STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	**306 DEER PARK ROAD , NEBO, North Carolina, 28761**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 8/6/2025 through 8/8/25. The credible allegation was validated on 08/14/25, therefore, the exit date was changed to 08/14/25. Event ID# 1D31B9-H1. The following intakes were investigated 2582187, 2578772, 2574713, and incident-2583721. Intake 2574713 resulted in immediate jeopardy. 3 of the 12-complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J CFR 483.12 at tag F600 at a scope and severity J The tags F684 and F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 7/17/25 and was removed on 8/13/25. A partial extended survey was conducted.	F0000		08/28/2025
F0580 SS = J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) 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);	F0580	F 580 How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/17/25 at 5:30 AM Resident #1's blood glucose level was 31. Nurse #1 stated she administered intramuscular glucagon to Resident #1 to treat her low blood glucose. Nurse #1 said she did not call the physician or check Resident #1's medical record for hypoglycemia treatment orders before administering the glucagon. Nurse #1 reported when Unit Manager (UM #1) arrived to the facility around 6:45 AM she asked UM #1 to call the physician to notify them about Resident #1's low blood glucose and what had been done to treat her low blood glucose. UM #1 documented she contacted the Provider at 7:13 AM. Unit Manager #1 did recognize that she was unable to place sugar under resident #1's tongue due to	08/30/2025

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

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F0580 SS = J	Continued from page 1 (C) 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); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, Nurse Practitioner (NP), and Medical Director interviews, staff failed to consult with the on-call provider immediately to obtain treatment orders for hypoglycemia when Resident #1, who had diabetes, had a critically low blood glucose level of 31 (normal 80-100), was lethargic, mumbling, and unable to receive anything by mouth as assessed by Nurse #1. Staff failed to communicate other symptoms that indicated urgent medical attention including	F0580	Continued from page 1 her clinched jaw; however, she failed to notify the MD of resident #1's emergent situation. Nurse #2 failed to notify the MD of abnormal eye movement, and tight hands which were signs of an emergent situation. Resident #1 was transferred to the hospital for signs of an emergent health condition on 7/17/25. How will the facility identify other residents having the potential to be affected by the same deficient practice? On August 8, 2025, the Director of Nursing and the Unit Manager reviewed medical records related to diabetes diagnoses and physician orders for diabetic medications and insulin. This was done to identify residents at risk of hypoglycemic episodes and to ensure that their physician orders were updated according to facility protocol. Notify the physician for blood glucose levels below 60 and above 500 or identified as “Hi” on the glucometer. For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1mg of Glucagon intramuscularly. (The Glucagon is located in the medication cart of each resident and in the pharmacy e-kit located in the medication room at the nursing units) and (3) notify the physician for additional orders and continue to monitor and evaluate the resident's status, (4) notify the physician of any changes. Also, all residents who were transferred to the hospital within the past 30 days were reviewed for life threatening events which included initiation of symptoms, time reported to the physician and time transferred to the hospital by the Director of Nursing on 8/8/25 to ensure proper notification of the physician and management of symptom/changes. No further deficient practices were identified. Nurse #1 was terminated on 8/8/2025 for deficient practice, failure to identify emergent resident situation, failure to notify MD of emergent situation in status, providing medications without MD order.	

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F0580 SS = J	Continued from page 2 abnormal eye movements, and tightness in her hands as assessed by Nurse #2, and inability to receive sugar under her tongue due to a tight jaw, as assessed by Unit Manager #1. Resident #1 was transferred to the hospital on 7/17/25. An emergency medical services (EMS) report dated 7/17/25 indicated when EMS arrived on scene at the facility at 4:48 PM “the patient was found lying in her bed, eyes open but only reactive to pain.” The EMS report stated Resident #1 was “noted to be comatose with seemingly left gaze with inability to follow any types of commands for more detailed assessment.” The hospital discharge summary dated 7/25/25 indicated Resident #1 did not have improvement in her mental status despite improvement in acute kidney injury and treatment for urinary tract infection. The hospital discharge summary stated, “suspect she had prolonged low blood glucose and seizure which led to comatose state.” Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. Immediate jeopardy began on 7/17/25 when staff failed to consult the physician about Resident #1’s critically low blood glucose level of 31, abnormal eye movements and tightness in her hands and jaw. Immediate jeopardy was removed on 8/12/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 11/8/21. Her diagnoses included type-2 diabetes mellitus. Resident #1’s July 2025 medication administration record (MAR) revealed an order dated 12/4/23, for glucometer checks before breakfast and at bedtime. The blood sugar goal was a range of 100 - 250. Interventions included to notify the Nurse Practitioner (NP) if the results were greater than 250 consistently. For blood sugar less than 70, offer oral glucose and recheck blood sugar in 1 hour. Notify Medical Doctor (MD), if blood sugar is not improved or patient symptomatic. Review of the medical record revealed the facility did not have standing orders. Review of Resident #1’s medical record revealed there were no nursing note entries from Nurse #1 on 07/17/25.	F0580	Continued from page 2 On 8/8/2025, UM#1 and Nurse #2 received disciplinary action for not identifying an emergent resident situation and failing to notify the MD of emergent situation, by the Director of Nursing. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? All licensed nurses, including agency nurses, were educated on 8/11/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident’s condition or with an emergent life-threatening event and feel as if the on call/ extended practice provider does not respond to a call or does not address an identified emergent situation as emergent the facility is to contact the Medical Director/Designee. All licensed nurses, including agency nurses, were educated on 8/7/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident’s condition or with an emergent life-threatening event. This education included once you identify a change in a resident's baseline (usual) status, the physician must be notified for further direction; and the nurse must document in the resident’s medical record the change in condition and physician notification. All staff education began on 8/7/2025 to notify the nurse if a resident emergent situation is identified or suspected and the importance of reporting resident emergent situations. Staff who had not received education by 8/8/2025 were not allowed to work until the education was completed. The Director of Nursing is responsible for ensuring all staff are educated prior to working. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? The Director of Nursing or designee will review blood sugar results and changes in resident conditions related to hypoglycemia 3 x weekly x 4 weeks then biweekly x 4 weeks, then monthly x 2 months to ensure hypoglycemia episodes and emergent situations are addressed timely and have been reviewed and communicated to the physician timely. The Director of Nursing will present the findings of the audits to the Quality Assurance and Performance	

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F0580 SS = J	Continued from page 3 The only entry made by Nurse #1 on 7/17/25 was a blood glucose result of 61 entered at 7:35 AM under vital signs. An interview was conducted on 8/7/25 at 9:09 AM with Nurse #1. She was the night shift (11PM-7AM) nurse for Resident #1 on the morning of 7/17/25. Nurse #1 recalled Resident #1 and her low blood sugars on the morning of 7/17/25. Nurse #1 recalled around 5:00 AM she checked Resident #1's blood glucose when she started her morning medication pass. She stated Resident #1's blood sugar was very low. Nurse #1 said Resident #1's blood sugar reading was 31. She remembered Resident #1 was lethargic and "in and out of it", she stated Resident #1 would open her eyes and look at her and mumble inaudibly but would then close her eyes and go back to sleep. Nurse #1 said she would not have felt comfortable giving Resident #1 anything by mouth, that "she was not alert enough." Nurse #1 explained she had intramuscular (IM) glucagon (emergency medicine used to treat low blood sugar) in the medication cart and administered the IM glucagon to Resident #1 right after she got the blood glucose reading of 31. Nurse #1 said she did not open Resident #1's medication administration record (MAR) or look at her orders for instructions on how to treat her hypoglycemia. She explained a few months ago Resident #1 had an episode of low blood sugar and IM glucagon had been used to treat the low blood sugar. Nurse #1 stated she assumed after that episode Resident #1 had an as needed standing order for IM glucagon. She reported she thought it was standard and that all residents with diabetes had an as needed order for IM glucagon. Nurse #1 stated after she administered the IM glucagon to Resident #1, she rechecked her blood glucose every 15 minutes. She recalled at first Resident #1's blood glucose went up steadily but then started to drop back down. Nurse #1 said the highest she could get Resident #1's blood glucose up to was 61. She reported by the time the day shift Unit Manager (UM #1) came in, around 6:45 AM, Resident #1's blood glucose was back down to 61. Nurse #1 said when UM #1 arrived at the facility she gave over care of Resident #1 to UM #1 because she had worked on Resident #1 for an hour and a half and 61 was the highest, she could get her blood sugar. Nurse #1 reported she asked UM #1 to call the on-call provider to let them know Resident #1 had an episode of hypoglycemia and what had been done to treat it and that what had been done was not effective. Nurse #1 explained she did not call the on-call provider during her shift when Resident #1's blood glucose was 31. Nurse #1 stated she was going to call the on-call provider after she treated Resident #1's hypoglycemia and let them know if it was effective	F0580	Continued from page 3 Committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. IJ removal date 8/12/2025 Date of Compliance 8/30/2025	

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F0580 SS = J	Continued from page 4 or not. She explained she wrote down Resident #1's blood sugar results and gave them to UM #1. Nurse #1 stated she asked UM #1 if she would call the on-call provider and ask them what to do and to call Resident #1's family member to update them. Nurse #1 stated UM #1 said she would document the blood glucose results, call the on-call provider, and call Resident #1's family. Nurse #1 reported she did not notice any seizure like activity or vomiting for Resident #1. A progress note by the day shift Unit Manager (UM) #1 dated 7/17/25 at 7:13 AM read, night nurse reported resident was experiencing hypoglycemia, blood sugars as follows: 5:30 AM-31, 5:45 AM- 52, 6:00 AM- 56, 6:15 AM-61, 6:30 AM- 66, 6:45 AM- 61. "On call notified and was advised to put sugar under her tongue and recheck blood sugar in 30 minutes." An interview was conducted with UM #1 on 8/6/25 at 3:05 PM. UM #1 reported she arrived to work on 7/17/25 between 6:30 AM and 7:00 AM. She did not recall the exact time. She said Nurse #1 reported to her when she arrived that Resident #1 had low blood sugar during the night. UM #1 said Nurse #1 reported she had given Resident #1 IM glucagon. She stated Nurse #1 did not ask her to document Resident #1's blood glucose checks from the night shift. UM #1 reported she did document the blood glucose results reported to her by Nurse #1 because she thought it was prudent to do so. UM #1 also reported Nurse #1 did not ask her to call the on-call provider or Resident #1's family. UM #1 did remember calling the on-call provider about Resident #1's low blood sugar and recalled the on-call provider gave her instructions to put sugar under Resident #1's tongue and recheck her blood sugar in 30 minutes. UM #1 stated when she went to put the sugar under Resident #1's tongue her mouth and jaw were tight, and she could not open her mouth. UM #1 said she did not want to pry open and force Resident #1's mouth open to put the sugar under her tongue. She reported she tried to put the sugar into her cheek as best as she could. UM #1 said she did not recall telling anyone about Resident #1's jaw being tight. She did not recall Resident #1 having tight arms or abnormal eye movement when she was in the room with her. A progress note by Nurse #2 dated 7/17/25 at 7:45 AM read, "On coming to shift during report resident was reported to have struggled with low blood sugars throughout the night." Last blood sugar check was 61 at on coming of shift 7:00 AM. I was told to recheck blood sugar at 7:30 AM and call provider back. I rechecked blood sugar at 7:30 AM blood sugar dropped down to 59. "I called provider to inform her of blood sugar level.	F0580		

