STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Park Health and Rehabilitation	306 Deer Park Road Nebo, NC 28761

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Nurse Practitioner (NP), and Medical Director interviews, staff failed to consult with the on-call provider immediately to obtain treatment orders for hypoglycemia when Resident #1, who had diabetes, had a critically low blood glucose level of 31 (normal 80-100), was lethargic, mumbling, and unable to receive anything by mouth as assessed by Nurse #1. Staff failed to communicate other symptoms that indicated urgent medical attention including abnormal eye movements, and tightness in her hands as assessed by Nurse #2, and inability to receive sugar under her tongue due to a tight jaw, as assessed by Unit Manager #1. Resident #1 was transferred to the hospital on 7/17/25. An emergency medical services (EMS) report dated 7/17/25 indicated when EMS arrived on scene at the facility at 4:48 PM the patient was found lying in her bed, eyes open but only reactive to pain. The EMS report stated Resident #1 was noted to be comatose with seemingly left gaze with inability to follow any types of commands for more detailed assessment. The hospital Discharge summary dated [DATE] indicated Resident #1 did not have improvement in her mental status despite improvement in acute kidney injury and treatment for urinary tract infection. The hospital discharge summary stated, suspect she had prolonged low blood glucose and seizure which led to comatose state. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. Immediate jeopardy began on 7/17/25 when staff failed to consult the physician about Resident #1's critically low blood glucose level of 31, abnormal eye movements and tightness in her hands and jaw. Immediate jeopardy was removed on 8/12/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included:Resident #1 was admitted to the facility on [DATE]. Her diagnoses included type-2 diabetes mellitus. Resident #1's July 2025 medication administration record (MAR) revealed an order dated 12/4/23, for glucometer checks before breakfast and at bedtime. The blood sugar goal was a range of 100 - 250. Interventions included to notify the Nurse Practitioner (NP) if the results were greater than 250 consistently. For blood sugar less than 70, offer oral glucose and recheck blood sugar in 1 hour. Notify Medical Doctor (MD), if blood sugar is not improved or patient symptomatic.Review of the medical record revealed the facility did not have standing orders. Review of Resident #1's medical record revealed there were no nursing note entries from Nurse #1 on 07/17/25. The only entry made by Nurse #1 on 7/17/25 was a blood glucose result of 61 entered at 7:35 AM under vital signs. An interview was conducted on 8/7/25 at 9:09 AM with Nurse #1. She was the night shift (11PM-7AM) nurse for Resident #1 on the morning of 7/17/25. Nurse #1 recalled Resident #1 and her low blood sugars on the morning of 7/17/25. Nurse #1 recalled around 5:00 AM she checked Resident #1's blood glucose when she started her morning medication pass. She stated Resident #1's blood sugar was very low. Nurse #1 said Resident #1's blood sugar reading was 31. She remembered Resident #1 was lethargic and in and out of it, she stated Resident #1 would open her eyes and look at her and mumble inaudibly but would then close her eyes and go back to sleep. Nurse #1 said she would not have felt comfortable giving Resident #1 anything by mouth, that she was not alert enough. Nurse #1 explained she had intramuscular (IM) glucagon (emergency medicine used to treat low blood sugar) in the medication cart and administered the IM glucagon to Resident #1 right after she got the blood glucose reading of 31. Nurse #1 said she did not open Resident #1's medication administration record (MAR) or look at her orders for instructions on how to treat her hypoglycemia. She explained a few months ago Resident #1 had an episode of low blood sugar and IM glucagon had been used to treat the low blood sugar. Nurse #1 stated she assumed after that episode Resident #1 had an as needed standing order for IM glucagon. She reported she thought it was standard and that all residents with diabetes had an as needed order for IM glucagon. Nurse #1 stated after she administered the IM glucagon to Resident #1, she rechecked her blood glucose every 15 minutes. She recalled at first Resident #1's blood glucose went up steadily but then started to drop back down. Nurse #1 said the highest she could get Resident #1's blood glucose up to was 61. She reported by the time the day shift Unit Manager (UM #1) came in, around 6:45 AM, Resident #1's blood glucose was back down to 61. Nurse #1 said when UM #1 arrived at the facility she gave over care of Resident #1 to UM #1 because she had worked on Resident #1 for an hour and a half and 61 was the highest, she could get her blood sugar. Nurse #1 reported she asked UM #1 to call the on-call provider to let them know Resident #1 had an episode of hypoglycemia and what

