| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 676083 | A. Building<br>B. Wing | 05/08/2025 |

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| Brownsville Nursing and Rehabilitation Center | 320 Lorenaly Dr<br>Brownsville, TX 78520 |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide doctor's orders for the resident's immediate care at the time the resident was admitted.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to have physician orders for the resident's immediate care at time of admission for 1 of 4 residents (Resident #2) reviewed for physician admission orders.<br><br>1.Resident #2 was readmitted to the facility on [DATE] and did not have orders in place for blood sugar checks and had an episode of low blood sugar on 04/08/25 that required him to be sent to hospital.<br><br>2.Resident #2 was readmitted to the facility on [DATE] and did not have wound care orders in place for identified impaired skin intergrity until 04/07/25.<br><br>An IJ was identified on 05/06/25. The IJ template was provided to the facility on [DATE] at 5:18PM . While the IJ was removed on 05/08/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.<br><br>These deficient practices could affect residents by placing them at risk of not having orders for the staff to follow in order to provide care and treatment for identified health needs.<br><br>The findings included:<br><br>1.Record review of Resident #2's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without hypoglycemia (low blood sugars) without coma, chronic systolic (congestive) (left ventricle lose ability to contract normally and the heart cant with enough force to push enough blood into circulation) heart failure, hyperlipidemia (abnormally high levels of lipids (fat) in the blood) and essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #2's Medicare 5-day MDS assessment, dated 02/27/25, revealed Resident #2 had a BIMS score of 11, indicating his cognition was moderately impaired.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #2's care plan with an initiation date of 04/16/25 reflected problems such as, [Resident #2] has Diabetes Mellitus and included a goal of the resident will have no complication related to diabetes and interventions including, Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor (Pale), Nervousness, Confusion, slurred speech, lack of coordination and Staggering gait. with initiation dates of 04/16/25.<br><br>Record review of Resident #2's hospital document titled, Physician - Discharge Med Rec Order Lansc (Definition unknown) dated 04/03/25 stated to stop Resident #2's order for insulin sliding scale and did not include any orders related to blood sugar checks.<br><br>Record review of Resident #2's hospital document titled; Discharge Medication dated 04/03/25 did not include any orders related to blood sugar checks.<br><br>Record review of Resident #2's order summary report from his admission on [DATE] indicated he had no orders for blood sugar checks.<br><br>Record review of Resident #2's order summary report from his admission on [DATE] indicated he had an order for dapagliflozin propanediol oral tablet 5MG 1 time a day every day and glipizide-metformin HCl oral tablet 5-500MG 2 times a day every day both with a start date of 04/04/25 and a discontinue date of 04/10/25.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay and stated LVN A had verified medication list with the NP.<br><br>Record review of Resident #2's order audit report revealed he had previously had blood sugar checks ordered on 03/05/25 and discontinued on 03/15/25 when resident was sent to the hospital prior to re-admitting to facility on 04/03/25.<br><br>Record review of Resident #2's blood sugar summary revealed his last blood sugar check was completed on 03/15/25 and was 174.<br><br>Record review of Resident #2's change in condition completed by LVN A dated 04/08/25 stated Resident #2 complained of shortness of breath, O2 saturation was at 98% and had a blood sugar reading of 50. Resident #2 was alert at all times, had no signs and symptoms of hypoglycemia or distress, had even and unlabored breathing, and was given glucose gel and a cup of orange juice. Resident #2 was transferred to hospital.<br><br>Record review of Resident #2's hospital admission dated 04/08/25 revealed he was admitted for episodes of hypoglycemia.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview with the NP on 04/16/25 at 9:02 a.m., he stated residents with diabetes and history of low of fluctuating blood sugars would absolutely have to have blood sugar checks. The NP did not recall the specific phone call with LVN A when Resident #2 returned to the facility on [DATE]. The NP stated he usually continues the hospital orders and resume hospital orders and the resident's orders. The NP did not recall saying specifically to check his blood sugars but stated Resident #2 has had episode of fluctuating blood sugars and would imagine the facility would be checking his blood sugar. The NP clarified that Resident #2 would require blood sugar checks. The NP did not know why he did not have any blood sugar checked from 04/03/25-04/08/25 and stated it would not make any sense to discontinue the glucometer checks on a diabetic and stated he was not aware of an order like that being given. The NP stated if a resident did not have their blood sugar checked there was a possibility of hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar) episodes.<br><br>During a telephone interview with LVN A on 04/16/25 at 12:36 p.m., she stated she went over the orders with the NP and stated there was no communication to the NP asking if he needed blood sugar checks and LVN A stated she did not ask if Resident #2 needed them because usually they would come on the medication list. LVN A stated there was not a reason why she did not ask for blood sugar checks for Resident #2 and stated she just did not and stated she just followed the order from the hospital. LVN A stated some people who had type 2 diabetes had to have blood sugar and stated some people do not check their blood. LVN A stated Resident #2 did not have blood sugar checks for a total of 5 days during his stay from 04/03/25-04/08/25. LVN A stated she did not know why Resident #2 did not have blood sugar checks. LVN A stated not having blood sugar checks could impact a resident negatively by their sugar dropping or going too high. LVN A stated she had not been trained in requesting or inputting orders for blood sugar checks and stated she just put in whatever orders were on the paper. LVN A did not know the facility policy regarding blood sugar checks or diabetic procedures. LVN A stated the only negative outcome Resident #2 had was on 04/08/25 he was complaining of shortness of breath and had his blood sugar was at 50. LVN A stated Resident #2 was sent out to the hospital.<br><br>During an interview on 04/16/25 at 4:12 p.m. ADON E stated normally when a resident is on diabetic PO (by mouth) medication they will do blood sugar checks on them and stated they reviewed the hospital medication list that Resident #2 came in with on 04/03/25 and stated they had discontinued his sliding scale insulin. ADON E stated she did not know if LVN A thought his blood sugar checks were discontinued because the sliding scale was discontinued. ADON E stated LVN A did document that she verified the medications with the NP but she did not know exactly what LVN A verified and did not know why the glucose checks were dropped. ADON E was not sure if there was any communication about getting blood sugar checks for Resident #2 and stated it was not documented on LVN As note. ADON E did not know why LVN A did not ask for blood sugar checks for Resident #2 and stated residents with type 2 diabetes should be on blood sugar checks. ADON E stated she spoke with the NP today who said if they would have addressed it with him he would have given the blood sugar checks. ADON E stated Resident #2 was without blood sugar checks for 5 days from 04/03/25-04/08/25. ADON E stated herself and ADON G had trained staff over requesting and in putting orders and about checking blood sugar for diabetics. ADON E stated they did not have a facility policy for diabetic procedures or blood sugar checks and stated it was just nursing 101 to check diabetics blood sugars before meals. ADON E stated LVN A did not follow procedure in this situation. ADON E stated not getting blood sugar checks could negatively impact a resident by causing them to go hypoglycemic (low blood sugar). ADON E stated she believed Resident #2 was sent out due to him becoming hypoglycemic on 04/08/25 and stated she did not see him during that time.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview with the DON on 05/02/25 at 6:11pm he stated there was a progress note from LVN A on 04/03/25 that stated she went over Resident #2's orders with the NP. The DON stated that progress note did not include communication regarding blood sugar checks. The DON stated some physicians did not have residents on blood glucose checks and would instead check their A1C. The DON stated if a resident's blood glucose is controlled with diet and oral medication, they can be taken off blood glucose checks and if they are uncontrolled then you really cannot take them off blood glucose checks. The DON was asked if there was a reason why LVN A did not ask the NP for blood glucose checks for Resident #2 and he stated it depended on the order that came in with the resident from the hospital, and stated it they were on insulin they are on glucose checks regardless but stated sometimes they went in with PO (oral) medication and would use an A1C to check their glucose. The DON stated Resident #2 did not have any order from blood sugar checks during his stay from 04/03/25 through 04/08/25. The DON stated Resident #2 had no negative outcomes from not having his blood glucose checked during that time that he knew of. The DON stated he was not sure if staff had been trained prior to Resident #2 over blood glucose checks but stated they had been trained since and stated the training occurred prior to him starting to work at the facility. The DON stated yes, the facility had a policy regarding diabetic procedures and blood glucose checks but had to read it to give me information regarding what it stated. The DON stated LVN A followed the admission process. The DON stated if someone had a history of hypoglycemia and did not have blood glucose checks it could put their life in danger. The DON reviewed Resident #2's blood sugar summary and stated he only identified 1 episode of Resident #2's blood sugar at 50 on 02/16/25.<br><br>During a follow up interview on 05/06/25 at 12:14pm The DON stated if a resident was responsive they could decompensate within 5 to 30 minutes if their blood glucose was at 50 and was not being monitored.<br><br>Record review of facility Inservice training report dated 04/11/25 revealed LVN A and ADON E had been trained on glucose checks, admissions and notifying the doctor.