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F0580 SS = J	Continued from page 5 Provider stated to just hold short acting and long-acting insulin for the morning and to recheck in an hour and give her a call back. Resident in bed. Eyes rolling side to side. Moaning. hands tight. Informed unit manager to recheck in an hour and call provider back." An interview was conducted with Nurse #2 on 8/6/25 at 2:53 PM. Nurse #2 was the day shift (7-3) and evening shift (3-11) nurse for Resident #1 on 7/17/25. Nurse #2 stated when she arrived on shift, the night shift (11PM-7AM) nurse (Nurse #1) reported to her Resident #1's blood sugars were extremely low in the 30's. Nurse #1 reported, "she said 33 to be exact". Nurse #2 stated Nurse #1 reported to her the on-call provider was aware of Resident #1's low blood sugar and had said to recheck Resident #1's blood sugar around 7:30 AM and call the on-call provider back with what Resident #1's blood sugar was. Nurse #2 said she rechecked Resident #1's blood sugar at 7:30 AM and it was in the 50's, she did not recall the exact number. She reported she called the on-call provider back after checking Resident #1's blood sugar at 7:30 AM and was told by the on-call provider to hold Resident #1's insulin. She stated the provider instructed her to try to give her something to eat to increase her blood sugar and to recheck her blood sugar in an hour. Nurse #2 stated she told the provider she did not have time to do that or keep rechecking Resident #1's blood sugar because she had to pass medications and check blood sugars for her other residents with diabetes, so they sent a Registered Nurse (Nurse #3) to help with Resident #1. Nurse #2 said she did not remember Resident #1 having abnormal eye movements and tight hands during the morning or reporting it to anyone. Nurse #2 said she remembered that more from the evening right before Resident #1 went out. She stated Resident #1's eyes were moving left and right slowly like her head was turning side to side but her head was not moving, and her arms were tight and hard to move. Nurse #2 stated Resident #1 was transferred to the hospital between 4:30 PM and 5:00 PM on 7/17/25. An interview was conducted on 8/6/25 at 4:33 PM with Nurse #3. Nurse #3 said she communicated with the NP about Resident #1 and received orders from the NP throughout the day. Nurse #1 stated she had not noticed seizure symptoms, abnormal eye movements, tightness of hands, arms, or mouth, or foaming at the mouth when she was in Resident #1's room. She said staff had not mentioned those symptoms to her. Nurse #3 explained she left the facility in the afternoon after lunch before 3 PM- 11 PM shift change but was not sure of the exact time. Nurse #3 stated Resident #1's blood sugar had	F0580		

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F0580 SS = J	Continued from page 6 increased to 74 that afternoon before she left but Resident #1 had not had any improvement in her mental status. Review of an EMS report dated 7/17/25, revealed EMS received the emergency call from the facility at 4:33 PM and arrived on scene at the facility at 4:48 PM. The EMS report stated when they arrived “the patient was found lying in her bed, eyes open but only reactive pain.” “Patient is noted to be comatose with seemingly left gaze with inability to follow any types of commands for more detained assessment.” “Her baseline is reported to be normal with some memory problems however, otherwise able to answer questions and hold conversation.” The EMS report stated her blood sugar was 94 and then 84 with direct blood drawn from midline. She was given 125 milliliters (ml) of D10 (10% dextrose (glucose) in water) to see if it improved her mental status. The report stated no improvement in mental status was noted and D10 was stopped after 125 ml. The EMS report said they departed the scene at 5:09 PM. A hospital discharge summary dated 7/25/25 indicated Resident #1 arrived to the hospital on 7/17/25 at 5:32 PM. The hospital course said Resident #1 presented to the hospital from the facility secondary to increasing lethargy, somnolence, with concern for acute metabolic encephalopathy. The discharge summary included the hospital workup was remarkable for acute kidney injury (AKI) and likely urinary tract infection (UTI). The hospital course stated Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, “suspect she had prolonged hypoglycemia and possible seizure which led to comatose state.” The Discharge summary included that goals of care were discussed with family, and the decision was made to transitions to comfort care with inpatient hospice. A death certificate for Resident #1 documented she passed away on 7/30/25. Acute metabolic encephalopathy was listed as the cause of death. An interview was conducted on 8/7/25 at 12:15 PM with the NP. The NP reported Nurse #1 should have called the on-call provider when to report Resident #1’s hypoglycemia and to get an order for how to treat the low blood glucose prior to giving Resident #1 glucagon. The NP said it had not been reported to her that Resident #1 had abnormal eye movements or tightness of her hands, arms, or mouth. She stated those were seizure symptoms and she was not made aware of that. NP #1 said she would have been worried about seizures if	F0580		

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F0580 SS = J	Continued from page 7 those symptoms had been reported to her and would have sent Resident #1 out that morning if she was concerned about seizures. An interview was conducted with the Medical Director on 8/7/25 at 11:15 AM. He stated the best thing in acute scenarios was to call the provider. He stated a medical provider should have been notified when Resident #1 had a critical blood sugar level of 31 at 5:30 AM on 7/17/25. He said the facility had a physician call service in place to manage hypoglycemia and that was better than paper standing orders. He explained the call service was 24 hours and if the on-call provider did not answer, the call would roll over to a backup on-call provider, and if the backup on-call provider did not answer, then the call would roll over to a second back up on call provider. He said he did not like standing orders because then you had someone with less knowledge making medical decisions. An interview was conducted with the interim Director of Nursing (DON) on 8/7/25 at 11:25 AM. The DON said Nurse #1 should have called the provider to report Resident #1's blood glucose level of 31 and to get an order for the IM glucagon. The DON stated the facility did not have standing orders and nurses needed to call the provider for everything. She reported Nurse #1 should have checked the MAR and called the provider before giving Resident #1 IM glucagon to get orders for how to treat her hypoglycemia. An interview was conducted with the Administrator on 8/7/25 at 3:50 PM. The Administrator said as a nurse she would have done what needed to be done to protect the resident at the time but would expect the nurse to call the provider timely to let them know what was going on. The facility's Administrator was informed of the immediate jeopardy on 8/7/25 at 4:03 PM. The facility submitted the following credible allegation of immediate jeopardy removal. 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On 7/17/25 at 5:30 AM Resident #1's blood glucose level was 31. Nurse #1 stated she administered intramuscular glucagon to Resident #1 to treat her low blood glucose.	F0580		

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F0580 SS = J	Continued from page 8 Nurse #1 said she did not call the physician or check Resident #1's medical record for hypoglycemia treatment orders before administering the glucagon. Nurse #1 reported when Unit Manager (UM #1) arrived to the facility around 6:45 AM she asked UM #1 to call the physician to notify them about Resident #1's low blood glucose and what had been done to treat her low blood glucose. UM #1 documented she contacted the Provider at 7:13 AM. Unit Manager #1 did recognize that she was unable to place sugar under resident #1's tongue due to her clinched jaw however she failed to notify the MD of resident #1's emergent situation. Nurse #2 failed to notify the MD of abnormal eye movement, and tight hands which were signs of an emergent situations. Failure to notify the physician about Resident #1's critically low blood glucose level could likely result in serious injury, harm, impairment, or death. All residents with diabetes or those taking antidiabetic medications are at risk. On August 8, 2025, the Director of Nursing and the Unit Manager reviewed medical records related to diabetes diagnoses and physician orders for diabetic medications and insulin. This was done to identify residents at risk of hypoglycemic episodes and to ensure that their physician orders were updated according to facility protocol. 1. Notify the physician for blood glucose levels below 60 and above 500 or identified as "Hi" on the glucometer.For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1milligram (mg) of Glucagon intramuscularly. (The Glucagon is located in the medication cart of each resident and in the pharmacy e-kit located in the medication room at the nursing units) and (3) notify the physician for additional orders and continue to monitor and evaluate the resident's status, (4) notify the physician of any changes. All licensed nurses, including agency nurses, were educated on 8/11/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident's condition or with an emergent life-threatening event and feel as if the on call/ extended practice provider does not respond to a call or does not address an identified emergent situation as emergent the facility is to contact the Medical Director/Designee. All residents who were transferred to the hospital	F0580		

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F0580 SS = J	Continued from page 9 within the past 30 days were reviewed for life threatening events which included initiation of symptoms, time reported to the physician and time transferred to the hospital by the Director of Nursing on 8/8/25 to ensure proper notification of the physician and management of symptom/changes. No further deficient practices were identified. 2. 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. All licensed nurses, including agency nurses, were educated on 8/7/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident's condition or with an emergent life-threatening event. This education included once you identify a change in a resident's baseline (usual) status, the physician must be notified for further direction; and the nurse must document in the resident's medical record the change in condition and physician notification. All staff education began on 8/7/2025 to notify the nurse if a resident emergent situation is identified or suspected and the importance of reporting resident emergent situations. Staff who have not received education by 8/8/2025 will not be allowed to work until education is completed. The Director of Nursing is responsible for ensuring all staff are educated prior to working. Nurse #1 has been suspended pending the completion of this investigation on 8/7/2025 Nurse #1 was terminated on 8/8/2025 for deficient practice, failure to identify emergent resident situation, failure to notify MD of emergent situation in status, providing medications without MD order. On 8/8/2025, UM#1 and Nurse #2 received disciplinary action for not identifying an emergent resident situation and failing to notify the MD of emergent situation, by the Director of Nursing. Immediate Jeopardy Removal Date: 8/12/2025 On 8/14/25 the facility's credible allegation of immediate jeopardy removal was validated by the following: Review of facility audits revealed the facility completed an audit of all diabetic residents residing	F0580		

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F0580 SS = J	Continued from page 10 in the building. Review of physician orders for diabetic residents, including non-insulin dependent diabetic residents revealed as needed (PRN) glucagon orders had been added for all residents. Medication cart observations were completed. Each medication cart was overserved to have emergency glucagon kits for individual residents. Review of in-service education logs revealed licensed nurses including UM #1 and Nurse #2 were educated on the facility protocol for treatment of hypoglycemia, when to notify the physician, emergent vs. non-emergent situations, including when to call 911, notifying the physician for change in a residents condition, and when to contact the Medical Director and/or designee if a provider does not treat an identified emergent situation as emergent. Additional in-service logs were reviewed and revealed all staff (including UM #1 and Nurse #2) were educated on the signs/ symptoms of hypoglycemia, emergent situations, including when to call 911, and notifying the nurse of change in condition. Interviews were conducted with licensed nurses, including agency nurses. The nurses confirmed they had received education on the facility protocol for treatment of hypoglycemia, when to notify the physician, emergent vs. non-emergent situations, including when to call 911, notifying the physician when there is a change in resident condition, and when to contact the Medical Director and/or designee if a provider does not treat an identified emergent situation as emergent. The licensed nurses were able to accurately verbalize the education they received. Interviews were conducted with licensed nurses, nurse aides, dietary staff, housekeeping, maintenance, office, administration/management, therapy, and agency staff. Interviews were conducted with staff from different shifts. The staff interviews revealed they had received education on the symptoms of hypoglycemia/ hyperglycemia, emergent situations including when to call 911, and notifying the nurse for change of condition. Staff were able to accurately verbalize the education they had received. Review of provider in-service logs revealed on 8/8/25 providers were educated by the Medical Director on the importance of notifying the medical Director when a resident is identified as having a critically low blood	F0580		

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F0580 SS = J	Continued from page 11 sugar and is showing symptoms that require emergency care. Education included: identification of emergent situation versus nonemergent situation, what is within the capabilities of the facility to properly care for residents with critically low blood sugar, and when to get the resident emergency medical attention. Education included acknowledgement of the devastation this type of scenario could bring if not treated properly. It was verified Nurse #1 no longer worked at the facility. An interview with the Administrator confirmed the involved NP was removed from facility services beginning on 8/7/25. The Administrator stated the facility had contacted the board of nursing and reported the involved NP but had not heard back from the board of nursing. Immediate Jeopardy Removal Date of 8/12/25 was validated.	F0580		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, staff, resident, family, Medical Director, and Nurse Practitioner (NP) interviews, the facility failed to protect a resident's (Resident #1) right to be free from neglect when the facility failed to ensure Resident #1 received emergent	F0600	F 600 How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/17/25 at 5:30 AM Resident #1's blood glucose level was 31. Nurse #1 stated she administered intramuscular glucagon to Resident #1 to treat her low blood glucose. Nurse #1 said she did not call the physician or check Resident #1's medical record for hypoglycemia treatment orders before administering the glucagon. Nurse #1 reported when Unit Manager (UM #1) arrived to the facility around 6:45 AM she asked UM #1 to call the physician to notify them about Resident #1's low blood glucose and what had been done to treat her low blood glucose. UM #1 documented she contacted the Provider at 7:13 AM. Unit Manager #1 did recognize that she was unable to place sugar under resident #1's tongue due to her clinched jaw; however, she failed to notify the MD of resident #1's emergent situation. Nurse #2 failed to notify the MD of abnormal eye movement, and tight hands which were signs of an emergent situation. Resident #1 was transferred to the hospital for signs of an emergent health condition on 7/17/25.	08/15/2025