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff, resident, family, Medical Director, and Nurse Practitioner (NP) interviews, the facility failed to protect a resident's (Resident #1) right to be free from neglect when the facility failed to ensure Resident #1 received emergent care extending beyond the capabilities of the facility when she had critically low blood sugar and was symptomatic. Symptoms included lack of responsiveness, eyes moving left to right, obtunded, jaw tightness, inability to swallow, tightness of hands, moaning, foaming at the mouth. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:09 PM on 7/17/25. Resident #1 was admitted to the hospital on [DATE]. Her hospital diagnoses included acute metabolic encephalopathy (brains function is impaired due to metabolic distubance), prolonged hypoglycemia, acute kidney injury (AKI), and urinary tract infection (UTI). The hospital Discharge summary dated [DATE] said, Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, suspect she had prolonged low blood glucose and seizure which led to comatose state. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. This deficient practice occurred for 1 of 1 resident reviewed for neglect. Immediate jeopardy began on 7/17/25 when the facility failed to recognize Resident #1 who had critically low blood sugar and was symptomatic, needed emergency medical services extending beyond the capabilities of the facility. Immediate jeopardy was removed on 8/13/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: This tag is cross referred to:F 684- Based on observations, record review, staff, family, Nurse Practitioner (NP), Physician Assistant and Medical Director interviews the facility failed to recognize that a diabetic resident (Resident #1) with critically low blood sugar (normal 80-100) needed emergency medical care that required transfer to a higher level of care. On 7/17/25 at 5:30 AM Resident #1's blood sugar was 31(a serious life-threatening medical condition) and Resident #1 was lethargic (sluggish), in and out of it, mumbling, and not alert enough to eat or drink. After an intramuscular (IM) injection of glucagon (medication to treat low blood sugar) the resident remained symptomatic and was still lethargic, in and out of it, and not alert enough to eat or drink. Symptoms Resident #1 experienced from the initial low blood sugar of 31 at 5:30 AM on 07/17/25 until her discharge at 5:09 PM on 07/17/25 included lack of responsiveness, eyes moving left to right, obtunded (reduced level of alertness), jaw tightness, inability to swallow, tightness of hands, moaning, and foaming at the mouth. Resident #1's blood glucose level remained less than 70 until 1:08 PM when it was documented her blood glucose level was 77, however she remained obtunded with no verbal response. Resident #1's blood glucose decreased again to 59 at 2:30 PM. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:09 PM on 7/17/25. Resident #1 was admitted to the hospital on [DATE]. Her hospital diagnoses included acute metabolic encephalopathy (brain dysfunction), prolonged hypoglycemia (low blood sugar), acute kidney injury (AKI), and urinary tract infection (UTI). The hospital Discharge summary dated [DATE] said, Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, suspect she had prolonged low blood glucose and seizure which led to comatose state. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. This deficient practice affected 1 of 3 residents reviewed for quality of care. F 580- Based on record review, staff, Nurse Practitioner (NP), and Medical Director interviews, staff failed to consult with the on-call provider immediately to obtain treatment orders for hypoglycemia when Resident #1, who had diabetes, had a critically low blood glucose level of 31, was lethargic, mumbling, and unable to receive anything by mouth as assessed by Nurse #1. Staff failed to communicate other symptoms that indicated urgent medical attention including abnormal eye movements, and tightness in her hands as assessed by Nurse #2, and inability to receive sugar under her tongue due to a tight jaw, as assessed by Unit Manager #1. Resident #1 was transferred to the hospital on 7/17/25. An emergency medical services (EMS) report dated 7/17/25 indicated when EMS arrived on scene at the facility at 4:48 PM the patient was found lying in her bed, eyes open but only reactive to pain. The EMS report stated Resident #1 was noted to be comatose with seemingly left gaze with inability to follow any