<br><br>Record review of LVN A's orientation and skills competency revealed a section titled, Physician Orders and a subsection titled, acquisition that indicated she had been evaluated over this area on 01/02/24 by a previous DON. There was no additional comments on comment section and was signed and dated by both LVN A and a previous DON on 01/02/24<br><br>Record review of facility in services revealed LVN A had been trained over medication reconciliation and verifying medication on 04/17/25.<br><br>Record review of facility Ad HOC QAPI dated 04/11/25 revealed, blood glucose as an agenda item.<br><br>During an interview on 04/16/25 at around 4:00pm the Regional Clinical Specialist stated they did not have a facility policy for diabetic procedures or blood sugar checks.<br><br>During an interview on 04/16/25 at 4:12pm ADON E stated they did not have a facility policy for diabetic procedures or blood sugar checks.<br><br>During an interview on 04/16/25 at 5:16pm the Administrator stated they did not have a facility policy for diabetic procedures or blood sugar checks.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of facility policy with an implementation date or 10/24/22 and titled Notification of Changes stated, the purpose of this policy is to ensure the facility prompt informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. and 3. Circumstances that require a need to alter treatment. This may include a. a new treatment.<br><br>2.Record review of Resident #2's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without hypoglycemia (low blood sugars) without coma, chronic systolic (congestive) (left ventricle lose ability to contract normally and the heart cant with enough force to push enough blood into circulation) heart failure, hyperlipidemia (abnormally high levels of lipids (fat) in the blood) and essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #2's Medicare 5-day MDS assessment, dated 02/27/25, revealed Resident #2 had a BIMS score of 11, indicating his cognition was moderately impaired. Resident #2's section M - skin conditions reflected Resident #2 was at risk for developing pressure ulcers/injuries, had no unhealed pressure ulcers/injuries, 1 venous and arterial ulcer present, had diabetic foot ulcer(s), moisture associated skin damage (MASD), had a pressure reducing device for bed and had application of non-surgical dressings (with or without topical medications) other than to feet.<br><br>Record review of Resident #2's care plan with an initiation date of 04/16/25 reflected problems such as, [Resident #2] has an arterial of the left dorsum foot, [Resident #2] has a stage 2 pressure injury to left gluteus and unstageable pressure injury to left heel and [Resident #2] has actual impairment to skin integrity of the sacrum r/t (related to) MASD and impairment to skin integrity of the penis r/t (related to) surgical wound. All 3 problem areas had an intervention of, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.<br><br>Record review of Resident #2's hospital documents dated 04/03/25 and titled Physician-Discharge Med (medications) Rec Order Landsc (definition unknown) and Discharge - Patient Medication Report did not include any orders for impaired skin integrity management.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay and stated LVN A had verified medication list with the NP.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay. Nursing note also stated Resident #2 present with Discoloration noted to bilateral arms. Multiple scabs noted to posterior left arm . Red discoloration noted to sacrum area .Surgical incision to penis area d/t (due to) circumcision. Swelling noted to groin area. Scab noted to top of left foot and left heel.<br><br>Record review of Resident #2's initial nursing evaluation dated 04/03/25 completed by LVN A had yes marked off indicating Resident #2 had skin impairments but did not mark anything on body diagram or site and description table that detailed location or measurement.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #2's skin assessments with an effective date of 04/07/25 revealed Resident #2 had the following: a diabetic wound to left dorsum foot that measured an area of 3.1 cm² with a length of 3.3 cm, width of 1.4 cm, depth of 0.1 cm. A diabetic would to left heel that measured an area of 1.8 cm² with a length of 2.2 cm, width of 1.0 cm, depth of 0.1 cm, MASD specifically incontinence associated dermatitis to sacrum that measured an area of 2.2 cm² with a length of 3.8 cm, width of 0.7 cm, depth of 0.1 cm. and an abrasion to penis that measured an area of 8.7 cm² with a length of 4.6 cm, width of 4.4 cm, depth of 0.1 cm. All areas of skin impairments were listed as present on admission on [DATE] and 01/26/25 and were all marked as resolved.<br><br>Record review of Resident #2's order summary report revealed he had no treatment orders for his identified skin impairments when admitted on [DATE] until 04/07/25, which include the following:<br><br>1.<br><br>Penile wound: clean with dakin's, dab dry with gauze, apply Mupirocin topically, LOTA (leave open to air) one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>2.<br><br>Sacral MASD (moisture associated skin damage): clean with Dakin's, apply Medihoney and optifoam patch. one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>3.<br><br>Lt (left) heel wound: clean with Dakin's, apply Betadine cast followed by kerlix. one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>4.<br><br>Lt (left) dorsum foot: clean with Dakin's, apply Silvadene, cover with gauze dssg. (dressing) one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>Record review of Resident #2's change in condition completed by LVN A and dated 04/08/25 stated Resident #2 complained of shortness of breath, O2 saturation was at 98% and had a blood sugar reading of 50. Resident #2 was alert at all times, had no signs and symptoms of hypoglycemia or distress, had even and unlabored breathing, and was given glucose gel and a cup of orange juice. Resident #2 was transferred to hospital.<br><br>During a telephone interview on 04/10/25 at 4:19 p.m., LVN A who was the admitting nurse for Resident #2 on 04/03/25 stated she recalled Resident #2 on 04/03/25 and recalled she did the initial nursing evaluation. LVN A stated she did not recall wounds too well and just put redness and discoloration. LVN A stated she did see redness on the sacrum and did not do anything, she stated she did not ask the doctor for any orders for the redness and stated it was more just on the sacrum. LVN A stated she did not know why she did not ask the doctor for any order. LVN A stated she just verified the medication list, LVN A stated they did not have an order for zinc and stated it was not on his medication list. LVN A stated LVN G assisted with the assessment of Resident #2. LVN A stated usually the wound care nurse would evaluate the resident the following day in the morning and stated if residents had wounds they usually came with order.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a follow up interview on 05/01/25 at 7:14pm with LVN A she stated when a resident arrived to the facility she would go and assess them, take vitals, verify orders and would complete a skin assessment that would be documented on a nursing note and stated she would complete a diagram as a reminder if they had things like a bruise. LVN A stated she did not open a new form for skin wound assessment when Resident #2 was admitted and stated she had since been educated to complete a wound form for new admissions.<br><br>During an interview with the NP on 04/16/25 at 9:02 a.m., he stated to determine skin or wound care orders the nurse would discuss any skin impairments with him or request orders from him which he would give if they were requested. The NP stated he did not recall if LVN A informed him of any skin impairments identified on Resident #2 when he was admitted on [DATE]. The NP stated not having wound care orders could potentially impact Resident #2 negatively due to being fragile elderly patient and could potentially have worsening wounds.<br><br>During an interview on 04/16/25 at 4:12 p.m., ADON E stated when a resident or new admission is identified with skin impairments or wounds the admitting nurse was responsible for doing a full head to toe and going over the medication with the doctor. ADON E stated the admitting nurse had to do a skin evaluation and document any skin impairment and if they came in without orders from the hospital then the admitting nurse needed to review any findings with the doctor. ADON E stated when Resident #2 admitted on [DATE], LVN A was the nurse who completed the initial nursing evaluation. ADON E stated the initial nursing evaluation did include a skin assessment but stated the model on the nursing evaluation did not have anything documented. ADON E confirmed that staff marked yes that skin impairments were identified but stated there was nothing documented on the model and stated there should be something documented on there. ADON E stated she is assuming LVN A did not communicate any skin impairment findings to the doctor because there was no order in place for wound care upon admission of Resident #2 on 04/03/25. ADON E stated identified skin impairments and wounds are something they needed to call the doctor about and see what changes he wanted to make and stated the NP was very accessible and if staff would have addressed the skin impairment with him then he would have given orders. ADON E did not know why staff did not communicate Resident #2's skin impairment findings from 04/03/25 with the doctor. ADON E stated it was important to communicate any findings to make sure they were not left untreated. ADON E stated staff had recently been trained by her and ADON G on making notifications to the doctor and requesting orders from the doctor. ADON E stated LVN A did not follow the facility policy which stated anything out of the norm should be reporting for monitoring or treatment. ADON E stated Resident #2 went without wound care for 5 days and stated she did not believe Resident #2 was receiving wound care during those days and stated she did not have a baseline from 04/03/25 to say if there was any deterioration to his wounds during that time and stated there was not any negative impact that she knew of. ADON E stated not having wound care could negatively impact residents by causing wounds to get bigger or infected or go septic.