

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2025
NAME OF PROVIDER OR SUPPLIER Florence Health Services		STREET ADDRESS, CITY, STATE, ZIP CODE 5778 Chapin St Florence, WI 54121	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600</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 staff and resident interview and record review, the facility did not ensure the resident environment remained free from abuse for 3 residents (R) (R3, R4, and R2) of 5 sampled residents. On 9/11/25, a resident-to-resident altercation occurred between R3 and R4 and involved verbal and physical aggression. The facility did not put interventions in place to address R3's aggressive behavior or prevent future instances of abuse, including a resident-to-resident altercation between R3 and R2 on 9/13/25. Findings include: The facility's Abuse, Neglect and Exploitation policy, revised 7/15/22, indicates: .2. The facility will designate a leadership position in the facility who is responsible for reporting allegations of suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law .V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur .VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services (APS), and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury .B. The Administrator will follow up with government agencies to report the results of the investigation when final within five working days of the incident, as required by state agencies. On 10/7/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia with behavioral disturbance and psychotic disturbance, anxiety, repeated falls, and type 2 diabetes. R3's most recent Minimum Data Set (MDS) assessment, dated 8/21/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R3 had moderate cognitive impairment. R3 had an activated Power of Attorney (POA) for healthcare decisions. R3's medical record included a progress note, dated 9/11/25 at 9:24 PM, that indicated R3 was in bed but attempted to take R3's roommate's (R4) soda which resulted in an altercation between R3 and R4 who were yelling, swearing, threatening each other, and pushing a wheelchair and walker against each other. Surveyor reviewed R3's care plan which did not include goals, identified triggers, or related interventions related to verbal and physical aggression toward others. On 10/8/25 at 3:33 PM, Surveyor interviewed R3 who did not recall an altercation with R4 and indicated nobody would live through it if they were aggressive with R3. On 10/8/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, cognitive communication deficit, depression, and type 2 diabetes. R4's most recent MDS assessment, dated 9/26/25, had a BIMS score of 9 out of 15 which indicated R4 had moderate cognitive impairment. On 10/8/25 at 3:39 PM, Surveyor interviewed R4 who indicated R3 and R4 argued with each other and slammed into each other. R4 indicated R3 was the initial aggressor. R4 indicated the facility moved R3 out of their shared room after the incident. (The facility's census indicated R3 moved into the room with R4 room on 9/10/25. R3 moved out of the room on 9/12/25 and moved into a room that shared a bathroom with R2.) The resident-to-resident altercation between R3 and R4 was not investigated by the facility or reported to the SA. On 10/7/25, Surveyor reviewed a facility-reported incident that indicated on 9/13/25, R3 entered R2's room and slapped R2 in the face multiple times. The facility investigated the incident and reported the incident to the SA. On 10/7/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), alcoholic cirrhosis of liver with ascites, type 2 diabetes, and respiratory failure with hypoxia. R2's most recent MDS assessment, dated 7/1/25, had a BIMS score of 15 out of 15 which indicated R2 had intact cognition. On 10/8/25 at 2:39 PM, Surveyor interviewed Unit Manager (UM)-H who was not aware of the physical aggression that occurred between R3 and R4 on 9/11/25. UM-H indicated verbal and physical aggression between R3 and R4 should have been investigated and reported per the facility's policy. UM-H understood how not addressing the incident on 9/11/25 between R3 and R4 could lead to a lack of protection for R2 during the altercation between R2 and R3 on 9/13/25. UM-H oversaw risk management for the facility since August of 2025 and indicated if interventions were implemented and R3's care plan was updated after the 9/11/25 altercation with R4, the 9/13/25 incident with R2 may not have occurred. On 10/8/25 at 4:05 PM, Surveyor interviewed Director of Nursing (DON)-B who wasn't aware of the extent of the resident-to-resident altercation between</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not report an allegation of abuse to the State Agency (SA) for 2 residents (R) (R3 and R4) of 5 sampled residents. On 9/11/25, an altercation occurred between R3 and R4 that