STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676408	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Nursing and Rehabilitation	3729 Ira E Woods Avenue Grapevine, TX 76051

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview, and record review, the facility failed to consult with the resident's physician of a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for one (Resident #1) of five residents reviewed for resident rights. The facility failed to notify the MD when Resident #1, who was a diabetic resident, had an elevated and abnormal lab with a blood glucose of 334 on 09/17/24, followed by a deterioration through 10/06/24 of his willingness to eat. Resident #1 had a change in condition which included him becoming unresponsive on 10/06/24. Resident #1 was sent to the hospital on 10/06/24 and was found to have a blood glucose reading of 1,139 (Normal glucose range for a person with diabetes who has well-controlled levels is 72-99 while fasting and up to 140 about 2 hours after eating) and an Hemoglobin A1C (three month average of blood sugar) of 13 (normal range is below 5.7). An Immediate Jeopardy (IJ) situation was identified on 10/23/24 at 4:42 PM. The IJ template was provided to the facility's Administrator on 10/23/24 at 4:50 PM. While the Immediate Jeopardy was removed on 10/25/24, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to implement and monitor the effectiveness of its corrective systems. This failure could place residents at risk for not receiving timely medical intervention as needed and ordered by the physician, of not having their health condition monitored timely for changes in condition, which could result in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. Findings included: (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's Face Sheet dated 10/23/24 reflected the resident was a [AGE] year-old male admitted to the facility on [DATE] with active diagnoses that included Type 2 Diabetes, Hemiplegia and Hemiparesis (weakness on one side of the body), Aphasia (a communication disorder that impairs a person's ability to process language), Dysphagia (difficulty swallowing), Systemic Lupus Erythematosus (a chronic autoimmune disease that can cause severe fatigue and joint pain), Hyperlipidemia (high levels of fat in the blood), Vascular Dementia (a type of dementia caused by brain damage due to impaired blood flow), Epilepsy (seizure disorder), COPD (persistent respiratory symptoms like breathlessness and cough), Functional Quadriplegia (complete immobility due to move)Atherosclerotic Heart Disease (heart disease where plague builds up in the arterial walls). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected minimal difficulty with hearing, unclear speech, sometimes understood and usually understood others, and no vision issues. Resident #1 was assessed as having a BIMS score of 15. He had no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #1 had range of motion impairment in both sides of his upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLs to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was always incontinent of bowel and bladder, he had a gastrostomy tube (a surgically placed device that provides direct access to the stomach for supplemental feeding, hydration or medication). Resident #1's assessment reflected he was not prescribed any insulin during the assessment period. Record review of an updated BIMS form in Resident #1's clinical chart completed on 10/21/24 by the SLP completed he Speech therapy assessment reflected a BIMS score of 00, which indicted severe cognitive impairment. Record review of Resident #1's care plan initiated 01/11/22 and last revised on 10/07/24 reflected, [Resident #1] has the potential for complication hypo-hyperglycemia r/t Diabetes, Date Initiated: 02/11/2022/Revision on: 08/02/2022; .Interventions: Resident will be free from s/s of hypo-hyperglycemia daily through next 90day review (Date Initiated: 02/11/2022, Revision on: 09/30/2024), Blood glucose as ordered (Date Initiated: 10/21/2024), Labs as ordered (Date Initiated: 02/11/2022), Monitor for s/s of HYPERGLYCEMIA i.e polyuria, polydipsia, dimmed/blurred vision, fruity breath, nausea, vomiting, abdominal pain, extreme weakness, confusion, stupor, weight loss-HYPOGLYCEMIA i.e.: tachycardia, palpitations, cool/clammy skin, diaphoresis, nervousness, tremors, lethargy, vision changes (Date Initiated: 02/11/2022), Notify MD at once if s/s occur (Date Initiated: 02/11/2022). Record review of Resident #1's physician orders for the past 12 months (10/01/2023 through 10/23/2024) reflected no orders for insulin, oral diabetic medication, blood glucose monitoring or routine A1C labs. Resident #1 did not have a physician's order to check his blood glucose routinely or PRN. (Note: Hypoglycemia occurs when the glucose levels in the blood are elevated, typically above 180 to 200 mg. If not managed, it can lead to severe complications such as nerve damage, kidney failure, and cardiovascular diseases). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #1's clinical chart to include previous hospital documentation, revealed that part of his pertinent medical history occurred when he went to the hospital on 01/29/22 when he experienced a change of condition at the facility. At that time, he was not a known diabetic and it was not a diagnosis listed in his clinical chart at the facility nor at the hospital. At the hospital, he was UA positive for high white blood cell count and a rare bacteria (name not listed in hospital documentation), his A1C was 7.9 and his blood glucose was 611 and he was septic due to likely severe dehydration. Resident #1 was stabilized and discharged back to the facility with new orders for insulin to be administered and a diagnosis of diabetes mellitus. Record review of nurse practitioner encounter progress note dated 10/26/22 by a previous extender for MD G reflected she reviewed Resident #1's past medical history, which she documented had not been done since 02/05/22. The DNP reviewed Resident #1's previous stay at the hospital on 01/29/22. The DNP stated that Resident #1 had been admitted to the ER due to weakness, cough, SOB, low sats and hypotension. The DNP noted Resident #1 was started on sepsis protocol at the hospital and antibiotics and was admitted to ICU. His labs showed a glucose of 611 and he was admitted with severe dehydration, sepsis, hyperglycemia, AKI, hypotension and metabolic acidosis. The DNP documented that on 08/10/22, the facility staff asked if the insulin Lantus could be discontinued. DNP stated, Pt seen in dining hall, doing well, no complaints. BS trends reviewed, BS well controlled with some BS on low side. Lantus d/c'ed. There was no documentation to reflect if Resident #1 would continue to receive routine or periodic blood glucose monitoring at the facility to monitor his diabetes. Record review of Resident #1's e-chart under the vitals sections reflected the following blood glucose readings were last ones recorded and taken by the facility and were over a year old: (10/05/2023)-BS 142, (09/07/2022 two years earlier)-BS 100. Prior to that, Resident #1's blood glucose was being taken three to four times a day by the nurses since his discharge from a ER hospital stay on 01/09/22 when he was readmitted to the facility and he was receiving a diabetic-formulated enteral feed as a supplement through his g-tube daily. Blood glucose readings during that time vacillated from 74 at the lowest to 295 at the highest, all while he was being administered insulin on a routine basis to control his hyperglycemia. There was no evidence that the blood glucose checks were discontinued by the MD in 2022 and 2023. Record review of Resident #1's completed metabolic panel lab completed on 09/17/24 reflected a high glucose level of 334 [reference range is 65-110). Record review of Resident #1's nursing progress notes after the abnormal lab value for his blood glucose on 09/17/24 reflected there was no documentation that the MD or NP was notified of Resident #1's elevated blood glucose or that his blood glucose was checked by the charge nurses after that. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of progress notes after the elevated blood glucose level on 09/17/24, reflected Resident #1 was not eating and the speech therapist was notified and his diet was changed to finger foods. Resident #1 continued to not eat and sustained a fall after losing his balance. On 10/06/24, he was noted in a nursing progress note to be throwing up and hiccupping continuously. At that time, his vitals were taken and were: Blood pressure 122/64, Pulse 99, Respirations 20, Temperature 97.8, Oxygen saturation at 97. On 10/06/24, Resident #1 was not able to eat breakfast and refused when the staff attempted to feed him. His attending physician [MD G] was notified and gave a new order to start IV Nacl0.9 % @ 100 ml/hr. x 2 liters, CBC, CMP and UA Stat. The progress note reflected, In a little moment before IV inserted, resident observed lethargic, more confused, B/S was reading HI on the machine, then started having SOB, [MD G] called again and recommended resident to be send out to ER [written by RN A]. Record review of Resident #1's hospital documentation reflected he was admitted to theER on [DATE] at 2:18 PM. In the critical care unit, he was diagnosed with DKA (diabetic ketoacidosis) and severe sepsis. Resident #1's blood glucose was 1139 and his A1C was 13. Hospital documentation by the physician reflected a concern that Resident #1 was diabetic and his decline was, Likely triggered by infection, ? Compliance, not clear that SNF was giving insulin- Fluid resuscitation with 2100 L NS bolus EMS and ED. Resident #1 received hourly finger sticks initially upon admission to the hospital and was placed on an NPO diet until the DKA resolved. Resident #1 was started on Lantus. Resident #1 met the Sepsis criteria and was administered antibiotics which included Rocephin by EMS and Zosyn and Vancomycin in ED. Resident #1 was also diagnosed with an AKI (acute kidney injury) which was noted to likely be secondary to severe dehydration. The ICU physician documented that all interventions provided by the hospital were necessary to prevent further life-threatening deterioration and/or death from conditions listed in the assessment and plan. Resident #1 remained in ICU for four days. On 10/10/24, Resident #1 was seen in the hospital by the Nephrologist who documented Resident #1 had Hyperkalemia, Likely secondary to uncontrolled blood sugars and potassium shifts. Resident #1 was discharged from the hospital back to the facility on [DATE] with orders for insulin glargine-Lantus 100 unit/mL injection-Inject 20 Units under the skin daily (start 10/18/24) and insulin lispro-Humalog Inject 0-15 Units into the skin 3(three) times daily with meals (start 10/18/24). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the Administrator and DON on 10/23/24 at 9:40 AM, revealed Resident #1 was sent to the hospital because he was unresponsive, sweating and had vomited. When he arrived at the ER, the hospital found him to have a high blood sugar and urine concentration. The family told the Administrator and DON Resident #1's blood glucose was over 1,000 and he was dehydrated. The DON stated Resident #1 had a peg-tube that was used for flushing and for administering his Keppra medication since he did not like the taste of it. The DON stated his peg-tube was flushed four times a day to make sure he was well-hydrated. The DON stated Resident #1 was also on two cans of Glucerna a day and he ate three meals a day with no restrictions and could drink by mouth. The DON stated she started employment at the facility in April 2024 and found that one of the previous DONs discontinued Resident #1's Lantus and insulin because his blood sugars were in the 80s and 90s. Since then, the DON stated the facility was doing a CBC, CMP and A1C every six months for Resident #1 and the values were normal. She stated the facility checked labs for Resident #1 in September 2024 and his sugar was a little high, but that was drawn right after his meal. Doctor said all previous readings were good, the doctor did not give new orders. After that he was well. The DON stated on weekend after that, Resident #1 was a little tired on a Friday night and by that next Sunday the nurse reported he looked very lethargic, So we sent him out. At the hospital, the DON stated his blood sugar was high but nothing had triggered the facility to place him back on insulin prior to that. She stated Resident #1's family was upset that the facility was not checking and monitoring Resident #1's blood sugar. The DON stated she explained to the family that Resident #1's diabetes was diet controlled and he was not showing signs or symptoms of hyperglycemia and was coming to the dining room every day and eating everything. She said Resident #1's weight was stable plus the nurses were flushing his peg tube four times a day. After the hospitalization , the Administrator and DON stated they had a care plan meeting with Resident #1's RP and the doctor covering for Resident #1's primary attending physician [Phy B] for about two hours. The meeting concerned whether or not the RP wanted to re-admit Resident #1 back to the facility's care. The DON stated there was an NP or PA at the hospital who had told Resident #1's RP that he should have not been in the condition he was in, although he had been here without many real issues for the past two years. The Administrator state that he explained to the RP about labs and how doctors prescribed medications to residents based on those lab values. The Administrator stated, I think she was off guard that he wasn't taking insulin. He stated at a second meeting, the Ombudsman was present and told the facility they needed to look at how frequently CNAs correctly observed and documented his meal intake because she felt it was not accurate. The DON stated a week before Resident #1 was sent to the ER, they started noticing he was being picky and they changed his diet to finger foods and he was doing okay with it. The Administrator stated Resident #1 was in the ICU for a while, But our system worked; we identified, sent him out and they saved his life. Since his discharge from the hospital back to the facility, the DON stated Resident #1 now had a continuous order for g-tube feedings during the night, 150 cc of water flushes every four hours, blood glucose checks three times daily and an order for Lantus sliding scale plus Lantus 20 units every morning. The DON stated that Resident #1 was not interviewable and only responded in the affirmative or negative, but not much. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A follow up interview with the DON on 10/23/24 at 12:38 PM, revealed she checked Resident #1's clinical records and discontinued orders to see when Resident #1 took his last dose of insulin at the facility. She stated the last time she saw that he got insulin was the month of February 2022 and blood sugar checks were stopped at some point in 2022 but she did not know why. The DON stated there were no routine blood sugar checks for Resident #1 at the facility since then but his CBC, CMP and A1C were routinely checked. The DON stated an A1C labs gave a three month look back at a resident's average blood glucose and the last one completed was in February 2024. The DON stated, We are a little late on getting the most recent one done. There is no time-frame but is the labs are in good range or a little high, they do them every six months. More than 10 (value) for an A1C and it is critical then we do the A1C every three months. She stated Resident #1 would have been due for an A1C in August 2024. She said a BMP was done in September 2024 which showed Resident #1 had a blood glucose reading of 334 but it was right after breakfast so PHY B told the DON to look at the time of the blood drawn and did not want another one drawn. The DON stated that diabetic residents should have an A1C lab completed every six months and that is was not a policy, it was standard practice. She stated she had not read the facility's policy on Diabetic Management since she started employment as the DON. In hindsight, the DON stated, If it were me, I would have questioned the blood sugar of over 300 and maybe rechecked it if I were the doctor, but he said it was due to the resident eating breakfast. The DON could not say if anyone at the facility had re-checked Resident #1's blood sugar once the abnormal lab came back. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with PHY B on 10/23/24 at 1:33 PM, revealed the last time he saw Resident #1 was when he came back from the hospital in October 2024. PHY B stated, I don't recall seeing him in 2024. Usually we see the long term once a year and a NP who sees him once a month, I may not have seen him this year at all. With abnormal labs, PHY B stated sometimes the facility would text him right away, routine labs were supposed to be faxed to his office number and put in PCC and he could review the lab for the skilled residents when he came to the facility twice a week. For long-term residents, like Resident #1, the NP mostly ordered labs and were supposed to review then and if there was any action needing to be taken, they will. He stated Resident #1 was long-term, so NP C would have been the one notified of his abnormal lab, not him. Phy B stated he was not notified about Resident #1's abnormal blood sugar of 334 on 09/17/24 until after the resident had a change of condition and was sent out to the hospital and the RP voiced concerns about Resident #1's care. Phy B stated for diabetic residents, if they were not prescribed insulin, then the recommendation was for them to have a A1C every six months, even if they were stable with their routine blood sugar checks. He stated that monitoring guideline was from the geriatric college of medicine and the blood glucose values for residents in a long-term care facility were done twice a year. Phy B stated he had gone back and reviewed Resident #1's chart after his ER visit and saw that he was on insulin in 2022 and at that time his sugars were running normal but it appeared that someone at that time decided to discontinue his insulin. Phy B stated that was not unusual because, We all know in diabetic patients they have a honeymoon period where their blood sugars are okay and we continue to monitor and take them off treatment because we don't want low blood sugars in nursing home patients because a lot of them can't communicate and tell us symptoms like [Resident #1]. Phy B stated once a resident's blood sugar went low and they are in a hypoglycemic state, it could be detrimental for their health, That is why we let their blood sugars run a little higher, even if the A1C is a little higher. So I think it wasn't unusual to do that and two years he did not have any problems. Phy B speculated that he felt Resident #1 had an infection which he felt was a common reason of putting a person into DKA-diabetic ketoacidosis, and Resident #1 also had a wound at the hospital which could have contributed to it as well. Phy B then stated, The only thing I identified to be honest with you, could still be the same outcome on our end, I am the first one to take blame, there wasn't oversight on our part that the A1C was not done in 6 months, it had last been done in February and it should have been done in August so we take blame for that. I told the [RP] that as well because it happened on my watch and I was supposed to oversee his care. It is a problem and I have asked the DON to implement a protocol for A1C every six months. So now, since this happened, we have asked the facility on their end to put an automatic protocol where they do them every six months- hemoglobin A1C. Phy B said the only thing he saw missing in Resident #1's care was that the A1C was not completed. He said that going in DKA was possible even in a fully controlled diabetic resident in a few days to a few hours, however, it was an unfortunate thing that happened and he took full responsibility for the lab not being done, it was a mistake and the facility was rectifying the problem. Phy B said that it would be hard to say if he would have acted on Resident #1's blood glucose level being over 300, he would have told the facility to check it a few more times to make sure it was not trending up. If he was trending up, then he would no longer be in the honeymoon period with his diabetes and they would need to start treating him for it. Phy B said all labs were supposed to be reviewed by himself or the NP C and for Resident #1, NP C should have reviewed them at that time. Additionally, the change of status should have been reported to him or the NP C because that was important information. If the facility did not notify him, then there is no way for him to know if the resident was having a change in condition. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the DOR on 10/24/24 at 12:29 PM revealed Resident #1 had expressive aphasia and could only speak a few words. The DOR did not specify a specific time/date, but stated before Resident #1 was sent to the hospital, the staff had come to her within a week or so prior saying that he was not wanting to eat, he complained about the food and he was sending it back to the kitchen. The DOR stated, So we adjusted for finger foods for better compliance. The DOR said Resident #1 came back from the hospital in October 2024 and was picked up for speech services. Record review of a Dietary Note dated 09/24/24 reflected, Resident was observed in the dining room during lunch time that he was not properly eating regular texture, after speaking to the resident and ST he agreed to change him to finger foods. An interview with LVN D on 10/25/24 at 12:43 PM revealed she worked with Resident #1 two days before he was sent to the hospital and to her, he did not seem different and had gone to the dining room to eat, picked at his lunch, but that was not unusual. She said she gave him supplement shakes and often had a hard time to get him to drink water. LVN D stated she knew She stated typically when a lab came back abnormal or critical, the nurse receiving the lab results was supposed to document it in a nursing note and put it in the 24-hour communication log. Then the nurse was supposed to report the results to the NP or MD and they were supposed to provide interventions or a new plan to start that resident on insulin. LVN D stated she did not know why Resident #1 was not prescribed insulin anymore. She said he had not been on insulin since she came back to work for the facility in December 2023 and she said maybe the facility thought it was controlled. With diabetics, LVN D said of they were not on insulin and not on weekly checks to make sure their blood sugars are stable, then they were supposed to get A1C every six months. She stated the MD was supposed to write that routine order into the online e-chart system and then it would generate on the MAR each time it was due. LVN D stated again she did not see much of a change in Resident #1 but could see how he became dehydrated since because it was hard for them to get him to drink water, but his blood sugars going up, I was not expecting that. (continued on next page)

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	676408	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Creek Nursing and Rehabilitation	3729 Ira E Woods Avenue Grapevine, TX 76051

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with CNA F on 10/25/24 at 1:35 PM, revealed she was Resident #1's CNA on the morning shifts and was present at the facility when he was sent out to the hospital. CNA F stated that whole week Resident #1 had not been feeling good, he was not eating. She took care of him every day and said he did not communicate, he did not eat, he did not want to drink water. On Saturday 10/05/24, he was still not feeling well, not eating, just lying in bed and was restless. CNA F told the charge nurse (RN A) and she looked at him but that was when CNA F was leaving for the end of her shift. CNA F stated she thought the facility would send him out to the hospital. But when she came in the next morning, Sunday 10/06/24, she went to the nurses' station and asked the overnight nurse how Resident #1 was doing because CNA F assumed he had been sent out the day prior based on his deteriorating condition. The overnight nurse said he was fine. So CNA F walked to Resident #1's room and the roommate at that time told her that Resident #1 had been making barking sounds all night long. When CNA F saw Resident #1, he was making squeaking sounds, which was unusual. He was sweating and throwing the blankets off of him. She said he was usually cold natured, so that was different for him as well. She said Resident #1 could not keep his eyes open when she tried to rouse him and talk to him. She was trying to ask him basic questions but he was not responding and was making a hiccupping sound. CNA F said the roommate told her no one came to check on Resident #1 throughout the night prior. CNA F then went to the overnight nurse again and told her that Resident #1 did not look right. The overnight nurse went to check on him along with another weekend nurse on the hall (name unknown). They checked Resident #1's oxygen saturation levels which were at 78. He was given oxygen and the nurses re-checked his O2 and it was still down at 78. It eventually started to come back up but he was still making the strange noise and then started throwing up watery yellowish bile, Like someone who had not eaten for a long time. CNA F said the morning nurse, RN A (same nurse as day before) came onto the floor and checked on him. CNA F said she told RN A the way Resident #1 was looking, he needed to be sent out. RN A then told CNA F she was going to send him out and contacted the DON and said Resident #1 was not looking good. The DON then told RN A, per CNA F, no, do not send him out because the facility's census was low, so RN A did not send him out to the hospital. Instead, CNA F said RN A said she would get an order for an IV and she did, but she did not know how to insert the line. CNA F said she was present and RN A did not even attempt to insert the IV. She told CNA F that she did not know how to do it, which part of the arm to access and that she could not find a vein. CNA F stated, I am asking her you are not going to send him out? And she says I need to try the IV with water, then that was when she said she didn't know how. So then, she didn't do anything. CNA F stated RN A tried to check his blood sugar, then told CNA F that Resident #1 might not even be a diabetic. She stated she was present when RN A and another nurse were in the room trying to get a blood sugar reading when the other nurse asked RN A if Resident #1 was a diabetic and RN A responded no. CNA F stated she never heard them say a blood sugar out loud, so she did not think they were able to get one. CNA F then stated later on, It was so frustrating because he was weak and now it's noon and he can't hold up his arms or legs. Around noon, CNA F said she was shaking Resident #1, his eyes would not open and he was breathing fast. She said told the nurses if his RP found out Resident #1 was in that condition, she was going to be very upset. CNA F stated, I said you got to send him out! She said at this point, the 2-10pm CNAs were coming into work and one of them tells her, wow, he is still like this? RN A responded to that CNA that she was overridden by the DON. CNA F stated, Now he was getting worse, [RN A] ended up sending him out. I told her he is a full code and has been like this all day and you have let this happen your whole shift and passing it along to the next shift, so she finally sent him out. It looked like he was dying. He had never been like that before. He had been declining for that past week since I had taken care of him, not eating. CNA F said she had told the weekday nurse earlier in the week to see if maybe they could do a UA or labs, but she did not know if any of that got done. CNA F stated, He should have been sent out Saturday. If the DON would not have intervened and said no, he would have been able to be sent out the day before things got worse. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of the facility's Diabetes-Clinical Protocol policy, revised November 2020, reflected: .Monitoring and [NAME] [TRUNCATED]

