STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345280	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Care of Raeford	1206 N Fulton Street , Raeford, North Carolina, 28376

(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 The survey team entered the facility on 9/24/25 to conduct a complaint investigation survey. The survey team was onsite 9/24/25 and 9/25/25. Additional information was obtained offsite on 9/26/25 and 9/29/25. Therefore, the exit date was 9/29/25. Event ID# 1D7A41-H1. In accordance with QSO-26-01-All, the posting of this Statement of Deficiencies was delayed as a result of the Federal Government shutdown. The following intakes were investigated: 2610048, 2610124, 2618103, and 2570042. Intake 2618103 resulted in immediate jeopardy. 1 of the 8 complaint allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity (J). The tag F684 constituted Substandard Quality of Care. Non-noncompliance began on 8/29/25. Immediate jeopardy was removed and the facility came back in compliance effective 9/4/25. A partial extended survey was conducted.	F0000		
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.	F0684	"Past Noncompliance - no plan of correction required"	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0684 SS = SQC-J	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews with staff, Responsible Party (RP), Emergency Medical Services (EMS) personnel, and the Medical Director, the facility failed to accurately transcribe necessary information from the FL2 (a medical form completed by a physician to document a patient's medical condition, necessary care, and recommended level of care) to ensure staff monitored a resident's blood glucose (sugar) and administered insulin or sought clarification from a medical provider for a resident with diabetes. Resident #1 was admitted to the facility from home on Friday 8/29/25 for respite care (short-term care that provides relief for caregivers) with an FL2 that indicated 5 units of Lantus (long-acting insulin used to manage blood glucose levels) at bedtime and continuous glucose monitoring. Lantus was not administered on 8/29/25 and 8/30/25 at bedtime and Resident #1's blood glucose was not monitored throughout his stay at the facility from 8/29/25 at approximately 1:45 PM through Sunday 8/31/25 at approximately 1:45 PM when he was discharged home with his RP. On 8/31/25 at approximately 2:06 PM after leaving the facility, the resident's continuous blood glucose monitoring device indicated HI (reading above 500) (normal blood glucose reference range is 70 -110 milligram [mg] per deciliter [dl]). A blood sugar of 500 is considered a medical emergency. The RP administered 5 units of Lantus to the resident. At 5:40 PM that same day (8/31/25), the RP contacted EMS who arrived at the resident's home at 6:09 PM and when they obtained Resident #1's blood glucose level it was 403. Resident #1 was transferred to the Emergency Department (ED) where he presented with an elevated blood glucose of 428 (7:17 PM), elevated heart rate and diarrhea. Resident #1 was monitored overnight at the ED and given intravenous (IV) fluids for persistent tachycardia (elevated heart rate above 100 beats per minute) and hyperglycemia (high blood glucose). This deficient practice affected 1 of 3 residents reviewed for diabetes care (Resident #1). The findings included: Resident #1's Long Term Care FL2 form signed by Resident #1's primary care provider on 8/11/25 included the following orders related to diabetes management: 1. Metformin (diabetes medication) 750 milligrams (mg) oral tablet twice a day with food 2. Empagliflozin (diabetes medication) 12.5 mg tablet by mouth daily	F0684		

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F0684 SS = SQC-J	Continued from page 2 3. Lantus (long-acting insulin) 5 units subcutaneously at bedtime 4. Continuous glucose monitoring During an interview with the Admissions Director on 9/25/25 at 9:56 AM she indicated that a representative from the Veteran's Affairs (VA) had reached out to her to set up the respite care at the facility with a referral date of 8/27/25 for respite services from 8/29/25 through 8/31/25. She indicated that the VA sent her the required paperwork to include the FL2 form which she reviewed to ensure the facility was in a position to care for the resident. The Admissions Director stated that she called Resident #1's RP on 8/28/25 and informed her to bring his medicine when she brought the resident to the facility for admission on 8/29/25. The Admissions Director stated that she took a hard copy of the FL2 form to the B-hall nurses' station because the nurse would need the FL2 form for admission orders and she gave it to a nurse, but she could not recall who the nurse was. She explained that she also scanned a copy into Resident #1's electronic record. During an interview with the Director of Nursing (DON) on 9/24/25 at 11:15 AM she indicated that Nurse #2 was initially supposed to admit Resident #1 and they thought that he was supposed to come to the facility on Thursday 8/28/25. The following orders were transcribed into Resident #1's electronic health record (EHR) by Nurse #2 on 8/28/25: 1. Albuterol sulfate 90 micrograms (mcg)/actuation hydrofluoroalkane (HFA) aerosol inhaler, administer two puffs every 6 hours as needed for shortness of breath/wheezing. 2. Amlodipine 5 mg tablet, administer one tablet daily for hypertension. 3. Cholecalciferol (vitamin D3) 50 mcg (2,000 unit) capsule, administer one tablet daily for vitamin D deficiency. 4. Donepezil 5 milligram mg tablet, administer one tablet daily for dementia.	F0684		

