of 55 mg/dl and before supper R1's blood sugar was 70 mg/dl, however, had not recorded either value into R1' s EHR because RN-A stated he believed that there was only one section to record the value in the medication administration record (MAR). RN-A stated he did not add the blood sugar results to the vitals section. During an interview on 6/5/26 at 11:44 a.m., PA stated she had seen R1 for a new admission visit on 5/15/26 and had not been notified of any hypoglycemic blood sugar readings during rounds. PA stated she had access to R1's electronic health record (EHR) and reviews blood sugars by looking at the documented vital signs. PA further explained by not having all the blood sugar values entered into R1's EHR, she was not able to accurately review R1's blood sugars to make adjustments to her insulin due to having episodes of hypoglycemia. R2 R2's face sheet dated 6/8/26, identified diagnoses of diabetes mellitus and long-term use of insulin. R2's (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Annual MDS dated [DATE], identified moderate cognitive impairment, had no behaviors, no rejection of cares, took insulin injections seven out of seven days during the assessment. R2's health condition focus care plan dated 2/18/20, identified R2 had a diagnosis of diabetes mellitus type 2. Goal to effectively manage health conditions along with nursing staff as evidenced by no acute exacerbation of condition. Interventions as follows:Monitor blood sugars per provider orders. Notify provider of out-of-range blood sugars per facility policy. Dated 4/8/24. Administer medications per providers orders. Dated 4/8/24. R2's medical record reviewed on 6/5/26 identified R2's blood sugar at 3:37 a.m. was 65 mg/dl. During an interview and observation on 6/5/26 at 9:46 a.m., licensed practical nurse (LPN)-C stated she was informed during report from LPN-B that R2 had a low blood sugar in the middle of the night around 3:37 a.m., with a value of 65 mg/dl. LPN-C reviewed R2's progress notes and did not identify any documentation of any symptoms during the low blood sugar and also reviewed R2's vitals and did not identify a recheck R2's blood sugar 15 minutes later. LPN-C stated LPN-B told her she gave R2 orange juice and a half a peanut butter sandwich when she identified the low blood sugar. LPN-C verified on R2's blood glucose monitor that a blood sugar had been rechecked 30 minutes after the value of 65 mg/dl and was listed as 110 mg/dl. LPN-C reviewed R2's medical record and did not identify R2's blood sugar had been recorded in the record 30 minutes after 3:37 a.m., and stated this value should have also been entered into R2's record to show R2's response after intervention. During an interview on 6/8/25 at 2:45 p.m., IC-QN stated her expectation for the nurse was to ensure that all blood sugars become a part of the resident's medical record to ensure the record is complete and accurate. IC-QN further explained by not entering all of the vitals into a resident's chart this could not prevent the physicians from identifying concerns when reviewing a chart and could miss serious concerns. Review of the facility's Management of Hypoglycemia Policy dated 2/26, identified the following for documentation: Document the resident's blood glucose before intervention. Note blood sugar after each administration of rapid acting glucose and the follow up blood sugar. Record the resident's level of consciousness before and after intervention. Document provider instructions. Requested a policy on complete and accurate medical record but did not receive.