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a follow up interview on 04/16/25 at 6:52 p.m., LVN A stated when a new admission is identified with skin impairments or wounds they would either get order from the medication list or the treatment nurse would assess the resident the following day. LVN A confirmed that she completed Resident #2's initial nursing evaluation when he admitted on [DATE]. She stated she thought the initial nursing evaluation included a skin assessment. LVN A stated she identified skin impairments to include redness to sacrum and scabs to feet. LVN A stated she did not communicate these findings to the NP and did not ask for orders based on her skin assessment and stated she only verified orders with the NP. LVN A stated skin impairments and wounds are something she should communicate with the doctor and stated that she knew of it being the treatment nurse who would communicate that but stated no one told her she was out. LVN A stated she did not communicate her findings with the doctor because she thought the treatment nurse would. LVN A stated it was important to communicate skin and wound findings to the doctor to make sure it would not get worse. LVN A stated she did not remember a training over reporting skin impairments or changes in condition but stated they had to report it to the DON and doctor. LVN A did not know her facility policy regarding communicating findings with the doctor. LVN A stated she did not know how many days Resident #2 went without wound care and stated she was off that following weekend and was not sure if he was receiving any kind of wound care and did not know if there was any deterioration to his wounds during that time. LVN A stated not getting wound care for 4 days could negatively impact the resident by causing the wounds to get infected. LVN A stated she should have notified the doctor if she had seen any signs or symptoms of infection and stated she should have asked him for wound care orders as time of assessment.<br><br>During an interview and record review with the DON on 05/02/25 at 6:11pm he stated he started working at the facility on 04/21/25. The DON stated LVN A completed Resident #2's initial nursing evaluation on 04/03/25. The DON reviewed Resident #2's initial nursing evaluation from 04/3/25 and stated there was a section for skin integrity on there and stated LVN A marked yes to skin impairments but did not identify them on that form and instead did so on her progress note. The DON stated a skin form was not completed until 04/07/25. The DON stated that LVN A did communicate findings with the NP based off a note that stated she verified medications with NP. The DON stated LVN A's note did not include if she asked for orders based on her skin assessment and stated he would have to ask the LVN A or the NP. The DON stated staff should communicate any findings that warranted an order with the NP. The DON did not know why LVN A had not communicate her findings with the NP. The DON stated communicating findings with the NP and getting order for wound care and skin impairments was important because wounds and skin impairments could get worse, go septic or get infected. The DON stated he knew staff had been trained on making notifications to the NP and getting orders for wound care and skin impairments prior to him starting to work at the facility. The DON stated the facility policy stated to notify the NP of any change in condition and anything to the skin. The DON stated LNV A followed the admission process and stated he didn't know if she actually asked the NP about the wounds or scans. The DON stated Resident #2 was without wound care orders from day of readmission on [DATE] until they were put in on 04/07/25. The DON stated not having wound care treatment in place could negatively impact a resident by causing deterioration of the wound, going septic or getting an infection and having pain.<br><br>The Treament Nurse was attempted to be contacted via telephone for an interview on 05/05/25 at 3:59pm with no success.<br><br>The Treament Nurse was attempted to be contacted via telephone for an interview on 05/05/25 at 4:00pm, the call was answered, reason for call was explained, however while explaining the reason for call the person who answered the phone hung up the phone.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | The Treatment Nurse was attempted to be contacted via telephone for an interview on 05/05/25 at 4:01pm with no success.<br><br>During an interview with ADON E on 05/05/25 at 4:08pm stated she stated the Treatment Nurse would have been the nurse who completed Resident #2's skin assessment on 04/07/25. ADON E reveiwed the skin assessments from 04/07/25 and stated the Treatment Nurse was indicated as the staff memeber who created the skin assessments on 04/07/25 for Resident #2.<br><br>Record review of facility Inservice training report dated 04/11/25 (after incident occurred) revealed LVN A and ADON E had been trained on glucose checks, admissions and notifying the doctor.<br><br>Record review of facility policy with an implementation date or 10/24/22 and titled Notification of Changes stated, the purpose of this policy is to ensure the facility prompt informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. and 3. Circumstances that require a need to alter treatment. This may include a. a new treatment.<br><br>This was determined to be an Immediate Jeopardy (IJ) on 05/06/25 at 4:55 PM. The administrator and the DON were notified. The Administrator and the DON were provided with the IJ template on 05/06/25 at 5:18pm<br><br>The following Plan of Removal (POR) submitted by the facility was accepted on 05/07/25 at 11:30 PM:<br><br>[Facility]<br><br>[Address]<br><br>[Phone Number]<br><br>LETTER OF CREDIBLE ALLEGATION FOR REMOVAL OF IMMEDIATE JEOPARDY<br><br>May 6, 2025<br><br>Attention Sir or Madam:<br><br>On May 6, 2025, the facility was notified by the surveyor that an Immediate Jeopardy had been called and the facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements. The immediate jeopardy is as follows:<br><br>Issue:<br><br>F 635 admission Orders<br><br>LVN A failed to obtain clarification orders for glucose checks upon readmission despite having a diagnosis of diabetes. R#2 complained of shortness of breath and suffered hypoglycemic episode with a blood glucose of 50 on 04/08/25.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Actions for Resident Involved<br><br>On 4/16/25, Resident #2 returned to the facility and orders were reviewed. Resident #2 was readmitted with Blood Glucose Check orders and was carried out as ordered.<br><br>Identification of Others:<br><br>On 4/10/25 and 5/6/2025 the DON/Designee conducted an audit of admissions/readmissions in the last 30 days to ensure that orders have been reconciled and reviewed by Medical Providers and carried out as ordered.<br><br>On 4/10/25 and 5/6/2025, residents with diagnosis of type 2 diabetes mellitus were identified and referred to medical providers to review if additional orders are needed related to management of diabetes.<br><br>Systemic Changes/ Education<br><br>On 4/10/25 and 5/6/2025, the Director of Nursing/Designee initiated and completed 100% education with licensed staff. Comprehension of training was verified by having nurses voice understanding of the training and repeat back training contents.<br><br>Those that are PRN and/ or out on FMLA/ LOA will be taken off schedule and have the education completed prior to accepting assignment for their next scheduled shift.<br><br>Licensed Nurses were educated on the following:<br><br>Admission/readmission order review process:<br><br>o<br><br>Medication reconciliation for admission/readmissions. Nurses to ensure all medications and orders upon admit/readmit have been verified with Medical Providers and carried out as ordered.<br><br>o<br><br>Compare Hospital Transfer orders to hospital records including review of diagnosis. The License nurse will contact the medical provider and obtain clarification orders as needed based on order review and nursing assessment.<br><br>Diabetes Mellitus and Blood Glucose Checks<br><br>Beginning 5/6/25 and ongoing, newly hired licensed nurses will receive this training during orientation prior to providing care to the residents. The training will include the above-stated educational components.<br><br>(continued on next page) |

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| F 0635<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Admission/readmission/ER (emergency room) visits orders will be reviewed during the morning clinical meeting to ensure orders have been reconciled with hospital record and orders and the Medical Provider is notified of any orders requiring clarifications based on record review and/or nurse's assessment.<br><br>Weekend RN Supervisor and/or ADON will complete and review Medication reconciliation for admission/readmissions over the weekend. Charge Nurses will ensure all medications and orders upon admit/readmit have been verified with Medical Providers and carried out as ordered.<br><br>Monitoring<br><br>Beginning 5/6/25 and going forward, The Director of Nursing/ designee will review new admissions /readmissions to ensure order reconciliation is completed and hospital records including the diagnosis are reviewed and medical provider is contacted if needed for clarifications based on order review and nursing assessment.<br><br>Beginning 5/6/25 and going, the Director of Nursing or designee will |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 1 of 4 residents (Resident #2) reviewed for quality of care.<br><br>1.Resident #2 was readmitted to the facility on [DATE] and did not have orders in place for wound care for MASD to sacrum, diabetic wound to left heel and left dorsum foot or abrasion to penis until 04/07/25.<br><br>2. Resident #2 was readmitted to the facility on [DATE] and did not have orders in place for blood sugar checks and had an episode of low blood sugar on 04/08/25 that required him to be sent to hospital.<br><br>An IJ was identified on 05/06/25. The IJ template was provided to the facility on [DATE] at 5:18PM . While the IJ was removed on 05/08/25, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.<br><br>These deficient practices could affect residents who receive wound care treatments by placing them at risk for receiving inadequate treatments resulting in the worsening of the wounds.<br><br>The findings included:<br><br>Record review of Resident #2's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without hypoglycemia (low blood sugars) without coma, chronic systolic (congestive) (left ventricle lose ability to contract normally and the heart cant with enough force to push enough blood into circulation) heart failure, hyperlipidemia (abnormally high levels of lipids (fat) in the blood) and essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #2's Medicare 5-day MDS assessment, dated 02/27/25, revealed Resident #2 had a BIMS score of 11, indicating his cognition was moderately impaired. Resident #2's section M - skin conditions reflected Resident #2 was at risk for developing pressure ulcers/injuries, had no unhealed pressure ulcers/injuries, 1 venous and arterial ulcer present, had diabetic foot ulcer(s), moisture associated skin damage (MASD), had a pressure reducing device for bed and had application of non-surgical dressings (with or without topical medications) other than to feet.