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F0684 SS = SQC-J	Continued from page 3 5. Empagliflozin 25 mg tablet, administer half tablet orally daily for diabetes mellitus. 6. Losartan 50 mg tablet, administer one tablet daily for hypertension. 7. Metformin 750 mg tablet, administer one tablet twice a day with food. 8. Pantoprazole 40 mg tablet, delayed release, administer one tablet daily for gastroesophageal reflux disease (GERD). There were no orders entered for 5 units Lantus at bedtime and/or continuous blood glucose monitoring. During an interview with Nurse #2 on 9/24/25 at 12:57 PM she indicated that she was initially supposed to admit Resident #1 to a room in her hallway (B-Hall) on 8/28/25, but he ended up in a different room and Nurse #1 completed the admission. Nurse #2 stated that she had transcribed Resident #1's orders from the FL2 form into the EHR on 8/28/25, but she was not sure why she did not enter the orders for blood glucose monitoring and 5 units of Lantus. Nurse #2 stated that the admitting nurse normally would transcribe the orders into the EHR and verify with the written orders to ensure they were entered correctly. She indicated that she would have verified the medicine brought in by the RP with the orders from the FL2. Resident #1 was admitted into the facility on 8/29/25 for respite care. His diagnoses included dementia, type 2 diabetes, hypertension and chronic kidney disease. An interview was conducted with Resident #1's RP on 9/24/25 at 3:56 PM. She indicated that Resident #1 had a continuous blood glucose monitoring device that functioned via a sensor on his arm that was linked to an application on her cellular phone. She indicated that she could not monitor the resident's blood glucose while the resident was at the facility because the application on her cellular phone had to be close to the sensor (approximately 30 feet) to capture the blood glucose reading. She indicated that the facility was aware the resident had diabetes and could have checked the resident's blood glucose by pricking his finger (and then utilizing a glucometer). The RP explained that the VA had organized the respite care stay for Resident #1 and sent the paperwork to the facility. She stated that nobody at the facility asked her about the continuous blood glucose monitoring sensor. She	F0684		

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F0684 SS = SQC-J	Continued from page 4 reported that after she brought the resident's medicine to the facility she expected the nursing staff to care for the resident and give him his medicine. She indicated that the resident's prescribed Lantus was with all the medicine she brought to the facility on admission as the Admissions Director instructed her to bring all of his medications. A progress note written by Nurse #1 dated 8/29/25 at 1:45 PM indicated Resident #1 was admitted to the facility from home via personal vehicle escorted by family. Resident #1 was alert, verbally responsive and only able to state his name and date of birth appropriately. A head to toe assessment was completed with no findings of open areas, bruises or unusual marks, and good skin care maintained. His vital signs included: blood pressure:145/90 (normal range: 90/60 to 120/80), pulse:102 (normal range: 60-100), respirations:18 (normal range: 12 to 18), temperature: 97.4, and oxygen saturations: 96 % (normal range 95%-100%). Resident #1 was admitted to the facility for respite care with an expected discharge date of 08/31/25. All personal belongings were noted. Resident's RP stated that resident had a tendency to wander. Wanderguard bracelet was applied to his right ankle to prevent elopement. There was no information in the progress note related to a continuous blood glucose monitoring sensor for Resident #1. During an interview with Nurse #1 on 9/24/25 at 12:07 PM she indicated she admitted Resident #1 on 8/29/25 around 1:45 PM. She stated she completed a head-to-toe assessment, applied a wanderguard bracelet on Resident #1 and completed an admission note. Nurse #1 indicated Resident #1's RP gave her a plastic bag with Resident #1's medications which she put in the medication cart, but she (Nurse #1) did not look inside the bag to see what the medications were at the time she received the medications. She indicated that after Resident #1 was settled in his room she went to the medication cart to compare the medications in the plastic bag and the medications transcribed in the MAR and they matched. She stated that she did not see Lantus in the plastic bag. Nurse #1 explained that the orders had been transcribed by Nurse #2 the previous day (8/28/25) because initially, Nurse #2 was supposed to admit Resident #1 to a different hallway. She reported that the process for transcribing admission orders was for the admitting nurse to transcribe the orders into the EHR and verify with the written orders to ensure they were entered correctly. She indicated she did not verify the orders in the MAR with the orders on the FL2 form because Nurse #2 told her that she had entered all the orders into the EHR. Nurse #1 verbalized that the	F0684		

