STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395430	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dubois Nursing Home	212 S. Eighth St. Dubois, PA 15801

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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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F 0658 Level of Harm - Actual harm Residents Affected - Few	Based on review of Pennsylvania's Nursing Practice Act, clinical records and staff interviews, it was determined that the facility failed to enter a new resident's physician's orders into the electronic health record which caused the resident to miss two doses of insulin resulting in hospitalization for elevated blood sugars, for one of five residents reviewed (Resident 3). Findings include:The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing 21.11 (a)(1)(2)(4) indicated that the registered nurse was responsible for assessing human responses and plans, implementing nursing care, analyzing/comparing data with the norm in determining care needs, and carrying out nursing care actions that promote, maintain and restore the well-being of individuals.admission paperwork for Resident 3, dated December 19, 2025, indicated that she was a diabetic with diabetic ulcers and that her blood sugar prior to leaving the hospital that day was 182. A nursing note for Resident 3, dated December 19, 2025, indicated that she was admitted from the hospital at 5:30 p.m. and that her physician's orders for medications were reviewed with the provider at 6:06 p.m.Physician's orders, dated December 19, 2025, for Resident 3 included orders for the resident to receive insulin Lispro with sliding scale coverage three times per day with meals; insulin Lispro with sliding scale coverage nightly at bedtime; insulin lispro 7 units daily before breakfast; insulin lispro 3 units two times a day before lunch and supper; insulin Glargine 20 units daily before breakfast; and insulin Glargine 30 units daily before supper.A nursing note for Resident 3, dated December 20, 2025, indicated that the resident was checked at 9:20 a.m. and was still laying on the hospital linens with a soiled disposable pad and brief, and was breathing at 33 breaths per minute (normal is 12 - 20 breaths per minute). The note indicated that the resident did not receive her insulin or medications the night before. Her blood sugar at that time was 503. A repeat blood sugar one hour after medication administration was 530. Her respiratory rate remained fast. At noon her blood sugar was 484 and she was again medicated with insulin. At 1:00 p.m. her blood sugar was 497. The nurse was instructed to send the resident to the hospital because the patient stated she did not feel well.A nursing note dated December 21, 2025 at 1:15 a.m. revealed that the resident was admitted to the hospital with Diabetic Ketoacidosis (DKA - a condition in which the body is lacking insulin and breaks fat down for fuel which produces acidic ketones that build up in the blood causing illness requiring hospitalization), altered mental status, and acute kidney injury, encephalopathy (any illness that changes brain function or structure) and dehydration. A review of Resident 3's December 2025 Medication Administration Record (MAR) revealed that she did not have any orders entered into the electronic health record system for December 19, 2025. A medication entry audit revealed that the orders for Resident 3's medications were entered on December 19, 2025 between 11 p.m. and 12 a. m. and that they were entered to start on December 20, 2025.Hospital emergency room documentation, dated December 20, 2025, revealed that Resident 3 sent to the emergency room with elevated blood sugars, and that she was admitted to the Intensive Care Unit (ICU) with diabetic ketoacidosis and on an insulin drip. Interview with the Director of Nursing on December 29, 2025 at 3:24 p.m. revealed that the Registered Nurse that entered the orders into the computer did not get around to entering them until around midnight on December 19, which pushed the start date of the orders until December 20. She further confirmed that Resident 3 did not receive her supper or bedtime insulin.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received care and treatment in accordance with professional standards of practice, by failing to ensure that physician's orders were followed for one of five residents reviewed (Resident 3). Findings include:admission paperwork for Resident 3, dated December 19, 2025, indicated that she was a diabetic with diabetic ulcers and that her blood sugar prior to leaving the hospital that day was 182. A nursing note for Resident 3, dated December 19, 2025, indicated that she was admitted from the hospital at 5:30 p. m. and that her physician's orders for medications were reviewed with the provider at 6:06 p.m.Physician's orders, dated December 19, 2025, for Resident 3 included orders for the resident to receive insulin Lispro with sliding scale coverage three times per day with meals; insulin Lispro with sliding scale coverage nightly at bedtime; insulin lispro 7 units daily before breakfast; insulin lispro 3 units two times a day before lunch and supper; insulin Glargine 20 units daily before breakfast; and insulin Glargine 30 units daily before supper.A nursing note for Resident 3, dated December 20, 2025, indicated that the resident was checked at 9:20 a.m. and was still laying on the hospital linens with a soiled disposable pad and brief, and was breathing at 33 breaths per minute (normal is 12 - 20 breaths per minute). The note indicated that the resident did not receive her insulin or medications the night before. Her blood sugar at that time was 503. A repeat blood sugar one hour after medication administration was 530. Her respiratory rate remained fast. At noon her blood sugar was 484 and she was again medicated with insulin. At 1:00 p.m. her blood sugar was 497. The nurse was instructed to send the resident to the hospital because the patient stated she did not feel well.A nursing note dated December 21, 2025 at 1:15 a.m. revealed that the resident was admitted to the hospital with Diabetic Ketoacidosis (DKA - a condition in which the body is lacking insulin and breaks fat down for fuel which produces acidic ketones that build up in the blood causing illness requiring hospitalization), altered mental status, and acute kidney injury, encephalopathy (any illness that changes brain function or structure) and dehydration. A review of Resident 3's December 2025 Medication Administration Record (MAR) revealed that she did not have any orders entered into the electronic health record system for December 19, 2025. A medication entry audit revealed that the orders for Resident 3's medications were entered on December 19, 2025 between 11 p.m. and 12 a.m. and that they were entered to start on December 20, 2025. Interview with the Director of Nursing on December 29, 2025 at 3:24 p.m. revealed that the Registered Nurse that entered the orders into the computer did not get around to entering them until around midnight on December 19, which pushed the start date of the orders until December 20. She further confirmed that Resident 3 did not receive her supper or bedtime insulin.28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.