<br><br>Record review of Resident #2's care plan with an initiation date of 04/16/25 reflected problems such as, [Resident #2] has an arterial of the left dorsum foot, [Resident #2] has a stage 2 pressure injury to left gluteus and unstageable pressure injury to left heel and [Resident #2] has actual impairment to skin integrity of the sacrum r/t (related to) MASD and impairment to skin integrity of the penis r/t (related to) surgical wound. All 3 problem areas had an intervention of, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #2's hospital documents dated 04/03/25 and titled Physician-Discharge Med (medications) Rec Order Landsc (definition unknown) and Discharge - Patient Medication Report did not include any orders for impaired skin integrity management.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay and stated LVN A had verified medication list with the NP.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay. Nursing note also stated Resident #2 present with Discoloration noted to bilateral arms. Multiple scabs noted to posterior left arm . Red discoloration noted to sacrum area .Surgical incision to penis area d/t (due to) circumcision. Swelling noted to groin area. Scab noted to top of left foot and left heel.<br><br>Record review of Resident #2's initial nursing evaluation dated 04/03/25 completed by LVN A had yes marked off indicating Resident #2 had skin impairments but did not mark anything on body diagram or site and description table that detailed location or measurement.<br><br>Record review of Resident #2's skin assessments with an effective date of 04/07/25 revealed Resident #2 had the following: a diabetic wound to left dorsum foot that measured an area of 3.1 cm² with a length of 3.3 cm, width of 1.4 cm, depth of 0.1 cm. A diabetic would to left heel that measured an area of 1.8 cm² with a length of 2.2 cm, width of 1.0 cm, depth of 0.1 cm, MASD specifically incontinence associated dermatitis to sacrum that measured an area of 2.2 cm² with a length of 3.8 cm, width of 0.7 cm, depth of 0.1 cm. and an abrasion to penis that measured an area of 8.7 cm² with a length of 4.6 cm, width of 4.4 cm, depth of 0.1 cm. All areas of skin impairments were listed as present on admission on [DATE] and 01/26/25 and were all marked as resolved.<br><br>Record review of Resident #2's order summary report revealed he had no treatment orders for his identified skin impairments when admitted on [DATE] until 04/07/25, which include the following:<br><br>1.<br><br>Penile wound: clean with dakin's, dab dry with gauze, apply Mupirocin topically, LOTA (leave open to air) one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>2.<br><br>Sacral MASD (moisture associated skin damage): clean with Dakin's, apply Medihoney and optifoam patch. one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>3.<br><br>Lt (left) heel wound: clean with Dakin's, apply Betadine cast followed by kerlix. one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>4.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Lt (left) dorsum foot: clean with Dakin's, apply Silvadene, cover with gauze dssg. (dressing) one time a day with an order date of 04/07/25 and a start date of 04/08/25.<br><br>Record review of Resident #2's change in condition completed by LVN A and dated 04/08/25 stated Resident #2 complained of shortness of breath, O2 saturation was at 98% and had a blood sugar reading of 50. Resident #2 was alert at all times, had no signs and symptoms of hypoglycemia or distress, had even and unlabored breathing, and was given glucose gel and a cup of orange juice. Resident #2 was transferred to hospital.<br><br>During a telephone interview on 04/10/25 at 4:19 p.m., LVN A who was the admitting nurse for Resident #2 on 04/03/25 stated she recalled Resident #2 on 04/03/25 and recalled she did the initial nursing evaluation. LVN A stated she did not recall wounds too well and just put redness and discoloration. LVN A stated she did see redness on the sacrum and did not do anything, she stated she did not ask the doctor for any orders for the redness and stated it was more just on the sacrum. LVN A stated she did not know why she did not ask the doctor for any order. LVN A stated she just verified the medication list, LVN A stated they did not have an order for zinc and stated it was not on his medication list. LVN A stated LVN G assisted with the assessment of Resident #2. LVN A stated usually the wound care nurse would evaluate the resident the following day in the morning and stated if residents had wounds they usually came with order.<br><br>During a follow up interview on 05/01/25 at 7:14pm with LVN A she stated when a resident arrived to the facility she would go and assess them, take vitals, verify orders and would complete a skin assessment that would be documented on a nursing note and stated she would complete a diagram as a reminder if they had things like a bruise. LVN A stated she did not open a new form for skin wound assessment when Resident #2 was admitted and stated she had since been educated to complete a wound form for new admissions.<br><br>During an interview with the NP on 04/16/25 at 9:02 a.m., he stated to determine skin or wound care orders the nurse would discuss any skin impairments with him or request orders from him which he would give if they were requested. The NP stated he did not recall if LVN A informed him of any skin impairments identified on Resident #2 when he was admitted on [DATE]. The NP stated not having wound care orders could potentially impact Resident #2 negatively due to being fragile elderly patient and could potentially have worsening wounds.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 04/16/25 at 4:12 p.m., ADON E stated when a resident or new admission is identified with skin impairments or wounds the admitting nurse was responsible for doing a full head to toe and going over the medication with the doctor. ADON E stated the admitting nurse had to do a skin evaluation and document any skin impairment and if they came in without orders from the hospital then the admitting nurse needed to review any findings with the doctor. ADON E stated when Resident #2 admitted on [DATE], LVN A was the nurse who completed the initial nursing evaluation. ADON E stated the initial nursing evaluation did include a skin assessment but stated the model on the nursing evaluation did not have anything documented. ADON E confirmed that staff marked yes that skin impairments were identified but stated there was nothing documented on the model and stated there should be something documented on there. ADON E stated she is assuming LVN A did not communicate any skin impairment findings to the doctor because there was no order in place for wound care upon admission of Resident #2 on 04/03/25. ADON E stated identified skin impairments and wounds are something they needed to call the doctor about and see what changes he wanted to make and stated the NP was very accessible and if staff would have addressed the skin impairment with him then he would have given orders. ADON E did not know why staff did not communicate Resident #2's skin impairment findings from 04/03/25 with the doctor. ADON E stated it was important to communicate any findings to make sure they were not left untreated. ADON E stated staff had recently been trained by her and ADON G on making notifications to the doctor and requesting orders from the doctor. ADON E stated LVN A did not follow the facility policy which stated anything out of the norm should be reporting for monitoring or treatment. ADON E stated Resident #2 went without wound care for 5 days and stated she did not believe Resident #2 was receiving wound care during those days and stated she did not have a baseline from 04/03/25 to say if there was any deterioration to his wounds during that time and stated there was not any negative impact that she knew of. ADON E stated not having wound care could negatively impact residents by causing wounds to get bigger or infected or go septic.<br><br>During a follow up interview on 04/16/25 at 6:52 p.m., LVN A stated when a new admission is identified with skin impairments or wounds they would either get order from the medication list or the treatment nurse would assess the resident the following day. LVN A confirmed that she completed Resident #2's initial nursing evaluation when he admitted on [DATE]. She stated she thought the initial nursing evaluation included a skin assessment. LVN A stated she identified skin impairments to include redness to sacrum and scabs to feet. LVN A stated she did not communicate these findings to the NP and did not ask for orders based on her skin assessment and stated she only verified orders with the NP. LVN A stated skin impairments and wounds are something she should communicate with the doctor and stated that she knew of it being the treatment nurse who would communicate that but stated no one told her she was out. LVN A stated she did not communicate her findings with the doctor because she thought the treatment nurse would. LVN A stated it was important to communicate skin and wound findings to the doctor to make sure it would not get worse. LVN A stated she did not remember a training over reporting skin impairments or changes in condition but stated they had to report it to the DON and doctor. LVN A did not know her facility policy regarding communicating findings with the doctor. LVN A stated she did not know how many days Resident #2 went without wound care and stated she was off that following weekend and was not sure if he was receiving any kind of wound care and did not know if there was any deterioration to his wounds during that time. LVN A stated not getting wound care for 4 days could negatively impact the resident by causing the wounds to get infected. LVN A stated she should have notified the doctor if she had seen any signs or symptoms of infection and stated she should have asked him for wound care orders as time of assessment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview and record review with the DON on 05/02/25 at 6:11pm he stated he started working at the facility on 04/21/25. The DON stated LVN A completed Resident #2's initial nursing evaluation on 04/03/25. The DON reviewed Resident #2's initial nursing evaluation from 04/3/25 and stated there was a section for skin integrity on there and stated LVN A marked yes to skin impairments but did not identify them on that form and instead did so on her progress note. The DON stated a skin form was not completed until 04/07/25. The DON stated that LVN A did communicate findings with the NP based off a note that stated she verified medications with NP. The DON stated LVN A's note did not include if she asked for orders based on her skin assessment and stated he would have to ask the LVN A or the NP. The DON stated staff should communicate any findings that warranted an order with the NP. The DON did not know why LVN A had not communicate her findings with the NP. The DON stated communicating findings with the NP and getting order for wound care and skin impairments was important because wounds and skin impairments could get worse, go septic or get infected. The DON stated he knew staff had been trained on making notifications to the NP and getting orders for wound care and skin impairments prior to him starting to work at the facility. The DON stated the facility policy stated to notify the NP of any change in condition and anything to the skin. The DON stated LNV A followed the admission process and stated he didn't know if she actually asked the NP about the wounds or scans. The DON stated Resident #2 was without wound care orders from day of readmission on [DATE] until they were put in on 04/07/25. The DON stated not having wound care treatment in place could negatively impact a resident by causing deterioration of the wound, going septic or getting an infection and having pain.