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F0600 SS = SQC-J	Continued from page 12 care extending beyond the capabilities of the facility when she had critically low blood sugar and was symptomatic. Symptoms included lack of responsiveness, eyes moving left to right, obtunded, jaw tightness, inability to swallow, tightness of hands, moaning, foaming at the mouth. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:09 PM on 7/17/25. Resident #1 was admitted to the hospital on 7/17/25. Her hospital diagnoses included acute metabolic encephalopathy (brains function is impaired due to metabolic distubance), prolonged hypoglycemia, acute kidney injury (AKI), and urinary tract infection (UTI). The hospital discharge summary dated 7/25/25 said, Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, “suspect she had prolonged low blood glucose and seizure which led to comatose state.” Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. This deficient practice occurred for 1 of 1 resident reviewed for neglect. Immediate jeopardy began on 7/17/25 when the facility failed to recognize Resident #1 who had critically low blood sugar and was symptomatic, needed emergency medical services extending beyond the capabilities of the facility. Immediate jeopardy was removed on 8/13/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: This tag is cross referred to: F 684- Based on observations, record review, staff, family, Nurse Practitioner (NP), Physician Assistant and Medical Director interviews the facility failed to recognize that a diabetic resident (Resident #1) with critically low blood sugar (normal 80-100) needed emergency medical care that required transfer to a higher level of care. On 7/17/25 at 5:30 AM Resident #1’s blood sugar was 31(a serious life-threatening medical condition) and Resident #1 was lethargic (sluggish), “in and out of it,” mumbling, and not alert enough to eat or drink. After an intramuscular (IM) injection of glucagon (medication to treat low blood sugar) the resident remained symptomatic and was still lethargic, “in and out of it,” and not alert enough to	F0600	Continued from page 12 Resident #1 was admitted to the hospital on 7/17/25. The hospital course stated, “suspect she had prolonged blood glucose and seizure which led to comatose state.” Her hospital diagnoses included acute metabolic encephalopathy, prolonged hypoglycemia, acute kidney injury, and urinary tract infection. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. How will the facility identify other residents having the potential to be affected by the same deficient practice? On August 8, 2025, the Director of Nursing and the Unit Manager reviewed medical records related to diabetes diagnoses and physician orders for diabetic medications and insulin. This was done to identify residents at risk of hypoglycemic episodes and to ensure that their physician orders were updated according to facility protocol. Notify the physician for blood glucose levels below 60 and above 500 or identified as “Hi” on the glucometer. For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1mg of Glucagon intramuscularly. (The Glucagon is located in the medication cart of each resident and in the pharmacy e-kit located in the medication room at the nursing units) and (3) notify the physician for additional orders and continue to monitor and evaluate the resident’s status, (4) notify the physician of any changes. Also, all residents who were transferred to the hospital within the past 30 days were reviewed for life threatening events which included initiation of symptoms, time reported to the physician and time transferred to the hospital by the Director of Nursing on 8/8/25 to ensure proper notification of the physician and management of symptom/changes. No further deficient practices were identified. Nurse #1 was terminated on 8/8/2025 for deficient practice, failure to identify emergent resident situation, failure to notify MD of emergent situation in status, providing medications without MD order.	

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F0600 SS = SQC-J	Continued from page 13 eat or drink. Symptoms Resident #1 experienced from the initial low blood sugar of 31 at 5:30 AM on 07/17/25 until her discharge at 5:09 PM on 07/17/25 included lack of responsiveness, eyes moving left to right, obtunded (reduced level of alertness), jaw tightness, inability to swallow, tightness of hands, moaning, and foaming at the mouth. Resident #1's blood glucose level remained less than 70 until 1:08 PM when it was documented her blood glucose level was 77, however she remained obtunded with no verbal response. Resident #1's blood glucose decreased again to 59 at 2:30 PM. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:09 PM on 7/17/25. Resident #1 was admitted to the hospital on 7/17/25. Her hospital diagnoses included acute metabolic encephalopathy (brain dysfunction), prolonged hypoglycemia (low blood sugar), acute kidney injury (AKI), and urinary tract infection (UTI). The hospital discharge summary dated 7/25/25 said, Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, "suspect she had prolonged low blood glucose and seizure which led to comatose state." Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. This deficient practice affected 1 of 3 residents reviewed for quality of care. F 580- Based on record review, staff, Nurse Practitioner (NP), and Medical Director interviews, staff failed to consult with the on-call provider immediately to obtain treatment orders for hypoglycemia when Resident #1, who had diabetes, had a critically low blood glucose level of 31, was lethargic, mumbling, and unable to receive anything by mouth as assessed by Nurse #1. Staff failed to communicate other symptoms that indicated urgent medical attention including abnormal eye movements, and tightness in her hands as assessed by Nurse #2, and inability to receive sugar under her tongue due to a tight jaw, as assessed by Unit Manager #1. Resident #1 was transferred to the hospital on 7/17/25. An emergency medical services (EMS) report dated 7/17/25 indicated when EMS arrived on scene at the facility at 4:48 PM "the patient was found lying in her bed, eyes open but only reactive to pain." The EMS report stated Resident #1 was "noted to be comatose with seemingly left gaze with inability to follow any types of commands for more detailed assessment." The hospital discharge summary dated 7/25/25 indicated Resident #1 did not have improvement in her mental status despite improvement in acute kidney injury and treatment for urinary tract	F0600	Continued from page 13 On 8/8/2025, UM#1 and Nurse #2 received disciplinary action for not identifying an emergent resident situation and failing to notify the MD of emergent situation, by the Director of Nursing. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? All licensed nurses, including agency nurses, were educated on 8/11/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident's condition or with an emergent life-threatening event and feel as if the on call/ extended practice provider does not respond to a call or does not address an identified emergent situation as emergent the facility is to contact the Medical Director/Designee. All licensed nurses, including agency nurses, were educated on 8/7/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident's condition or with an emergent life-threatening event. This education included once you identify a change in a resident's baseline (usual) status, the physician must be notified for further direction; and the nurse must document in the resident's medical record the change in condition and physician notification. All staff education began on 8/7/2025 to notify the nurse if a resident emergent situation is identified or suspected and the importance of reporting resident emergent situations. Staff who had not received education by 8/8/2025 were not allowed to work until the education was completed. The Director of Nursing is responsible for ensuring all staff are educated prior to working. Nurse #1 has been suspended pending the completion of this investigation on 8/7/2025 Nurse #1 was terminated on 8/8/2025 for deficient practice, failure to identify emergent resident situation, failure to notify MD of emergent situation in status, providing medications without MD order. On 8/8/2025, UM#1 and Nurse #2 received disciplinary action for not identifying an emergent resident situation and failing to notify the MD of emergent situation, by the Director of Nursing.	

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F0600 SS = SQC-J	Continued from page 14 infection. The hospital discharge summary stated, “suspect she had prolonged low blood glucose and seizure which led to comatose state.” Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. The Administrator was notified of immediate jeopardy on 8/11/25 at 3:30 PM. The facility submitted the following credible allegation of immediate jeopardy removal 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. The facility’s failure to ensure Resident #1 received emergent care extending beyond the capabilities of the facility had the high likelihood of resulting in serious injury, serious harm, serious impairment or death. Failure to notify the physician about Resident #1’s critically low blood glucose level could likely result in serious injury, harm, impairment, or death. On 7/17/25 at 5:30 AM Resident #1’s blood glucose level was 31. Nurse #1 stated she administered intramuscular glucagon to Resident #1 to treat her low blood glucose. Nurse #1 said she did not call the physician or check Resident #1’s medical record for hypoglycemia treatment orders before administering the glucagon. Nurse #1 reported when Unit Manager (UM #1) arrived to the facility around 6:45 AM she asked UM #1 to call the physician to notify them about Resident #1’s low blood glucose and what had been done to treat her low blood glucose. UM #1 documented she contacted the Provider at 7:13 AM. Unit Manager #1 did recognize that she was unable to place sugar under resident #1’s tongue due to her clinched jaw however she failed to notify the MD of resident #1’s emergent situation. Nurse #2 failed to notify the MD of abnormal eye movement, and tight hands which were signs of an emergent situations. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:06 PM on 7/17/25. Resident #1 was admitted to the hospital on 7/17/25. The hospital course stated, “suspect she had prolonged	F0600	Continued from page 14 Nurse Practitioner involved was removed from facility services effective 8/7/2025 by the Facility Director of Operations and the Extended Provider Practice. On 8/12/2025 The Facility Administrator filed a report to the NCBON regarding Nurse Practitioner involved. Confirmation YLLNP-64QQU. All staff education began on 8/11/2025 by the Director of Nursing and the Human Resource Director on Abuse, Neglect and Exploitation policy with the emphasis on neglect, such as “failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.” Staff who have not received education by 8/11/2025 will not be allowed to work until education is completed. The Director of Nursing is responsible for ensuring all staff are educated prior to working. On 8/12/2025 The Facility Administrator filed a report to the NCBON regarding Nurse Practitioner involved. Confirmation YLLNP-64QQU. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? The Director of Nursing or designee will review blood sugar results and changes in resident conditions related to hypoglycemia 3 x weekly x 4 weeks then biweekly x 4 weeks, then monthly x 2 months to ensure hypoglycemia episodes and emergent situations are addressed timely and have been reviewed and communicated to the physician timely. The Director of Nursing will present the findings of the audits to the Quality Assurance and Performance Committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. IJ removal date 8/13/2025 Date of compliance 8/15/2025	

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F0600 SS = SQC-J	Continued from page 15 blood glucose and seizure which led to comatose state." Her hospital diagnoses included acute metabolic encephalopathy, prolonged hypoglycemia, acute kidney injury, and urinary tract infection. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. All residents in the facility have the potential to be affected by this deficient practice. All residents with diabetes or those taking antidiabetic medications are at risk. On August 8, 2025, the Director of Nursing and the Unit Manager reviewed medical records related to diabetes diagnoses and physician orders for diabetic medications and insulin. This was done to identify residents at risk of hypoglycemic episodes and to ensure that their physician orders were updated according to facility protocol. Notify the physician for blood glucose levels below 60 and above 500 or identified as "Hi" on the glucometer.For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1mg of Glucagon intramuscularly. (The Glucagon is located in the medication cart of each resident and in the pharmacy e-kit located in the medication room at the nursing units) and (3) notify the physician for additional orders and continue to monitor and evaluate the resident's status, (4) notify the physician of any changes. All licensed nurses, including agency nurses, were educated on 8/11/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident's condition or with an emergent life-threatening event and feel as if the on call/ extended practice provider does not respond to a call or does not address an identified emergent situation as emergent the facility is to contact the Medical Director/Designee. 2. 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. On August 8, 2025, the Medical Director conducted a training session for all primary care physician extenders. The purpose was to emphasize the importance of notifying the Medical Director when a resident is identified as having critically low blood sugar and is showing symptoms that require emergency care. Education included identification of emergent situation versus nonemergent situation and within the capabilities of the facility to properly care for the resident with critically low blood sugar and when to get the resident	F0600		

