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F 000	INITIAL COMMENTS The survey team entered the facility on 08/09/23 to conduct a complaint investigation survey and exited on 08/10/23. Additional information was obtained on 08/15/23 through 08/18/23. Therefore, the exit date was changed to 08/18/23. 2 of the 2 complaint allegations did not result in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/05/23 and was removed on 08/10/23. A partial extended survey was conducted.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff, friend, Nurse Practitioner, Physician Assistant and Medical Director interviews, the facility failed to monitor 1 of 1 resident (Resident #1) when her blood sugar	F 684	F684 1.On 8/5/2023 at 17:47, Resident #1 blood glucose level was obtained by Nurse #1. Blood glucose level was 544.	9/8/23

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

Electronically Signed | 09/04/2023

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F 684	Continued From page 1 was dangerously high, 544 milligrams per deciliter (normal blood sugar levels are considered to be between 70mg/dL (milligrams per deciliter) to 100mg/dL). Fast-acting insulin (Humalog insulin 12 units) was administered to Resident #1 by Nurse #1 on 8/5/23 at 5:47 PM. On 8/5/23 at 9:00 PM Nurse #1 found Resident #1 unresponsive, and her blood sugar was 33mg/dL, critically low. Resident #1 was transferred to the Emergency Department unresponsive and was intubated and admitted to the Intensive Care Unit (ICU). Immediate Jeopardy began on 8/5/2023 when Nurse #1 failed to monitor Resident #1 after she had a dangerously high blood sugar. Immediate Jeopardy was removed on 8/10/2023 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level D to ensure education is completed and monitoring systems put in place are effective. Findings included: Resident #1 was admitted to the facility on 7/7/2023 with diagnoses that included end stage renal disease, dependence on renal dialysis, and Type 2 diabetes. On 7/7/2023 an order for Insulin Glargine Subcutaneous Solution 100 unit/milliliter (a long-acting insulin with effects generally beginning an hour after injection and lasts 24-36 hours) to inject 12 units subcutaneously one time a day at 6:00 AM for Diabetes Mellitus hold if blood sugar less than 100.	F 684	Nurse #1 contacted the medical provider. An order was received to administer 12 units of fast-acting insulin to Resident #1. On 8/5/2023 at 21:00, Nurse #1 entered Resident #1 room to find Resident #1 unresponsive. Nurse #1 immediately checked blood glucose level, which was 33. Nurse #1 administered Glucagon. Nurse #1 rechecked the blood glucose level after approximately 10 minutes, blood glucose level was 32. Nurse #1 administered glucagon again. Resident #1 remained unresponsive. 911 called. Resident #1 was sent out to ER (Emergency Room) for evaluation and treatment. Based upon review of hospital records upon arrival to the ER. Resident #1's blood glucose level was less than 10mg/dl. Resident #1 was intubated and placed on a ventilator. Resident #1 was admitted into the Intensive Care Unit for hypoglycemia and respiratory failure. 2. All diabetic residents who require insulin are at risk for not being monitored after insulin is given for a critically high blood glucose level; therefore an audit of current diabetic residents was conducted on 8/9/23 by the DON and Unit Managers to include the following: • Parameters for MD notification and follow-up for all diabetic residents. • Insulin hyperglycemic and hypoglycemic orders to include monitoring and when to obtain a re-check of blood glucose level per facility policy and/or physician order: 1. Blood glucose levels as needed for signs and symptoms of hypo/hyperglycemia	