<br><br>The Treament Nurse was attempted to be contacted via telephone for an interview on 05/05/25 at 3:59pm with no success.<br><br>The Treament Nurse was attempted to be contacted via telephone for an interview on 05/05/25 at 4:00pm, the call was answered, reason for call was explained, however while explaining the reason for call the person who answered the phone hung up the phone.<br><br>The Treatment Nurse was attempted to be contacted via telephone for an interview on 05/05/25 at 4:01pm with no success.<br><br>During an interview with ADON E on 05/05/25 at 4:08pm stated she stated the Treatment Nurse would have been the nurse who completed Resident #2's skin assessment on 04/07/25. ADON E reveiwed the skin assessments from 04/07/25 and stated the Treatment Nurse was indicated as the staff memeber who created the skin assessments on 04/07/25 for Resident #2.<br><br>Record review of facility Inservice training report dated 04/11/25 (after incident occurred) revealed LVN A and ADON E had been trained on glucose checks, admissions and notifying the doctor.<br><br>Record review of facility policy with an implementation date or 10/24/22 and titled Notification of Changes stated, the purpose of this policy is to ensure the facility prompt informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. and 3. Circumstances that require a need to alter treatment. This may include a. a new treatment.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. Record review of Resident #2's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without hypoglycemia (low blood sugars) without coma, chronic systolic (congestive) (left ventricle lose ability to contract normally and the heart cant with enough force to push enough blood into circulation) heart failure, hyperlipidemia (abnormally high levels of lipids (fat) in the blood) and essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #2's Medicare 5-day MDS assessment, dated 02/27/25, revealed Resident #2 had a BIMS score of 11, indicating his cognition was moderately impaired.<br><br>Record review of Resident #2's care plan with an initiation date of 04/16/25 reflected problems such as, [Resident #2] has Diabetes Mellitus and included a goal of the resident will have no complication related to diabetes and interventions including, Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor (Pale), Nervousness, Confusion, slurred speech, lack of coordination and Staggering gait. with initiation dates of 04/16/25.<br><br>Record review of Resident #2's hospital document titled, Physician - Discharge Med Rec Order Lansc (Definition unknown) dated 04/03/25 stated to stop Resident #2's order for insulin sliding scale and did not include any orders related to blood sugar checks.<br><br>Record review of Resident #2's hospital document titled; Discharge Medication dated 04/03/25 did not include any orders related to blood sugar checks.<br><br>Record review of Resident #2's order summary report from his admission on [DATE] indicated he had no orders for blood sugar checks.<br><br>Record review of Resident #2's order summary report from his admission on [DATE] indicated he had an order for dapagliflozin propanediol oral tablet 5MG 1 time a day every day and glipizide-metformin HCl oral tablet 5-500MG 2 times a day every day both with a start date of 04/04/25 and a discontinue date of 04/10/25.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay and stated LVN A had verified medication list with the NP.<br><br>Record review of Resident #2's order audit report revealed he had previously had blood sugar checks ordered on 03/05/25 and discontinued on 03/15/25 when resident was sent to the hospital prior to re-admitting to facility on 04/03/25.<br><br>Record review of Resident #2's blood sugar summary revealed his last blood sugar check was completed on 03/15/25 and was 174.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #2's change in condition completed by LVN A dated 04/08/25 stated Resident #2 complained of shortness of breath, O2 saturation was at 98% and had a blood sugar reading of 50. Resident #2 was alert at all times, had no signs and symptoms of hypoglycemia or distress, had even and unlabored breathing, and was given glucose gel and a cup of orange juice. Resident #2 was transferred to hospital.<br><br>Record review of Resident #2's hospital admission dated 04/08/25 revealed he was admitted for episodes of hypoglycemia.<br><br>During an interview with the NP on 04/16/25 at 9:02 a.m., he stated residents with diabetes and history of low of fluctuating blood sugars would absolutely have to have blood sugar checks. The NP did not recall the specific phone call with LVN A when Resident #2 returned to the facility on [DATE]. The NP stated he usually continues the hospital orders and resume hospital orders and the resident's orders. The NP did not recall saying specifically to check his blood sugars but stated Resident #2 has had episode of fluctuating blood sugars and would imagine the facility would be checking his blood sugar. The NP clarified that Resident #2 would require blood sugar checks. The NP did not know why he did not have any blood sugar checked from 04/03/25-04/08/25 and stated it would not make any sense to discontinue the glucometer checks on a diabetic and stated he was not aware of an order like that being given. The NP stated if a resident did not have their blood sugar checked there was a possibility of hyperglycemic (high blood sugar) or hypoglycemic (low blood sugar) episodes.<br><br>During a telephone interview with LVN A on 04/16/25 at 12:36 p.m., she stated she went over the orders with the NP and stated there was no communication to the NP asking if he needed blood sugar checks and LVN A stated she did not ask if Resident #2 needed them because usually they would come on the medication list. LVN A stated there was not a reason why she did not ask for blood sugar checks for Resident #2 and stated she just did not and stated she just followed the order from the hospital. LVN A stated some people who had type 2 diabetes had to have blood sugar and stated some people do not check their blood. LVN A stated Resident #2 did not have blood sugar checks for a total of 5 days during his stay from 04/03/25-04/08/25. LVN A stated she did not know why Resident #2 did not have blood sugar checks. LVN A stated not having blood sugar checks could impact a resident negatively by their sugar dropping or going too high. LVN A stated she had not been trained in requesting or inputting orders for blood sugar checks and stated she just put in whatever orders were on the paper. LVN A did not know the facility policy regarding blood sugar checks or diabetic procedures. LVN A stated the only negative outcome Resident #2 had was on 04/08/25 he was complaining of shortness of breath and had his blood sugar was at 50. LVN A stated Resident #2 was sent out to the hospital.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 04/16/25 at 4:12 p.m. ADON E stated normally when a resident is on diabetic PO (by mouth) medication they will do blood sugar checks on them and stated they reviewed the hospital medication list that Resident #2 came in with on 04/03/25 and stated they had discontinued his sliding scale insulin. ADON E stated she did not know if LVN A thought his blood sugar checks were discontinued because the sliding scale was discontinued. ADON E stated LVN A did document that she verified the medications with the NP but she did not know exactly what LVN A verified and did not know why the glucose checks were dropped. ADON E was not sure if there was any communication about getting blood sugar checks for Resident #2 and stated it was not documented on LVN As note. ADON E did not know why LVN A did not ask for blood sugar checks for Resident #2 and stated residents with type 2 diabetes should be on blood sugar checks. ADON E stated she spoke with the NP today who said if they would have addressed it with him he would have given the blood sugar checks. ADON E stated Resident #2 was without blood sugar checks for 5 days from 04/03/25-04/08/25. ADON E stated herself and ADON G had trained staff over requesting and in putting orders and about checking blood sugar for diabetics. ADON E stated they did not have a facility policy for diabetic procedures or blood sugar checks and stated it was just nursing 101 to check diabetics blood sugars before meals. ADON E stated LVN A did not follow procedure in this situation. ADON E stated not getting blood sugar checks could negatively impact a resident by causing them to go hypoglycemic (low blood sugar). ADON E stated she believed Resident #2 was sent out due to him becoming hypoglycemic on 04/08/25 and stated she did not see him during that time.<br><br>During an interview with the DON on 05/02/25 at 6:11pm he stated there was a progress note from LVN A on 04/03/25 that stated she went over Resident #2's orders with the NP. The DON stated that progress note did not include communication regarding blood sugar checks. The DON stated some physicians did not have residents on blood glucose checks and would instead check their A1C. The DON stated if a resident's blood glucose is controlled with diet and oral medication, they can be taken off blood glucose checks and if they are uncontrolled then you really cannot take them off blood glucose checks. The DON was asked if there was a reason why LVN A did not ask the NP for blood glucose checks for Resident #2 and he stated it depended on the order that came in with the resident from the hospital, and stated it they were on insulin they are on glucose checks regardless but stated sometimes they went in with PO (oral) medication and would use an A1C to check their glucose. The DON stated Resident #2 did not have any order from blood sugar checks during his stay from 04/03/25 through 04/08/25. The DON stated Resident #2 had no negative outcomes from not having his blood glucose checked during that time that he knew of. The DON stated he was not sure if staff had been trained prior to Resident #2 over blood glucose checks but stated they had been trained since and stated the training occurred prior to him starting to work at the facility. The DON stated yes, the facility had a policy regarding diabetic procedures and blood glucose checks but had to read it to give me information regarding what it stated. The DON stated LVN A followed the admission process. The DON stated if someone had a history of hypoglycemia and did not have blood glucose checks it could put their life in danger. The DON reviewed Resident #2's blood sugar summary and stated he only identified 1 episode of Resident #2's blood sugar at 50 on 02/16/25.