involved verbal and physical aggression. The facility did not report the allegation of abuse to the SA. Findings include: The facility's Abuse, Neglect and Exploitation policy, with a revised date of 7/15/22, indicates: .2. The facility will designate a leadership position in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to ensure that its policies are implemented as written .VII. Reporting/Response: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services (APS), and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury .B. The Administrator will follow up with government agencies to report the results of the investigation when final within five working days of the incident, as required by state agencies. On 10/7/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia with behavioral disturbance and psychotic disturbance, anxiety, and repeated falls. R3's most recent Minimum Data Set (MDS) assessment, dated 8/21/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R3 had moderate cognitive impairment. R3 had an activated Power of Attorney (POA) for healthcare decision making. A progress note, dated 9/11/25 at 9:24 PM, indicated R3 was in bed but attempted to take R3's roommate's (R4) soda which resulted in verbal and physical aggression that involved yelling, swearing, threatening, and pushing a wheelchair and walker against each other. On 10/8/25 at 3:33 PM, Surveyor interviewed R3 who did not recall the altercation with R4 and indicated nobody would live through it if they were aggressive with R3. On 10/8/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, cognitive communication deficit, and depression. R4's most recent MDS assessment, dated 9/26/25, had a BIMS score of 9 out of 15 which indicated R4 had moderate cognitive impairment. On 10/8/25 at 3:39 PM, Surveyor interviewed R4 who indicated R3 and R4 had an argument and slammed into each other. R4 indicated R3 was the initial aggressor and was moved out of the room after the incident. On 10/8/25, Surveyor requested a copy of the facility's report to the SA. On 10/8/25 at 4:05 PM, Surveyor interviewed Director of Nursing (DON)-B who wasn't aware of the extent of the resident-to-resident altercation between R3 and R4 and stated the altercation was not reported to the SA. DON-B indicated the facility takes incidents of abuse seriously and verified the resident-to-resident altercation should have been reported to the SA.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not thoroughly investigate a resident-to-resident altercation for 2 residents (R) (R3 and R4) of 5 sampled residents. On 9/11/25, a resident-to-resident altercation occurred between R3 and R4 that involved verbal and physical aggression. The facility did not thoroughly investigate the altercation. Findings include: The facility's Abuse, Neglect and Exploitation policy, with a revised date of 7/15/22, indicates: .2. The facility will designate a leadership position in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the State Survey Agency and other officials in accordance with state law. 3. The facility will provide ongoing oversight and supervision of staff in order to ensure its policies are implemented as written. .V. Investigation of Alleged Abuse, Neglect and Exploitation: A. An immediate investigation is warranted when allegation or suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect or exploitation occur. On 10/7/25, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including dementia with behavioral disturbance and psychotic disturbance, anxiety, and repeated falls. R3's most recent Minimum Data Set (MDS) assessment, dated 8/21/25, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated R3 had moderate cognitive impairment. R3 had an activated Power of Attorney (POA) for healthcare decision making. A progress note, dated 9/11/25 at 9:24 PM, indicated R3 was in bed but attempted to take R3's roommate's (R4) soda which resulted in a verbal and physical altercation that involved yelling, swearing, threatening, and pushing a wheelchair and walker against each other. On 10/8/25 at 3:33 PM, Surveyor interviewed R3 who did not recall an altercation with R4 and indicated nobody would live through it if they were aggressive with R3. On 10/8/25, Surveyor reviewed R4's medical record. R4 was admitted to the facility on [DATE] and had diagnoses including cerebral infarction, cognitive communication deficit, and depression. R4's most recent MDS assessment, dated 9/26/25, had a BIMS score of 9 out of 15 which indicated R4 had moderate cognitive impairment. On 10/8/25 at 3:39 PM, Surveyor interviewed R4 who indicated R3 and R4 had an argument and slammed into each other. R4 indicated R3 was the initial aggressor and was moved out of the room after the incident. On 10/8/25, Surveyor requested the facility's investigation for the resident-to-resident altercation. On 10/8/25 at 4:05 PM, Surveyor interviewed Director of Nursing (DON)-B who wasn't aware of the extent of the resident-to-resident altercation between R3 and R4 and indicated the facility did not have an investigation for the incident. DON-B indicated the facility takes incidents of abuse seriously and verified the resident-to-resident altercation should have been thoroughly investigated.