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F 684	Continued From page 2 On 7/10/2023 an order for Insulin Lispro Injection Solution 100 unit/milliliter, (a fast-acting insulin that starts to work about 15 minutes after injection) was received with the following guidelines: Inject per sliding scale if blood glucose 150-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351 - 400 = 10 units subcutaneously before meals and at bedtime. Call Physician if blood sugar less than 70 or greater than 400. Resident #1 had an order for blood glucose checks to be performed before meals and at bedtime. Resident #1's care plan revised on 7/10/2023 was reviewed and contained the following information: Resident #1 had an altered endocrine system status related to diabetes with a goal to maintain blood glucose values within normal limits for the resident. The interventions included: labs/diagnostics as ordered, medications/treatments as ordered, monitor for signs and symptoms of hyperglycemia: increased thirst and appetite, weight loss, fatigue, dry skin, poor healing, muscle cramps, abdominal pain, deep labored breathing, acetone (fruity) breath, stupor, coma. Monitor for signs and symptoms of hypoglycemia: sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. The Admission minimum data set dated 7/13/2023 indicated that Resident # 1 was cognitively intact, and Resident #1 had received insulin injections 6 days out of the last 7 days and was receiving renal dialysis. A review of the Medication Administration Record revealed:	F 684	2. Monitor/document/report to provider PRN s/s of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. 3. If finger stick blood glucose is less than 70 and resident is symptomatic give orange juice, apple juice or instant glucose, recheck blood glucose level in 15 minutes. Notify provider if finger stick blood sugar remains less than 70 after protocol being followed. If finger stick blood glucose level less than 40, give IM (intramuscular) glucagon and recheck blood glucose level in 15 minutes and notify provider. After review, no further issues were identified. 3. On 8/9/23, Nurse #1 was provided one to one education by the Director of Nursing on the facility policy related to monitoring of diabetic residents after administration of fast acting insulin for any critically high blood glucose level. On 8/9/23, education was completed by the Director of Nursing and Unit Managers to all Licensed Nurses related to the facility policy on hyperglycemia and hypoglycemia. To include obtaining blood glucose levels as needed for signs and symptoms of hypo/hyperglycemia. If insulin is given for critically high blood glucose levels, the nurse must ensure the resident is monitored after administration by obtaining a re-check of the blood glucose level per physician order. Monitor/document/report to provider PRN	

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F 684	Continued From page 3 - On 8/3/2023 Resident #1's blood glucose at 5:21 AM was 215mg/dL and she received 4 units of Lispro insulin, her blood sugar was rechecked at 8:27 AM and noted to be 98 mg/dL. At 11:52 AM Resident #1 blood glucose was 248 mg/dL and received 4 units of Lispro insulin and at 4:36 PM noted blood glucose to be 131 mg/dL and no insulin was given and at 8:31 PM her blood glucose was 152 mg/dL and received 2 units of Lispro insulin. - On 8/4/2023 Resident #1's blood glucose level at 5:10 AM was 242 mg/dL and Resident #1 received Lispro insulin 4 units. At 9:38 AM her blood glucose level was rechecked and was 207 she received no insulin, her blood glucose level was rechecked again at 10:09 AM and was 207 mg/dL, she received 4 units of Lispro insulin. At dinner time Resident #1 was out of the facility, at 9:20 PM Resident #1's blood glucose level was 201 mg/dL and she received 4 units of Lispro insulin. - On 8/5/2023 included at 6:16 AM the blood glucose was 133 mg/dL Resident #1 refused her morning Glargine insulin and received no Lispro insulin, at 12:12 PM blood glucose was 233 mg/dL and Resident #1 received 4 units of Lispro insulin, at 5:35 PM blood glucose was 544 mg/dL and Resident #1 received 12 units of Lispro insulin and at 9:00PM the blood glucose was 33 mg/dL. Nursing progress note dated 8/5/2023 at 5:35 PM written by Nurse #1 read in part, Resident #1's blood glucose level was 544mg/dL. Nurse #1 did not document any signs of hyperglycemia at that time. According to the note, Nurse #1 called	F 684	s/s of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination and staggering gait. If fingerstick blood sugar is less than 70 and resident is symptomatic give orange juice, apple juice or instant glucose and recheck blood sugar in 15 minutes. Notify provider if fingerstick blood glucose remains less than 70 after protocol being followed. If fingerstick blood glucose level is less than 40, give IM (intramuscular) glucagon and recheck blood glucose level in 15 minutes and notify provider for further orders. On 8/9/23, Nurse #1 was provided one to one education by the Director of Nursing on the facility policy related to monitoring of diabetic residents after administration of fast acting insulin for any critically high blood glucose level. On 8/18/23 standing orders were updated and re-education was initiated by the Director of Nursing and Unit Managers to all licensed nurses related to the facility policy on hyperglycemia and hypoglycemia. If finger stick blood sugar is less than 70 and resident is alert and responsive, give milk and graham cracker or instant glucose. Recheck blood sugar in 15 minutes. If blood sugar remains low or resident declines taking milk and graham cracker, give insta-glucose gel 77.4% as ordered. If unconscious &/or unable to swallow and blood sugar is below 40 then inject 1 mg Glucagon intramuscular as needed for low blood sugar and recheck blood sugar in 15 minutes and notify provider. Notify provider for additional orders if fingerstick	