<br><br>During a follow up interview on 05/06/25 at 12:14pm The DON stated if a resident was responsive they could decompensate within 5 to 30 minutes if their blood glucose was at 50 and was not being monitored.<br><br>Record review of facility Inservice training report dated 04/11/25 revealed LVN A and ADON E had been trained on glucose checks, admissions and notifying the doctor.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of LVN A's orientation and skills competency revealed a section titled, Physician Orders and a subsection titled, acquisition that indicated she had been evaluated over this area on 01/02/24 by a previous DON. There was no additional comments on comment section and was signed and dated by both LVN A and a previous DON on 01/02/24<br><br>Record review of facility in services revealed LVN A had been trained over medication reconciliation and verifying medication on 04/17/25.<br><br>Record review of facility Ad HOC QAPI dated 04/11/25 revealed, blood glucose as an agenda item.<br><br>During an interview on 04/16/25 at around 4:00pm the Regional Clinical Specialist stated they did not have a facility policy for diabetic procedures or blood sugar checks.<br><br>During an interview on 04/16/25 at 4:12pm ADON E stated they did not have a facility policy for diabetic procedures or blood sugar checks.<br><br>During an interview on 04/16/25 at 5:16pm the Administrator stated they did not have a facility policy for diabetic procedures or blood sugar checks.<br><br>Record review of facility policy with an implementation date or 10/24/22 and titled Notification of Changes stated, the purpose of this policy is to ensure the facility prompt informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. and 3. Circumstances that require a need to alter treatment. This may include a. a new treatment.<br><br>2.Record review of Resident #2's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without hypoglycemia (low blood sugars) without coma, chronic systolic (congestive) (left ventricle lose ability to contract normally and the heart cant with enough force to push enough blood into circulation) heart failure, hyperlipidemia (abnormally high levels of lipids (fat) in the blood) and essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #2's Medicare 5-day MDS assessment, dated 02/27/25, revealed Resident #2 had a BIMS score of 11, indicating his cognition was moderately impaired. Resident #2's section M - skin conditions reflected Resident #2 was at risk for developing pressure ulcers/injuries, had no unhealed pressure ulcers/injuries, 1 venous and arterial ulcer present, had diabetic foot ulcer(s), moisture associated skin damage (MASD), had a pressure reducing device for bed and had application of non-surgical dressings (with or without topical medications) other than to feet.<br><br>Record review of Resident #2's care plan with an initiation date of 04/16/25 reflected problems such as, [Resident #2] has an arterial of the left dorsum foot, [Resident #2] has a stage 2 pressure injury to left gluteus and unstageable pressure injury to left heel and [Resident #2] has actual impairment to skin integrity of the sacrum r/t (related to) MASD and impairment to skin integrity of the penis r/t (related to) surgical wound. All 3 problem areas had an intervention of, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Record review of Resident #2's hospital documents dated 04/03/25 and titled Physician-Discharge Med (medications) Rec Order Landsc (definition unknown) and Discharge - Patient Medication Report did not include any orders for impaired skin integrity management.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay and stated LVN A had verified medication list with the NP.<br><br>Record review of Resident #2's nursing note dated 04/03/25 at 7:41 p.m., written by LVN A reflected he had returned to the facility at that time after a hospital stay. Nursing note also stated Resident #2 present with Discoloration noted to bilateral arms. Multiple scabs noted to posterior left arm . Red discoloration noted to sacrum area .Surgical incision to penis area d/t (due to) circumcision. Swelling noted to groin area. Scab noted to top of left foot and left heel.<br><br>Record review of Resident #2's initial nursing evaluation dated 04/03/25 completed by LVN A had yes marked off indicating Resident #2 had skin impairments but did not mark anything on body diagram or site and description table that detailed location or measurement.<br><br>Record review of Resident #2's skin assessments with an effective date of 04/07/25 revealed Resident #2 had the following: a diabetic wound to left dorsum foot that measured an area of 3.1 cm² with a length of 3.3 cm, width of 1.4 cm, depth of 0.1 cm. A diabetic would to left heel that measured an area of 1.8 cm² with a length of 2.2 cm, width of 1.0 cm, depth of 0.1 cm, MASD specifically incontinence associated dermatitis to sacrum that measured an area of 2.2 cm² with a length of 3.8 cm, width of 0.7 cm, depth of 0.1 cm. and an abrasion to penis that measured an area of 8.7 cm² with a length of 4.6 cm, width of 4.4 cm, depth of 0.1 cm. All areas of skin impairments were listed as present on admission on [DATE] and 01/26/25 and were all marked as resolved.<br><br>Record review of Resident #2's order summary repo[TRUNCATED] |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 4 residents (Resident #1 and Resident #2 and Resident #7) reviewed for medical records accuracy, in that:<br><br>1. Resident #1's March 2025 Treatment Administration Record (TAR) documentation was incomplete. Staff did not sign off on the treatment ordered for Resident #1's wound care.<br><br>2. Resident #2's March 2025 TAR documentation was incomplete. Staff did not sign off on the treatment ordered for Resident #2's wound care. Resident #2's April Medication Administration Record (MAR) was incomplete. Staff did not document and sign off on Resident #2's blood sugar checks and insulin orders.<br><br>3. Resident #7's April and May 2025 MAR documentation was incomplete. Staff did not document and sign off on Resident #7's order for sliding scale insulin.<br><br>This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care, and treatment.<br><br>The findings included:<br><br>1. Record review of Resident #1's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without complication, Chronic obstructive pulmonary disease (progressive lung condition characterized by damage to the lungs leading to inflammation and restricted airflow), unspecified, acute (sudden) respiratory failure (air sacs of lungs cannot release enough oxygen into the blood) with hypoxia (low levels of oxygen), essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #1's admission MDS assessment, dated 03/07/25, revealed Resident #1 had a BIMS score of 09, indicating his cognition was moderately impaired. Resident #1's section M - skin conditions reflected Resident #1 was at risk for developing pressure ulcers/injuries, had no unhealed pressure ulcers/injuries, no venous and arterial ulcers present and had a pressure reducing device for bed.<br><br>Record review of Resident #1's care plan with an initiation date of 03/03/25 reflected, [Resident #1] has stage 2 pressure injury to right gluteus, DTI to left heel, DTI to right heel with an initiation date of 03/05/25 and with interventions that included, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate with an initiation date of 03/05/25.<br><br>Record review of Resident #1's physician's orders revealed orders for Mattress: Pressure Reduction, with directions of every shift with a start date of 03/04/25 and a status of active.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #1's physician's orders revealed an order for Silver sulfADIAZINE External Cream 1 % (Silver Sulfadiazine) with directions to Apply to Buttocks and Coccyx every shift for Skin<br><br>breakdown with a start date of 03/03/25 and a status of active.<br><br>Record review of Resident #1's physician's orders revealed an order for Venelex External Ointment<br><br>(Balsam Peru Castor Oil) with directions to Apply to Bilateral heels topically every shift for skin breakdown, with a start date of 03/03/25 and an end date of 04/01/25.<br><br>Record review of Resident #1's TAR revealed, Resident #1's physician order for, Mattress: Pressure Reduction was unsigned on the day shift of 03/09/25 and 03/23/25 and was unsigned for the night shifts on 03/04/25, 03/07/25, 03/08/25, 03/13/25, 03/17/25-03/20/25, 03/26/25, 03/27/25 and 03/31/25 for a total of 13 unsigned sections.<br><br>Record review of Resident #1's TAR revealed, Resident #1's physician order for, Silver sulfADIAZINE External Cream 1 % (Silver Sulfadiazine) Apply to Buttocks and Coccyx every shift for Skin breakdown was unsigned on the day shift of 03/09/25 and 03/23/25 and was unsigned for the night shifts on 03/04/25, 03/07/25, 03/08/25, 03/13/25, 03/17/25-03/20/25, 03/26/25, 03/27/25 and 03/31/25 for a total of 13 unsigned sections.<br><br>Record review of Resident #1's TAR revealed Resident #1's physician order for, Venelex External Ointment (Balsam Peru Castor Oil) Apply to Bilateral heels topically every shift for skin breakdown, was unsigned on the day shift of 03/09/25 and 03/23/25 and was unsigned for the night shifts on 03/04/25, 03/07/25, 03/08/25, 03/13/25, 03/17/25-03/20/25, 03/26/25, 03/27/25 and 03/31/25 for a total of 13 unsigned sections.<br><br>During an interview on 04/16/25 at 6:28 a.m., RN B stated she worked with Resident #1 on the night shifts for March 4th, 7th,8th,13th,17th,18th, 26th, 27th, 31st, 2025 and was responsible for signing off on the TAR for those shifts and dates. RN B stated the nurses were responsible for checking residents pressure reducing mattress and were responsible for signing off for any treatment orders for skin impairments. RN B reviewed Resident #1's March 2025 TAR and stated she was not sure what the blanks on the TAR meant but did confirm there were multiple unsigned areas on Resident #1's TAR as well on the dates and shifts she worked with him. RN B stated on the days and shifts she worked she ensured Resident #1 had his pressure reduction mattress in place and stated she applied his treatments as orders but did not sign off on the TAR and stated she should have signed off the TAR but stated she probably was going so fast and forgot to go back and clear them off. RN B stated she had been trained within the last year on signing off the TAR when providing ordered treatment by their previous DON. RN B did not recall the facility policy over documentation of treatment administered and stated not accurately documenting the administration of ordered treatments could negatively impact residents because it will look like the order is always pending and would not let you know if the other shifts provided the treatment or not and things could fall through the cracks.