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F0600 SS = SQC-J	Continued from page 16 emergency medical attention. Additionally, on August 8, 2025, the Director of Nursing, Minimum Data System (MDS) RN, and Weekend RN Unit Manager provided education for all staff. This education covered the signs and symptoms of hypoglycemia and provided guidance on when to notify the nurse, the medical doctor, and when to call 911 if a resident appears to be in an emergency situation. Education included if blood sugar levels fall outside the parameters specified in the physician's orders and the patient exhibits symptoms of hypoglycemia—such as shakiness, chills, nausea, a rapid heartbeat, or hunger—but remains responsive, this is considered a non-emergent situation. Education was provided regarding emergent events, such as non-responsiveness or seizure activity, which would require immediate notification of a physician and a call to 911. The training included the importance of treating hypoglycemia as it can lead to devastation including up to death if left untreated. A100% audit was conducted of all identified diabetic resident's medication orders was completed by the Director of Nursing, and/or Unit Manager on 8/8/25 to identify residents without parameters for when to contact the MD for abnormal glucose blood level. For those residents identified, orders were updated to include the parameters of when to notify the physician. New protocol established: 1. Notify the physician for blood glucose levels below 60 and above 500 or identified as "Hi" on the glucometer. 2. For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1mg Glucagon intramuscularly. Glucagon is stored in the medication cart for all residents with a diabetic diagnosis, including those on diet control, insulin-dependent residents, and residents taking antidiabetic medications who are at risk for hypoglycemic episodes. Glucagon was added to each resident's medication drawer on 8/8/2025, who was identified as a diabetic. Additionally, it can be found in the pharmacy emergency kit located in the medication room at the nursing station. The following additional actions should be taken: (1) notify the physician for additional orders, (2) continue to monitor the resident, (3) evaluate their condition, and (4) inform the physician of any changes. All licensed nurses, including agency nurses, were	F0600		

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F0600 SS = SQC-J	Continued from page 17 educated on 8/7/25 by the Director of Nursing or Unit Manager in person or via phone on notifying the physician of changes in the resident's condition or with an emergent life-threatening event. This education included once you identify a change in a resident's baseline (usual) status, the physician must be notified for further direction; and the nurse must document in the resident's medical record the change in condition and physician notification. All staff education began on 8/7/2025 to notify the nurse if a resident emergent situation is identified or suspected and the importance of reporting resident emergent situations. Staff who have not received education by 8/8/2025 will not be allowed to work until education is completed. The Director of Nursing is responsible for ensuring all staff are educated prior to working. Nurse #1 has been suspended pending the completion of this investigation on 8/7/2025 Nurse #1 was terminated on 8/8/2025 for deficient practice, failure to identify emergent resident situation, failure to notify MD of emergent situation in status, providing medications without MD order. On 8/8/2025, UM#1 and Nurse #2 received disciplinary action for not identifying an emergent resident situation and failing to notify the MD of emergent situation, by the Director of Nursing. Nurse Practitioner involved was removed from facility services effective 8/7/2025 by the Facility Director of Operations and the Extended Provider Practice. All staff education began on 8/11/2025 by the Director of Nursing and the Human Resource Director on Abuse, Neglect and Exploitation policy with the emphasis on neglect, such as "failure to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Staff who have not received education by 8/11/2025 will not be allowed to work until education is completed. The Director of Nursing is responsible for ensuring all staff are educated prior to working. On 8/12/2025 The Facility Administrator filed a report to the North Carolina Board of Nursing regarding Nurse Practitioner involved. Immediate Jeopardy Removal Date: 8/13/2025 On 8/14/25 the facility's credible allegation of immediate jeopardy removal was validated by the	F0600		

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F0600 SS = SQC-J	Continued from page 18 following: An onsite facility revisit was conducted on 8/14/25. Review of facility audits revealed the facility completed an audit of all diabetic residents residing in the building. Review of physician orders for diabetic residents, including non-insulin dependent diabetic residents revealed as needed (PRN) glucagon orders had been added for all residents. Medication cart observations were completed. Each medication cart was overserved to have emergency glucagon kits for individual residents. Review of in-service education logs revealed licensed nurses including UM #1 and Nurse #2 were educated on the facility protocol for treatment of hypoglycemia, when to notify the physician, emergent vs. non-emergent situations, including when to call 911, notifying the physician for change in a residents condition, and when to contact the Medical Director and/or designee if a provider does not treat an identified emergent situation as emergent. Additional in-service logs were reviewed and revealed all staff (including UM #1 and Nurse #2) were educated on abuse/ neglect including the facility abuse/ neglect policy, the signs/ symptoms of hypoglycemia, emergent situations, including when to call 911, and notifying the nurse of change in condition. Interviews were conducted with licensed nurses, including agency nurses. The nurses confirmed they had received education on the facility protocol for treatment of hypoglycemia, when to notify the physician, emergent vs. non-emergent situations, including when to call 911, notifying the physician when there is a change in resident condition, and when to contact the Medical Director and/or designee if a provider does not treat an identified emergent situation as emergent. The licensed nurses were able to accurately verbalize the education they received. Interviews were conducted with licensed nurses, nurse aides, dietary staff, housekeeping, maintenance, office, administration/management, therapy, and agency staff. Interviews were conducted with staff from different shifts. The staff interviews revealed they had received education abuse/ neglect, on the symptoms of hypoglycemia/ hyperglycemia, emergent situations	F0600		

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F0600 SS = SQC-J	Continued from page 19 including when to call 911, and notifying the nurse for change of condition. Staff were able to accurately verbalize the education they had received. Review of provider in-service logs revealed on 8/8/25 providers were educated by the Medical Director on the importance of notifying the medical Director when a resident is identified as having a critically low blood sugar and is showing symptoms that require emergency care. Education included: identification of emergent situation versus nonemergent situation, what is within the capabilities of the facility to properly care for residents with critically low blood sugar, and when to get the resident emergency medical attention. Education included acknowledgement of the devastation this type of scenario could bring if not treated properly. It was verified Nurse #1 no longer worked at the facility. An interview with the Administrator confirmed the involved NP was removed from facility services beginning on 8/7/25. The Administrator stated the facility had contacted the board of nursing and reported the involved NP but had not heard back from the board of nursing. Immediate Jeopardy Removal Date of 8/13/25 was validated.	F0600		
F0684 SS = SQC-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 observations, record review, staff, family, Nurse Practitioner (NP), Physician Assistant and Medical Director interviews the facility failed to recognize that a diabetic resident (Resident #1) with	F0684	F 684 How will corrective action be accomplished for those residents found to have been affected by the deficient practice? On 7/17/25 at 5:30 AM Resident #1's blood glucose was 31. After IM glucagon the resident remained symptomatic. Symptoms included lack of responsiveness, eyes moving left to right, obtunded, jaw tightness, inability to swallow, tightness of hands, moaning, foaming at the mouth. Resident #1's blood glucose level remained less than 70 until 1:08 PM when it was documented her blood glucose level was 77, however she remained obtunded with no verbal response. Resident #1's blood glucose decreased again to 59 at 2:30 PM. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the	08/15/2025

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F0684 SS = SQC-J	Continued from page 20 critically low blood sugar (normal 80-100) needed emergency medical care that required transfer to a higher level of care. On 7/17/25 at 5:30 AM Resident #1's blood sugar was 31 (a serious life-threatening medical condition) and Resident #1 was lethargic (sluggish), "in and out of it," mumbling, and not alert enough to eat or drink. After an intramuscular (IM) injection of glucagon (medication to treat low blood sugar) the resident remained symptomatic and was still lethargic, "in and out of it," and not alert enough to eat or drink. Symptoms Resident #1 experienced from the initial low blood sugar of 31 at 5:30 AM on 07/17/25 until her discharge at 5:09 PM on 07/17/25 included lack of responsiveness, eyes moving left to right, obtunded (reduced level of alertness), jaw tightness, inability to swallow, tightness of hands, moaning, and foaming at the mouth. Resident #1's blood glucose level remained less than 70 until 1:08 PM when it was documented her blood glucose level was 77, however she remained obtunded with no verbal response. Resident #1's blood glucose decreased again to 59 at 2:30 PM. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:09 PM on 7/17/25. Resident #1 was admitted to the hospital on 7/17/25. Her hospital diagnoses included acute metabolic encephalopathy (brain dysfunction), prolonged hypoglycemia (low blood sugar), acute kidney injury (AKI), and urinary tract infection (UTI). The hospital discharge summary dated 7/25/25 said, Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, "suspect she had prolonged low blood glucose and seizure which led to comatose state." Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. This deficient practice affected 1 of 3 residents reviewed for quality of care. Immediate jeopardy began on 7/17/25 when the facility failed to recognize that Resident #1 had a critically low blood sugar and was symptomatic and needed emergency care extending beyond the capabilities of the facility. Immediate jeopardy was removed on 8/9/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place were effective. Findings included: Resident #1 was admitted to the facility on 11/8/21.	F0684	Continued from page 20 emergency room at 5:06 PM on 7/17/25. Resident #1 was admitted to the hospital on 7/17/25. The hospital course stated, "suspect she had prolonged blood glucose and seizure which led to comatose state." Her hospital diagnoses included acute metabolic encephalopathy, prolonged hypoglycemia, acute kidney injury, and urinary tract infection. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. How will the facility identify other residents having the potential to be affected by the same deficient practice? On August 8, 2025, the Director of Nursing and the Unit Manager reviewed medical records related to diabetes diagnoses and physician orders for diabetic medications and insulin. This was done to identify residents at risk of hypoglycemic episodes and to ensure that their physician orders were updated according to facility protocol. A100% audit was conducted of all identified diabetic resident's medication orders was completed by the Director of Nursing, and/or Unit Manager on 8/8/25 to identify residents without parameters for when to contact the MD for abnormal glucose blood level. For those residents identified, orders were updated to include the parameters of when to notify the physician. New protocol established: 1. Notify the physician for blood glucose levels below 60 and above 500 or identified as "Hi" on the glucometer. 2. For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1mg Glucagon intramuscularly. Glucagon is stored in the medication cart for all residents with a diabetic diagnosis, including those on diet control, insulin-dependent residents, and residents taking antidiabetic medications who are at risk for hypoglycemic episodes. Glucagon was added to each resident's medication drawer on 8/8/2025, who was identified as a diabetic. Additionally, it can be found in the pharmacy emergency kit located in the medication	

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F0684 SS = SQC-J	Continued from page 21 Her diagnoses included type-2 diabetes mellitus. She was discharged from the facility on 7/17/25 to an acute care hospital. The quarterly Minimum Data Set (MDS) assessment dated 5/31/25 indicated Resident #1 had severe cognitive impairment. The MDS documented revealed that she received insulin injections and hypoglycemic medication. A care plan revised on 06/13/25 read, Resident #1 has diabetes mellitus and has fluctuations in blood sugars, sliding scale insulin and capillary blood glucose (CBG) per orders. Resident #1 often refuses meals at times. The care plan goal last revised on 6/13/25 was for Resident #1 to not have any complications related to diabetes through the review date. The care plan interventions included: -monitor/ document/ report as needed any signs or symptoms of hyperglycemia (high blood sugar) (increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (a deep and labored breathing pattern), acetone breath (smells fruity), stupor, coma. -Monitor/document/report as needed any signs or symptoms of hypoglycemia (low blood sugar) (sweating, tremor, increased heart rate, pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait). -The care plan interventions additionally included, diabetes medications as ordered by the doctor, monitor/ document for side effects and effectiveness. Fasting serum blood sugar as ordered by the doctor. Review of Resident #1's July 2025 medication administration record (MAR) revealed the following orders: - An order dated 11/22/22 read, Jardiance (diabetic medication) tablet 25 milligrams (mg) give one tablet by mouth in the morning. The medication was documented by Nurse #2 as not administered on 7/17/25 at 8:00 AM due to "drug refused". The MAR documented the medication was also not received on 7/11/25 due to "drug refused". Resident #1 received all other doses as ordered for the month of July 2025. -An order dated 12/4/23 read, glucometer (blood sugar) checks before breakfast and at bedtime blood sugar goal-100-250 range. Notify Nurse Practitioner (NP) if	F0684	Continued from page 21 room at the nursing station. The following additional actions should be taken: (1) notify the physician for additional orders, (2) continue to monitor the resident, (3) evaluate their condition, and (4) inform the physician of any changes. The Nurse Practitioner involved in this incident was removed from the facility services effective 8/7/2025 by the Director of Operations and the Extended Provider Practice. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? On August 8, 2025, the Medical Director conducted a training session for all primary care physician extenders. The purpose was to emphasize the importance of notifying the Medical Director when a resident is identified as having critically low blood sugar and is showing symptoms that require emergency care. Education included identification of emergent situation versus nonemergent situation and within the capabilities of the facility to properly care for the resident with critically low blood sugar and when to get the resident emergency medical attention. Additionally, on August 8, 2025, the Director of Nursing, Minimal Data System (MDS) RN, and Weekend RN Unit Manager provided education for all staff. This education covered the signs and symptoms of hypoglycemia and provided guidance on when to notify the nurse, the medical doctor, and when to call 911 if a resident appears to be in an emergency situation. Education included if blood sugar levels fall outside the parameters specified in the physician's orders and the patient exhibits symptoms of hypoglycemia—such as shakiness, chills, nausea, a rapid heartbeat, or hunger—but remains responsive, this is considered a non-emergent situation. Education was provided regarding emergent events, such as non-responsiveness or seizure activity, which would require immediate notification of a physician and a call to 911. The training included the importance of treating hypoglycemia as it can lead to devastation including up to death if left untreated. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?	