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F 684	Continued From page 4 telehealth Physician and received an order for a one-time dose of Humalog insulin 12 units to be given subcutaneously. A review of the Physician orders noted an order dated 8/5/2023 for Lispro insulin 12 units subcutaneously for one dose. A nursing progress note dated 8/5/2023 at 9:42 PM revealed that at 9:00 PM Nurse #1 went into Resident #1's room to administer Resident #1's medication and check her blood glucose as ordered and noted Resident #1 was unresponsive Nurse #1 checked Resident #1's blood glucose level and noted it to be 33 mg/dL. Nurse #1 then gave Resident #1 Glucagon (a hormone made by the pancreas that raises blood glucose levels. A manmade version is used to treat very low blood glucose levels in people with diabetes) IM (intramuscular) twice and called Emergency Medical Services. Resident #1 was then transferred to the hospital. A record review of Physician progress notes noted an addendum to the Telehealth Physicians progress note dated 8/5/2023 included the order to recheck the blood glucose level of Resident #1 in one hour and changed the insulin to be given from Novolog to Humalog. A review of the hospital records dated 8/5/2023 revealed the Resident #1 presented for concern for unresponsiveness and hypoglycemia. Shortly after arrival Resident #1 went from sonorous respirations (a production of loud, harsh, or vibrating sounds during breathing typically caused by the partial obstruction of the airway) to prolonged episodes of apnea (a temporary cessation of breathing). With bag-valve-mask	F 684	blood sugar remains less than 70 or greater than 400 after current orders being followed. Newly Hired Licensed Nurses will be educated during their orientation period regarding P&P on hyperglycemia/hypoglycemia and monitoring of blood glucose levels after administering any fast acting insulin. Education will be completed by 9/7/23. 4.To ensure retention of education provided to Licensed Nurses, DON or Unit Manager will conduct education retention questionnaires related to diabetic management and monitoring. A sample of 3 questionnaires will be conducted weekly x 12 weeks. DON and/or Unit Managers will review progress notes and the electronic vitals dashboard daily during clinical meeting to identify any residents with documented critically high blood glucose levels to ensure proper monitoring and follow-up 5 days a week x 12 weeks. DON and/or Unit Manager will perform a diabetic audit for current diabetic residents weekly to ensure hypoglycemic and hyperglycemic monitoring orders are evident with any needed monitoring orders for any critically high blood glucose levels (as applicable). Monitoring will be completed weekly x 12 weeks. Data obtained during the audit process will be analyzed for patterns and trends and reported to Quality Assurance and Performance Improvement (QAPI) by the Director of Nursing monthly x 3 months. At that time, the QAPI committee will	

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F 684	Continued From page 5 Resident #1 did improve her spontaneous respirations however, any cessation of bag-valve-mask ventilation resulted in apnea again within 60 seconds. Resident #1 was noted to have a blood sugar of less than 10 mg/dL however after receiving 2 ampules of D50 (used to treat low blood glucose levels) the blood glucose was rechecked and noted to be 395 mg/dL. Resident #1 was euglycemic (a blood glucose less than 11 millimoles per liter) for at least several minutes with a Glasgow Coma Scale (a scale used to objectively describe the extent of impaired consciousness) never improving above 8 (considered to have suffered a severe head injury) and Resident #1 continued to episodes of apnea. Resident #1 was then intubated (a tube is inserted through the mouth down into the windpipe so air can get through) for airway protection and placed on a ventilator. Resident #1 was then admitted into the Intensive Care Unit. On 8/10/2023 Resident #1 was taken off the ventilator and her breathing tube removed but remained in the Intensive Care Unit. A telephone interview was conducted on 8/9/2023 at 10:46 AM with Resident #1's Friend revealed that she was on the phone with Resident #1 at approximately 6:00 PM on 8/5/2023 and Resident #1 had told her that she was not feeling well that she felt like her blood sugar was low. Friend #1 stated that Resident #1 had been a diabetic for a long time and could usually tell when her sugar was going low. Resident #1's Friend later revealed that Resident #1 had told her that she had turned on the call light so that staff could check her blood sugar. Friend #1 stated they talked for a while longer, approximately 20 minutes, and the staff had not been in the room before they hung up.	F 684	evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Corrective completion date: 9/8/23	

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A telephone interview was conducted with Telehealth Physician on 8/9/2023 at 3:08 PM indicated that she remembered receiving a call regarding Resident #1's blood glucose level and had ordered 12 units of Humalog. The Telehealth Physician also revealed that she had told Nurse #1 to recheck Resident #1's blood glucose level in one hour.