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 2. Record review of Resident #2's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without hypoglycemia (low blood sugars) without coma, chronic systolic (congestive) (left ventricle lose ability to contract normally and the heart cant with enough force to push enough blood into circulation) heart failure, hyperlipidemia (abnormally high levels of lipids (fat) in the blood) and essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #2's Medicare 5-day MDS assessment, dated 02/27/25, revealed Resident #2 had a BIMS score of 11, indicating his cognition was moderately impaired. Section M - skin conditions reflected Resident #2 was at risk for developing pressure ulcers/injuries, had no unhealed pressure ulcers/injuries, one venous (wounds that are caused by problems with blood flow in veins) and arterial ulcer ( wounds resulting from inadequate blood flow to tissue) present, had diabetic foot ulcer(s), moisture associated skin damage (MASD), had a pressure reducing device for bed and had application of non-surgical dressings (with or without topical medications) other than to feet.<br><br>Record review of Resident #2's care plan with an initiation date of 04/16/25 reflected problems such as, [Resident #2] has an arterial of the left dorsum foot, [Resident #2] has a stage 2 pressure injury to left gluteus and unstageable pressure injury to left heel and [Resident #2] has actual impairment to skin integrity of the sacrum r/t (related to) MASD and impairment to skin integrity of the penis r/t (related to) surgical wound. All 3 problem areas had initiation dates of 04/16/25 and all had an intervention of, Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Resident #2 also had a problem that read, [Resident #2] has Diabetes Mellitus with an initiation date of 04/16/25 and interventions including, Monitor/document/report PRN any s/sx of hypoglycemia: Sweating, Tremor, Increased heart rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait. With an initiation date of 04/16/25.<br><br>Record review of Resident #2's nursing note with an effective date of 04/25/25 and a created date of 05/08/25 at 12:38pm by the DON stated he had confirmed with LVN A that Resident #2 had refused blood glucose checks on 04/25/25.<br><br>Record review of Resident #2's physician orders revealed orders for HumuLIN R Injection Solution 100 UNIT/ML (Insulin Regular (Human)) with a start date of 04/16/25 and an end date of indefinite.<br><br>Record review of Resident #2's order summary report revealed orders for Mattress: Pressure Reduction, with a directions of every shift with a start date of 02/25/25 and no end date noted, with a status of discontinued.<br><br>Record review of Resident #2's order summary report revealed orders for Black scab to left heel. Cleanse with NS (normal saline), pat dry, apply Betadine cast, cover with kerlix and secure with tape. With directions of one time a day for Black scab healing with a start date of 02/25/25 and no end date noted, with a status of discontinued.<br><br>Record review of Resident #2's order summary report revealed orders for MASD @ [at] Sacrum: Cleanse with Dakin's, pat dry, apply Silvadene and cover with Mepilex dressing. Daily with direction of, one time a day for Skin Abrasion with Red discoloration with a start date of 03/06/25 and no end date noted, with a status of discontinued.<br><br>(continued on next page) |

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|---|---|---|---|
| | 676083 | A. Building<br>B. Wing | 05/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Brownsville Nursing and Rehabilitation Center | 320 Lorenaly Dr<br>Brownsville, TX 78520 |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #2's order summary report revealed orders for Open wound to Penis area. Cleanse with NS (normal saline), pat dry, apply TAO (triple antibiotic ointment), and leave open to air. With directions of one time a day for Open wound healing with a start date of 02/25/25 and no end date noted, with a status of discontinued.<br><br>Record review of Resident #2's order summary report revealed orders for Silvadene External Cream 1 %<br><br>(Silver Sulfadiazine) with direction to Apply to Left [NAME] (top surface of) foot topically one time a day for Scab healing, with a start date of 02/25/25 and no end date noted, with a status of discontinued.<br><br>Record review of Resident #2's order summary report revealed orders for Skin abrasion and red<br><br>discoloration to Sacrum area. Cleanse with NS (normal saline), pat dry, apply Medihoney and cover with Mepilex dressing. Daily. With directions of one time a day for Skin Abrasion with Red discoloration, with a start date of 02/25/25 and no end date noted, with a status of discontinued.<br><br>Record review of Resident #2's order summary report revealed orders for Venelex External Ointment<br><br>(Balsam Peru Castor Oil) with direction to Apply to Sacrum topically two times a day for Skin Abrasion with Red discoloration, with a start date of 02/25/25 and no end date noted, with a status of discontinued.<br><br>Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, Mattress: Pressure Reduction with a start date of 02/25/25 and a D/C (discontinue) date of 03/15/25 was unsigned for the night shifts on 03/05/25, 03/10/25, 03/11/25 for a total of 3 unsigned sections.<br><br>Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, Black scab to left heel. Cleanse with NS (normal saline), pat dry, apply Betadine cast, cover with kerlix and secure with tape. With directions of one time a day for Black scab healing with a start date of 02/25/25 and D/C (discontinue) date of 03/15/25 was unsigned for the day shifts on 03/01/25, 03/08/25, 03/09/25 for a total of 3 unsigned sections.<br><br>Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, MASD @ [at] Sacrum: Cleanse with Dakin's, pat dry, apply Silvadene and cover with Mepilex dressing. Daily with direction of, one time a day for Skin Abrasion with Red discoloration with a start date of 03/06/25 and D/C (discontinue) date of 03/15/25 was unsigned for the day shifts on 03/08/25, 03/09/25 for a total of 2 unsigned sections.<br><br>Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, Open wound to Penis area. Cleanse with NS (normal saline), pat dry, apply TAO (triple antibiotic ointment), and leave open to air. With directions of one time a day for Open wound healing with a start date of 02/25/25 and D/C (discontinue) date of 03/15/25 was unsigned for the day shifts on 03/01/25, for a total of 1 unsigned section.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, Silvadene External Cream 1 % (Silver Sulfadiazine) with direction to Apply to Left [NAME](top surface of) foot topically one time a day for Scab healing, with a start date of 02/25/25 and D/C (discontinue) date of 03/15/25 was unsigned for the day shifts on 03/01/25, 03/08/25, 03/09/25 for a total of 3 unsigned sections.<br><br>Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, Skin abrasion and red discoloration to Sacrum area. Cleanse with NS (normal saline), pat dry, apply Medihoney and cover with Mepilex dressing. Daily. With directions of one time a day for Skin Abrasion with Red discoloration, with a start date of 02/25/25 and D/C (discontinue) date of 03/05/25 was unsigned for the day shifts on 03/01/25, for a total of 1 unsigned section.<br><br>Record review of Resident #2's March 2025 TAR revealed Resident #2's physician order for, Venelex External Ointment(Balsam Peru Castor Oil) with direction to Apply to Sacrum topically two times a day for Skin Abrasion with Red discoloration, with a start date of 02/25/25 and D/C (discontinue) date of 03/11/25 was unsigned for the day shifts on 03/01/25, 03/08/25 03/09/25 and the night shifts on 03/02/25 -03/07/25, and 03/10/25 for a total of 10 unsigned sections.<br><br>Record review of Resident #2's April 2025 MAR revealed Resident #2's physician order for, HumuLIN R Injection Solution 100 UNIT/ML (Insulin Regular (Human))<br><br>Inject as per sliding scale:<br><br>if 150 - 199 = 2 units;<br><br>200 - 249 = 4 units;<br><br>250 - 299 = 6 units;<br><br>300 - 349 = 8 units;<br><br>350 - 399 = 10 units;<br><br>400 - 450 = 10 units CALL MD,<br><br>subcutaneously before meals and at bedtime for DM with a start date of 04/16/25 was unsigned on 04/25/25 at 1600 (4:00pm) and did not include blood glucose reading for a total of 1 unsigned section.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 04/16/25 at 6:16 a.m., LVN C stated she worked with Resident #2 on the night shift on 03/13/25 and was responsible for signing off on the TAR for those shifts and dates. LVN C stated it depended on who was responsible for checking residents pressure reducing mattress because they also had med aides and stated nurses were responsible for signing off the skilled nursing TAR. LVN C stated a blank on the TAR meant it was not signed. LVN C reviewed Resident #2's March 2025 TAR and confirmed there were multiple unsigned areas on Resident #2's TAR as well on the date and shift she worked with him. LVN C stated on the days and shifts she worked she ensured Resident #2 had his pressure reduction mattress in place and stated she applied his treatments as ordered but did not sign off on the TAR on 03/13/25 for Resident #2's pressure reduction mattress and stated he did have it in place at that time. LVN C stated she should have signed off the TAR but stated she maybe did not see it right at that time and did not know why she did not sign. LVN C stated she had been trained monthly on signing off the TAR when providing ordered treatment by their leadership staff. LVN C stated their facility policy stated they had to document treatments provided and sign off on the TAR. LVN C stated because she did not sign off on Resident #2's TAR she did not follow the facility policy. LVN C stated not accurately documenting the administration of ordered treatments could negatively impact residents because it could cause skin risks.<br><br>During an interview on 04/16/25 at 7:45 p.m., LVN D stated she worked with Resident #2 on March 2nd, 5th, 6th, 10th, 11th, and 14th. LVN D stated if residents pressure reduction mattress was on the medication administration record (MAR) then the nurses were responsible. For checking and singing off. LVN D stated the nurse on shift was responsible for signing off for any treatment provided for skin impairment. LVN D stated she would not know what a blank on the TAR meant and stated she did not think there was a specific answer. LVN D reviewed Resident #2's March 2025 TAR and confirm there were multiple unsigned areas on Resident #2's TAR as well on the date and shift she worked with him. LVN D stated on the days and shifts she worked she ensured Resident #2 had his pressure reduction mattress in place. LVN D stated she could not specifically recall if she provided Resident #2 with his treatments for skin impairments or not and was not sure why she did not sign off the TAR. LVN D stated she should have signed off the TAR. LVN D stated she had been trained a couple of months prior on signing off the TAR by the Administrator and the facility ADONs. LVN D was not sure of the facility policy related to documentation of treatments provided. LVN D stated not accurately documenting the administration of treatments to residents could cause med errors and confusion with no clarification.