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record review, the facility failed to make prompt efforts by the facility to resolve grievances the resident may have, receive and track grievances through to their conclusions; leading any necessary investigations by the facility; and the facility failed to ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued for one (Resident #2) of two residents reviewed for resident rights. The facility failed to complete and/or provide a grievance form when the RP for Resident #2 verbally voiced numerous concerns about the resident's care; nor was there evidence the facility completed an investigation to ensure the concerns were promptly addressed and rectified and documented the resolution of the grievance. This failure could place residents at risk with unresolved grievances and unmet care needs. Findings included: Record review of Resident #2's Face Sheet dated 10/25/24 reflected she resident was an [AGE] year old female who admitted to the facility on [DATE] and had active diagnoses which included dementia and Parkinson's disease. Record review of Resident #2's admission MDS assessment dated [DATE] reflected she had a BIMS score of 11, which indicated moderate cognitive impairment. Resident #2's mood score was a 23, with issues related to feeling down, depressed, trouble with appetite and energy, and issues with concentration. Resident #2 was frequently incontinent of bowel and bladder and was dependent on toileting hygiene. Resident #2 had two unstageable deep unstageable pressure injuries, surgical wounds and moisture-associated skin damage. Resident #2 required pressure ulcer/injury care, surgical wound care, applications of ointments/medications other than to feet, and application of dressings to feet. Resident #2 was taking the following high-risk medications: an anticoagulant, diuretic, opioid and hypoglycemic medication and received physical, speech and occupational therapy. An interview with Resident #2's RPs on 10/23/24 at 5:37 PM, revealed they had numerous concerns about the resident's care that had not been addressed after numerous vocal attempts to bring it to the facility staff, DON and Administrator's attention. The RPs stated the concerns involved: 1. Gabapentin (a medicine used to treat partial seizures, nerve pain from shingles and restless leg syndrome) was added to Resident #2's medication regime, without MPOA approval and involvement in the treatment decision. 2. Grievances not being addressed when brought up with the facility staff and management. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's RP stated she was livid after seeing Resident #2 in the condition she was in at the doctor's appointment. When they came back to the facility from that appointment on 10/07/24, she made sure everyone knew that she was upset and the CNA and nurse cleaned the resident and ADON E was also made aware. The RP stated Resident #2's wheelchair cushion was so saturated that when she lifted it out of the wheelchair, urine dripped onto the floor. She had to take it home and wash it, which took three days to completely clean and dry it out. The RP also stated the heel wound that was on Resident #2's foot was caused by the staff not consistently putting the heel protector boot on or if they did, the heel boot was not applied correctly to be effective, as the RP had witnessed on numerous occasions. She said when the heel boot was observed off, she would have to remind the staff to put it on. The RP said prior to that, the wound on her heel had been healing beautifully and the wound care doctor had been taking great care of her. However, when the wound suddenly worsened, the wound care doctor and the podiatrist both told the RP that is was a result of the staff not applying the heel protector boot on her foot as ordered. She said the heel protector boot was supposed to be worn 24/7 and the podiatrist ordered its use in the beginning of August 2024. Resident #2's RP also said that Resident #2 also had a small dime size wound on her coccyx that was being treated with barrier cream that worsened due to a concern the staff were not re-positioning and off-loading her bottom. The RP said she observed Resident #2 also be showered during that time with no dressing in place, which she felt allowed grime and germs to get into her wound. She said when she saw that, she went crazy livid. She walked up and down the hall of the facility with a photo of the worsened wound. She said the CNAs that worked with Resident #2 were also upset when they saw the photos because they told her Resident #2's skin did not look like that when they had last worked with her the week before. The RP stated as a direct result of the worsening wound, Resident #2 had to have a PICC line with an antibiotic Vancomycin (an antibiotic that fights bacteria in the intestines) twice a day. She said the wound doctor had to come out and debride the wound and the infectious disease doctor was called in who said she did as much debridement as she could but could not make it to healthy skin. The following week the wound care doctor was able to make it to Resident #2's healthy skin during the next debridement and after a week or two the wound started improving. The RP felt the most of the staff were good, but very busy, They are working under an untenable situation. She said one day she came to the facility and saw that the PICC line was not adhered properly to Resident #2 and had not been changed. She asked the DON what the policy was for changing the PICC line and the DON told her every seven days. However, the last date on the dressing was 10/11/24, so she said seven days had passed. The DON told the RP she would let the charge nurse know and dressed the nurse down in front of the RP, which the RP thought was disrespectful, embarrassing and unprofessional and does not address the issue. She said the facility promised they would train the staff on the heel protector boots but she did not think they followed through with it. The RP stated on 10/23/24, Resident #2 had not been changed out of her dirty clothes and was still observed to be wearing the clothing she had on from the day before. The RP also observed a male CNA try to put Resident #2 to bed and she had the bandage on her wound on her coccyx and tried to do peri care by wiping feces out from underneath the dressing where he had gotten in. She reported her concern to the Administrator at that time because she and the DON were not copasetic. The RP said the Administrator told her he would write up a grievance for her but never followed up with her about it. The RP said she was never told that Resident #2 was seen by a pain management doctor and new orders given for a new medication Gabapentin that did not address the pain because that medication was more for nerve pain, which was not what Resident #2 had. The RP stated, This is all upsetting, I've told the Administrator. She [Resident #2] deserves dignity and respect. She is not being cared for, not turning her, not putting her call light in reach, the urine soaked cushion. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Resident #2 on 10/23/24 at 5:45 PM revealed she had not been changed and was wet when she was at the doctor's appointment and that the call light was often not in reach. Resident #2 said she was often in pain due to her Parkinson's, her wound and it hurt up and down her backbone and It is not a little [pain]. I scream so they all know. Review of the facility's grievances for the past 60 days reflected there were none for Resident #2. Record review of a blank grievance form indicated the following areas were to be completed when there was a grievance/concern: (Page one) Date Reported:_____ Time:_____ Grievance/Concern:_____ Communicated to:_____ Communicated via: _____ Concern about:_____ Describe in detail your concern_____ Name of Witness (if applicable):_____ Immediate corrective action required? Yes or No; If yes, describe _____ This section completed by: _____ (Page 2-This page to be completed by Investigating Committee) Staff Member(s) assigned responsibility for the investigation/Assigned by/Date Assigned/Due Date:_____ Department impacted by grievance:_____ Account of resident/witness/staff as applicable:_____ Findings of investigation:_____ Recommendations for corrective action:_____ Results of Action Taken:_____ (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reported to State Agency or other Local Agency:_____ This section completed by/Date:_____ Resolution-Complaint Grievance resolved. Yes/No, If no, specify further follow-up:_____ Is complaint/grievance satisfied?_____ Complainant Remarks:_____ Investigation results and resolution steps were reported to: Family/Resident/Resident Council Results communicated via: Verbal/Written/Other Signature of Resident/Guest Advocate/Date:_____ Signature of Grievance Official completing this section/Date:_____ Signature of Administrator:_____ An interview with the Administrator on 10/23/24 at 7:06 PM, revealed he did not have any grievances for Resident #2. He stated the RP had come to him with some concerns the week prior, but he did not complete a grievance form. He stated the RP did not like how the DON had talked to her and also had some care concerns related to Resident #2. The Administrator stated the issue had to do with an appointment that Resident #2 was supposed to be at and at the appointment, Resident #2 was soiled and it appeared she had not been checked on or changed for a long time. The Administrator stated when he investigated it, it appeared Resident #2 had gone to therapy that morning of the appointment and the CNA had claimed she checked her brief prior to going to therapy. After therapy, she did not come back to her room and went directly to the appointment, it was last minute due to confusion on if the appointment was cancelled or not, So they hurried her out. The Administrator said he met with Resident #2's CNA about the proper process for checking a resident after clocking into work. The Administrator stated he did not know there were any issues related to Resident #2's pain medication. He said he met with Resident #2's RP about the concern and it was discussed that maybe a Fentanyl patch would provide her a more steady supply of pain management, but he was leaving the facility so he did not document a grievance related to it. The Administrator stated about two to three weeks ago, Resident #2 had a pressure ulcer on her bottom and there was no dressing on it after a shower and the daughter brought the concern to him. The Administrator stated, To be honest, the [RP] that lives here, brings me a concern every day. She is here a lot, every day, takes pictures of things, but at the same token when I speak to her, I feel like her concerns are validated and let her know we can address them .She is a very anxious person. The Administrator stated the RP was concerned Resident #2 was giving up her will to live and felt she was on a downward route. Regarding grievances, the Administrator stated it was a judgement call whether or not something was a grievance, Because with [Resident #2], the [RP] will bring up a grievance every day, to be honest, I don't want my staff all the time to create grievance forms. I feel like we are addressing her concerns. The Administrator said there was another issue with a wound on Resident #2's heel which happened when she was at the facility for skilled rehab and her offloading boot was digging into her foot, but that was the first time he had received a concern. The Administrator stated the following day (10/24/24) the facility DON and himself were going to have a meeting with Resident #2's RP. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Corporate Registered Nurse on 10/24/24 at 11:20 AM, revealed he had participated in a meeting with Resident #2's family that morning (10/24/24) and he did not know why the facility had not completed any grievances prior to that meeting about the RP's issues, But they seemed to be making progress with the family and hearing their concerns. The Corporate Registered Nurse stated that most of the RP's issues seemed to be about staffing. He said, But the facility staffs at a higher rate than most facilities and that was explained to them. An interview with ADON E on 10/25/24 at 1:27 PM, revealed when there was a grievance voiced by a resident's RP, as the ADON, she would go and assess the resident and address the concerns lodged by the RP or the resident and after that, We tell them to fill out the [grievance] form and then see if we need to retrain or educate staff; we need to implement what was lacking and we keep following up. ADON E said the reason a grievance form needed to be completed by the staff or by the person lodging the concern was so that everyone who worked with that resident understood what was lacking in their care and everyone had equal responsibility to know what was going on and the solution, That is why we do grievances and not just handle it. ADON E stated the social services staff was responsible for gathering the grievance forms and making sure they went to the right department. If it could not be solved, then management needed to be consulted to see if there was anything further that could be done. An interview with the DON on 10/25/24 at 1:57 PM, revealed with Resident #2, some of the issues presented to her by the RP were that the resident got a new wound, there were concerns about the resident's clothing not being changed and then a concern about Resident #2's brief being changed. The DON stated she did talk with the RP about therapy and who was responsible for changing Resident #2 when she was soiled. The DON stated that the issue brought up recently by Resident #2's RP was related to incontinent care. A CNA who provided care to Resident #2 thought therapy had changed the resident and therapy thought the CNA had changed the resident, as a result, Resident #2 was sent to a doctor's appointment wet with urine. Resident #2's RP came to the DON and expressed her complaint. The DON went to the social services staff (SS H) and SS H went to the CNA and disciplined her for not providing incontinent care prior to the doctor's appointment because, It is her job, not therapy's. The DON said moving forward, she had now instructed the van driver to make sure residents were clean and not soiled with urine or feces prior to a doctor's appointment. The DON stated, We did everything and resolved it, but after that, still yesterday, [RP] is still talking about the same thing. The DON said the facility provided the RP a grievance the day prior (10/24/24) but she had not given it back yet. She said the RP wanted to fill one out, that was why the Administrator gave her one. She stated the day prior was the first time the RP mentioned any concerns with the staff and had never mentioned it before. With the boot, the DON said Resident #2's RP always talked to the wound nurse who took care of any concerns and the DON also reminded the CNAs when the boot should be placed on her feet. The DON felt that Resident #2's RP did not voice anything that would rise to a grievance level, we took care of it. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 10/25/24 at 2:32 PM. revealed that relating to grievances for Resident #2, I can't say where my notes went from our conversation with [Resident #2's RP] but I do feel like the concerns were voiced that day she [Resident #2] went out and was wet. The Administrator stated Resident #2's RP had come to him after that appointment the day it happened and was very upset. The RP reported to him that Resident #2 was soiled and what was the facility going to do about it. The Administrator said he did an investigation and interviewed a lot of people, including therapy. He said he needed to be better at documenting the grievances lodged by family members but it was a challenge because he was out on the floor a lot. The Administrator stated he had a meeting with Resident #2's RP the day prior (10/24/24) and the RP was bringing up issues from three weeks prior, so he told her to write up her concerns and gave her a grievance form. An email correspondence with Resident #2's RP on 10/28/24 at 12:16 AM, revealed on Thursday, 10/24/24, the Administrator approached her and asked her if she had ever seen a grievance form and handed her one. She reminded him that during one of their previous conversations, he had offered to complete it for her. The RP said, [The Administrator] looked upward then said 'Uhhh, I don't think I did. I'll check on that'. The RP stated, I don't believe you will find a grievance form noting my concerns for [Resident #2's] care. This would also explain why my questions were not answered. Review of the facility's Recording and Investigating Grievances/Complaints, policy, revised April 2017, reflected: All grievances filed with the facility will be investigated and corrective action will be taken to resolve the grievance(s); .2. Upon receiving a grievance and complaint report, the grievance officer will begin an investigation into the allegations, 3. The department director(S) of any named employe will be notified of the nature of the complaint and that an investigation is underway, .5. The grievance officer will record nd maintain all grievances and complaints on the 'Resident Grievance Complaint Log', .6. The 'Resident Grievance/Complaint Investigation Report Form' will be filed with the administrator within five (5) working days of the incident, 7. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within _____[blank] working days of the filing of the grievance or complaint, 8. The grievance officer will coordinate actions with the appropriate state and federal agencies depending on the nature of the allegations. All alleged violations of neglect, abuse and or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation or property, as per state law.

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record review, the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for one (Resident #1) of five residents reviewed for neglect. 1. The facility neglected to ensure Resident #1 who was a diabetic resident, was accurately assessed, monitored and treated for a change in condition he had when he had an elevated and abnormal lab with a blood glucose of 334 on 09/17/24, followed by a deterioration through 10/06/24 of his willingness to eat. Resident #1 had a change in condition which included him becoming unresponsive on 10/06/24. Resident #1 was sent to the hospital on 10/06/24 and was found to have a blood glucose reading of 1,139 (Normal glucose range for a person with diabetes who has well-controlled levels is 72-99 while fasting and up to 140 about 2 hours after eating) and an Hemoglobin A1C (three month average of blood sugar) of 13 (normal range is below 5.7). 2. The facility neglected to have a system in place for Resident #1, who was no longer on hyperglycemic medication, to have routine blood glucose monitoring in the facility via daily, weekly or monthly checks for the past 12 months. 4. The facility neglected to complete an Hemoglobin A1C on Resident #1 every six months to monitor any increases in his blood glucose. An Immediate Jeopardy (IJ) situation was identified on 10/23/24 at 4:42 PM. The IJ template was provided to the facility's Administrator on 10/23/24 at 4:50 PM. While the Immediate Jeopardy was removed on 10/25/24, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to implement and monitor the effectiveness of its corrective systems. This failure could place residents at risk for not receiving timely medical intervention as needed and ordered by the physician, of not having their health condition monitored timely for changes in condition, which could result in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. Findings included: Record review of Resident #1's Face Sheet dated 10/23/24 reflected the resident was a [AGE] year old male admitted to the facility on [DATE] with active diagnoses that included Type 2 Diabetes, Hemiplegia and Hemiparesis (weakness on one side of the body), Aphasia (a communication disorder that impairs a person's ability to process language), Dysphagia (difficulty swallowing), Systemic Lupus Erythematosus (a chronic autoimmune disease that can cause severe fatigue and joint pain), Hyperlipidemia (high levels of fat in the blood), Vascular Dementia (a type of dementia caused by brain damage due to impaired blood flow), Epilepsy (seizure disorder), COPD (persistent respiratory symptoms like breathlessness and cough), Functional Quadriplegia (complete immobility due to move)Atherosclerotic Heart Disease (heart disease where plague builds up in the arterial walls). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected minimal difficulty with hearing, unclear speech, sometimes understood and usually understood others, and no vision issues. Resident #1 was assessed as having a BIMS score of 15. He had no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #1 had range of motion impairment in both sides of his upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLS to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was always incontinent of bowel and bladder, he had a gastrostomy tube (a surgically placed device that provides direct access to the stomach for supplemental feeding, hydration or medication) Resident #1's assessment reflected he was not prescribed any insulin during the assessment period. Record review of an updated BIMS form in Resident #1's clinical chart completed on 10/21/24 by the SLP when she completed he Speech therapy assessment reflected a BIMS score of 00, which indicted severe cognitive impairment. Record review of Resident #1's care plan initiated 01/11/22 and last revised on 10/07/24 reflected, [Resident #1] has the potential for complication hypo-hyperglycemia r/t Diabetes, Date Initiated: 02/11/2022/Revision on: 08/02/2022; .Interventions: Resident will be free from s/s of hypo-hyperglycemia daily through next 90day review (Date Initiated: 02/11/2022, Revision on: 09/30/2024), Blood glucose as ordered (Date Initiated: 10/21/2024), Labs as ordered (Date Initiated: 02/11/2022), Monitor for s/s of HYPERGLYCEMIA i.e polyuria, polydipsia, dimmed/blurred vision, fruity breath, nausea, vomiting, abdominal pain, extreme weakness, confusion, stupor, weight loss-HYPOGLYCEMIA i.e.: tachycardia, palpitations, cool/clammy skin, diaphoresis, nervousness, tremors, lethargy, vision changes (Date Initiated: 02/11/2022), Notify MD at once if s/s occur (Date Initiated: 02/11/2022). Record review of Resident #1's physician orders for the past 12 months (10/01/2023 through 10/23/2024) reflected no orders for insulin, oral diabetic medication, blood glucose monitoring or routine A1C labs. Resident #1 did not have a physician's order to check his blood glucose routinely or PRN. (Note: Hypoglycemia occurs when the glucose levels in the blood are elevated, typically above 180 to 200 mg. If not managed, it can lead to severe complications such as nerve damage, kidney failure, and cardiovascular diseases). Review of Resident #1's clinical chart to include previous hospital documentation, revealed that part of his pertinent medical history occurred when he went to the hospital on 01/29/22 when he experienced a change of condition at the facility. At that time, he was not a known diabetic and it was not a diagnosis listed in his clinical chart at the facility nor at the hospital . At the hospital, he was UA positive for high white blood cell count and a rare bacteria (name not listed in hospital documentation), his A1C was 7.9 and his blood glucose was 611 and he was septic due to likely severe dehydration. Resident #1 was stabilized and discharged back to the facility with new orders for insulin to be administered and a diagnosis of diabetes mellitus. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of nurse practitioner encounter progress note dated 10/26/22 by a previous extender for MD G reflected she reviewed Resident #1's past medical history, which she documented had not been done since 02/05/22. The DNP reviewed Resident #1's previous stay at the hospital on 01/29/22. The DNP stated that Resident #1 had been admitted to the ER due to weakness, cough, SOB, low sats and hypotension. The DNP noted Resident #1 was started on sepsis protocol at the hospital and antibiotics and was admitted to ICU. His labs showed a glucose of 611 and he was admitted with severe dehydration, sepsis, hyperglycemia, AKI, hypotension and metabolic acidosis. The DNP documented that on 08/10/22, the facility staff asked if the insulin Lantus could be discontinued. DNP stated, Pt seen in dining hall, doing well, no complaints. BS trends reviewed, BS well controlled with some BS on low side. Lantus d/c'ed. There was no documentation to reflect if Resident #1 would continue to receive routine or periodic blood glucose monitoring at the facility to monitor his diabetes. Record review of Resident #1's clinical chart reflected the following blood glucose readings were last ones recorded and taken by the facility and were over a year old: (10/05/2023)-BS 142, (09/07/2022 two years earlier)-BS 100. Prior to that, Resident #1's blood glucose was being taken three to four times a day by the nurses since his discharge from a ER hospital stay on 01/09/22 when he was readmitted to the facility and he was receiving a diabetic-formulated enteral feed as a supplement through his g-tube daily. Blood glucose readings during that time vacillated from 74 at the lowest to 295 at the highest, all while he was being administered insulin on a routine basis to control his hyperglycemia. There was no evidence that the blood glucose checks were discontinued by the MD in 2022 and 2023. Record review of Resident #1's completed metabolic panel lab completed on 09/17/24 reflected a high glucose level of 334 (reference range is 65-110). Record review of Resident #1's nursing progress notes after the abnormal lab value for his blood glucose on 09/17/24 reflected there was no documentation that the MD or NP were notified of Resident #1's elevated blood glucose or that his blood glucose was checked by the charge nurses after that. Dietary and nursing progress notes after the elevated blood glucose level reflected Resident #1 was not eating; the speech therapist was notified and his diet was changed to finger foods. Resident #1 continued to not eat and sustained a fall after losing his balance. On 10/06/24, he was noted in a nursing progress note to be throwing up and hiccupping continuously. At that time, his vitals were taken and were: Blood pressure 122/64, Pulse 99, Respirations 20, Temperature 97.8, Oxygen saturation at 97. On 10/06/24, Resident #1 was not able to eat breakfast and refused when the staff attempted to feed him. His attending physician [MD G] was notified and gave a new order to start IV Nacl0.9 % @ 100 ml/hr. x 2 liters, CBC, CMP and UA Stat. The progress note reflected, In a little moment before IV inserted, resident observed lethargic, more confused, B/S was reading HI on the machine, then started having SOB, [MD G] called again and recommended resident to be send out to ER [written by RN A]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's hospital documentation reflected he was admitted to theER on [DATE] at 2:18 PM. In the critical care unit, he was diagnosed with DKA (diabetic ketoacidosis) and severe sepsis. Resident #1's blood glucose was 1139 and his A1C was 13. Hospital documentation by the physician reflected a concern that Resident #1 was diabetic and his decline was, Likely triggered by infection, ? Compliance, not clear that SNF was giving insulin- Fluid resuscitation with 2100 L NS bolus EMS and ED. Resident #1 received hourly finger sticks initially upon admission to the hospital and was placed on an NPO diet until the DKA resolved. Resident #1 was started on Lantus. Resident #1 met the Sepsis criteria and was administered antibiotics which included Rocephin by EMS and Zosyn and Vancomycin in ED. Resident #1 was also diagnosed with an AKI (acute kidney injury) which was noted to likely be secondary to severe dehydration. The ICU physician documented that all interventions provided by the hospital were necessary to prevent further life-threatening deterioration and/or death from conditions listed the assessment and plan. Resident #1 remained in ICU for four days. On 10/10/24, Resident #1 was seen in the hospital by the Nephrologist who documented Resident #1 had Hyperkalemia, Likely secondary to uncontrolled blood sugars and potassium shifts. Resident #1 was discharged from the hospital back to the facility on [DATE] with orders for insulin glargine-Lantus 100 unit/mL injection-Inject 20 Units under the skin daily (start 10/18/24) and insulin lispro-Humalog Inject 0-15 Units into the skin 3(three) times daily with meals (start 10/18/24). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the Administrator and DON on 10/23/24 at 9:40 AM, revealed Resident #1 was sent to the hospital because he was unresponsive, sweating and had vomited. When he arrived at the ER, the hospital found him to have a high blood sugar and urine concentration. The family told the Administrator and DON Resident #1's blood glucose was over 1,000 and he was dehydrated. The DON stated Resident #1 had a peg-tube that was used for flushing and for administering his Keppra medication since he did not like the taste of it. The DON stated his peg-tube was flushed four times a day to make sure he was well-hydrated. The DON stated Resident #1 was also on two cans of Glucerna a day and he ate three meals a day with no restrictions and could drink by mouth. The DON stated she started employment at the facility in April 2024 and found that one of the previous DONs discontinued Resident #1's Lantus and insulin because his blood sugars were in the 80s and 90s. Since then, the DON stated the facility was doing a CMP, CMP and A1C every six months for Resident #1 and the values were normal. She stated the facility checked labs for Resident #1 in September 2024 and high sugar was a little high, but that was drawn right after his meal. Doctor said all previous readings were good on that sugar, the doctor did not give new orders. After that he was well. The DON stated on weekend after that, Resident #1 was a little tired on a Friday night and by that next Sunday the nurse reported he looked very lethargic, So we sent him out. At the hospital, the DON stated his blood sugar was high but nothing had triggered the facility to place him back on insulin prior to that. She stated Resident #1's family was upset that the facility was not checking and monitoring Resident #1's blood sugar. The DON stated she explained to the family that Resident #1's diabetes was diet controlled and he was not showing signs or symptoms of hyperglycemia and was coming to the dining room every day and eating everything. She said Resident #1's weight was stable plus the nurses were flushing his peg tube four times a day. After the hospitalization , the Administrator and DON stated they had a care plan meeting with Resident #1's RP and the doctor covering for Resident #1's attending ([NAME]) for about two hours. The meeting concerned whether or not the RP wanted to re-admit Resident #1 back to the facility's care. The DON stated there was an NP or PA at the hospital who had told Resident #1's RP that he should have not been in the condition he was in, although he had been here without many real issues for the past two years. The Administrator state that he explained to the RP about labs and how doctors prescribed medications to residents based on those lab values. The Administrator stated, I think she was off guard that he wasn't taking insulin. He stated at a second meeting, the Ombudsman was present and told the facility they needed to look at how frequently CNAs correctly observed and documented his meal intake because she felt it was not accurate. The DON stated a week before Resident #1 was sent to the ER, they started noticing he was being picky and they changed his diet to finger foods and he was doing okay with it. The Administrator stated Resident #1 was in the ICU for a while, But our system worked; we identified, sent him out and they saved his life. Since his discharge from the hospital back to the facility, the DON stated Resident #1 now has a continuous order for g-tube feedings during the night, 150 cc of water flushes every four hours, blood glucose checks three times daily and an order for Lantus sliding scale plus Lantus 20 units every morning. The DON stated that Resident #1 was not interviewable and only responded in the affirmative or negative, but not much. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A follow-up interview with the DON on 10/23/24 at 12:38 PM revealed she checked Resident #1's clinical records and discontinued orders to see when Resident #1 took his last dose of insulin at the facility. She stated the last time she saw that he got insulin was the month of February 2022 and blood sugar checks were stopped at some point in 2022 but she did not know why. The DON stated there were no routine blood sugar checks for Resident #1 at the facility since then but his CBC, CMP and A1C were routinely checked. The DON stated an A1C labs gave a three month look back at a resident's average blood glucose and the last one completed was in February 2024. The DON stated, We are a little late on getting the most recent one done. There is no time-frame but is the labs are in good range or a little high, they do them every six months. More than 10 (value) for an A1C and it is critical then we do the A1C every three months. She stated Resident #1 would have been due for an A1C in August 2024. She said a BMP was done in September 2024 which showed Resident #1 had a blood glucose reading of 334 but it was right after breakfast so Physician B told the DON to look at the time of the blood drawn and did not want another one drawn. The DON stated that diabetic residents should have an A1C lab completed every six months and that is was not a policy, it was standard practice. She stated she had not read the facility's policy on Diabetic Management since she started employment as the DON. In hindsight, the DON stated, If it were me, I would have questioned the blood sugar of over 300 and maybe rechecked it if I were the doctor, but he said it was due to the resident eating breakfast. The DON could not say if anyone at the facility had re-checked Resident #1's blood sugar once the abnormal lab came back. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with Physician B on 10/23/24 at 1:33 PM revealed the last time he saw Resident #1 was when he came back from the hospital in October 2024. Physician B stated, I don't recall seeing him in 2024. Usually we see the long term once a year and a NP who sees him once a month, I may not have seen him this year at all. With abnormal labs, Physician B stated sometimes the facility would text him right away, routine labs were supposed to be faxed to his office number and put in PCC and he could review the lab for the skilled residents when he came to the facility twice a week. For long-term residents, like Resident #1, the NP mostly ordered labs and were supposed to review then and if there was any action needing to be taken, they will. He stated Resident #1 was long-term, so NP C would have been the one notified of his abnormal lab, not him. Phy B stated he was not notified about Resident #1's abnormal blood sugar of 334 on 09/17/24 until after the resident had a change of condition and was sent out to the hospital and the RP voiced concerns about Resident #1's care. Phy B stated for diabetic residents, if they were not prescribed insulin, then the recommendation was for them to have a A1C every six months, even if they were stable with their routine blood sugar checks. He stated that monitoring guideline was from the geriatric college of medicine and the blood glucose values for residents in a long-term care facility were done twice a year. Phy B stated he had gone back and reviewed Resident #1's chart after his ER visit and saw that he was on insulin in 2022 and at that time his sugars were running normal but it appeared that someone at that time decided to discontinue his insulin. Phy B stated that was not unusual because, We all know in diabetic patients they have a honeymoon period where their blood sugars are okay and we continue to monitor and take them off treatment because we don't want low blood sugars in nursing home patients because a lot of them can't communicate and tell us symptoms like [Resident #1]. Phy B stated once a resident's blood sugar went low and they are in a hypoglycemic state, it could be detrimental for their health, That is why we let their blood sugars run a little higher, even if the A1C is a little higher. So I think it wasn't unusual to do that and two years he did not have any problems. Phy B speculated that he felt Resident #1 had an infection which he felt was a common reason of putting a person into DKA-diabetic ketoacidosis, and Resident #1 also had a wound at the hospital which could have contributed to it as well. Phy B then stated, The only thing I identified to be honest with you, could still be the same outcome on our end, I am the first one to take blame, there wasn't oversight on our part that the A1C was not done in 6 months, it had last been done in February and it should have been done in August so we take blame for that. I told the [RP] that as well because it happened on my watch and I was supposed to oversee his care. It is a problem and I have asked the DON to implement a protocol for A1C every six months. So now, since this happened, we have asked the facility on their end to put an automatic protocol where they do them every six months- hemoglobin A1C. Phy B said the only thing he saw missing in Resident #1's care was that the A1C was not completed. He said that going in DKA was possible even in a fully controlled diabetic resident in a few days to a few hours, however, it was an unfortunate thing that happened and he took full responsibility for the lab not being done, it was a mistake and the facility was rectifying the problem. Phy B said that it would be hard to say if he would have acted on Resident #1's blood glucose level being over 300, he would have told the facility to check it a few more times to make sure it was not trending up. If he was trending up, then he would no longer be in the honeymoon period with his diabetes and they would need to start treating him for it. Phy B said all labs were supposed to be reviewed by himself or the NP C and for Resident #1, NP C should have reviewed them at that time. Additionally, the change of status should have been reported to him or the NP C because that was important information. If the facility did not notify him, then there is no way for him to know if the resident was having a change in condition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with ADON E on 10/23/24 at 2:06 PM revealed nothing dramatic had occurred with Resident #1 prior to him being sent to the hospital. ADON E stated Resident #1 was not on insulin and his A1C lab should be done every six months if there was no order for it. If there was a change in condition, then the facility needed to notify the doctor and get an order immediately and monitor to see if more frequent labs needed to be done. ADON E stated Resident #1's elevated CMP lab on 09/16/24 may have been higher than expected depending on if the lab tech was able ot get a fasting lab or if it was glucose random. She stated with an abnormal glucose reading over 300, the NP or MD was present in the facility each week so the charge nurse should have relayed the abnormal lab value to them and they could have given an order. The nurse then would need to document what the plan was, that there was an abnormal lab, even if no new orders. ADON E stated the reason to notify the doctor was to see if the resident needed insulin or oral medication for hyperglycemia. ADON E stated when a resident's lab was abnormal for high blood glucose, she would expect the charge nurse to assess the resident to see if they were eating or drinking well and doing their regular activities and also alert the doctor and communicate to them the results. If the resident was sweating, lethargic, then the nurse should know there was something going on and needed to check the resident's vitals and maybe their blood sugar. She stated, Maybe they didn't check his glucose because he had been stable. ADON E stated a resident with hypoglycemia would present with lethargy, sweating and confused. She said Resident #2 was not showing any of those signs when she rounded during the mornings and no one had reported anything to her. An interview with NP C on 10/23/24 at 2:25 PM revealed she was made aware of Resident #1's change in condition when he came back from the hospital and the facility had informed her that there were going to be new protocols that would be implemented. NP C stated the issues had to do with some lack of oversight on the facility and her/Phy B's end like Resident #1 could have had an A1C a little sooner. NP C stated she saw Resident #1 occasionally and he did not seem off to her and she had not heard from the facility that he was declining. NP C stated, In the future, we need to have a protocol in place for diabetics. I don't believe I was made aware of his high blood sugar, that would have prompted me for further testing . I would have done accuchecks, A1C and a repeat BMP. NP C stated Resident #1 had not been administered insulin even though he was diabetic because he was previously diet-managed, so he was being monitored through routine A1Cs. NP C stated, We are fixing that, there should have been a routine order. NP C stated the failure was the breakdown in communication and an oversight on their part. She said if she had heard Resident #1 was not drinking or eating, she would also check for UTI, That is my standard .this one was very unfortunate for [Resident #1], it's not okay and I hope some of those measures we are taking moving forward help. An observation and attempted interview of Resident #1 on 10/24/24 at 9:45 AM revealed he was lying in bed, the fingers on his left hand were contracted, his right leg was contracted and he was not able to articulate words verbally nor was his communication device charged and functional. There was a strong smell of feces coming from him. At the time of the observation, Resident #1 could not answer questions related to his diabetic care and change of condition that sent him to the hospital. He tugged on his bed sheet and motioned to some dark brown spots on it. When asked if he made a bowel movement and needed to be changed he nodded his head yes. After that, Resident #1 did not respond to any more questions. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the DOR on 10/24/24 at 12:29 PM revealed Resident #1 had expressive aphasia and could only speak a few words. The DOR did not specify a specific time/date, but stated before Resident #1 was sent to the hospital, the staff had come to her within a week or so prior saying that he was not wanting to eat, he complained about the food and he was sending it back to the kitchen. The DOR stated, So we adjusted for finger foods for better compliance. The DOR said Resident #1 came back from the hospital in October 2024 and was picked up for speech services. Record review of a Dietary Note dated 9/24/24 reflected, Resident was observed in the dining room during lunch time that he was not properly eating regular texture, after speaking to the resident and ST he agreed to change him to finger foods. An interview with LVN D on 10/25/24 at 12:43 PM revealed she worked with Resident #1 two days before he was sent to the hospital and to her, he did not seem different and had gone to the dining room to eat, picked at his lunch, but that was not unusual. She said she gave him supplement shakes and often had a hard time to get him to drink water. LVN D stated she knew Resident #1 had an BMP lab ordered, but was not aware of the results. She stated typically when a lab came back abnormal or critical, the nurse receiving the lab results was supposed to document it in a nursing note and put it in the 24-hour communication log. Then the nurse was supposed to report the results to the NP or MD and they were supposed to provide interventions or a new plan to start that resident on insulin. LVN D stated she did not know why Resident #1 was not prescribed insulin anymore. She said he had not been on insulin since she came back to work for the facility in December 2023 and she said maybe the facility thought it was controlled. With diabetics, LVN D said of they were not on insulin and not on weekly checks to make sure their blood sugars are stable, then they were supposed to get A1Csevery six months. She stated the MD was supposed to write that routine order into the online e-chart system and then it would generate on the MAR each time it was due. LVN D stated again she did not see much of a change in Resident #1 but could see how he became dehydrated since because it was hard for them to get him to drink water, but his blood sugars going up, I was not expecting that. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with CNA F on 10/25/24 at 1:35 PM revealed she was Resident #1's CNA on the morning shifts and was present at the facility when he was sent out to the hospital. CNA F stated that whole week Resident #1 had not been feeling good, he was not eating. She took care of him every day and said he did not communicate, he did not eat, he did not want to drink water. On Saturday 10/05/24, he was still not feeling well, not eating, just lying in bed and was restless. CNA F told the charge nurse (RN A) and she looked at him but that was when CNA F was leaving for the end of her shift. CNA F stated she thought the facility would send him out to the hospital. But when she came in the next morning, Sunday 10/06/24, she went to the nurses' station and asked the overnight nurse how Resident #1 was doing because CNA F assumed he had been sent out the day prior based on his deteriorating condition. The overnight nurse said he was fine. So CNA F walked to Resident #1's room and the roommate at that time told her that Resident #1 had been making barking sounds all night long. When CNA F saw Resident #1, he was making squeaking sounds, which was unusual. He was sweating and throwing the blankets off of him. She said he was usually cold natured, so that was different for him as well. She said Resident #1 could not keep his eyes open when she tried to rouse him and talk to him. She was trying to ask him basic questions but he was not responding and was making a hiccupping sound. CNA F said the roommate told her no one came to check on Resident #1 throughout the night prior. CNA F then went to the overnight nurse again and told her that Resident #1 did not look right. The overnight nurse went to check on him along with some other weekend nurse on the hall. They checked Resident #1's oxygen saturation levels which were at 78. He was given oxygen and the nurses re-checked his O2 and it was still down at 78. It eventually started to come back up but he was still making the strange noise and then started throwing up watery yellowish bile, Like someone who had not eaten for a long time. CNA F said the morning nurse, RN A (same nurse as day before) came onto the floor and checked on him. CNA F said she told RN A the way Resident #1 was looking, he needed to be sent out. RN A then told CNA F she was going to send him out and contacted the DON and said Resident #1 was not looking good. The DON then told RN A, per CNA F, no, do not send him out because the facility's census was low, so RN A did not send him out to the hospital. Instead, CNA F said RN A said she would get an order for an IV and she did, but she did not know how to insert the line. CNA F said she was present and RN A did not even attempt to insert the IV. She told CNA F that she did not know how to do it, which part of the arm to access and that she could not find a vein. CNA F stated, I am asking her you are not going to send him out? And she says I need to try the IV with water, then that was when she said she didn't know how. So then, she didn't do nothing. CNA F stated RN A tried to check his blood sugar, then told CNA F that Resident #1 might not even be a diabetic. She stated she was present when RN A and another nurse were in the room trying to get a blood sugar reading when the other nurse asked RN A is Resident #1 was a diabetic and RN A responded no. CNA F stated she never heard them say a blood sugar out loud, so she did not think they were able to get one. CNA F then stated later on, It was so frustrating because he was weak and now it's noon and he can't hold up his arms or legs. Around noon, CNA F said she was shaking Resident #1, his eyes would not open and he was breathing fast. She said told the nurses if his RP found out Resident #1 was in that condition, she was going to be very upset. CNA F stated, I said you got to send him out! She said at this point, the 2-10pm CNAs were coming into work and one of them tells her, wow, he is still like this? RN A responded to that CNA that she was overridden by the DON. CNA F stated, Now he was getting worse, [RN A] ended up sending him out. I told her he is a full code and has been like this all day and you have let this happen your whole shift and passing it along to the next shift, so she finally sent him out. It looked like he was dying. He had never been like that before. He had been declining for that past week since I had taken care of him, not eating. CNA F said she had told the weekday nurse earlier in the week to see if maybe they could do a UA or labs, but she did not know if any of that got done. CNA F stated, He should have been sent out Saturday. If the DON would not have intervened and said no, he would have been able to be sent out the day before things [TRUNCATED]

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive resident-centered care plan for one (Resident #1) of five residents reviewed for quality of care. 1. The facility failed to ensure Resident #1 who was a diabetic resident, was accurately assessed, monitored and treated for a change in condition he had when he had an elevated and abnormal lab with a blood glucose of 334 on 09/17/24, followed by a deterioration of his willingness to eat then a change in condition which included him becoming unresponsive. At the hospital, Resident #1 was found to have a blood glucose reading of 1,139 (Normal glucose range for a person with diabetes who has well-controlled levels is 72-99 while fasting and up to 140 about 2 hours after eating) and an Hemoglobin A1C three month average of blood sugar) of 13 (normal range is below 5.7). 2. The facility charge nurses across all shifts failed to check Resident #1's blood glucose when he experienced a decline and a change of condition during the two weeks after an abnormal lab glucose value of 334 on 09/17/24 to being sent out to the hospital on 10/06/24. Additionally, the facility did not contact the MD or NP to notify them of the elevated blood glucose level. Only prior to calling sending Resident #1 to the ER, did the charge nurse attempt to check Resident #1's blood glucose, but it could not register on the glucometer and indicated HI [high]. 3. The facility failed to have routine blood glucose monitoring in the facility via daily, weekly or monthly checks for Resident #1 for the past 12 months. 4. The facility failed to have a system in place to routinely monitor Resident #1 blood glucose via an A1C lab every six months. An Immediate Jeopardy (IJ) situation was identified on 10/23/24 at 4:42 PM. The IJ template was provided to the facility's Administrator on 10/23/24 at 4:50 PM. While the Immediate Jeopardy was removed on 10/25/24, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to implement and monitor the effectiveness of its corrective systems. This failure could place residents at risk for not receiving timely medical intervention as needed and ordered by the physician, of not having their health condition monitored timely for changes in condition, which could result in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. Findings included: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's Face Sheet dated 10/23/24 reflected the resident was a [AGE] year old male admitted to the facility on [DATE] with active diagnoses that included Type 2 Diabetes, Hemiplegia and Hemiparesis (weakness on one side of the body), Aphasia (a communication disorder that impairs a person's ability to process language), Dysphagia (difficulty swallowing), Systemic Lupus Erythematosus (a chronic autoimmune disease that can cause severe fatigue and joint pain), Hyperlipidemia (high levels of fat in the blood), Vascular Dementia (a type of dementia caused by brain damage due to impaired blood flow), Epilepsy (seizure disorder), COPD (persistent respiratory symptoms like breathlessness and cough), Functional Quadriplegia (complete immobility due to move)Atherosclerotic Heart Disease (heart disease where plague builds up in the arterial walls). Record review of Resident #1's quarterly MDS assessment dated [DATE] reflected minimal difficulty with hearing, unclear speech, sometimes understood and usually understood others, and no vision issues. Resident #1 was assessed as having a BIMS score of 15. He had no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #1 had range of motion impairment in both sides of his upper and lower extremities. Resident #1 used a wheelchair for mobility and was dependent on staff for all ADLS to include dressing, hygiene, transfers, eating and basic mobility. Resident #1 was always incontinent of bowel and bladder, he had a gastrostomy tube (a surgically placed device that provides direct access to the stomach for supplemental feeding, hydration or medication). Resident #1's assessment reflected he was not prescribed any insulin during the assessment period. Record review of an updated BIMS form in Resident #1's clinical chart completed on 10/21/24 by the SLP when she completed he Speech therapy assessment reflected a BIMS score of 00, which indicted severe cognitive impairment. Record review of Resident #1's care plan initiated 01/11/22 and last revised on 10/07/24 reflected, [Resident #1] has the potential for complication hypo-hyperglycemia r/t Diabetes, Date Initiated: 02/11/2022/Revision on: 08/02/2022; .Interventions: Resident will be free from s/s of hypo-hyperglycemia daily through next 90day review (Date Initiated: 02/11/2022, Revision on: 09/30/2024), Blood glucose as ordered (Date Initiated: 10/21/2024), Labs as ordered (Date Initiated: 02/11/2022), Monitor for s/s of HYPERGLYCEMIA i.e polyuria, polydipsia, dimmed/blurred vision, fruity breath, nausea, vomiting, abdominal pain, extreme weakness, confusion, stupor, weight loss-HYPOGLYCEMIA i.e.: tachycardia, palpitations, cool/clammy skin, diaphoresis, nervousness, tremors, lethargy, vision changes (Date Initiated: 02/11/2022), Notify MD at once if s/s occur (Date Initiated: 02/11/2022). Record review of Resident #1's physician orders for the past 12 months (10/01/2023 through 10/23/2024) reflected no orders for insulin, oral diabetic medication, blood glucose monitoring or routine A1C labs. Resident #1 did not have a physician's order to check his blood glucose routinely or PRN. (Note: Hypoglycemia occurs when the glucose levels in the blood are elevated, typically above 180 to 200 mg. If not managed, it can lead to severe complications such as nerve damage, kidney failure, and cardiovascular diseases). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of Resident #1's clinical chart to include previous hospital documentation, revealed that part of his pertinent medical history occurred when he went to the hospital on 01/29/22 when he experienced a change of condition at the facility. At that time, he was not a known diabetic and it was not a diagnosis listed in his clinical chart at the facility nor at the hospital . At the hospital, he was UA positive for high white blood cell count and a rare bacteria (name not listed in hospital documentation), his A1C was 7.9 and his blood glucose was 611 and he was septic due to likely severe dehydration. Resident #1 was stabilized and discharged back to the facility with new orders for insulin to be administered and a diagnosis of diabetes mellitus. Record review of nurse practitioner encounter progress note dated 10/26/22 by a previous extender for MD G reflected she reviewed Resident #1's past medical history, which she documented had not been done since 02/05/22. The DNP reviewed Resident #1's previous stay at the hospital on 01/29/22. The DNP stated that Resident #1 had been admitted to the ER due to weakness, cough, SOB, low sats and hypotension. The DNP noted Resident #1 was started on sepsis protocol at the hospital and antibiotics and was admitted to ICU. His labs showed a glucose of 611 and he was admitted with severe dehydration, sepsis, hyperglycemia, AKI, hypotension and metabolic acidosis. The DNP documented that on 08/10/22, the facility staff asked if the insulin Lantus could be discontinued. DNP stated, Pt seen in dining hall, doing well, no complaints. BS trends reviewed, BS well controlled with some BS on low side. Lantus d/c'ed. There was no documentation to reflect if Resident #1 would continue to receive routine or periodic blood glucose monitoring at the facility to monitor his diabetes. Record review of Resident #1's clinical chart reflected the following blood glucose readings were last ones recorded and taken by the facility and were over a year old: (10/05/2023)-BS 142, (09/07/2022 two years earlier)-BS 100. Prior to that, Resident #1's blood glucose was being taken three to four times a day by the nurses since his discharge from a ER hospital stay on 01/09/22 when he was readmitted to the facility and he was receiving a diabetic-formulated enteral feed as a supplement through his g-tube daily. Blood glucose readings during that time vacillated from 74 at the lowest to 295 at the highest, all while he was being administered insulin on a routine basis to control his hyperglycemia. There was no evidence that the blood glucose checks were discontinued by the MD in 2022 and 2023. Record review of Resident #1's completed metabolic panel lab completed on 09/17/24 reflected a high glucose level of 334 (reference range is 65-110). Record review of Resident 1's nursing progress notes after the abnormal lab value for his blood glucose on 09/17/24 reflected there was no documentation that the MD or NP were notified of Resident #1's elevated blood glucose or that his blood glucose was checked by the charge nurses after that. Dietary and nursing progress notes after the elevated blood glucose level reflected Resident #1 was not eating; the speech therapist was notified and his diet was changed to finger foods. Resident #1 continued to not eat and sustained a fall after losing his balance. On 10/06/24, he was noted in a nursing progress note to be throwing up and hiccupping continuously. At that time, his vitals were taken and were: Blood pressure 122/64, Pulse 99, Respirations 20, Temperature 97.8, Oxygen saturation at 97. On 10/06/24, Resident #1 was not able to eat breakfast and refused when the staff attempted to feed him. His attending physician [MD G] was notified and gave a new order to start IV Nacl0.9 % @ 100 ml/hr. x 2 liters, CBC, CMP and UA Stat. The progress note reflected, In a little moment before IV inserted, resident observed lethargic, more confused, B/S was reading HI on the machine, then started having SOB, [MD G] called again and recommended resident to be send out to ER [written by RN A]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's hospital documentation from reflected he was admitted to theER on [DATE] at 2:18 PM. In the critical care unit, he was diagnosed with DKA (diabetic ketoacidosis) and severe sepsis. Resident #1's blood glucose was 1139 and his A1C was 13. Hospital documentation by the physician reflected a concern that Resident #1 was diabetic and his decline was, Likely triggered by infection, ? Compliance, not clear that SNF was giving insulin- Fluid resuscitation with 2100 L NS bolus EMS and ED. Resident #1 received hourly finger sticks initially upon admission to the hospital and was placed on an NPO diet until the DKA resolved. Resident #1 was started on Lantus. Resident #1 met the Sepsis criteria and was administered antibiotics which included Rocephin by EMS and Zosyn and Vancomycin in ED. Resident #1 was also diagnosed with an AKI (acute kidney injury) which was noted to likely be secondary to severe dehydration. The ICU physician documented that all interventions provided by the hospital were necessary to prevent further life-threatening deterioration and/or death from conditions listed the assessment and plan. Resident #1 remained in ICU for four days. On 10/10/24, Resident #1 was seen in the hospital by the Nephrologist who documented Resident #1 had Hyperkalemia, Likely secondary to uncontrolled blood sugars and potassium shifts. Resident #1 was discharged from the hospital back to the facility on [DATE] with orders for insulin glargine-Lantus 100 unit/mL injection-Inject 20 Units under the skin daily (start 10/18/24) and insulin lispro-Humalog Inject 0-15 Units into the skin 3 (three) times daily with meals (start 10/18/24). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the Administrator and DON on 10/23/24 at 9:40 AM revealed Resident #1 was sent to the hospital because he was unresponsive, sweating and had vomited. When he arrived at the ER, the hospital found him to have a high blood sugar and urine concentration. The family told the Administrator and DON Resident #1's blood glucose was over 1,000 and he was dehydrated. The DON stated Resident #1 had a peg-tube that was used for flushing and for administering his Keppra medication since he did not like the taste of it. The DON stated his peg-tube was flushed four times a day to make sure he was well-hydrated. The DON stated Resident #1 was also on two cans of Glucerna a day and he ate three meals a day with no restrictions and could drink by mouth. The DON stated she started employment at the facility in April 2024 and found that one of the previous DONs discontinued Resident #1's Lantus and insulin because his blood sugars were in the 80s and 90s. Since then, the DON stated the facility was doing a CMP, CMP and A1C every six months for Resident #1 and the values were normal. She stated the facility checked labs for Resident #1 in September 2024 and high sugar was a little high, but that was drawn right after his meal. Doctor said all previous readings were good on that sugar, the doctor did not give new orders. After that he was well. The DON stated on weekend after that, Resident #1 was a little tired on a Friday night and by that next Sunday the nurse reported he looked very lethargic, So we sent him out. At the hospital, the DON stated his blood sugar was high but nothing had triggered the facility to place him back on insulin prior to that. She stated Resident #1's family was upset that the facility was not checking and monitoring Resident #1's blood sugar. The DON stated she explained to the family that Resident #1's diabetes was diet controlled and he was not showing signs or symptoms of hyperglycemia and was coming to the dining room every day and eating everything. She said Resident #1's weight was stable plus the nurses were flushing his peg tube four times a day. After the hospitalization , the Administrator and DON stated they had a care plan meeting with Resident #1's RP and the doctor covering for Resident #1's attending ([NAME]) for about two hours. The meeting concerned whether or not the RP wanted to re-admit Resident #1 back to the facility's care. The DON stated there was an NP or PA at the hospital who had told Resident #1's RP that he should have not been in the condition he was in, although he had been here without many real issues for the past two years. The Administrator state that he explained to the RP about labs and how doctors prescribed medications to residents based on those lab values. The Administrator stated, I think she was off guard that he wasn't taking insulin. He stated at a second meeting, the Ombudsman was present and told the facility they needed to look at how frequently CNAs correctly observed and documented his meal intake because she felt it was not accurate. The DON stated a week before Resident #1 was sent to the ER, they started noticing he was being picky and they changed his diet to finger foods and he was doing okay with it. The Administrator stated Resident #1 was in the ICU for a while, But our system worked; we identified, sent him out and they saved his life. Since his discharge from the hospital back to the facility, the DON stated Resident #1 now has a continuous order for g-tube feedings during the night, 150 cc of water flushes every four hours, blood glucose checks three times daily and an order for Lantus sliding scale plus Lantus 20 units every morning. The DON stated that Resident #1 was not interviewable and only responded in the affirmative or negative, but not much. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	A follow up interview with the DON on 10/23/24 at 12:38 PM revealed she checked Resident #1's clinical records and discontinued orders to see when Resident #1 took his last dose of insulin at the facility. She stated the last time she saw that he got insulin was the month of February 2022 and blood sugar checks were stopped at some point in 2022 but she did not know why. The DON stated there were no routine blood sugar checks for Resident #1 at the facility since then but his CBC, CMP and A1C were routinely checked. The DON stated an A1C labs gave a three month look back at a resident's average blood glucose and the last one completed was in February 2024. The DON stated, We are a little late on getting the most recent one done. There is no time-frame but is the labs are in good range or a little high, they do them every six months. More than 10 (value) for an A1C and it is critical then we do the A1C every three months. She stated Resident #1 would have been due for an A1C in August 2024. She said a BMP was done in September 2024 which showed Resident #1 had a blood glucose reading of 334 but it was right after breakfast so Physician B told the DON to look at the time of the blood drawn and did not want another one drawn. The DON stated that diabetic residents should have an A1C lab completed every six months and that is was not a policy, it was standard practice. She stated she had not read the facility's policy on Diabetic Management since she started employment as the DON. In hindsight, the DON stated, If it were me, I would have questioned the blood sugar of over 300 and maybe rechecked it if I were the doctor, but he said it was due to the resident eating breakfast. The DON could not say if anyone at the facility had re-checked Resident #1's blood sugar once the abnormal lab came back. (continued on next page)

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	676408	A. Building B. Wing	10/25/2024

