

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335451	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2025
NAME OF PROVIDER OR SUPPLIER Golden Hill Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Golden Hill Drive Kingston, NY 12401	

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	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility did not ensure that one (1) of three (3) residents reviewed for blood sugar monitoring and insulin administration received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Specifically, Resident #1 had an order placed on admission, 09/24/2025, for 70/30 insulin with no clear order for blood sugar monitoring. Nursing staff inconsistently monitored Resident #1's blood sugar without an order for blood sugar monitoring until one was placed on 10/08/2025. Additionally, the physician notes indicated that Resident #1's blood sugars were being monitored before meals and at hour of sleep from 09/29/2025, but no order was entered until 10/08/2025. Resident #1 had diagnoses that included diabetes, heart failure, and left ankle fracture and repair. The admission Minimum Data Set, dated [DATE] documented Resident #1 had intact cognition, diagnoses included diabetes mellitus, and medications included insulin. The facility policy titled 70/30 insulin administration and monitoring last reviewed 08/2025 documented that the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 70/30 Insulin will be administered only per physician order, using proper timing in relation to meals to prevent hypoglycemia. Blood glucose levels will be monitored and documented according to the care plan and prescriber orders. The physician order dated 09/24/2025 documented Insulin 70/30 pen-injector 100 unit/milliliter administer 24 units subcutaneously two times a day for diabetes. The Care Plan titled Resident has Diabetes Mellitus dated 09/24/2025, documented a goal that Resident #1 will remain free of signs and symptoms of hyperglycemia or hypoglycemia and have no complications related to diabetes. Interventions included diabetes medication as ordered, monitor for side effects and effectiveness. The physician progress notes dated 09/29/2025, 10/03/2025, and 10/06/2025 documented to monitor blood glucose before meals and at hour of sleep and document trends. There was no evidence of a blood sugar monitoring order from 09/24/2025-10/07/2025. The physician order dated 10/08/2025 documented to monitor Resident #1's blood sugar before meals and at bedtime. If blood sugar is greater than 200 or less than 70 notify the physician. The blood sugar monitoring log for Resident #1, dated 10/21/2025, documented multiple inconsistencies with the frequency of blood sugar readings obtained. The readings were as follows; blood sugar readings once daily on 09/24/2025, 09/29/2025, and 10/2-10/05/2025, twice daily on 09/25-09/28/2025, 09/30/2025, and 10/06-10/07/2025, and none on 10/01/2025. Blood sugar readings before meals and at hour of sleep (four times per day) were completed from 10/08/2025-10/12/2025, except for 10/10/2025 when the reading before breakfast was not obtained. Resident #1 was discharged on 10/13/2025, before which the one ordered blood sugar reading was obtained. During an interview on 10/21/25 at 3:09 PM, Registered Nurse Unit Manager #8 stated that Resident #1 did not have a separate order for blood sugars to be obtained before meals and at hour of sleep until 10/08/2025. Registered Nurse Unit Manager #8 stated that when a nurse signs to administer the 70/30 insulin the system prompts them to enter a blood sugar reading. It seems some nurses were uncertain and only some blood sugars were obtained from 09/24/2025 until 10/07/2025. Registered Nurse Unit Manager #8 stated that on 10/08/2025 there was a separate order entered for blood sugars to be obtained before meals and at hour of sleep. This order was entered after the family expressed concern about the monitoring of Resident #1's blood sugar. During an interview on 10/22/2025 at 12:18 PM, it was determined that Physician #9 was documenting in their notes starting 09/29/2025, prior to their order on 10/08/2025, that Resident #1's blood sugar was being monitored before meals and at bedtime. Physician #9 stated that the frequency of monitoring was not essential because of the type of insulin they were receiving, however it would assist in evaluating the trends for the management of their diabetes. Physician #9 was unable to state why there was no order to correspond with the notes they had been writing prior to 10/08/2025. During an interview on 10/22/2025 at 1:15PM Charge Licensed Practical Nurse #10 stated that orders could be entered by a nurse after a verbal request from the physician, or the physician will enter the order themselves. Charge Licensed Practical Nurse #10 referred to a conversation that occurred on 10/06/2025, when Resident #1's family expressed a concern about the frequency and timing of Resident #1's blood sugar monitoring. Charge Licensed Practical Nurse #10 stated they had not received any concerns from the family or resident regarding blood sugar monitoring, or any requests from the physician to enter an order for blood sugars to be monitored before meals and at the hour of sleep, before the conversation with</p>		