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</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 staff interview and record review, the facility did not develop or implement an individualized comprehensive resident-centered care plan for 1 resident (R) (R2) of 5 sampled residents. R2 was identified as having trauma on quarterly assessments. R2's diagnoses list did not contain a trauma-related diagnosis and R2's care plan did not contain resident-specific trauma interventions. Findings include: The facility's Comprehensive Care Plan policy, revised 9/23/2022, indicates: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .Trauma-informed care is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization . 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, shall be culturally competent and trauma-informed. 2. The comprehensive care plan will be developed within seven days after the completion of the comprehensive Minimum Data Set (MDS) assessment. Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care .3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .g. Individualized interventions for trauma survivors that recognize the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident .5. The comprehensive care plan will be reviewed and revised as appropriate by the Interdisciplinary Team (IDT) after each comprehensive and quarterly MDS assessment and as needed with changes in condition . On 10/7/25, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE] and had diagnoses including chronic obstructive pulmonary disease (COPD), alcoholic polyneuropathy, alcoholic cirrhosis of liver with ascites, type 2 diabetes, and respiratory failure with hypoxia. R2's most recent Minimum Data Set (MDS) assessment, dated 9/3/24, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 had intact cognition. A Trauma-Informed Care Observation assessment, dated 7/10/25, indicated R2 had trauma related to life-threatening illness and learned about combat and captivity. The assessment indicated R2 personally experienced life-threatening illness and had trauma related to it. R2 indicated the trauma bothered R2 a lot and had been happening for longer than a month (which was the longest time selection available). R2 indicated R2's triggers and reactions related to the trauma as well as effective interventions. The facility identified a focus, goal, and interventions for the trauma-informed care plan. The interventions included: The resident may (specify) when they have a triggered response to past trauma. To deescalate the resident (specify preferred intervention(s)). The following circumstances have been identified as possible triggers: (Specify trigger) avoid and/or remove the resident from circumstances as able. If unavoidable, follow preferred de-escalation preference, debrief resident, and monitor coping after circumstance. R2 indicated R2 feels irritated and frustrated when triggered. R2 indicated R2 liked to relax and spend quiet time alone and receive medication in response to trauma events.A Trauma Informed Care Observation assessment, dated 9/29/25, indicated R2 had trauma related to life-threatening illness and learned about combat and captivity. The assessment indicated R2 personally experienced life-threatening illness and had trauma related to it. R2 indicated the trauma bothered R2 a lot and had been happening for longer than a month. R2 indicated R2's triggers and reactions related to the trauma as well as effective interventions. The facility identified a focus, goal, and interventions for the trauma-informed care plan. R2 indicated R2 liked to relax and spend quiet time alone and receive medication in response to trauma events.R2's care plan, initiated 7/1/25, indicated R2 was at risk for re-traumatization of past event or experience where reminders/triggers of event or experience may cause behavioral changes and/or emotional distress. The care plan contained a goal that R2 will use coping techniques in coordination with individualized interventions to minimize the impact of potential</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>		