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F0684 SS = SQC-J	Continued from page 22 greater than 250 consistently. For blood sugar less than 70 offer oral glucose and recheck blood sugar in 1 hour- notify Medical Doctor (MD) if blood sugar is not improved or patient symptomatic. Review of the medical record revealed Resident #1 had blood sugar results that ranged from 30-439 during the month of July 2025. -An ordered dated 2/27/25 read, Humalog (short acting insulin/diabetic medication) Kwik Pen subcutaneous solution pen injector 100 unit/ ml inject as per sliding scale: if 0 - 150 = 0 151 - 200 = 2 units 201 - 250 = 4 units 251 - 300 = 6 units 301 - 350 = 8 units 351 - 400 = 10 units 401 - 450 = 12 units 451 - 999 = call Medical Doctor (MD) Subcutaneously before meals and at bedtime for diabetes. The order was discontinued on 7/17/25 at 1:39 PM. The MAR documented the medication was last administered on 7/15/25 at 8:00 PM. - An order dated 2/28/25 read, Tresiba (long-acting insulin/diabetic medication) FlexTouch subcutaneous solution pen injector 100 unit/ milliliter (ml) inject 45 units subcutaneously in the morning. The MAR documented the medication was last administered on 7/16/25 at 9:00 AM All of Resident #1's morning (8:00 AM and 9:00 AM) and evening (2:00 PM and 5:00 PM) scheduled medications on 7/17/25 were documented as not administered by Nurse #2 due to "drug refused". Additional review of Resident #1's medical record revealed that there was no standing order for the administration of IM glucagon. Review of Resident #1's medical record revealed there were no nursing note entries from Nurse #1 on 07/17/25. An interview was conducted on 8/7/25 at 9:09 AM with	F0684	Continued from page 22 The Director of Nursing or designee will review blood sugar results and changes in resident conditions related to hypoglycemia 3 x weekly x 4 weeks then biweekly x 4 weeks, then monthly x 2 months to ensure hypoglycemia episodes and emergent situations are addressed timely and have been reviewed and communicated to the physician timely. The Director of Nursing will present the findings of the audits to the Quality Assurance and Performance Committee monthly for 3 months to review the results, make recommendations to ensure compliance is sustained ongoing, and determine the need for further monitoring. IJ removal 8/9/2025 Date of Compliance 8/15/2025	

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F0684 SS = SQC-J	Continued from page 23 Nurse #1. She was the night shift (11pm-7am) nurse for Resident #1 on the morning of 7/17/25. Nurse #1 recalled Resident #1 and her low blood sugars on the morning of 7/17/25. Nurse #1 recalled around 5:30AM she checked Resident #1's blood sugar when she started her morning medication pass. Nurse #1 said Resident #1's blood sugar reading was very low and was 31. She remembered Resident #1 was lethargic and "in and out of it", she stated Resident #1 would open her eyes and look at her and mumble inaudibly but would then close her eyes and go back to sleep. Nurse #1 said she would not have felt comfortable giving Resident #1 anything by mouth, that "she was not alert enough." Nurse #1 explained she had IM glucagon in the medication cart and administered the IM glucagon to Resident #1 right after she got the blood glucose reading of 31. Nurse #1 said she did not open Resident #1's MAR or look at her orders for instructions on how to treat her hypoglycemia. She explained a few months ago Resident #1 had an episode of low blood sugar and IM glucagon had been used to treat the low blood sugar. Nurse #1 stated she assumed after that episode Resident #1 had an as needed standing order for IM glucagon. She reported she thought it was pretty standard and that all diabetic residents had an as needed order for IM glucagon. Nurse #1 stated after she administered the IM glucagon to Resident #1, she rechecked her blood sugar every 15 minutes. She recalled at first Resident #1's blood sugar went up steadily but then it started to drop back down. Nurse #1 said the highest she could get Resident #1's blood sugar up to was 66. She stated by the time the day shift Unit Manger (UM #1) came in around 6:45 AM her blood sugar was back down to 61. Nurse #1 said when UM #1 arrived at the facility she turned over care of Resident #1 to UM #1 because she had worked on Resident #1 for an hour and a half and "61" was the highest, she could get her blood sugar. Nurse #1 reported she asked UM #1 to call the on-call provider to let them know Resident #1 had an episode of hypoglycemia and what had been done to treat it and that what had been done was not being effective. Nurse #1 explained she did not call the on-call provider during her shift when Resident #1's blood glucose was 31. Nurse #1 stated she was going to call the on-call provider after she treated Resident #1's hypoglycemia and let them know if it was effective or not but she did not. She explained she did not document the every 15 minute blood sugar check results in Resident #1's medical record but she did write them down and gave them to UM #1. Nurse #1 stated she had asked UM #1 if she would call the on-call provider and ask them what to do and call Resident #1's family member to update them. Nurse #1 stated UM #1 said she would document the blood sugar results, call the on-call provider, and	F0684		

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F0684 SS = SQC-J	Continued from page 24 call Resident #1's family. Nurse #1 reported she did not notice any seizure like activity or vomiting for Resident #1. A progress note by UM#1 dated 7/17/25 at 7:13 AM read, night nurse reported resident was experiencing hypoglycemia, blood sugars as follows: 5:30 AM-31, 5:45 AM- 52, 6:00 AM- 56, 6:15 AM-61, 6:30 AM- 66, 6:45 AM-61. On call notified and was advised to put sugar under her tongue and recheck blood sugar in 30 minutes. An additional progress note dated 7/17/25 at 8:33 AM by UM #1 read, "blood sugar is 61 and resident is still not responding, called provider and left message for NP, as to resident's condition. An order dated 7/17/25 entered at 1:00 PM on the MAR read, please have midline catheter (IV access) placed one time only for 2 days. A progress note dated 7/17/25 at 2:11 PM by UM #1 read, "[mobile X-ray vascular company] called to come and start PICC (peripherally inserted central catheter) line, informed they will be here around 3:15 PM. "Rocephin (antibiotic) 1 gram, administered IM 1 gram in left hip and 1 gram in right hip, resident obtunded and made no response. [NP] notified." An interview was conducted with UM #1 on 8/6/25 at 3:05 PM. UM #1 reported she arrived at work on 7/17/25 between 6:30 AM and 7:00 AM, but she did not recall the exact time. She said Nurse #1 reported to her when she arrived that Resident #1 had low blood sugar during the night. UM #1 said Nurse #1 reported she had given Resident #1 IM glucagon. UM #1 reported she documented the blood glucose results reported to her by Nurse #1 because she thought it was prudent to do so. UM #1 stated Nurse #1 did not ask her to call the on-call provider or Resident #1's family. UM #1 remembered calling the on-call provider about Resident #1's low blood sugar at the start of her shift but did not recall the exact time. She recalled the on-call provider gave her instructions to put sugar under Resident #1's tongue and recheck her blood sugar in 30 minutes. UM #1 stated when she went to put the sugar under Resident #1's tongue her mouth and jaw were tight, and she could not open her mouth. UM #1 said she did not want to pry open and force Resident #1's mouth open to put the sugar under her tongue. She reported she tried to put the sugar into her cheek as best as she could. She did not recall Resident #1 having tight arms or abnormal eye movement when she was in the room	F0684		

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F0684 SS = SQC-J	Continued from page 25 with her and no one had reported that to her. UM #1 said she did not recall Resident #1 having any seizure like activity. UM #1 stated Resident #1 was given another dose of glucagon at some point, but she was not entirely sure when. UM #1 explained she thought there was no more glucagon in the building but that when she looked, she was able to find another dose of glucagon on the other side of the building. She was not sure if it was in the morning or the afternoon when she found the second dose. UM #1 stated she did not administer any glucagon to Resident #1 on 07/17/25. She reported when she found the glucagon she gave it to Nurse #2 to administer. She stated she was not sure if Resident #1 had an order for glucagon but thought it was a standing order for diabetic residents. UM #1 said Resident #1's blood sugar hoovered between 50 and 60 throughout the day, she stated Resident #1's blood sugar never came up above 61. She explained that a Registered Nurse (RN) who worked for the NP provider group (Nurse #3) was at the facility and was in and out of Resident #1's room all day. She said when Nurse #3 arrived at the facility she took over care of Resident #1 and communicated with the NP directly. UM #1 recalled that Nurse #3 attempted several times to start an intravenous (IV) access site on Resident #1 but was unsuccessful. She recalled 5% dextrose in water (D5W) was administered to Resident #1 by hypodermoclysis (clysis) (fluids administered subcutaneous) by Nurse #3. UM #1 recalled talking to the NP about vascular access for Resident #1 and setting that up with the mobile vascular company to come to the facility and place a midline (vascular access) for Resident #1. She stated she called the mobile vascular access company and set up for them to come to the facility to place the midline with an estimated time of arrival at 3:15 PM that day. UM #1 said she was in and out of Resident #1's room during the day and Resident #1 was not awake, not alert, and was not responsive at all the entire time. When asked if Resident #1 was able to eat or drink anything that day, UM #1 stated "heavens no she was not eating she was somnolent [sleepy/drowsy]". UM #1 did not recall if she asked the NP about sending Resident #1 to emergency room (ER) when she spoke to her on the phone. UM #1 stated if it had been the facility's Medical Director provider group they would have sent Resident #1 out. UM #1 stated if she was the provider she would have sent Resident #1 out to the ER but that that was not a nurse's call to make. UM #1 stated she had no idea why the NP did not send Resident #1 out earlier. UM #1 reported Nurse #2 called Resident #1's family to update them on what was going on but was not sure what time she called. UM #1 explained Resident #1 was sent out the ER that afternoon after Nurse #2 called the family. UM #1 stated she did not see Resident #1 when she went	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD , NEBO, North Carolina, 28761