<br><br>During an interview with LVN M on 05/08/25 at 6:29 pm she confirmed she worked with Resident #2 on 04/25/25. LVN M stated the nurses were responsible for singing off on the residents MAR's and stated she was responsible for singing off on Resident #2's MAR on 04/25/25. LVN M stated a blank on the MAR indicated it was not signed off. LVN M stated on 04/25/25 Resident #2 had refused his orders for blood sugar check and insulin. LVN M stated she did not sign off on Resident #2's MAR because she forgot to go back and double check that. LVN M stated she should have coded the MAR appropriately for a refusal. LVN M stated she had been trained over signing off on the MAR and stated the last time was within the last 30 days and was provided by the DON and Regional Clinical Specialist. LVN M stated she did not know the facility policy regarding documentation policy. LVN M stated not accurately coding a residents MAR could have a big impact that could be serious because if you don't give a resident a medication that needed to be given it could hurt the resident.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Record review of Resident #7's face sheet, dated 04/16/25, revealed the resident was an [AGE] year-old male who was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes mellitus (insufficient production of insulation causing high blood sugar) without complication, heart failure (when the heart cant pump enough blood to meet the body's need), acute (sudden) respiratory failure (air sacs of lungs cannot release enough oxygen into the blood) with hypoxia (low levels of oxygen), essential (primary) hypertension (high blood pressure).<br><br>Record review of Resident #7's admission Medicare 5 -day MDS assessment, dated 04/23/25, revealed Resident #7 had a BIMS score of 06, indicating his cognition was severely impaired. Resident #7's section N - medications reflected Resident #7 was taking insulin.<br><br>Record review of Resident #7's care plan that was retrieved on 05/07/25 revealed, the resident has Diabetes Mellitus with an initiation date of 05/07/25/25 and with interventions that included, Educate regarding medication and importance of compliance. And Fasting Serum Blood Sugar as ordered by doctor with an initiation date of 05/07/25.<br><br>Record review of Resident #7's progress note with an effective date of 05/05/25 and a created date of 05/07/25 at 6:11pm by LVN D stated it was a late entry and that Resident #7 refused blood sugar check at that time.<br><br>Record review of Resident #7's physician's orders revealed orders for Accu checks (blood glucose check) as ordered before meals and at bedtime with an indication of use for glucose checks with a start date of 04/21/25 at 1600 (4:00pm) and an end date of 04/22/25.<br><br>Record review of Resident #7's physician's orders revealed orders for HumuLIN R injection solution (insulin) 100 UNIT/ML, with directions of inject subcutaneously before meals and at bedtime for glucose sliding scale with a start date of 04/21/25 at 1600 (4:00pm) and an indefinite end date.<br><br>Record review of Resident #7's April and May's 2025 MAR revealed Resident #7's physician order for, Accu checks (blood glucose check) as ordered before meals and at bedtime with directions of before meals and at bedtime for glucose checks revealed Resident #7 had his blood glucose checks on 04/21/25 at his scheduled time of 1600 (4:00pm) with a reading of 140, which indicated he did not require insulin.<br><br>Record review of Resident #7's April and May's 2025 MAR revealed Resident #7's physician order for, HumuLIN R Injection Solution 100 UNIT/ML (Insulin Regular (Human))<br><br>Inject as per sliding scale:<br><br>if 0 - 149 = 0 units;<br><br>150 - 199 = 2 units;<br><br>200 - 249 = 4 units;<br><br>250 - 299 = 6 units;<br><br>300 - 349 = 8 units;<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 350 - 399 = 10 units<br><br>if bs is greater than 400, give insulin and call MD, subcutaneously before meals with a start date of 04/21/25 was unsigned for and did not include blood glucose documentation on 04/21/25 at the scheduled time of 1600 (4:00pm) and on 05/05/25 at the scheduled time of 2100 (9:00pm) for a total of 2 unsigned sections.<br><br>During an interview on 04/16/25 at 4:12 p.m., ADON E stated the nurses was responsible for checking and singing off on resident's pressure reduction mattress. ADON E stated the treatment nurse was responsible for signing off on the resident's treatment for skin impairments Monday - Friday from 8am-5pm and stated on the weekends it was the charge nurse and at night it was the nurse who was responsible. ADON E stated a blank on the TAR meant it was not done. ADON E reviewed Resident #1's and #2's March 2025 TAR and confirm there were multiple unsigned areas on Resident #1 and Resident #2's TAR. ADON E was not exactly sure who worked on the days identified with unsigned spots but stated the nurses would have been responsible for providing and signing off on the TAR. ADON E stated she had not spoken to staff to see if treatment had been provided on the days and shifts that were unsigned. ADON E stated normally if there was an order for a pressure reducing mattress it was in place, but they just did not sign it off. ADON E stated staff should have signed off on the TAR when providing treatment to residents. ADON E stated her and ADON F and the Administrator had provided staff a training over documentation of completing orders the week prior. ADON E stated the facility policy stated that treatments administered needed to be documented and stated in this situation staff had not followed the facility policy. ADON E stated not accurately documenting the administration of ordered treatment could negatively impact residents because they may go untreated and that could lead to a wound getting deeper, bigger or infected.<br><br>During an interview and record review with LVN I on 05/08/25 at 6:40pm she confirmed she worked with Resident #7 on 04/21/25 but did not recall that day. LVN I stated the nurses were responsible for singing off on the residents MAR's and stated she was responsible for singing off on Resident #7's MAR on 04/21/25. LVN I stated she recalled previously providing Resident #7 insulin but could not recall the specifics on 04/21/25. LVN I stated she would have to review her MAR to indicate what a blank on the MAR meant. LVN I reviewed the copy of Resident #7's April MAR on this Surveyor's computer, LVN I stated she did see the blank, unsigned area on 04/21/25. LVN I did not know why it was not signed and did not remember and stated she should have signed it or input the appropriate code. LVN I stated she had previously been trained over signing off on the MAR when administering physician orders within the last 7 days by the Regional Clinical Specialist and the DON. LVN I stated their facility policy stated they needed to make sure to document any refusal or if they gave the medication as a progress note or on the MAR itself. LVN I stated she did follow her policy in this situation. LVN I stated not accurately documenting to coding a residents MAR could negatively impact them because it would not reflect if they did or did not get their medication. LVN I requested to review her MAR on her computer and identified that she had documented Resident #7's blood sugar on 04/21/25 at 17:35 (5:35pm) as 140 and stated he would not require insulin at that reading.<br><br>LVN D was attempted to be reached via phone call on 05/08/25 at 7:11pm however attempt was unsuccessful. Voicemail was left for LVN however no call back was received.<br><br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview and record review with the DON on 05/08/24 at 7:14pm he stated the skilled nurses on the floor were responsible for signing off on the MAR for Resident #2 and Resident #7 on 04/21/25, 04/25/25 and 05/05/25. The DON stated he had spoken to and verified with LVN M who worked with Resident #2 on 04/25/25 and LVN D who worked with Resident #7 on 05/05/25. The DON stated the Regional Clinical Specialist had spoken to the nurse responsible for Resident #7 on 04/21/25. The DON stated that LVN D and LVN M had told him that Resident #2 refused blood sugar checks on 04/25/25 and Resident #7 refused on 05/05/25. The DON reviewed the April 2025 MAR for Resident #2 and April and May 2025 MAR for #7 with unsigned areas and confirmed there were left unsigned. The DON stated this meant that either the nurse had forgotten to document or missed the documentation or had not saved it properly. The DON Stated it was not signed because the nurses were busy and sometimes, they forgot to go back and document after attempts. The DON stated staff should have signed on the MAR or input the corresponding codes for refusal. The DON stated staff had been trained over MAR documentation, and stated an Inservice was completed with LVN D and M over the phone and stated LVN D was brought back to the facility to finish the documentation. The DON stated he did not have any formal documentation of the in-service provided. The DON stated the facility policy stated there should always be documentation and a progress note and stated if a patient refuses the system will prompt a progress note. The DON stated prior to being notified by this surveyor staff had not followed the facility policy in this situation but did after they were notified. The DON stated not accurately coding or documenting on residents MAR could negatively impact them because they could be a little more hyperglycemic.<br><br>During an interview and record review on 05/08/25 at 7:25pm with the Regional Clinical Specialist he stated Resident #7 had double orders with 1 for blood sugar checks and 1 with the sliding scale. The Regional Clinical Specialist stated Resident #7 had a blood glucose of 140 on 04/21/25 and did not need any units of insulin.<br><br>Record review of facility in service training report dated 04/11/25 covered accurate documentation on the MAR and TAR revealed the training had been completed by RN B, LVN C, LVN D, ADON E and LVN M.<br><br>Record review of facility policy titled Documentation in Medical Record with an implementation date of 10/24/2022 stated, 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. and b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the residents care and or response to care. and c. documentation shall be timely and in chronological order. and f. Sign each entry with name and credentials of the person making the entry. |