The Director of Nursing was interviewed on 8/9/2023 at 12:30PM. The Director of Nursing indicated that she expected the blood glucose level to be checked in 1 ½ to 2 hours after giving insulin for hyperglycemia from a physician's order. She further revealed that monitoring was needed to ensure that the medication was lowering the blood glucose level as expected and to ensure the resident was responding appropriately.

An interview with Nurse Practitioner, who works daily in the facility and had stated that she had seen Resident #1 the previous week, was completed on 8/9/2023 at 1:30 PM revealed that the expectation was that a blood sugar was checked again after receiving and order to give insulin in 30 minutes to 1 hour to ensure that the blood glucose level was responding by decreasing in mg/dL. The Nurse Practitioner further stated that it is possible for a blood glucose to continue to rise even with the insulin given and it was important to recheck the blood glucose to ensure the insulin given was effective.

A phone interview with Nurse #1(an agency nurse) on 8/9/2023 at 2:12 PM revealed that on 8/5/2023 at 5:35 PM when Nurse #1 checked Resident #1's blood glucose level it was 544

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mg/dL, she did not verify the results by repeating the blood glucose check. Nurse #1 then called Telehealth and spoke with the Physician who gave an order for Humalog 12 units one time, she then administered the medication at 5:47 PM. At 9:00 PM she went into Resident # 1's room and noticed Resident #1 did not respond to voice or touch, her eyes were closed, and she sounded like she was snoring when breathing. Nurse #1 stated that she remembered giving the fast-acting insulin (Humalog) earlier so immediately checked Resident #1's blood glucose level and noted it was 33 mg/dL. She reported she gave Resident #1 Glucagon. Nurse #1 further stated that at the time she was just trying to make sure that Resident #1 did not die because her blood sugar was so low. Nurse #1 stated that she contacted Resident #1's Physician after Resident #1 left with Emergency Medical Services. Nurse #1 further revealed that she had not checked the blood glucose level at any time after giving the initial 12 units and checking the blood glucose at 9:00 PM. An additional phone interview with Nurse #1 on 8/10/2023 at 10:12 AM indicated that she gave Glucagon two times, without checking the blood glucose level in between injections and stated that she knew that for a low blood glucose level that Glucagon was given. Nurse #1 further revealed that she had not checked the blood glucose level at any time after giving the initial 12 units of Humalog and checking the blood glucose at 9:00 PM. Nurse #1 stated that she did not have an order to recheck Resident #1's blood glucose after administrating the 12 units of fast-acting insulin. Nurse #1 stated her normal practice was to check a blood glucose whenever it was ordered and that she did not have an order to obtain one prior to the bedtime order so she did not check Resident #1's blood glucose until

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then. Nurse #1 stated that she gave Glucagon twice due to Resident #1's blood glucose being so low. A phone interview conducted on 8/15/23 at 3:07 PM with Nurse #1 clarified that that Nurse #1 did not ask the assigned Nursing Assistant to tell Nurse #1 how Resident #1 ate that evening. Nurse #1 stated that she looked for the Nursing Assistant after dinner, however she did not see him and got busy and never asked him. Nurse #1 further revealed that there were no obvious signs of hyperglycemia when Resident #1 had the blood glucose level of 544 mg/dL that Resident #1 was talking to her as she normally did and had no requests or complaints while Nurse #1 was in the room. Nurse #1 stated that she did not see or look at Resident #1 after giving Resident #1 the 12 units of fast-acting insulin (5:47 PM) until shewent to Resident #1's room to do her nightly medication administration and blood glucose level monitoring at 9:00 PM. Nurse #1 revealed she checked Resident #1's blood glucose level in between administering the Glucagon and Resident #1's blood glucose level was then 32 mg/dL so Nurse #1 administered a second Glucagon injection. Nurse #1 stated she did not know why she said before that she had not checked the blood glucose in between the two Glucagon injections indicating that she was "just nervous". She reported there was no documentation of the blood glucose levels being obtained in between the Glucagon injections.

