STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675564	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Care at Giddings	1181 N Williamson Giddings, TX 78942

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for one resident (Resident #1) out of four residents reviewed for the development of the comprehensive care plans. The facility failed to ensure Resident #1 had a comprehensive person-centered care plan completed to reflect Resident #1's care needs for Catheter, Diabetes, Oxygen therapy, medications (antibiotics , anti-hypertensive, anticoagulant), and Cognition. This deficient practice places the resident at risk for not receiving the necessary and appropriate care. Findings included: Review of Resident # 1's face sheet dated 05/18/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Autistic disorder (is a developmental disorder that affects communication, behavior and social interaction, with symptoms typically appearing in early childhood), Hypertension (HTN - High blood pressure), Urinary retention, history of Urinary Tract Infections (UTI -occurs when bacteria get in the urinary system, often through the urethra, and begin to multiply in the bladder), Diabetes Mellitus type II (a chronic condition characterized by insulin resistance and elevated blood sugar levels). Resident #1's admission MDS dated [DATE] indicated he had a BIMS score of not conducted indicating severe cognitive impairment. Staff assessment of Mental Status reflected Resident #1 has short-term and long-term memory problems. Section H- Bladder and Bowel reflected Resident #1 had an indwelling catheter. Section I- Active Diagnoses reflected Resident #1 had Diabetes Mellitus. Section N Medication reflected Resident #1 took an anticoagulant medication. Section O-Special Treatments, procedures and Program reflected Resident #1 was on oxygen therapy. Review of Resident #1's Care Plan initiated 04/14/2025 reflected only Resident #1's dietary needs were addressed and there was no plan of care for catheter, DM, Oxygen therapy, Anticoagulant or Hypertension. Review of Resident #1's MAR reflected the following orders: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lisinopril Oral Tablet 20MG (Lisinopril) Give 1 tablet by mouth one time a day for HTN -Start Date- 04/02/2025 9:00 am . Carvedilol Oral Tablet 25 MG (Carvedilol) Give 1 tablet by mouth two times a day for High BP -Start Date- 04/02/2025 9:00 am. Nifedipine ER Oral Tablet Extended Release 24 Hour 60 MG (Nifedipine) Give 1 tablet by mouth two times a day for HTN -Start Date- 04/02/2025 9:00 am. Hydralazine HCl Oral Tablet 100 MG (Hydralazine HCl) Give 1 tablet by mouth three times a day for High BP-Start Date- 04/02/2025 9:00 am. Apixaban Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day for Anticoagulant -Start Date- 04/02/2025 9:00 am. Tamsulosin HCl Oral Capsule 0.4 MG (Tamsulosin HCl) Give 0.8 mg by mouth two times a day for Enlarged Prostate -Start Date- 04/02/2025 0900. CHANGE F/C 14fr 10cc Q MONTH AND PRN IF DISLOGED. one time a day starting on the 9th and ending on the 9th every month. Provide catheter care Q-shift/PRN every shift. During an interview on 05/19/2025 at 12:41 pm the DON stated the facility had a remote MDS Nurse who was responsible to complete care plans. The DON stated Resident #1 should have had a comprehensive care plan completed but was not sure of the time frame, maybe within 48-72 hours. The DON stated she usually checked to see if the baseline care plans were developed. The DON stated she was wearing so many heads and it was hard to keep up. The DON stated Residents needed care plans to know how to take care of them. During an interview on 05/19/2025 at 1:35 pm, the Interim Administrator stated the initial baseline care plan should be done 48-72 hours after admission. The Interim Administrator stated compressive care plans should be done with the initial MDS assessment and quarterly updates, and when there is a significant change. The Interim Administrator stated a comprehensive care plan was a road map to provide care for a particular resident. The Interim Administrator stated it was not good that Resident #1's comprehensive care plan only addressed his dietary needs, and she did not have explanation as to why Resident #1's comprehensive care plan was not completed. The Interim Administrator stated the MDS Nurse was responsible to complete the comprehensive care plans with information provided by the DON. During a phone interview on 05/19/2025 at 3:17 pm the MDS nurse stated she completes the comprehensive care plan after she had completed her assessment about 21 days after admission. The MDS Nurse stated she completed Resident #1's MDS assessment on 04/14/2025 but did not complete his comprehensive Care Plan. The MDS nurse stated it looked like it fell through the cracks, and she did not have explanation as to why Resident #1's comprehensive care plan was not done. Review of facility's policy titled Care Plan; Comprehensive Person-Centered dated March 2022 reflected: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy Statement A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable. physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment. (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care. c. includes the resident's stated goals upon admission and desired outcomes. d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons. b. culturally competent; and c. trauma informed. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition. b. when the desired outcome is not met. c. when the resident has been readmitted to the facility from a hospital stay; and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 (Resident #1) of 4 residents review for catheter care. The facility failed to change Resident #1's foley catheter (a medical device used to drain urine from the bladder.) as ordered monthly on 04/09/2025 and 5/9/2025. Resident #1 was sent to the local ER on [DATE] due to fever and lethargy and was diagnosed with possible sepsis (is a life-threatening condition that occurs when the body has extreme response to infection). This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/19/2025 at 4:19 pm and an IJ template was given. While the IJ was removed on 05/20/2025 at 7:01 pm, the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for hospitalization, coma and death. Findings included: Review of Resident # 1's face sheet dated 05/18/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Autistic disorder (is a developmental disorder that affects communication, behavior and social interaction, with symptoms typically appearing in early childhood), Hypertension (HTN - High blood pressure), Urinary retention, history of Urinary Tract Infections (UTI -occurs when bacteria get in the urinary system, often through the urethra, and begin to multiply in the bladder), Diabetes Mellitus type II (a chronic condition characterized by insulin resistance and elevated blood sugar levels). Review of Resident #1's hospital discharge papers dated 4/1/2025 reflected: Urinary retention -multiple trials of foley removal without success -continue foley -continue Flomax -3/10 foley replaced by urology. replace foley monthly. Review of Resident #1's admission MDS dated [DATE] indicated he had a BIMS score of not conducted indicating severe cognitive impairment. Staff assessment of Mental Status reflected Resident #1 has short-term and long-term memory problems. Section H- Bladder and Bowel reflected Resident #1 had an indwelling catheter. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's MAR/TAR reflected: CHANGE F/C 14fr 10cc Q MONTH AND PRN IF DISLOGED. one time a day starting on the 9th and ending on the 9th every month dated 04/03/2025 with start date of 04/09/2025. Provide catheter care Q-shift/PRN every shift. Review of Resident #1's Care Plan initiated 04/14/2025 reflected no plan of care for catheter, DM or Hypertension. Review of Resident #1's TAR reflected his Foley was changed on 4/9/25 by MA E. Review of Resident #1's TAR reflected his Foley was changed on 5/9/25 by MA A. Review of Resident #1's progress notes written by LVN C dated 05/17/2025 at 1:39 pm reflected: Resident transferred to ER due to difficult to arouse, decrease in urine output and low blood pressure. Review of Resident #1 current hospital records dated 5/17/2025 reflected: He was sent over from his nursing home for fever of 101, more lethargic than usual and his glucose reading was high. On arrival his serum glucose is around 478, sodium is 156, creatinine of 4. He is very lethargic and barely opens eyes. Initial work up shows likely diagnosis of DKA/ hyperosmolar diabetes (is a serious complication of diabetes, primarily occurring in individual with type 2 diabetes), possible sepsis, UTI (his foley was exchanged in ER, had brown urine with some pus in penile area), possible right lung pneumonia, with AKI. During an interview on 05/19/2025 at 10:11 am MA A stated she did not change Resident #1's foley catheter because it was outside her scope of practice. MA A stated Resident #1's foley catheter order to change was on her MAR and she accidentally signed it. MA A also stated she did not tell the nurse who worked on 5/9/2025 about the foley catheter needing to be changed. During an interview on 05/19/2025 at 11:04 am the DON stated, foley catheters were supposed to be changed once a month. The DON stated if foley catheters were not changed as ordered, the resident would get infection. The DON stated Resident #1's foley catheter was supposed to be changed around 5/09/2025 and the nurse was supposed to initial when it was changed. The DON stated staff did not document urine output because Resident #1 did not have orders to document urine output and Resident #1 did not have issues with output. The DON stated MAs cannot change foley catheters because it was not within their scope of practice. The DON reviewed Resident #1's TAR and noted that it was not changed on 4/9 and 5/9 but was initialed by MAs. The DON stated Resident #1's order for catheter change was revised on 5/10/2025 by LVN F to reflect on the nurse's TAR, according to the DON. During an interview on 05/19/2025 at 11:43 am the NP stated Resident #1 had a foley catheter due to urinary retention. The NP stated she usually did not write orders for foley catheters, and she let the urologist deal with foley catheters. The NP stated she expected the facility to keep foley catheters clean and free from infection. The NP asked to step out and call the MD, came back later and stated she would not continue with the interview unless her MD was present. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 05/19/2025 at 2:45 pm the MD stated, there was new evidence that indicated not to change the foley catheter monthly. The MD stated changing foley monthly, really did not make a difference in infection prevention. The MD stated the hospital may have said change the foley catheter monthly, but he disagreed with the urologist (are medical specialists who focus on the diagnosis and treatment of conditions related to the urinary tract and male reproductive system) . The MD stated Resident #1 would have to be scheduled for urology follow-up, maybe his foley catheter was difficult. During an interview on 05/19/2025 at 1:35 pm, the Interim Administrator stated not changing the foley catheter as ordered can lead to possible infection. The Interim Administrator stated the CNAs were supposed to document urine output. The interim Administrator stated if Resident #1 had the foley catheter due to urinary retentions, it was important to document urine output. Attempts was made to contact MA E on 05/19/2025 at 10:30 am but was unsuccessful. Attempts was made to contact LVN F on 05/19/2025 at 12:21 pm but was unsuccessful . Review of facility's policy titled Catheter Care; Urinary dated August 2022 reflected: Purpose The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Preparation 1. Review the resident's care plan to assess for any special needs of the resident. 2. Assemble the equipment and supplies as needed. The VP for Operation, Interim Administrator and the DON were notified on 05/19/25 at 4:19 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on 05/20/25 at 12:51 pm. F690 Immediate Jeopardy Removal Actions Taken 1. Immediate Resident Response o (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 was immediately transferred to the emergency room on 5/17/2025 due to fever, lethargy, and suspected sepsis. o A full head-to-toe assessment was conducted by licensed staff prior to transfer. (No skin breakdown, foley catheter intact) o Foley catheter was replaced in the ER. The resident was diagnosed with UTI, possible sepsis, AKI, and pneumonia. o Family and physician were notified immediately. 