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F0684 SS = SQC-J	Continued from page 26 out. A progress note dated 7/17/25 and timed 5:10 PM by Nurse #3 read, “Seen today at the request of the nurse for low blood glucose levels. Nurse reports that member with noted blood glucose levels this morning 31-61.” It was reported that she received 1 mg glucagon injection prior to my arrival. She is seen lying in bed, eyes open but she appears obtunded. [Capillary Blood Glucose] CBG at that time was 43. Glucagon 1 mg was repeated. NP aware with new order to obtain IV and administer D5 [5% dextrose (sugar) in water]. IV attempted x 3 unsuccessful. Clysis [fluids given subcutaneously] was initiated at that time at 60cc [cubic centimeters]/hr. Blood glucose levels checked periodically after initiation of clysis and slowly increased to 74, however she remained obtunded with no verbal responses. Underlying infection suspected- UA [urinalysis] C&S [culture & sensitivity] ordered, Rocephin [antibiotic] 2 gm IM x 1 dose. Tresiba decreased to 38 units daily- hold for CBG less than 150, SSI [sliding scale insulin] discontinued. Also order to have midline [vascular access] placed for continuous fluid with initial 500 cc bolus of NS [normal saline] and then resume D5 at 125cc/hr for remainder of current liter. She has had no po [by mouth] intake today and NA caring for member reports very little po intake for the previous day. UM updated on orders and reports that call has been placed for midline and approximate ETA [estimated time of arrival] is 3:15 pm. VS [vital signs] ordered every 4 hours x 3 days and CBG every 3 hours x 24 hours. NP left message for son to return call. Administrator also updated. Staff to notify provider group with any concerns or needs.” An order dated 7/17/25 entered at 1:30 PM read, ceftriaxone (Rocephin) (antibiotic) injection solution, inject 2 grams (gm) intramuscularly one time only for urinary tract infection (UTI) for 1 day. An order dated 7/17/25 entered at 2:30 PM read, normal saline flush intravenous solution 0.9 %, use 500 ml intravenously one time only for dehydration for 1 day bolus 999 ml /hour (hr.) once midline placed. An order dated 7/17/25 entered at 1:45 PM read, dextrose (glucose) intravenous solution 5 %, use 1 liter intravenously one time only for Dehydration for 1 Day, 60 ml/hr. clysis. Call NP once midline placed.	F0684		

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F0684 SS = SQC-J	Continued from page 27 An interview was conducted on 8/6/25 at 4:33 PM with Nurse #3. Nurse #3 worked for the NP's provider group and with the NP which was a separate provider group from the Medical Director provider group. She explained she went to the facility several days a week to check on their patients. She reported she arrived at the facility around 9:00 AM on 7/17/25. She stated the NP called her that morning before she arrived at the facility and updated her that Resident #1 was having problems with low blood sugar. Nurse #3 reported when she arrived at the facility, she went to see Resident #1 first. Nurse #3 explained she checked Resident #1's blood sugar when she arrived and it was 43. Nurse #3 said it was reported to her Resident #1 had been given glucagon before she arrived, she was not sure what time it was given. She explained it was told to her there was no other glucagon available in the building at that time. Nurse #3 said when she arrived, Resident #1 was not her normal self and was not verbally responsive. She said Resident #1 was not able to take fluids, she explained she was not able to swallow the fluids and would just hold the fluids in her mouth. Nurse #3 explained she spoke with the NP and communicated with her throughout the day about Resident #1. She said the NP had wanted her to try to start an IV on Resident #1 to administer fluids. She further explained they had wanted to administer IV fluids because they were worried Resident #1 would aspirate because she was not swallowing and was holding fluids in her mouth. Nurse #3 stated she assumed Resident #1 usually did not have any trouble swallowing because she normally ate and drank. Nurse #3 said she tried three times to place an IV access site unsuccessfully. Nurse #3 reported then the facility found more glucagon and they gave it to Resident #1. She did not see them administer the glucagon and was not sure who administered it to Resident #1, but she thought it was UM #1. She thought it had been sometime between 9:00-10:00 AM but was not sure of the exact time. Nurse #3 was not sure what Resident #1's blood sugar came up to after the second dose of glucagon was administered. Nurse #3 said around 10:00 AM she started D5W administered by hypodermoclysis on Resident #1. She reported Resident #1's eyes were open, but she was not verbally responsive. Nurse #3 said she did not stay at Resident #1's bedside the entire time, she explained she had other patients to see at the facility. She reported she was in and out of Resident #1's room every 15-20 minutes to check on her and recheck her blood sugar. Nurse #3 said Resident #1's blood sugar was 55 at 12:06 PM. She explained she had checked Resident #1's blood sugar before that but did not remember what the blood	F0684		

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F0684 SS = SQC-J	Continued from page 28 sugar results were. She further explained she had rechecked her blood sugars to make sure they were going up and not falling, she recalled they had been going up but did not remember the results. Nurse #3 said after the hypodermoclysis was started she spoke to the NP again and the NP thought it would be best to get a mid-line (vascular access) placed for Resident #1. She did not remember what time she talked to the NP but said it was sometime between 10:00 AM- 12:00 PM. She said UM #1 called the mobile vascular access company and they were able to come to the facility at 3:15 PM that day to place the midline. Nurse #3 reported Resident #1 stayed in bed the entire day. She said she had arrived at the facility after breakfast, but the staff reported to her Resident #1 did not eat breakfast. Nurse #3 said Resident #1 did not eat lunch or anything because she was not alert enough to eat. She reported Resident #1's mentation was the same and unchanged the entire time she was there. Nurse #3 said she did not stay at the facility the entire day. She explained she left the facility sometime after lunch before the 3-11 shift change but was not sure of the exact time. She said Resident #1's last blood sugar before she left was 74 and she still had no improvement in her mental status. She explained she spoke with the NP, and they thought maybe there was another issue other than Resident #1's low blood sugar causing her decreased mental status. She explained that was why the NP ordered the intramuscular Rocephin (antibiotic) and a urinalysis (UA) for Resident #1. Nurse #3 said she was not in the room when the Rocephin was administered to Resident #1, but it was reported it had been given to her. Nurse #3 said she had not called the family but that the NP told her she had tried to call and update Resident #1's family. When Nurse #3 was asked if she and the NP discussed transferring Resident #1 to the ER, Nurse #3 said the NP had asked her what her thoughts were. Nurse #3 reported she told the NP she was at the facility and would hang around and see how Resident #1 did. Nurse #3 explained they were doing the fluids with hypodermoclysis and were going to be able to get the midline placed and would be able to get some hydration in her. She further explained the initial concern was her low blood sugar and treating her hypoglycemia. She reported that if Resident #1 had not stabilized after the midline was placed then she would have needed to go the ER. Nurse #3 stated she had not witnessed Resident #1 having any seizure activity. Nurse #3 stated she had not noticed any tightness in Resident #1's hands, arms, or jaw, abnormal eye movements, or foaming at the mouth. A progress note by Nurse #2 dated 7/17/25 at 7:45 AM	F0684		

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F0684 SS = SQC-J	Continued from page 29 read: “On coming to shift during report resident was reported to have struggled with low blood sugars throughout the night. Last blood sugar check was 61 at on coming of shift 7:00 AM. I was told to recheck blood sugar at 7:30 AM and call provider back. I rechecked blood sugar at 7:30 AM blood sugar dropped down to 59. I called provider to inform her of blood sugar level. Provider stated to just hold short acting and long-acting insulin for the morning and to recheck in an hour and give her a call back. Resident in bed. Eyes rolling side to side. Moaning. hands tight. Informed unit manager to recheck in an hour and call provider back.” A progress note dated 7/17/25 at 1:08 PM by Nurse #2 read, “[Nurse #3] nurse reported resident's blood sugar increased to 77. Resident does have hypodermoclysis in right low abdominal. Resident is looking around. [Nurse #3] with resident.” An interview was conducted with Nurse #2 on 8/6/25 at 2:53 PM. Nurse #2 was the day shift (7-3) and evening shift (3-11) nurse for Resident #1 on 7/17/25. Nurse #2 stated when she arrived on shift, the night shift nurse (Nurse #1) reported to her Resident #1’s blood sugars were extremely low in the 30’s. Nurse #2 reported, “she said 33 to be exact”. Nurse #2 stated Nurse #1 reported to her the on-call provider was aware of Resident #1’s low blood sugar and had said to recheck Resident #1’s blood sugar around 7:30 AM and call the on-call provider back with what Resident #1’s blood sugar was. Nurse #2 said she rechecked Resident #1’s blood sugar at 7:30 AM and it was in the 50’s, she did not recall the exact number. She reported she called the on-call provider back after checking Resident #1’s blood sugar at 7:30 AM and was told by the on-call provider to hold Resident #1’s insulin. She stated the provider instructed her to try to give her something to eat to increase her blood sugar and to recheck her blood sugar in an hour. Nurse #2 stated she told the provider she did not have time to do that or keep rechecking Resident #1’s blood sugar because she had to pass medications and check blood sugars for her other diabetic residents, so the NP’s provider group sent a Nurse (Nurse #3) who worked for the NP provider group to help with Resident #1. She explained Nurse #3 was with Resident #1 during her day shift while she worked with the other residents, she was assigned to take care of. She reported UM #1 was also helping with Resident #1 throughout the day. Nurse #2 did not recall Resident #1 having abnormal eye movements and tight hands during the morning or reporting it to anyone. Nurse #2 said	F0684		

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F0684 SS = SQC-J	Continued from page 30 she remembered that more from the evening right before Resident #1 went out. She stated Resident #1's eyes were moving left and right slowly like her head was turning side to side but her head was not moving, and her arms were tight and hard to move. She said Resident #1 was not talking or responding. Nurse #2 said Nurse #3 checked Resident #1's blood sugars while she was at the facility and had communicated with the NP. She did not know what the blood sugar results were but reported Nurse #3 told her Resident #1's blood sugar would go up and then drop back down. Nurse #2 stated she did not administer any glucagon to Resident #1. She reported glucagon had not been mentioned to her to administer. Nurse #2 said it was the providers' call for how low someone's blood sugar needed to be before they sent them out to the hospital. Nurse #2 stated Nurse #3 left sometime around the 3-11 shift change. Nurse #2 said she needed someone there to help with Resident #1 because she had other residents to take care of. When she noticed no one was going to be there to watch Resident #1 she spoke to UM #1 and recalled UM #1 had to do something else. Nurse #2 reported she went and checked Resident #1's blood sugar herself and it was low, she said she could not remember the exact number but remembered it was in the 50's once again. Nurse #2 said she asked UM #1 if anyone had called Resident #1's family to let them know what was going on and UM #1 told her she had not. Nurse #2 said she looked in the nursing notes to see if anyone had reached out to the family and saw no one had called, so she called the family to let them know what was going on. She did not recall the exact time she called Resident #1's family. Nurse #2 stated Resident #1's family member arrived at the facility not long after she called them. She said when Resident #1's family member saw Resident #1 they were concerned about the way she looked and requested for her to be sent out to the hospital. Nurse #2 stated she called the provider and let them know Resident #1's family was requesting for her to go out to the hospital. She reported she called the on-call provider and the on-call provider initially said they were going to call the NP, Nurse #2 reported she told the provider her family wanted her to go to the hospital as soon as possible (ASAP) and the provider then said okay. Nurse #2 said she thought Resident #1 needed to go to the hospital that morning and that was why she had called the provider. She explained when someone's blood sugar was that low, she felt it was above the capabilities of the facility and that they could only do so much at the facility. She further explained they had been trying to increase her blood sugar, and it was going up and then dropping back down, she said there was only so much that could be done at the facility. Nurse #2 stated she called Resident #1's family herself because she knew	F0684		