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F0684 SS = SQC-J	Continued from page 5 orders for blood glucose monitoring and 5 units Lantus were not entered in the EHR and she did not realize that all the orders were not entered because she did not look at the FL2 form. Nurse #1 indicated she transferred Resident #1 to the locked unit later that day (8/29/25) before the end of her shift at 7:00 PM because he had exit seeking behaviors. She stated she did not check or monitor Resident #1's blood glucose during her shift because she did not realize the resident was supposed to have his blood glucose monitored. She stated that she did not see the continuous blood glucose monitoring sensor on the resident's arm. She reiterated that did not realize that Resident #1 needed blood glucose monitoring because there was no order in the EHR. Resident #1's 5-day Medicare Minimum Data Set (MDS) Assessment dated 8/31/25 indicated his cognition was severely impaired. Diabetes was listed as an active diagnosis and he was coded as taking hypoglycemic medication (medication utilized to lower blood glucose). Resident #1's Medication Administration Record (MAR) from admission on 8/29/25 through discharge on 8/31/25 indicated the medications that were entered in the EHR were administered as ordered. The MAR did not include any evidence that continuous blood glucose monitoring was completed and/or that 5 units of Lantus was administered at bedtime as indicated on the FL2. An interview was conducted on 9/25/25 at 2:55 PM with Nurse #4. She indicated she was assigned to care for Resident #1 during the night shift on 8/29/25 at 7:00 PM to 8/30/25 at 7:00 AM. Nurse #4 stated that Resident #1 was up at night walking in the hallways and his vital signs were stable. She stated that she did not monitor his blood glucose or administer any insulin because she did not see those orders in the MAR during her shift. Nurse #4 indicated that she did not see the continuous blood glucose monitoring sensor on the resident's arm. She reported that Resident #1's diabetes oral medications were not scheduled for the night shift and therefore she would not have thought that he needed glucose monitoring. Nurse #4 indicated that she did not look in Resident #1's medicine bag because he was not scheduled to get any medicine during the night shift. During an interview on 9/24/25 at 1:42 PM with Nurse #3 she indicated that she cared for Resident #1 on 8/30/25 during the day shift (7:00 AM- 7:00 PM). She verbalized that she had followed the orders on the MAR and did not monitor Resident #1's blood glucose because it was not	F0684		

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F0684 SS = SQC-J	Continued from page 6 on the MAR. She indicated that Resident #1's vital signs were stable throughout her shift. Nurse #3 stated that if she had seen the continuous blood glucose monitoring sensor on the resident's arm it would probably have jogged her memory that the resident required glucose monitoring, but she did not see it. She indicated that she administered the scheduled diabetes medicine to Resident #1 during her shift, she did not see Lantus in the bag that had the resident's medications, and she did not realize that he might need glucose monitoring. During an interview on 9/25/25 at 3:12 PM with Nurse #5 she stated that she had cared for Resident #1 during the night shift on 8/30/25 at 7:00 PM to 8/31/25 at 7:00 AM. She indicated that Resident #1's vital signs were stable during her shift and that she did not monitor Resident #1's blood glucose or administer insulin at bedtime because it did not come up on the MAR as orders to be completed. Nurse #5 stated that she did not see the continuous blood glucose monitoring sensor on the resident's arm and there were no diabetes medications scheduled for Resident #1 during the night shift. She indicated that she did not need to administer any medicine to the resident during the night shift so she did not look in his medication bag. During an interview on 9/24/25 at 2:00 PM with Nurse #6 she indicated that she had cared for Resident #1 with Nurse #3 on 8/31/25 because she was on orientation during the day shift (7:00 AM – 7:00 PM). Nurse #6 stated that Resident #1's vital signs were stable, and she administered the medications that were scheduled on the MAR during her shift but she did not realize that the resident needed glucose monitoring. She stated that she did not monitor Resident #1's blood glucose because she did not see an order for blood glucose monitoring and she did not see the continuous blood glucose monitoring sensor on the resident's arm. She also stated that she did not see any insulin in the plastic bag which had Resident #1's medications. She indicated she did not notice any signs of hyperglycemia when she worked with the resident (8/31/25). Nurse #6 stated that Resident #1 was given a bath by Nurse #3 and Nursing Assistant (NA) #1 because he had an incontinent episode just before he was discharged home around 2:00 PM on 8/31/25. During an interview with NA #1 on 9/24/25 at 3:18 PM she stated that she had cared for Resident #1 on 8/30/25 and 8/31/25 during the 7:00 AM to 3:00 PM shift. She stated that Resident #1 was able to feed himself and his nutritional intake on both dates was 76 - 100%. She indicated that she bathed Resident #1 with	F0684		