2. Resident Safety Review o 100% audit of all residents with Foley catheters completed on [5/19/2025] by the Director of Nursing (audit tool created to monitor foley catheter orders) (DON was in-serviced prior to completing audit on 5/19/2025 by CNO) Reviewed orders for catheter care and replacement schedule. (Review of 1 resident with foley pre-discharged orders in PCC were reviewed by DON as resident #1 is in the hospital. (No residents other than resident # 1 have a foley catheter. Verified compliance with physician orders, TAR/MAR accuracy, and documented output as needed. Any overdue changes were immediately completed by a licensed nurse. (Currently no residents in the facility with foley catheter orders) None are affected. Any discrepancies in documentation were immediately addressed and corrected. 3. Order Clarification & Physician Review o All current Foley catheter orders reviewed with attending physicians to ensure: By: CNO and DON 5/19/2025. Specific frequency for changes (monthly, prn, etc.) (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Whether urology follow-up is required. Clear instructions on who is responsible (facility vs. specialist). o Physician orders revised accordingly and entered into EMR (1 resident total) (DON/ designee will monitor upon admission and weekly in Standards of care meeting). 4. Scope of Practice Enforcement o Immediate education and competency check completed on 5/19/2025 for all medication aides (MAs) clarifying: (DON completed education. Staff that were not present we called by the DON. Staff that could not be reached must be in-serviced prior to next scheduled shift. MAs may not change Foley catheters. MAs must report Foley orders to licensed nurses immediately. MAs may not document, or initial Foley care they did not perform. o The MA involved was removed from the schedule pending retraining and counseling (In-service and posttest). (Next scheduled shift for MA is 5/21/25 and she will not be allowed to work prior to the in-service and test for acknowledgement. 5. Documentation & Tracking System Improvements o New Foley catheter tracking log implemented for all residents with catheters (monitored by DON/ Designee. o TARs and MARs updated to reflect accurate task assignments and responsibilities. (DON completed the task after in-service by CNO on 5/19/2025. o (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON or designee to verify completion of catheter change orders date. (This will be reviewed after admission and weekly in Standards of Care meeting) (Continuously). 6. Care Planning & Assessment o Resident #1's care plan updated by DON immediately to reflect catheter management needs. o 100% audit of care plans (foley catheter audit) for all catheterized residents completed by DON to ensure individualized interventions for infection prevention, hydration, and output monitoring (3 resident's care plans were updated). (This will be tracked in the weekly Standards of care meeting) o Facility policy updated to require catheter care plans within 24 hours of admission. (DON will be responsible and the CNO will provide oversight weekly X 6 weeks and then monthly. 7. Staff Education o In-service conducted for all licensed nurses and MAs by DON (in-service and posttest) on: (DON will provide continuous training with new hires, agency, and staff who were not present to ensure compliance is met and sustained. Foley catheter management per HHSC/CMS standards. Identifying early signs of UTI and sepsis. Documentation protocols and scope of practice. o DON and ADON re-trained on oversight responsibility for order reconciliation, scope of practice enforcement, and task delegation (in-service by CNO) (By verbal and written acknowledgement of training. 8. Quality Assurance and Monitoring (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Daily (clinical morning meeting) review for 14 days (continuously in weekly Standards of care meeting) of: Catheter care orders. Documentation of changes. Correct scope of task completion. o QA team to review catheter log weekly and monitor compliance during rounds. (Monthly in QAPI meeting indefinitely-as long as there are residents with foley catheters) o Findings reviewed in monthly QAPI meetings. 9. Leadership Accountability o MA involved received documented disciplinary counseling. (DON via phone on 5/20/25) All MAs and nurses have been in-serviced by DON via in person or phone. (Post test was sent via phone after in-service by DON to the staff who were not present at the time of the in-person training. All staff will be required to acknowledge the education was given by presenting the signed posttest prior to the next scheduled shift. o DON received education on catheter care orders, identifying signs of UTI and sepsis, and documentation protocols and scope of practice. Chief Nursing Officer providing oversight (5/19/25 daily X 10 days in person, then weekly X 4 remotely, and then monthly remotely and prn to ensure continued compliance with the plan. The Surveyor monitored the POR on 05/20/2025 from 1:00 pm to 7:00 pm as follows: During interviews on 05/20/2025 from 1:00 pm -7:00 pm, three LVNs (LVN B, C and D), 1 RN (RN D) from all shifts stated they had been in-serviced by the DON and the Interim Administrator/ CNO (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During interviews on 05/20/2025 from 1:00 pm -7:00 pm, two MAs (MA A and B), from all shifts, they both stated they had been in-serviced by the DON and the Interim Administrator/ CNO that MAs and Nurses were responsible for documenting on the MAR. They stated MAs were responsible for documenting in the MAR non-nursing responsibilities. Nurses were responsible for documenting in the MAR nursing responsibilities, such as catheter care. They were trained on MAR documentation. They learned to notify the charge nurse or DON if they observed incorrect entries or nursing responsibilities in the MAR. They stated if they accidentally checked off performing nursing responsibilities, such as ointment, on the MAR, they would strike out and notify nurse on duty. They stated they knew it was important to notify the nurse whenever they observe nursing responsibilities on the MA's MAR. They stated It's important because it could be abuse or neglect. Resident won't get attention they need as ordered from the doctor. Resident needs to get their treatment. Residents won't get what they need, such as wound care or ointment. Residents could not receive a medication or treatment if the MAR was checked off as received but they did not receive. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/2025 at 3:40 pm the DON stated she was in-serviced on 05/19/25 by the CNO. She learned about the types of orders, expectations, what to look for when reviewing orders, admissions/readmissions process, new procedures, scope of practices for MAs and nurses, following orders, and reviewing and revising care plans. She also reviewed orders for catheter care and replacement schedule on 05/19/25 and found there were no residents other than Resident #1 who had a foley catheter. She reviewed Resident #1's EHR and verified compliance with physician orders, TAR/MAR accuracy, and urinary output documentation on 05/19/25. There were no overdue changes that immediately needed to be completed by a licensed nurse during review and verification. She also did not identify any discrepancies in documentation. Attending physicians, her and the CNO reviewed all current foley catheter orders on 05/19/25 for frequency for changes in output, urology follow-up, and who was responsible for changing. MD became oversight for ensuring urinary output documented, urology follow-ups were made, and foley catheters were changed according to orders. She started and completed the audit of all residents with foley catheters on 05/19/25 and found there were no residents with foley pre-discharged orders in EHR other than Resident #1. Resident #1's physician orders were revised and entered in EHR on 05/19/25 . She provided immediate education and competency checks by phone and in-person to the MAs on 05/19/25 regarding MAs not changing foley catheters, reporting foley orders to licensed nurses immediately, and not documenting or initialing foley care they did not perform. All MAs have been reached by in-person or phone before their next scheduled shift. MA involved was removed from the schedule. She reached out to the MA involved and the MA was scheduled to visit the facility to receive counseling and retraining on 05/21/25. She initiated and was monitoring a new foley catheter tracking log on 05/19/25. No discrepancies and errors observed. She updated Resident #1's TAR/MAR to reflect task assignments and responsibilities after being trained by the CNO on 05/19/25. There were no other residents. She was to start verifying completion of catheter change orders date and review after Resident #1's readmission and weekly. She updated Resident #1's care plan to reflect catheter management needs on 05/20/25. She completed an audit of all catheterized residents' care plans to ensure interventions were included and implemented and was tracking weekly. The DON stated the CNO updated the facility's policy to reflect requiring catheter care plans within 24 hours of admission and overseeing weekly for next 6 weeks and then monthly thereafter. She in-serviced all licensed nurses and MAs and gave post-tests to them regarding foley catheter management, documentation protocols, and identifying early signs of UTI and sepsis. CNO retrained her and had her sign written acknowledgment on oversight responsibility for order reconciliation, scope of practice enforcement, and task delegation on 05/19/25. QA was reviewing daily for 14 days and then weekly on catheter care orders, documentation of changes, and correct scope of task completion. QA team also reviewing catheter log weekly to monitor compliance during rounds and findings monthly in QAPI meeting. CNO was overseeing from 05/19/25, daily for the next 10 days in person, weekly for the next four weeks, and then monthly remotely and as needed to ensure compliance. (continued on next page)

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Harmony Care at Giddings	1181 N Williamson Giddings, TX 78942

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/2025 at 5:18pm Interim Administrator/CNO stated she in-serviced the DON on 05/19/25 regarding order reconciliation, ensuring orders were in nurses' MAR, ensuring orders for foley care and monitoring were in place, ensuring MAs notifying nurses of any orders in their MAR, and DON reviewing and tracking any discrepancies and errors and correcting. The Interim Administrator/CNO stated the DON signed an acknowledgement of receiving the in-service before performing the audit of residents with foley catheters. The Interim Administrator/CNO stated she, the DON, and MD reviewed current residents' foley catheter orders on 05/19/25 and found no other discrepancies and errors. The Interim Administrator/CNO stated she and the DON discussed with the MD the IJs as well. The Interim Administrator/CNO stated she in-serviced the DON on updating TARs and MARs to reflect accurate task assignments and responsibilities on 05/19/25 before the DON updated the TARs and MARs. DON signed an acknowledgement of receiving the in-service before updating the TARs and MARs. She was overseeing weekly for the next 6 weeks to ensure facility policy was updated and followed regarding catheter care plans were required within 24 hours of admission. She in-serviced the DON on oversight responsibility for order reconciliation, scope of practice enforcement, and task delegation. DON signed an acknowledgement of receiving the in-service before initiating oversight responsibility for order reconciliation, scope of practice enforcement, and task delegation. She oversaw to ensure processes completed daily for the next 10 days in person, then weekly for four weeks remotely, and then monthly remotely and as needed to ensure continued compliance. Review of facility's in-services dated 05/19/2025 reflected the following: Facility had an ADHOC QAAC for identification of deficient practice. DON: Foley Catheter Review: Foley Catheter Policy presented by the Interim Administrator/CNO and signed by the DON. Nurses: Foley catheter, Foley catheter management/policy