An interview was conducted with Nursing Assistant #1 on 8/9/2023 at 2:24 PM who stated he worked the 3:00 PM to 11:00 PM shift on 8/5/2023 and was assigned Resident #1. He stated he delivered and picked up Resident #1's dinner tray and that Resident #1 turned on her light one time that shift to be repositioned.

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Nursing Assistant #1 could not recall any other details about the time Resident #1 turned on her call light. Nursing Assistant #1 stated that Resident #1 did not tell him that she did not feel good at that time. He further stated that he could not remember what Resident #1 ate for her evening meal on 8/5/2023 but he had documented it. He added that he had not passed out bedtime snacks prior to Nurse #1 going into the room on 8/5/2023 at 9:00 PM. Nursing Assistant #1 further revealed that Nurse #1 had not asked him to monitor Resident #1 for any reason or give him symptoms to watch for.

A review of activity of daily living documentation for 8/5/2023 revealed that Resident #1 had eaten 0-25% of her evening meal.

An interview with the Physician Assistant who worked at the facility one day a week and had assessed Resident #1 previously, was completed on 8/9/2023 at 3:30 PM. The Physician Assistant indicated that a reasonable expectation was that the nurse would recheck the blood glucose after the nurse received an order to administer insulin within a time frame of 30 minutes to an hour to ensure that the intervention was effective. Physician Assistant further explained that at times a blood glucose would continue to increase even with insulin given or could decrease more rapidly than anticipated which is why monitoring the blood glucose level was important.

On 8/17/2023 at 2:29 PM a phone interview was completed with the Medical Director who stated that 2 extra units of insulin would not have caused this to escalate to lower her blood sugar. He stated that he would have not given an order to re-check the blood glucose. He indicated he

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expected the nurse to give the insulin as ordered and then expected the nurse to recheck the blood glucose at the next scheduled time and that in this case it was bedtime. The physician also stated the Department of Health and Human Services, and the Centers for Medicare and Medicaid Services were recommending not to use the blood glucose as a monitoring system but to monitor the Hgb A1c (a test which tells the average level of blood glucose over the past two to three months) and use that for recommendations for insulin management.

The facility Administrator was informed of Immediate Jeopardy on 8/15/2023 at 6:13 PM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
On 8/5/2023 at 5:47pm, Resident #1's blood glucose level was obtained by Nurse #1. Blood glucose level was 544. Nurse #1 contacted the medical provider. An order was received to administer 12 units of fast-acting insulin to Resident #1. Nurse #1 did not return to Resident #1's room until 9:00pm at which time she checked Resident #1's blood glucose level. At 9:00pm, Nurse #1 entered Resident #1's room to find Resident #1 unresponsive. Nurse #1 immediately checked blood glucose level, which was 33. Nurse #1 administered Glucagon. Nurse #1 (agency nurse) rechecked the blood glucose level after approximately 10 minutes, blood glucose level was 32. Nurse #1 administered glucagon again. Resident #1 remained unresponsive. Nurse #1 called 911 at

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approximately 9:15pm. Resident #1 was sent to the ER (Emergency Room) for evaluation and treatment. Based upon review of hospital records upon arrival to the ER, Resident #1's blood glucose level was less than 10mg/dl. Resident #1 was intubated and placed on a ventilator. Resident #1 was admitted into the Intensive Care Unit for hypoglycemia and respiratory failure.

All diabetic residents who require insulin are at risk for not being monitored after insulin is given for a critically high blood glucose level therefore the facility has established interventions to address this risk.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

An Ad Hoc (Quality Assurance Performance Improvement) QAPI meeting was conducted on 8/9/2023 by the QAPI Committee (Administrator, Director of Nursing (DON), Social Service Manager, Infection Prevention Control Officer, Minimum Data Set (MDS) Coordinator, Therapy Manager, Unit Manager(s), Business Office Manager, Medical Director (via phone) and Corporate - Director of Clinical Services to discuss this event and plan to address the event.