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F0684 SS = SQC-J	Continued from page 31 Resident #1's family was usually there for her and had not been there that day, she thought Resident #1's family would want her to be sent out and what the family wanted went above the NP. She reported that Emergency Medical Services (EMS) arrived at the facility quickly after she called them. Nurse #2 stated she thought Resident #1 went out around 4:40 PM. An interview was conducted with Nurse Aide (NA) #1 on 8/6/25 at 5:00 PM. NA #1 recalled she had worked 1st shift (7am-3pm) and 2nd shift (3pm-11pm) on 7/17/25, she did not recall if Resident #1 was assigned to her that day but said she remembered going into her room to provide care to her on 7/17/25. She remembered 7/17/25 was the day she was transferred to the hospital. She recalled she was doing rounds when a nurse was trying to put an IV site in Resident #1, and she could not get to her for rounds. She recalled it had been between 10:00-11:00 AM and Resident #1 had been foaming at the mouth. She said in the afternoon right before Resident #1 went out to the hospital she was foaming at the mouth again, she said it had been around the 3-11 shift change. NA #1 recalled she had asked the nurse why Resident #1 was having foaming at the mouth. She reported the nurse told her "they were handling it.", She thought the nurse she spoke to was UM #1. An order dated 7/17/25 entered at 1:15 PM read, Glucagon Emergency Injection Kit 1mg, inject subcutaneously as needed for low capillary blood glucose (CBG), recheck CBG in 15 minutes. The glucagon was not documented as administered on the MAR. There were no other orders for glucagon present on the MAR. The order was entered by Nurse #4. An interview was conducted with Nurse #4 on 8/14/25 at 4:15 PM. Nurse #4 said she was not Resident #1's nurse on 7/17/25 but had worked day shift (7am-3pm) that day. She explained she had been an extra nurse and had been trying to help where needed that day. Nurse #4 reported she entered the order for IM glucagon into the electronic medical record for Resident #1 because UM #1 had asked her to. Nurse #4 said she did not know when the glucagon was administered or who had administered it. She remembered seeing Resident #1 during the morning on 7/17/25, she said Resident #1 was not well. Nurse #4 explained Resident #1 had a decreased level of consciousness and her eyes "looked weird". She said Resident #1's eyes were set like they were stuck, and she showed no response when you spoke or talked to her. She stated Resident #1's eyes were open, but she was not alert or responsive. Nurse #4 recalled Resident #1's eyes would move but not like she was following or	F0684		

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F0684 SS = SQC-J	Continued from page 32 focusing on anything. She further recalled her eyes "rocking back and forth" moving left and right very slowly but she was not moving her head. Nurse #4 said her eyes were not always like that, that sometimes they would just stare straight off and then other times they would move slowly back and forth. Nurse #4 remembered being in Resident #1's room at mealtime, she did not say what meal but said the NA attempting to assist Resident #1 with her meal stated he could not feed Resident #1 because she would not open her mouth. Nurse #4 reported she told the NA Resident #1 did not look safe to eat. Nurse #4 said as far as she knew Resident #1 did not eat anything that day, she said she was not safe to eat because she was not alert enough. She did not remember the name of the NA. Nurse #4 reported she was in and out of Resident #1's room during her shift just checking on her because she was concerned and curious about what was going on. Nurse #4 stated she saw Resident #1 multiple times during her shift, she said she was trying to be helpful and available if she was needed. Nurse #4 stated she remembered Resident #1's blood sugar was in the 30's multiple times during the day. She was not sure about Resident #1's blood sugars from the night shift but remembered during the day shift her blood sugars were in the 30's and 50's multiple times. Nurse #4 stated she thought one time they were able to get Resident #1's blood sugar up to the 70's but then it dropped again. Nurse #4 said her shift ended at 3:00 PM and she left sometime between 3:00 PM and 4:00 PM that day. She recalled hearing Nurse #2 talking to Resident #1's family on the phone right before she left. Nurse #4 stated Resident #1 did not wake up and was non-responsive the entire time. Nurse #4 said Resident #1 was pretty much the same from the time she got there in the morning until she left at the end of her shift that day. She reported she did not remember seeing anything that looked like seizures that day. Nurse #4 said she did not think the eye movements were seizure related because she did not see Resident #1's having jerking body movements. Nurse #4 stated she did not try to move Resident #1 and did not know if she had tightness in her arms or hands. Nurse #4 stated she absolutely felt Resident #1 needed to go to the hospital that day. Nurse #4 reported since Nurse #3 was there with Resident #1 and everyone, UM #1, Nurse #3, and the NP were aware of the situation that her blood sugar would come up just a little bit and then drop she did not think she needed to do anything. A note by the NP dated 7/17/25 at 1:50 PM read, "Alerted by Registered Nurse (RN) [Nurse #3] regarding patients hypoglycemia of 31 at 5:30 AM, up to 61 at 6:45 AM after dextrose given. RN called at 7:30AM to	F0684		

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F0684 SS = SQC-J	Continued from page 33 inform me of a sugar of 59, held morning dose of Tresiba and sliding scale. [Nurse #3] assessed patient at the building. Patient is somnolent [sleepy], moving her head to the side occasionally, not interacting with RN. IV attempted for D5 fluids to raise glucose, unsuccessful. Went ahead and ordered clysis D5 60ml/hr. Sugar increased to 77, no improvement in patients' mentation according to [Nurse #3], RN. Ordered for patient to have midline placed for fluids. U/A with culture ordered. Rocephin 2gm IM ordered for possible urinary tract infection (UTI). Blood Glucose (BG) ordered every 3 hours for the next 24 hours as well as vital signs every 4 hours times 3 days. Discontinued sliding scale all together as patient sometimes does not eat her meals when insulin lispro given leading to hypoglycemia. Son called with no answer, left voice message. Spoke with unit manager (UM #1) regarding patient and for staff to call for midline placement as soon as possible (ASAP). Will switch over to normal saline when midline access is obtained as sugars are improving. If patient does not improve after fluids and Rocephin, will send for evaluation at the ER." An interview was conducted on 8/6/25 at 3:19 PM with the NP. The NP recalled Resident #1 and her low blood sugars on 7/17/25. She reported she was not at the facility that day, but Nurse #3 was at the facility. The NP explained she communicated with her RN, Nurse #3 that day and gave her orders. She said Nurse #3 went to the facility three days a week to check on patients. The NP stated while Nurse #3 was at the facility she noted Resident #1 had low blood sugar so she called her. The NP recalled that once her RN had already gotten to the facility someone from the facility called to tell her Resident #1's blood sugar was low. The NP said she told the nurse who called to recheck Resident #1's blood sugar in an hour and hold her insulin. The NP did not remember if she was aware of how low Resident #1's blood sugars were that morning. The NP reviewed the on-call records and stated the facility had called prior to 7:30 AM and reported her blood sugar was 31 and glucagon had been given times one dose. She reported the facility must have called her around 8:00 AM on 7/17/25 because that was what time she came on call for the day. The NP stated her RN (Nurse #3) had stayed with Resident #1 most of the day until she went out. The NP stated she did that because they were worried about Resident #1 and would not want to leave a patient with low blood sugar alone. The NP stated her RN (Nurse #3) reported to her that Resident #1 was in the common area asleep but arousable and that she declined breakfast because she was full. She reported the RN said Resident #1 was more lethargic	F0684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD , NEBO, North Carolina, 28761

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F0684 SS = SQC-J	Continued from page 34 than usual. The NP said that was why they were trying to get her blood sugar up, she said she thought it was a blood sugar issue or dehydration. The NP said she communicated with her RN (Nurse #3) that day by phone calls and did not have messages in regard to how frequently Nurse #3 was checking Resident #1's blood sugars or how high her blood sugar went up that day. She stated she knew Nurse #3 was checking Resident #1's blood sugars frequently because she was not leaving her side. The NP reported she tried to call Resident #1's family and had left voice message. The NP explained that anytime there was an issue like this with a patient she needed to know from the family what the goals of care were, do they want to treat in place or go out to the hospital. The NP reviewed her notes and stated she had contacted Resident #1's family at 7:17 AM and left a voice message. The NP further explained, she was trying to treat Resident #1 in place with interventions before sending her out. She reported the interventions included trying intravenous fluids to see if she was dehydrated, treating her with IM Rocephin if it was an infection. The NP said she was trying to treat Resident #1 in place to see if the interventions would make a difference before deciding to send her out. The NP said Resident #1's blood sugar did come up to 74 and she thought what was done to treat Resident #1 was appropriate. The NP reported no one reported to her Resident #1 had abnormal eye movements, tightness in her mouth/ jaw, or tightness of her hands/ arms. The NP said if it had been reported to her, she would have been concerned about seizures. She said if she had been concerned about seizures she may have sent Resident out to the hospital sooner and that she may have sent her out that morning. The NP said in her clinical opinion a blood sugar level in the 20's-30's could cause a diabetic coma or seizure. The NP stated if someone did not respond after two doses of IM glucagon then she would send them out. She reported Resident #1's blood sugars were coming up just slowly but were not dipping into the 30-40's. She said it depended on the patient on how much and how fast someone's blood glucose would increase after receiving glucagon. The NP said she was not aware of Resident #1's hospital discharge summary stating they "suspected she had prolonged hypoglycemia and possible seizure that led to comatose state." The NP also indicated that she had not consulted with the MD regarding Resident #1 and her low blood sugar and the interventions that had not been effective in treating her low blood sugar. A progress note dated 7/17/25 at 3:43 PM by Nurse #2 read, Resident's last blood sugar check by [Nurse #3] Nurse at 2:30 pm dropped down from 74 to 59. New orders	F0684		

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F0684 SS = SQC-J	Continued from page 35 from NP. Family, Son and daughter-in-law notified at 3:30 pm. An interview was conducted on 8/6/25 at 12:56 PM with Family Member #1. She said the facility had not called an ambulance to send Resident #1 to the hospital when her blood sugar was in the 30's-50's on 7/17/25. She explained she received a phone call from a nurse at the facility around 3:30 PM on 7/17/25. She stated she did not know the nurse's name but said the nurse had worked with Resident #1 previously and knew her. Family Member #1 said the nurse told her Resident #1 was not herself and she needed to come see her. Family Member #1 recalled the way the nurse talked about Resident #1 had scared her. Family Member #1 stated she arrived at the facility about 30 minutes later around 4:00 PM. She reported when she walked into Resident #1's room and saw her she immediately told the nurse to call an ambulance. Family Member #1 stated Resident #1 was unable to talk and was unresponsive. She said Resident #1's eyes were open, and they may have been moving side to side, but they were not really moving to focus on anything. She explained Resident #1's eyes did not track her or react to her. She said Resident #1's mouth was tight and clenched, and she was foaming at the mouth. Family Member #1 said EMS arrived at the facility in about 15 minutes. Family Member #1 reported the hospital treated Resident #1 with fluids and antibiotics but said "she never came back from it" and became responsive again. She explained that the hospital told her Resident #1's "blood sugar dropped so low she went into a glycemic coma." Family Member #1 did not understand why the facility had not called an ambulance to send Resident #1 to the hospital sooner. She felt the facility should have called an ambulance sooner and that Resident #1 would not have been in that condition if she had been transferred to the hospital sooner. She said, "they just sat there and watcher her". Family Member #1 reported she had not received any phone calls or messages from the facility or the NP before the nurse called her at 3:30 PM on 7/17/25. She said her husband also had not received any phone calls or messages. Family Member #1 explained the hospital told them Resident #1 was not going to come back and Resident #1 was transitioned to hospice. Family Member #1 reported Resident #1 passed away on 7/30/25. A progress note dated 7/17/25 at 5:06 PM by Nurse #2 read, Family visited facility and requested that resident be sent out to hospital as soon as possible. Family stated she doesn't look right. On call provider notified of family's request to send resident out to	F0684		