and procedure, identify early signs of UTI and sepsis, documentation presented by the Interim Administrator/CNO and the DON; signed by LVN B and LVN F and via phone for LVN C and RN D. Medication Aides: Foley Catheter: MAs may not change foley catheter, MAs must report foley catheter orders to nurse, MAs may not document or initial on foley catheter, presented by the Interim Administrator/CNO and the DON; signed by MA A, MA E via phone. Education to Physician/NP on MARs/TARs on new/readmissions. Weekly Review of high-risk residents regardless of payer. LOA residents require same level of care as skilled. MD stated and acknowledged understanding of medication process and foley catheter orders to be specified if would like catheter changed monthly. Nursing: Scope of Practice/ Medication Administration presented by the DON via phone for MA F. Foley Catheter test completed on 05/19/2025 by Nurses including the DON, LVN B, LVN C via phone, RN D via phone, MA E via phone, LVN F Review of facility's in-services dated 05/20/2025 reflected the following: Foley Catheter management, notification of change in condition to nurse, where to document output dated 05/20/2025 presented by the DON signed by CNAs . (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Facility's Indwelling (Foley) Catheter Insertion policy, revised 05/19/25, reflected the policy was updated to required care plan updates with foley catheter within 24 hours of admission, verify resident specific output orders related to diagnosis for foley catheter insertion, and verify resident specific foley change orders with physician monthly or PRN for occlusions and dislodgement. DON audit of all residents with foley catheters, completed on 05/19/25, reflected Resident #1 was the only resident. Orders for catheter care and replacement schedule were reviewed and present. Foley change frequency was ordered. Foley changed as ordered. Care plan reflected foley use. Tracking log was used for foley catheter care residents. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/19/2025 at 4:19 pm and an IJ template was given. While the IJ was removed on 05/20/2025 at 7:01 pm, the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for 1 (Resident #1) of 4 residents review for pharmacy services. The facility failed to carry out Resident #1's orders from the hospital for insulin to control his blood glucose. Resident #1 was sent to the local ER on [DATE] due to fever and lethargy and was diagnosed with Diabetes Ketone Acidosis (DKA-Diabetes Ketone Acidosis is serious and can be life threatening. DKA is when your body doesn't have enough insulin to allow blood sugar into your cells for use as energy (with a blood serum level of 478. Normal blood serum glucose levels: Fasting blood glucose 70 to 99 mg/dL. Random blood glucose: generally, it should be 125 mg/dL.) . This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/19/2025 at 4:19 pm and an IJ template was given. While the IJ was removed on 05/20/2025 at 7:01pm, the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for high blood glucose, hospitalization, coma and death. Findings included: Review of Resident # 1's face sheet dated 05/18/2025 reflected a [AGE] year-old male admitted on [DATE] with diagnoses that included: Autistic disorder (is a developmental disorder that affects communication, behavior and social interaction, with symptoms typically appearing in early childhood), Hypertension (HTN - High blood pressure), Urinary retention, history of Urinary Tract Infections (UTI -occurs when bacteria get in the urinary system, often through the urethra, and begin to multiply in the bladder), Diabetes Mellitus type II (a chronic condition characterized by insulin resistance and elevated blood sugar levels). Review of Resident #1's hospital discharge orders dated 4/1/2025 reflected: Insulin NPH Hum/Reg 70/30 (Trade name: Novolin 70/30) 15 Units Subcutaneous before Breakfast and Dinner Review of Resident #1's hospital discharge papers dated 4/1/2025 reflected: Type 2 diabetes mellitus uncontrolled with hyperglycemia (high blood sugar level), A1c 7.5% - Home regimen; NPH 70/30 15 units b.i.d. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- continue at l0u BID due to hypoglycemia - sliding scale insulin, monitor for hypoglycemia Review of Resident #1's admission MDS dated [DATE] indicated he had a BIMS score of not conducted indicating severe cognitive impairment. Staff assessment of Mental Status reflected Resident #1 has short-term and long-term memory problems. Section I- Active Diagnoses reflected Resident #1 had Diabetes Mellitus. Section N- Medications did not indicate Resident #1 was on insulin. Review of Resident #1's initial physician/NP narrative note written by the MD dated 05/04/2025 reflected: Type 2 Diabetes Mellitus with Foot Ulcer Continue insulin regimen as prescribed. Monitor glucose levels and foot ulcer healing. Review of Resident #1's Care Plan initiated 04/14/2025 reflected no plan of care for a catheter, DM. Review of Resident #1's progress notes written by NP dated 05/04/2025 reflected: Type 2 Diabetes Mellitus with Foot Ulcer Continue insulin regimen as prescribed. Monitor glucose levels and foot ulcer healing. Chief Complaint Management of chronic medical conditions including the ones listed above. Review of Resident #1's MAR/TAR reflected no orders for Insulin or blood sugar checks for the months of April and May 2025. Review of Resident #1's progress notes written by LVN C dated 05/17/2025 at 1:39 pm reflected: Resident transferred to ER due to difficult to arouse, decrease in urine output and low blood pressure. Review of Resident #1's current hospital records dated 5/17/2025 reflected: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	He was sent over from his nursing home for fever of 101, more lethargic than usual and his glucose reading was high. On arrival his serum glucose is around 478, sodium is 156, creatinine of 4. He is very lethargic and barely opens eyes. Initial work up shows likely diagnosis of DKA/ hyperosmolar diabetes (is a serious complication of diabetes, primarily occurring in individual with type 2 diabetes), possible sepsis (is a life threatening condition that occurs when the body has extreme response to infection), UTI (his foley (foley- a medical device that helps drain urine from the bladder when you can't pee on your own) was exchanged in ER), had brown urine with some pus in penile area, possible right lung pneumonia, with AKI. Normal blood serum glucose levels: Fasting blood glucose 70 to 99 mg/dL Random blood glucose: generally, it should be 125 mg/dL. Medlineplus https://medlineplus.gov.ency/article During an interview on 05/19/2025 at 10:01 am LVN B stated he was not aware of Resident #1 needing accu checks (accu check refer to the use of a glucometer to test a patient's blood sugar level) or insulin. During an interview on 05/19/2025 at 11:04 am the DON stated, she knew Resident #1 was diabetic from his referral papers that were faxed over. The DON stated she reviewed Resident #1's admission papers and she didn't see Resident #1 was on Insulin. The DON stated she participated in Resident #1's admission assessments and reviewed his orders from the referral papers sent in February 2025. The DON stated she did not put Resident #1's orders in Point Click Care (PCC- a web based EHR that helps long-term care provider manage the complete lifecycle of a resident care). The DON stated Resident #1 was admitted to the facility with only 2 pieces of paper. The DON stated she called the local hospital for Resident #1's hospital records and was told the records would be faxed over. The DON stated she did not follow up to find out if Resident #1's hospital records were faxed or document that she had called for the hospital records. The DON stated she did not see Resident #1 showing signs or symptoms of Hypo (low) or Hyperglycemia (high blood glucose). The DON stated if a Resident was supposed to get insulin and did not get the insulin, the resident would have hyperglycemia which can lead to DKA and coma. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/19/2025 at 11:43 am the NP stated, Resident #1 was seen once a month because he was non-funded (no Payal source). The NP stated she had seen Resident #1 twice since he was admitted to the facility. The NP stated she visited with Resident #1 on 5/17/2025. She said he was not responding well, he was unresponsive, and she ordered for him to be sent to the ER for further evaluation. The NP stated she documented on 05/04/2025 that Resident #1 should continue insulin regimen as prescribed, monitor glucose levels and foot ulcer healing based on the MD's previous documentation and Resident #1's hospital records. The NP stated she did not review Resident #1's MAR/TAR for his glucose reading during her visits. The NP stated she did not have access to PCC to put in orders. The NP stated if a resident was ordered insulin and did not get the insulin as ordered, the resident can go into DKA or hyperosmolarity (blood is more concentrated than normal due to dehydration). The NP stated, generally, you want the serum blood glucose around 80 and not more than 200, and 400 plus serum blood glucose can indicate uncontrol diabetes/blood sugar. The NP stated she ordered labs on 5/4/2025 but was not able to get the lab done due to Resident #1's funding. The NP stated she gave the lab ordered sheet to the DON and spoke with the MD regarding that. The NP stated, if the insulin was ordered from the hospital for Resident #1, Resident #1 should have gotten the insulin as ordered. During a phone interview on 05/19/2025 at 12:15 pm RN D stated he worked with Resident #1 but could not remember putting Resident #1's orders in the EMR upon admission. RN D stated he did not recall Resident #1 having orders for accu checks or insulin. RN D stated he had never given Resident #1 insulin or checked his blood glucose level. During an interview on 05/19/2025 at about 12:41 pm, the DON stated the NP gave her a sheet with orders for labs for Resident #1, but the labs were not completed due to Resident's payment source (LOA-Letter of Agreement). The DON stated Resident #1 contract with the hospital only pay for room and boarding only. During an interview on 05/19/2025 at 1:35 pm, the Interim Administrator stated when a resident is being admitted from the hospital, the admitting nurse was responsible to call the hospital for clarification of orders. She stated, if the Resident was transported to the facility without hospital papers, the admitting nurse is responsible to contact the hospital for discharge papers and follow up on the papers. The Interim Administrator stated the DON was responsible to ensure the nurses were following all orders. The Interim Administrator stated for a resident who was ordered insulin and did not get the insulin, the resident's blood glucose would be high. The Interim Administrator stated the facility missed the insulin order for Resident #1, it was a mistake, and they were working on fixing the problem. The Interim Administrator stated for a Resident with LOA funding, the facility gets paid a flat rate per day through the hospital contract. The Interim Administrator also stated the facility would pay for labs because the Resident had to be taken care of. The Interim Administrator stated that was a misunderstanding. The Interim Administrator stated the MD should be able to see and treat every Resident regardless of their payment source. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a phone interview on 05/19/2025 at 2:45 pm the MD stated he had just reviewed Resident #1's chart and the insulin and accu checks were an error on their part. He stated it was an oversight not looking for the accu check and the insulin administration. The MD stated his office should have realized that Resident #1's insulin was held. The MD stated he was told by the NP that the DON said the insulin was discontinued due to insurance problem/ LOA. The MD stated the facility should have continued with Resident #1's accu checks and stopped the 70/30 insulin when the blood glucose was stable. The MD stated his NP should have asked the facility to monitor Resident #1's blood glucose reading regardless of payment source. The MD stated DKA was considered life threatening, but we can bring the Resident/Patient back from it. He stated DKA can also be triggered by acute infection, but again, the blood glucose should have been monitored before the facility can decide on keeping Resident #1 on the insulin or not. Review of Resident #1's Letter of Agreement dated 04/01/2025 reflected the following: Obligations of Facility a. Facility shall provide quality service to patient without discriminating of the basis of source of payment, gender, nationality, ethnicity, age, or handicap. b. Facility shall invoice Hospital by the 15th of each month for services to patient. An itemized statement will accompany each invoice. c. Facility agrees to provide the following services to the Patient: i. Nursing Care ii. Physical Therapy iii. Speech Therapy iv. Occupation Therapy d. Facility agrees to provide the medications prescribed by transferring physician. A list of the prescribed medications is located in Exhibit A and is included by reference herein. Review of facility's policy titled Reconciliation of Medications on admission dated July 2017 reflected: Purpose The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility. Preparation 1. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Gather the information needed to reconcile the medication list: a. Approved medication reconciliation form. b. Discharge summary from referring facility. c. admission order sheet. d. All prescription and supplement information obtained from the resident/family during the medication history; and e. Most recent medication administration record (MAR), if this is a readmission. 2. Find a quiet place that is free from distractions. General Guidelines 1. Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care. 2. Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process. 3. Medication reconciliation helps to ensure that all medications, routes and dosages on the list are appropriate for the resident and his/her condition, and do not interact in a negative way with other medications/supplements on the list. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	f. Contact the community pharmacy used by the resident; or g. Contact the admitting and/or Attending Physician. The VP for Operation, Interim Administrator and the DON were notified on 05/19/25 at 4:19 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on 05/20/25 at 12:51 pm. F755 Immediate Jeopardy Removal Actions Taken 1. Immediate Clinical Response o Resident #1 was immediately transferred to the hospital upon identification of altered mental status and signs of sepsis and hyperglycemia on 5/17/2025. o Full head-to-toe nursing assessment completed and documented prior to transfer. o Family and physician were notified promptly. 2. Resident Review & Safety Measures o 100% audit of all current residents with diabetes diagnoses was conducted on [5/19/2025] by Director of Nursing. (Documented on audit tool developed for new admit medication reconciliation) DON was in-serviced before completing audit by Chief Nursing Officer. o Review included MAR/TAR, physician orders, care plans, and hospital discharge records for insulin, glucose monitoring, or diabetic care needs. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	o Any missing or incorrect orders were immediately clarified with the physician and implemented. (1 resident) o Any residents found without current diabetic monitoring or medication orders received immediate physician review. (All medications for non-funded residents will be ordered through the pharmacy and charged in the same manner as a skilled resident, facility's responsibility). (All care plans were audited, with 2 updates made to care plans) 3. Hospital Discharge Order Reconciliation o A new protocol was implemented effective immediately: A licensed nurse and the DON or designee will review all hospital discharge papers at time of admission or return to ensure all orders are entered correctly into the EMR (PCC). (Medication reconciliation form) The receiving nurse must confirm medication orders, follow-up appointments, and labs on all new and readmitted resident. (This will be tracked daily in the clinical morning meeting by the DON/Designee) Any additional education will be provided to the DON if there are any discrepancies.) Orders will be reviewed by the DON or designee on all admission and noted as reviewed in the EMR. (Within 24 hours after admission) 4. Physician/Nurse Practitioner Notification and Oversight o The facility's Medical Director and NP were re-educated by the Chief Nurse Officer 5/19/25 on the responsibility to review MAR/TAR and hospital discharge notes on every visit. o The facility implemented a process that requires weekly NP review of high-risk residents, including diabetic and non-funded residents. (Medications will be ordered from the pharmacy and cost occurred outside of LOA will be supported by the facility. NP review will be monitored by use of change of condition form) (Change of condition forms on PCC will be reviewed daily in clinical stand up by DON / Designee to ensure compliance. (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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Education and Training o Emergency in-service conducted on May 19th, 2025, by Director of Nurses to all licensed nursing staff on: (DON was provided training prior to in-servicing others by CNO. Importance of following hospital discharge orders. Recognizing signs/symptoms of hypo/hyperglycemia. Diabetic care management and documentation requirements. Immediate reporting of missing or unclear orders. (in-service and posttest) o Re-education for DON and ADON on responsibilities during admission/re-admission. (By: CNO) 5/19/25) 6. Monitoring and Quality Assurance o Indefinite Daily audits of all new admissions and re-admissions to ensure: Hospital discharge orders are obtained, reviewed, and implemented timely. Daily review in clinical morning meeting). Medication orders are entered into the EMR correctly. o All audits are reviewed by the Administrator or Regional Nurse Consultant daily. o Ongoing Monthly QA audits will be conducted thereafter and tracked via QAPI. 7. Accountability and Leadership Oversight o (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675564	A. Building B. Wing	05/20/2025