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<p>F 0755</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 staff interview and record review, the facility did not provide pharmaceutical services to ensure the accurate administration of medication for 1 resident (R) (R1) of 5 sampled residents. R1's hospital discharge summary contained an order for sliding scale insulin and a recommendation to monitor R1's blood sugars closely. R1's Medication Administration Record (MAR) did not reflect the order or recommendation. Findings include: The facility's Blood Glucose Monitoring policy, revised 8/5/22, indicates: It is the policy of this facility to perform blood glucose monitoring to diabetic residents per physician orders. Procedure: 1. Verify the physician's order. The facility's Medication Orders Non-Controlled Medication Orders policy, revised 1/2023, states: . Documentation of the Medication Order: .b. Written transfer orders (sent with a resident from a hospital or other healthcare facility): Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete. If the order is unsigned or signed by another prescriber, the receiving nurse verifies the order with the current attending prescriber before the medication is administered. The nurse documents verification on the admission order record. Orders are transmitted to the pharmacy with any additional information required for new admission. 3. Complete documentation by clarifying orders as necessary. From 10/7/25 to 10/8/25, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including type 2 diabetes, coronary artery disease, hypertension, chronic obstructive pulmonary disease (COPD), left foot diabetic ulcers with associated gangrene, cellulitis, and sepsis status post below-knee amputation (BKA). R1's Minimum Data Set (MDS) assessment, dated 7/6/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R1 had intact cognition. R1 was R1's own decision maker. R1's hospital Discharge summary, dated [DATE], indicated under hospital course: Lantus 15 units twice daily (BID) plus lispro 10 units three times daily (TID) with meals plus lispro sliding scale as follows: Blood sugar less than 70 milligrams (mg)/deciliter (dl) follow hypoglycemia protocol. Lispro sliding scale is as follows: 71-140 mg/dl=no treatment necessary; 141-180 mg/dl=4 units; 181-220 mg/dl=6 units; 221-260 mg/dl=8 units; 261-300 mg/dl=10 units; 301-350 mg/dl=12 units; 351-400 mg/dl=14 units; Greater than 400 mg/dl=16 units and notify provider. Recommend monitoring blood sugars closely and adjusting insulin regimen as needed. On 10/7/25, Surveyor reviewed R1's physician orders and noted R1's MAR did not contain a sliding scale insulin order. Surveyor noted there was an order for insulin glargine subcutaneous solution, inject 15 units subcutaneously BID. (R1's MAR indicated the insulin was administered appropriately). Surveyor also noted an order for insulin lispro inject 10 units subcutaneously with meals at 7:00 AM, 11:00 AM, and 4:00 PM. (R1's MAR indicated the insulin was administered appropriately) and blood glucose monitoring once daily at 6:00 AM. On 10/7/25 at 1:27 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated orders are transcribed from a resident's hospital discharge summary. After the orders are entered in the MAR, they are reviewed by the provider and the pharmacy. DON-B indicated blood sugar checks are based on the resident. DON-B stated the facility does not have a policy on how often blood sugars should be checked and refers to physician orders. On 10/7/25 at 1:49 PM, Surveyor interviewed Registered Nurse (RN)-E who indicated nurses check R1's blood sugar per the physician order. RN-E thought R1 was on a sliding scale and appeared surprised when Surveyor indicated R1's blood sugar was only checked once daily. On 10/7/25 at 2:19 PM, Surveyor interviewed Licensed Practical Nurse (LPN)-C who indicated staff do not check blood sugars for residents with scheduled insulin orders and only check if there is a sliding scale order. LPN-C verified R1's MAR did not include a sliding scale order. On 10/7/25 at 4:19 PM, Surveyor interviewed Pharmacist (PH)-F who stated the pharmacy reviews orders that are faxed. PH-F indicated the pharmacy does not review every medication to ensure the order is entered correctly unless the medication appears to be off. PH-F indicated the sliding scale order should be entered by the facility and stated the best practice is to have blood sugar checks ordered before meals to ensure the insulin is working properly. On 10/8/25 at 8:57 AM, Surveyor interviewed RN-G who was unsure why R1's MAR contained only one daily blood sugar check. RN-G reviewed R1's hospital discharge summary and confirmed there was a sliding scale insulin order in the summary. RN-G stated the sliding scale is an order and RN-G would have clarified the sliding scale if RN-G had transcribed the orders. RN-G indicated discharge summaries should be read thoroughly and discrepancies should be clarified with the discharge hospitalist. RN-G indicated even if R1 was on scheduled short acting insulin, R1's blood sugar should be checked prior to meals and insulin should be</p>		