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F0684 SS = SQC-J	Continued from page 36 hospital ASAP. Resident transferred to hospital via EMS stretcher. Review of an EMS report dated 7/17/25, revealed EMS received the emergency call from the facility at 4:33 PM and arrived on scene at the facility at 4:48 PM. The EMS report stated when they arrived “the patient was found lying in her bed, eyes open but only reactive pain.” “Patient is noted to be comatose with seemingly left gaze with inability to follow any types of commands for more detained assessment.” “Her baseline is reported to be normal with some memory problems however, otherwise able to answer questions and hold conversation.” The EMS report stated her blood sugar was 94 and then 84 with direct blood drawn from midline. She was given 125 ml of D10 (10% dextrose (glucose) in water) to see if it improved her mental status. The report stated no improvement in mental status was noted and D10 was stopped after 125 ml. The EMS report indicated they departed the scene at 5:09 PM. The hospital ER report dated 7/17/25 stated Resident #1 presented stupor (a state of greatly reduced responsiveness where a person can only be aroused by vigorous or painful stimulation), withdraws to pain. The report stated per EMS, Resident #1 was found to be stupor upon initial exam. EMS reported D10 was given. The report stated Resident #1’s glucose was 105 upon triage at the ER. Under the physical exam neurological section it was noted she had a “left beating nystagmus” (involuntary, rhythmic oscillation of the eyes. in left-beating nystagmus, the eye drifts slowly to the right and then quickly snap back to the left). A hospital discharge summary dated 7/25/25 indicated Resident #1 arrived to the hospital on 7/17/25 at 5:32 PM. The hospital course said Resident #1 presented to the hospital from the facility secondary to increasing lethargy, somnolence, with concern for acute metabolic encephalopathy. The discharge summary included the hospital workup was remarkable for acute kidney injury (AKI) and likely urinary tract infection (UTI). The hospital course stated Resident #1 did not have improvement in her mental status despite improvement in AKI and treatment for UTI. The discharge summary stated, “suspect she had prolonged hypoglycemia and possible seizure which led to comatose state.” The Discharge summary included that goals of care were discussed with family, and the decision was made to transitions to comfort care with inpatient hospice.	F0684		

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F0684 SS = SQC-J	Continued from page 37 A death certificate for Resident #1 documented she passed away on 7/30/25. Acute metabolic encephalopathy was listed as the cause of death. An interview was conducted with the Medical Director on 8/7/25 at 11:15 AM. The Medical Director said they should have sent Resident #1 out long before they did. He explained his background was working in the hospital and he knew how to treat hypoglycemia in the hospital setting. He explained he would give oral glucose if a patient was alert and able to take it. He said if that was not effective or depending on the level, if someone was unresponsive, they would need an IV for hydration therapy and could try D5 NS, D50, or a glucose drip in the hospital setting. The Medical Director said that level of care should not be provided in a nursing home. He said in a facility he would give a patient oral glucose if they were alert. The Medical Director said if the patient was alert and the oral glucose did not work, he would maybe give IM glucagon one time and if that did not work, he would send them out to the hospital. The Medical Director reported that if someone was obtunded or unresponsive he would send them out to the hospital because they would need an IV glucose concentrate. The Medical Director stated that a nursing home was not the place to treat this, that they did not have the capabilities. The Medical Director stated Resident #1 was acutely ill and he would have sent her out that morning after the IM glucagon did not work. He said if he had been notified, someone was obtunded or not responsive he would probably have sent them out on that alone but may have tried to give one does of glucose or glucagon if the patient was alert. The Medical Director stated if they did not respond they needed to be in a different place and that they were not post-acute level of care anymore and needed to be in the acute care (hospital) world. An interview was conducted with the Director of Nursing (DON) on 8/7/25 at 11:25 AM. The DON reported she knew Resident #1 was struggling with blood sugar that day but did not know all the details. She reported she knew the NP had attempted to contact the family that morning and they did not answer. When asked why Resident #1 was not sent out to the hospital earlier, the DON said the NP provider group tried to treat in-house. The DON thought Resident #1 not being sent out to the hospital until 5:00 PM on 7/17/25 may have been a little prolonged. The DON reported that a lot of the facility nurses said they felt Resident #1 should have been sent out earlier too but when the NP does not want to send her out there is not much they can do. The DON said she was not aware the Medical Director was above the NP	F0684		

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F0684 SS = SQC-J	Continued from page 38 provider group until today. The DON stated she thought the nurses should have gone to the Medical Director's provider group earlier that day to let them know what was going on and see if they wanted to send Resident #1 out. The DON reported the Medical Director provider group Physician Assistant (PA) had been in the building that day and the only reason she could think the nurses had not gone to him was that the NP's RN (Nurse #3) was in the building and was in contact with the NP. The DON stated she thought the PA for the Medical Director Provider group was at the facility that day around shift change and that the nursing staff had notified him that the family wanted Resident #1 sent out. She believed the PA had given the order to send Resident #1 to the ER. An interview was conducted with the PA on 8/7/25 at 2:02 PM. The PA explained he worked for the Medical Director provider group and was in the building Monday through Friday. He said he would have been at the facility on 7/17/25 but that the staff had not come to him that day about Resident #1 or her low blood sugars. The PA stated he had not given the order to send Resident #1 to the ER. The PA said he would not have kept her in the building that long that he would have sent her out if staff had come to him about Resident #1. An interview was conducted with the Administrator on 8/7/25 at 3:50 PM. The Administrator stated this was the first time she was becoming aware of the entire situation. She reported, except for the NP not being able to get in touch with the family, she did not know all the other details. The Administrator stated she was proud of Nurse #2 who contacted the family and did what she needed to do when she sent Resident #1 out. The Administrator said the NP's RN (Nurse #3) had been at the facility and had to be in Resident #1's room every 15-20 minutes. The Administrator stated she did not know how it could be expected for the staff to do that when they had other residents to take care of. The Administrator reported she was disappointed in the NP provider group process. The Administrator said she wanted to know where the NP would have drawn the line and sent Resident #1 out. The Administrator reported she would have wanted to see something done differently and a practitioner to act timelier. The Administrator did not understand lack of family involvement, she stated she would not have called the family only once. The facility's Administrator was informed of the immediate jeopardy on 8/7/25 at 4:03 PM.	F0684		

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F0684 SS = SQC-J	Continued from page 39 The facility submitted the following credible allegation of immediate jeopardy removal 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. The facility failed to recognize that a diabetic resident (Resident #1) with critical low blood sugar and symptomatic needed emergent care On 7/17/25 at 5:30 AM Resident #1's blood glucose was 31. After IM glucagon the resident remained symptomatic. Symptoms included lack of responsiveness, eyes moving left to right, obtunded, jaw tightness, inability to swallow, tightness of hands, moaning, foaming at the mouth. Resident #1's blood glucose level remained less than 70 until 1:08 PM when it was documented her blood glucose level was 77, however she remained obtunded with no verbal response. Resident #1's blood glucose decreased again to 59 at 2:30 PM. Resident #1 was not transferred to the emergency room until her family arrived at the facility and requested, she be transferred. Resident #1 was transferred to the emergency room at 5:06 PM on 7/17/25. Resident #1 was admitted to the hospital on 7/17/25. The hospital course stated, "suspect she had prolonged blood glucose and seizure which led to comatose state." Her hospital diagnoses included acute metabolic encephalopathy, prolonged hypoglycemia, acute kidney injury, and urinary tract infection. Resident #1 was transitioned to inpatient hospice and passed away on 7/30/25. Resident #1 had critically low blood sugar and displayed symptoms that required emergency care; however, the facility failed to recognize the emergent situation. All residents in the facility have the potential to be affected by this deficient practice. All residents with diabetes or those taking antidiabetic medications are at risk. On August 8, 2025, the Director of Nursing and the Unit Manager reviewed medical records related to diabetes diagnoses and physician orders for diabetic medications and insulin. This was done to identify residents at risk of hypoglycemic episodes and to ensure that their physician orders were updated according to facility protocol. 2. Specify the action the entity will take to alter the	F0684		

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F0684 SS = SQC-J	Continued from page 40 process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On August 8, 2025, the Medical Director conducted a training session for all primary care physician extenders. The purpose was to emphasize the importance of notifying the Medical Director when a resident is identified as having critically low blood sugar and is showing symptoms that require emergency care. Education included identification of emergent situation versus nonemergent situation and within the capabilities of the facility to properly care for the resident with critically low blood sugar and when to get the resident emergency medical attention. Nurse Practitioner involved was removed from facility services effective 8/7/2025 by the Facility Director of Operations and the Extended Provider Practice. Additionally, on August 8, 2025, the Director of Nursing, Minimal Data System (MDS) RN, and Weekend RN Unit Manager provided education for all staff. This education covered the signs and symptoms of hypoglycemia and provided guidance on when to notify the nurse, the medical doctor, and when to call 911 if a resident appears to be in an emergency situation. Education included if blood sugar levels fall outside the parameters specified in the physician's orders and the patient exhibits symptoms of hypoglycemia—such as shakiness, chills, nausea, a rapid heartbeat, or hunger—but remains responsive, this is considered a non-emergent situation. Education was provided regarding emergent events, such as non-responsiveness or seizure activity, which would require immediate notification of a physician and a call to 911. The training included the importance of treating hypoglycemia as it can lead to devastation including up to death if left untreated. A 100% audit was conducted of all identified diabetic resident’s medication orders was completed by the Director of Nursing, and/or Unit Manager on 8/8/25 to identify residents without parameters for when to contact the MD for abnormal glucose blood level. For those residents identified, orders were updated to include the parameters of when to notify the physician. New protocol established: 1. Notify the physician for blood glucose levels below	F0684		

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F0684 SS = SQC-J	Continued from page 41 60 and above 500 or identified as “Hi” on the glucometer. 2. For blood glucose levels 50 and below: (1) Verify blood glucose level using a finger on the opposite hand, if the blood glucose level remains the same or below 50, then (2) give 1mg Glucagon intramuscularly. Glucagon is stored in the medication cart for all residents with a diabetic diagnosis, including those on diet control, insulin-dependent residents, and residents taking antidiabetic medications who are at risk for hypoglycemic episodes. Glucagon was added to each resident's medication drawer on 8/8/2025, who was identified as a diabetic. Additionally, it can be found in the pharmacy emergency kit located in the medication room at the nursing station. The following additional actions should be taken: (1) notify the physician for additional orders, (2) continue to monitor the resident, (3) evaluate their condition, and (4) inform the physician of any changes. Immediate Jeopardy Removal Date: 8/9/2025 On 8/14/25 the facility’s credible allegation of immediate jeopardy removal was validated by the following: Review of facility audits revealed the facility completed an audit of all diabetic residents residing in the building. Review of physician orders for diabetic residents, including non-insulin dependent diabetic residents revealed as needed (PRN) glucagon orders had been added for all residents. Medication cart observations were completed. Each medication cart was observed to have emergency glucagon kits for individual residents. Review of in-service education logs revealed licensed nurses, including Nurse #2 and UM #1 were educated on the facility protocol for treatment of hypoglycemia, when to notify the physician, emergent vs. non-emergent situations, including when to call 911, and when to contact the Medical Director and/or designee if a provider does not treat an identified emergent situation as emergent. Additional in-service logs were reviewed and revealed all staff were educated on the signs/ symptoms of hypoglycemia, emergent situations, including when to call 911, and notifying the nurse of change in condition. Interviews were conducted with licensed nurses,	F0684		

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F0684 SS = SQC-J	Continued from page 42 including agency nurses. The nurses confirmed they had received education on the facility protocol for treatment of hypoglycemia, when to notify the physician, emergent vs. non-emergent situations, including when to call 911, and when to contact the Medical Director and/or designee if a provider does not treat an identified emergent situation as emergent. The licensed nurses were able to accurately verbalize the education they received. Interviews were conducted with licensed nurses, nurse aides, dietary staff, housekeeping, maintenance, office, administration/management, therapy, and agency staff. Interviews were conducted with staff from different shifts. The staff interviews revealed they had received education on the symptoms of hypoglycemia/ hyperglycemia, emergent situations including when to call 911, and notifying the nurse for change of condition. Staff were able to accurately verbalize the education they had received. Review of provider in-service logs revealed on 8/8/25 providers were educated by the Medical Director on the importance of notifying the medical Director when a resident is identified as having a critically low blood sugar and is showing symptoms that require emergency care. Education included: identification of emergent situation versus nonemergent situation, what is within the capabilities of the facility to properly care for residents with critically low blood sugar, and when to get the resident emergency medical attention. Education included acknowledgement of the devastation this type of scenario could bring if not treated properly. An interview with the Administrator confirmed the involved NP was removed from facility services beginning on 8/7/25. The Administrator stated the facility had contacted the board of nursing and reported the involved NP but had not heard back from the board of nursing. Immediate Jeopardy Removal Date of 8/9/25 was validated.	F0684		