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON educated on policy and procedure. (By: CNO policy reviewed, and DON acknowledged understanding with verbal and written acknowledgment. o Additional coverage and oversight by Chief Nursing Officer (Weekly X 6 weeks then monthly. The Surveyor monitored the POR on 05/20/2025 from 1:00pm to 7:00 pm as follows: During interviews on 05/20/2025 from 1:00 pm -7:00 pm, three LVNs (LVN B, C and D), 1 RN (RN D) from all shifts stated they had been in-serviced by the DON and the Interim Administrator/ CNO and they learned about the types of orders, expectations, what to look for when reviewing orders, admissions/readmissions process, new procedures, scope of practices for MAs and nurses, following orders, review residents EHR and verified compliance with physician orders, review MAR/TAR, physician orders, care plans, and hospital discharge records for insulin, glucose monitoring, or diabetic care needs. They all stated the DON would review orders on all admissions and comparing to EHR to ensure completed within 24 hours of admission. During an interview on 05/20/2025 at 3:40 pm the DON stated she completed a full audit of all current residents with diabetes diagnoses on 05/19/25. Review included MAR/TAR, physician orders, care plans, and hospital discharge records for insulin, glucose monitoring, or diabetic care needs. The DON stated the CNO in-serviced her before completing the audit on 05/19/25. The DON stated Resident #1 was identified as the only resident with missing or incorrect orders that was immediately clarified with the physician on 05/19/25. The DON stated there were no residents identified as requiring immediate physician review because none were without current diabetic monitoring and medication orders. New protocol immediately implemented by her and licensed nurses on 05/19/25 on reviewing all hospital discharge papers at the time of admission and readmission. The DON stated there were no new admissions nor readmissions since 05/19/25. The DON stated she was conducting daily tracking to ensure receiving nurse confirmed receiving discharge papers and orders at time of admission and readmission. The DON stated she was also reviewing orders on all admissions and comparing to EHR to ensure completed within 24 hours of admission. The DON stated the MD and NP were re-educated by the CNO on 05/19/25 to review MAR/TAR and hospital discharge notes on every visit. The facility also started having NP review weekly high-risk residents on 05/19/25. The DON stated she immediately in-serviced and gave post-tests on all licensed nursing staff on 05/19/25 on importance of following hospital discharge orders, recognizing signs/symptoms of hypo/hyperglycemia, diabetic care management and documentation requirements, and immediate reporting of missing or unclear orders. She was also trained before the in-service by the CNO on 05/19/25. The DON stated the CNO re-educated her on admission/readmission process on 05/19/25. Indefinite daily audits of all new admissions and re-admissions to ensure hospital discharge orders are obtained, reviewed, and implemented timely and medication orders are entered into the EHR correctly. QAPI was conducting monthly reviews thereafter. The DON stated she was educated by the CNO and signed an acknowledgement of the policies and procedures regarding medication administration, physician orders for diabetic's process, and admission/readmission process. CNO would oversee weekly for the next six weeks and then monthly. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675564	A. Building B. Wing	05/20/2025

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 05/20/2025 at 5:18pm Interim Administrator/CNO stated she in-serviced the DON on the importance of admission/readmission process and responsibilities, following hospital discharge orders, recognizing signs/symptoms of hypo/hyperglycemia, diabetic care management and documentation requirements, immediate reporting of missing or unclear orders on 05/19/25. The Interim Administrator/CNO stated the DON also signed an acknowledgement on 05/19/25 before in-servicing the remainder of staff on 05/19/25. The Interim Administrator/CNO stated she reviewed the policy and DON signed acknowledging policy and procedure reviewed on processes. The Interim Administrator/CNO stated she oversaw to ensure processes completed weekly for the next 6 weeks and then monthly. Review of facility's in-services dated 05/19/2025 reflected the following: Facility had an ADHOC QAAC for identification of deficient practice. DON: Review Medication orders on admission: following hospital discharge orders, recognizing symptoms of hypo/hyperglycemia, Diabetes care/ management, reporting missing/unclear orders presented by the Interim Administrator/CNO and signed by the DON. Nurses: Medication Administration: following hospital discharge orders, recognizing symptoms of hypo/hyperglycemia, Diabetes care/ management, reporting missing/unclear orders presented by the Interim Administrator/CNO and the DON; signed by LVN B and LVN F and via phone for LVN C and RN D. Education to Physician/NP on MARs/TARs on new/readmissions. Weekly Review of high-risk residents regardless of payer. LOA residents require same level of care as skilled. MD stated and acknowledged understanding of medication process, missed dosage of medication due to transcription error presented by the Interim Administrator and the DON signed by Interim Administrator and the DON on behalf of the MD and the NP . Abuse, Neglect and Physician Orders quiz completed by Nurses including the DON, LVN B, LVN C via phone, RN D via phone, MA E via phone, LVN F Administering Medications policy, revised April 2019, reflected DON was reeducated on policy. Abuse, neglect and physician's orders post-tests were completed by licensed nurses. DON audit of all residents with diabetes diagnoses, conducted 05/19/25, reflected the DON reviewed MAR/TAR reflecting accurate orders, ensured medication reconciliation, diagnosis of diabetes, physician orders, care plans reflect diabetes, glucose monitoring and diabetic care needs, hospital discharge orders reviewed, and insulin ordered and administered as ordered. This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/19/2025 at 4:19 pm and an IJ template was given. While the IJ was removed on 05/20/2025 at 7:01pm, the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of pattern, due to the facility's need to evaluate the effectiveness of the corrective systems.