Based upon record review and staff interview(s) the QAPI Committee has identified the following root cause of the event:
- Nurse #1 failed to monitor a high blood glucose level after 12 units of fast-acting insulin was administered to Resident #1 on 8/5/23 at 5:47 PM. Nurse #1 states she did not obtain a recheck of the blood glucose level because she did not

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receive an order from the Physician when she called concerning the blood sugar level being 544. Nurse #1 states she asked the physician after obtaining the order for the 12 units of insulin was there anything further orders. Nurse #1 states the physician said "no". After Nurse #1 administered the insulin at 5:47pm, she did not complete an observation of Resident #1 until 9:00pm.

Root cause: Nurse #1 failed to follow professional standards when she did not recheck blood glucose level after administering 12 units of fast acting insulin.

On 8/9/23, Nurse #1 was provided one to one education by the Director of Nursing on the facility policy related to monitoring of diabetic residents after administration of fast acting insulin for any critically high blood glucose level. An emphasis was placed on ensuring residents are monitored closely. Monitoring should include obtaining a re-check of the blood glucose level (1 hour after administration of fast acting insulin (per professional standards and facility protocol) or based upon the physician order).

On 8/9/23, education was initiated by the Director of Nursing and Unit Managers to all Licensed Nurses (including agency/contract nurses) related to the facility policy on hyperglycemia and hypoglycemia. To include obtaining blood glucose levels as needed for signs and symptoms of hypo/hyperglycemia. If insulin is given for critically high blood glucose levels, the nurse must ensure the resident is monitored after administration by obtaining a re-check of the blood glucose level per physician order or facility protocol (1 hour after administration). Monitor/document/report to

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provider PRN s/s of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination and staggering gait. If fingerstick blood sugar is less than 70 and resident is symptomatic give orange juice, apple juice or instant glucose and recheck blood sugar in 15 minutes. Notify provider if fingerstick blood glucose remains less than 70 after protocol being followed. If fingerstick blood glucose level is less than 40, give IM (intramuscular) glucagon and recheck blood glucose level in 15 minutes and notify provider for further orders.

Newly Hired Licensed Nurses (including agency/contract nurses) will be educated during their orientation period regarding policy and protocol on hyperglycemia/hypoglycemia and monitoring of blood glucose levels after administering any fast acting insulin.

On 8/9/23, an audit of current diabetic resident's medical record was conducted for past 72hrs by the Unit Manager(s) and DON to review for any critically high blood glucose levels to ensure proper monitoring was conducted after administering any fast acting insulin. After review, no further issues were identified.

An audit of current diabetic residents was conducted on 8/9/23 by the DON and Unit Managers to include the following:
- Parameters for MD notification and follow-up for all diabetic residents.
- Insulin hyperglycemic and hypoglycemic orders to include monitoring and when to obtain a re-check of blood glucose level per facility protocol and/or physician order:
1. Blood glucose levels as needed for signs and

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symptoms of hypo/hyperglycemia
2. Monitor/document/report to provider PRN s/s of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait.
3. If fingerstick blood glucose is less than 70 and resident is symptomatic give orange juice, apple juice or instant glucose, recheck blood glucose level in 15 minutes. Notify provider if fingerstick blood sugar remains less than 70 after protocol being followed.
4. If fingerstick blood glucose level less than 40, give IM (intramuscular) glucagon and recheck blood glucose level in 15 minutes and notify provider

The Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged immediate jeopardy Removal Date: 8/10/23

The credible allegation for immediate jeopardy removal was validated onsite on 8/17/23. Staff interviews and record review verified licensed nurses were educated on the facility policy on hyperglycemia and hypoglycemia. This included signs and symptoms of hypo/hyperglycemia, what to do if signs/symptoms were observed, and how to respond to a critically high blood glucose level. An audit of current residents with diabetes' medical records was verified as completed by the Unit Manager(s) and DON. This included auditing the records to ensure any critically high blood glucose levels in the past 72 hours were monitored after administering any fast-acting

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F 684	Continued From page 15 insulin, ensure parameters for MD notification and instructions for follow-up for all diabetic residents were present, and that insulin hyperglycemic and hypoglycemic orders included monitoring and when to obtain a re-check of blood glucose level per facility protocol and/or physician order. The immediate jeopardy removal date of 8/10/23 was validated.	F 684		