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with Physician B on 10/23/24 at 1:33 PM, revealed the last time he saw Resident #1 was when he came back from the hospital in October 2024. Physician B stated, I don't recall seeing him in 2024. Usually we see the long term once a year and a NP who sees him once a month, I may not have seen him this year at all. With abnormal labs, Physician B stated sometimes the facility would text him right away, routine labs were supposed to be faxed to his office number and put in PCC and he could review the lab for the skilled residents when he came to the facility twice a week. For long-term residents, like Resident #1, the NP mostly ordered labs and were supposed to review then and if there was any action needing to be taken, they will. He stated Resident #1 was long-term, so NP C would have been the one notified of his abnormal lab, not him. Phy B stated he was not notified about Resident #1's abnormal blood sugar of 334 on 09/17/24 until after the resident had a change of condition and was sent out to the hospital and the RP voiced concerns about Resident #1's care. Phy B stated for diabetic residents, if they were not prescribed insulin, then the recommendation was for them to have a A1C every six months, even if they were stable with their routine blood sugar checks. He stated that monitoring guideline was from the geriatric college of medicine and the blood glucose values for residents in a long-term care facility were done twice a year. Phy B stated he had gone back and reviewed Resident #1's chart after his ER visit and saw that he was on insulin in 2022 and at that time his sugars were running normal but it appeared that someone at that time decided to discontinue his insulin. Phy B stated that was not unusual because, We all know in diabetic patients they have a honeymoon period where their blood sugars are okay and we continue to monitor and take them off treatment because we don't want low blood sugars in nursing home patients because a lot of them can't communicate and tell us symptoms like [Resident #1]. Phy B stated once a resident's blood sugar went low and they are in a hypoglycemic state, it could be detrimental for their health, That is why we let their blood sugars run a little higher, even if the A1C is a little higher. So I think it wasn't unusual to do that and two years he did not have any problems. Phy B speculated that he felt Resident #1 had an infection which he felt was a common reason of putting a person into DKA-diabetic ketoacidosis, and Resident #1 also had a wound at the hospital which could have contributed to it as well. Phy B then stated, The only thing I identified to be honest with you, could still be the same outcome on our end, I am the first one to take blame, there wasn't oversight on our part that the A1C was not done in 6 months, it had last been done in February and it should have been done in August so we take blame for that. I told the [RP] that as well because it happened on my watch and I was supposed to oversee his care. It is a problem and I have asked the DON to implement a protocol for A1C every six months. So now, since this happened, we have asked the facility on their end to put an automatic protocol where they do them every six months- hemoglobin A1C. Phy B said the only thing he saw missing in Resident #1's care was that the A1C was not completed. He said that going in DKA was possible even in a fully controlled diabetic resident in a few days to a few hours, however, it was an unfortunate thing that happened and he took full responsibility for the lab not being done, it was a mistake and the facility was rectifying the problem. Phy B said that it would be hard to say if he would have acted on Resident #1's blood glucose level being over 300, he would have told the facility to check it a few more times to make sure it was not trending up. If he was trending up, then he would no longer be in the honeymoon period with his diabetes and they would need to start treating him for it. Phy B said all labs were supposed to be reviewed by himself or the NP C and for Resident #1, NP C should have reviewed them at that time. Additionally, the change of status should have been reported to him or the NP C because that was important information. If the facility did not notify him, then there is no way for him to know if the resident was having a change in condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with ADON E on 10/23/24 at 2:06 PM revealed nothing dramatic had occurred with Resident #1 prior to him being sent to the hospital. ADON E stated Resident #1 was not on insulin and his A1C lab should be done every six months if there was no order for it. If there was a change in condition, then the facility needed to notify the doctor and get an order immediately and monitor to see if more frequent labs needed to be done. ADON E stated Resident #1's elevated CMP lab on 09/16/24 may have been higher than expected depending on if the lab tech was able ot get a fasting lab or if it was glucose random. She stated with an abnormal glucose reading over 300, the NP or MD was present in the facility each week so the charge nurse should have relayed the abnormal lab value to them and they could have given an order. The nurse then would need to document what the plan was, that there was an abnormal lab, even if no new orders. ADON E stated the reason to notify the doctor was to see if the resident needed insulin or oral medication for hyperglycemia. ADON E stated when a resident's lab was abnormal for high blood glucose, she would expect the charge nurse to assess the resident to see if they were eating or drinking well and doing their regular activities and also alert the doctor and communicate to them the results. If the resident was sweating, lethargic, then the nurse should know there was something going on and needed to check the resident's vitals and maybe their blood sugar. She stated, Maybe they didn't check his glucose because he had been stable. ADON E stated a resident with hypoglycemia would present with lethargy, sweating and confused. She said Resident #2 was not showing any of those signs when she rounded during the mornings and no one had reported anything to her. An interview with NP C on 10/23/24 at 2:25 PM revealed she was made aware of Resident #1's change in condition when he came back from the hospital and the facility had informed her that there were going to be new protocols that would be implemented. NP C stated the issues had to do with some lack of oversight on the facility and her/Phy B's end like Resident #1 could have had an A1C a little sooner. NP C stated she saw Resident #1 occasionally and he did not seem off to her and she had not heard from the facility that he was declining. NP C stated, In the future, we need to have a protocol in place for diabetics. I don't believe I was made aware of his high blood sugar, that would have prompted me for further testing . I would have done accuchecks, A1C and a repeat BMP. NP C stated Resident #1 had not been administered insulin even though he was diabetic because he was previously diet-managed, so he was being monitored through routine A1Cs. NP C stated, We are fixing that, there should have been a routine order. NP C stated the failure was the breakdown in communication and an oversight on their part. She said if she had heard Resident #1 was not drinking or eating, she would also check for UTI, That is my standard .this one was very unfortunate for [Resident #1], it's not okay and I hope some of those measures we are taking moving forward help. An observation and attempted interview of Resident #1 on 10/24/24 at 9:45 AM revealed he was lying in bed, the fingers on his left hand were contracted, his right leg was contracted and he was not able to articulate words verbally nor was his communication device charged and functional. There was a strong smell of feces coming from him. At the time of the observation, Resident #1 could not answer questions related to his diabetic care and change of condition that sent him to the hospital. He tugged on his bed sheet and motioned to some dark brown spots on it. When asked if he made a bowel movement and needed to be changed he nodded his head yes. After that, Resident #1 did not respond to any more questions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with the DOR on 10/24/24 at 12:29 PM revealed Resident #1 had expressive aphasia and could only speak a few words. The DOR did not specify a specific time/date, but stated before Resident #1 was sent to the hospital, the staff had come to her within a week or so prior saying that he was not wanting to eat, he complained about the food and he was sending it back to the kitchen. The DOR stated, So we adjusted for finger foods for better compliance. The DOR said Resident #1 came back from the hospital in October 2024 and was picked up for speech services. Record review of a Dietary Note dated 9/24/24 reflected, Resident was observed in the dining room during lunch time that he was not properly eating regular texture, after speaking to the resident and ST he agreed to change him to finger foods. An interview with LVN D on 10/25/24 at 12:43 PM revealed she worked with Resident #1 two days before he was sent to the hospital and to her, he did not seem different and had gone to the dining room to eat, picked at his lunch, but that was not unusual. She said she gave him supplement shakes and often had a hard time to get him to drink water. LVN D stated she knew Resident #1 had an BMP lab ordered, but was not aware of the results. She stated typically when a lab came back abnormal or critical, the nurse receiving the lab results was supposed to document it in a nursing note and put it in the 24-horu communication log. Then the nurse was supposed to report the results to the NP or MD and they were supposed to provide interventions or a new plan to start that resident on insulin. LVN D stated she did not know why Resident #1 was not prescribed insulin anymore. She said he had not been on insulin since she came back to work for the facility in December 2023 and she said maybe the facility thought it was controlled. With diabetics, LVN D said of they were not on insulin and not on weekly checks to make sure their blood sugars are stable, then they were supposed to get A1Csevery six months. She stated the MD was supposed to write that routine order into the online e-chart system and then it would generate on the MAR each time it was due. LVN D stated again she did not see much of a change in Resident #1 but could see how he became dehydrated since because it was hard for them to get him to drink water, but his blood sugars going up, I was not expecting that. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An interview with CNA F on 10/25/24 at 1:35 PM revealed she was Resident #1's CNA on the morning shifts and was present at the facility when he was sent out to the hospital. CNA F stated that whole week Resident #1 had not been feeling good, he was not eating. She took care of him every day and said he did not communicate, he did not eat, he did not want to drink water. On Saturday 10/05/24, he was still not feeling well, not eating, just lying in bed and was restless. CNA F told the charge nurse (RN A) and she looked at him but that was when CNA F was leaving for the end of her shift. CNA F stated she thought the facility would send him out to the hospital. But when she came in the next morning, Sunday 10/06/24, she went to the nurses' station and asked the overnight nurse how Resident #1 was doing because CNA F assumed he had been sent out the day prior based on his deteriorating condition. The overnight nurse said he was fine. So CNA F walked to Resident #1's room and the roommate at that time told her that Resident #1 had been making barking sounds all night long. When CNA F saw Resident #1, he was making squeaking sounds, which was unusual. He was sweating and throwing the blankets off of him. She said he was usually cold natured, so that was different for him as well. She said Resident #1 could not keep his eyes open when she tried to rouse him and talk to him. She was trying to ask him basic questions but he was not responding and was making a hiccupping sound. CNA F said the roommate told her no one came to check on Resident #1 throughout the night prior. CNA F then went to the overnight nurse again and told her that Resident #1 did not look right. The overnight nurse went to check on him along with some other weekend nurse on the hall. They checked Resident #1's oxygen saturation levels which were at 78. He was given oxygen and the nurses re-checked his O2 and it was still down at 78. It eventually started to come back up but he was still making the strange noise and then started throwing up watery yellowish bile, Like someone who had not eaten for a long time. CNA F said the morning nurse, RN A (same nurse as day before) came onto the floor and checked on him. CNA F said she told RN A the way Resident #1 was looking, he needed to be sent out. RN A then told CNA F she was going to send him out and contacted the DON and said Resident #1 was not looking good. The DON then told RN A, per CNA F, no, do not send him out because the facility's census was low, so RN A did not send him out to the hospital. Instead, CNA F said RN A said she would get an order for an IV and she did, but she did not know how to insert the line. CNA F said she was present and RN A did not even attempt to insert the IV. She told CNA F that she did not know how to do it, which part of the arm to access and that she could not find a vein. CNA F stated, I am asking her you are not going to send him out? And she says I need to try the IV with water, then that was when she said she didn't know how. So then, she didn't do nothing. CNA F stated RN A tried to check his blood sugar, then told CNA F that Resident #1 might not even be a diabetic. She stated she was present when RN A and another nurse were in the room trying to get a blood sugar reading when the other nurse asked RN A is Resident #1 was a diabetic and RN A responded no. CNA F stated she never heard them say a blood sugar out loud, so she did not think they were able to get one. CNA F then stated later on, It was so frustrating because he was weak and now it's noon and he can't hold up his arms or legs. Around noon, CNA F said she was shaking Resident #1, his eyes would not open and he was breathing fast. She said told the nurses if his RP found out Resident #1 was in that condition, she was going to be very upset. CNA F stated, I said you got to send him out! She said at this point, the 2-10pm CNAs were coming into work and one of them tells her, wow, he is still like this? RN A responded to that CNA that she was overridden by the DON. CNA F stated, Now he was getting worse, [RN A] ended up sending him out. I told her he is a full code and has been like this all day and you have let this happen your whole shift and passing it along to the next shift, so she finally sent him out. It look [TRUNCATED]