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff, family, Nurse Practitioner (NP), Physician Assistant and Medical Director interviews the facility failed to recognize that a diabetic resident (Resident #1) with critically low blood sugar (normal 80-100) needed emergency medical care that required transfer to a higher level of care. On 7/17/25 at 5:30 AM Resident #1's blood sugar was 31 (a serious life-threatening medical condition) and Resident #1 was lethargic (sluggish), in and out of it, mumbling, and not alert enough to eat or drink. After an intramuscular (IM) injection of glucagon (medication to treat low blood sugar) the resident remained symptomatic and was still lethargic, in and out of it, and not alert enough to eat or drink. Symptoms Resident #1 experienced from the initial low blood sugar of 31 at 5:30 AM on 07/17/25 until her discharge at 5:09 PM on 07/17/25 included lack of responsiveness, eyes moving left to right, obtunded (reduced level of alertness), jaw tightness, inability to swallow, tightness of hands, moaning, and foaming at the mouth. Resident #1's blood glucose level remained less than 70 until 1:08 PM when it was documented her blood glucose level was 77, however she remained obtunded with no verbal response. Resident #1's blood glucose decreased again to 59 at 2:30 PM. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:09 PM on 7/17/25. Resident #1 was admitted to the hospital on [DATE]. Her hospital diagnoses included acute metabolic encephalopathy (brain dysfunction), prolonged hypoglycemia (low blood sugar), acute kidney injury (AKI), and urinary tract infection (UTI). The hospital Discharge summary dated [DATE] said, Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, suspect she had prolonged low blood glucose and seizure which led to comatose state. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. This deficient practice affected 1 of 3 residents reviewed for quality of care. Immediate jeopardy began on 7/17/25 when the facility failed to recognize that Resident #1 had a critically low blood sugar and was symptomatic and needed emergency care extending beyond the capabilities of the facility. Immediate jeopardy was removed on 8/9/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place were effective. Findings included:Resident #1 was admitted to the facility on [DATE]. Her diagnoses included type-2 diabetes mellitus. She was discharged from the facility on 7/17/25 to an acute care hospital. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had severe cognitive impairment. The MDS documented revealed that she received insulin injections and hypoglycemic medication.A care plan revised on 06/13/25 read, Resident #1 has diabetes mellitus and has fluctuations in blood sugars, sliding scale insulin and capillary blood glucose (CBG) per orders. Resident #1 often refuses meals at times. The care plan goal last revised on 6/13/25 was for Resident #1 to not have any complications related to diabetes through the review date. The care plan interventions included:-monitor/ document/ report as needed any signs or symptoms of hyperglycemia (high blood sugar) (increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (a deep and labored breathing pattern), acetone breath (smells fruity), stupor, coma. -Monitor/document/report as needed any signs or symptoms of hypoglycemia (low blood sugar) (sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait). -The care plan interventions additionally included, diabetes medications as ordered by the doctor, monitor/ document for side effects and effectiveness. Fasting serum blood sugar as ordered by the doctor. Review of Resident #1's July 2025 medication administration record (MAR) revealed the following orders:- An order dated 11/22/22 read, Jardiance (diabetic medication) tablet 25 milligrams (mg) give one tablet by mouth in the morning. The medication was documented by Nurse #2 as not administered on 7/17/25 at 8:00 AM due to drug refused. The MAR documented the medication was also not received on 7/11/25 due to drug refused. Resident #1 received all other doses as ordered for the month of July 2025. -An order dated 12/4/23 read, glucometer (blood sugar) checks before breakfast and at bedtime blood sugar goal-100-250 range. Notify Nurse Practitioner (NP) if greater than 250 consistently. For blood sugar less than 70 offer oral glucose and recheck blood sugar in 1 hour- notify Medical Doctor (MD) if blood sugar is not improved or patient symptomatic. Review of the medical record revealed Resident #1 had blood sugar results that ranged