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F0684 SS = SQC-J	Continued from page 7 Nurse #3 on 8/31/25 between 1:00 PM and 2:00 PM just before he was discharged home because he had diarrhea. She indicated that was the first time he had loose stools. She stated that she did not notice any change in condition with Resident #1 during the two days she cared for him (8/30/25 and 8/31/25). A nursing progress note dated 8/31/25 at 2:31 PM written by Nurse #6 indicated Resident #1 was discharged home, via private vehicle. His RP signed discharge paperwork and a copy was provided to the RP. All personal belongings and medications were given to the resident's RP. There were no signs or symptoms of acute distress, respiratory distress/discomfort, or pain. Resident #1's RP was advised to contact the facility with any questions/concerns. On 9/24/25 at 12:08 PM Resident #1's RP shared a screen shot from the cellular application linked to the resident's continuous blood glucose monitoring sensor revealing a reading of "HI" on 8/31/25 at 2:06 PM. An interview was conducted with Resident #1's RP on 9/24/25 at 3:56 PM. She indicated that she came to the facility between 1:00 PM and 2:00 PM on 8/31/25 to take Resident #1 home after the 2-night stay for respite care at the facility. She indicated that when she got to the resident's room he was lying in bed and he was soiled. She reported that when she mentioned it to Nurse #3, the nurse offered to go and wash the resident up before the RP took him home. The RP stated that after she exited the facility with Resident #1, the application on her cellular phone linked to Resident #1's continuous blood glucose monitoring sensor kept on vibrating. She stated that the vibration started when she got the resident to the car at the facility parking lot and as she drove away from the facility the phone kept vibrating. She stated that she stopped on the side of the road at 2:06 pm, and it read "HI" which meant it was out of range (greater than 500) for the machine to read it. She stated that she stopped at the side of the road and administered 5 units of Lantus and 750 mg of metformin to the resident prior to returning home. She stated she also stopped at a store to buy water for Resident #1 to drink to dilute his blood glucose and lower it. The RP indicated that Resident #1 had a dry mouth, he was thirsty, clammy, tired and sleepy. She indicated that the drive from the facility to their home would normally take her one and a half hours without stopping, but that it took her a little bit longer on 8/31/25 because she had to stop at the side of the road to administer Lantus and metformin and stop at the store to buy water. She stated that after she got home, she checked Resident #1's blood glucose by	F0684		

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F0684 SS = SQC-J	Continued from page 8 pricking the resident’s finger and using a glucometer and the blood glucose reading was 596. She stated that the resident was also having diarrhea, and she called EMS who came to assess Resident #1 and transferred him to the ED. An EMS report dated 8/31/25 indicated EMS received the phone call at 5:40 PM and paramedics were dispatched at 5:45 PM. Paramedics arrived at Resident #1’s home at 6:09 PM and found him lying in bed and the chief complaint was hyperglycemia and diarrhea. His vital signs were as follows at 6:10 PM: heart rate:112 beats per minute, blood pressure:170/90, oxygen saturation: 99% on room air, temperature: 98.6 degrees Fahrenheit, and blood glucose: 403. The resident was alert. He was moved into the ambulance on a stretcher at 6:20 PM. A peripheral intravenous catheter was inserted, and 500 milliliter lactated ringer’s (intravenous fluids used to replenish electrolytes and fluids) was administered at 6:33 PM. They arrived at the ED at 7:08 PM and report was given to the ED nurse. A phone interview was conducted on 9/29/25 at 9:18 AM with the Paramedic who had transferred Resident #1 from his home to the ED on 8/31/25. She indicated that when they arrived on scene Resident #1 was lying in bed. She indicated that Resident #1’s skin was warm to touch, his blood glucose was 403, his RP reported that she had administered insulin and the resident was experiencing diarrhea so they decided to transfer him to ED for further evaluation. ED progress notes dated 8/31/25 indicated Resident #1 was seen by the ED provider at 7:45 PM for a chief complaint of symptomatic elevated blood glucose. His blood glucose at the ED at 7:17 PM was 428. His vital signs at 10:00 PM were as follows: blood pressure: 153/89, heart rate: 112, respirations: 28 beats per minute, and oxygen saturations: 96%. He was given intravenous fluids for an elevated heart rate and elevated blood glucose. He tested negative for Covid, influenza and respiratory syncytial virus (RSV). At 11:36 PM he had had 4 episodes of diarrhea at the ED, and an abdominal computed tomography (CT) scan was completed with no abnormal findings. A urinalysis test was negative for urinary tract infection. The urinalysis also revealed the following findings: Protein:1+ (normal reference range: negative), Glucose: 4+ (normal reference range: negative), and Ketones:1+ (normal reference range: negative). Positive glucose in the urine can be an indication of high blood glucose, kidney damage, uncontrolled diabetes or sodium-glucose cotransporter-2 inhibitors (medications that are used to lower blood glucose). Positive ketones and protein	F0684		

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F0684 SS = SQC-J	Continued from page 9 in the urine can be an indication of uncontrolled diabetes, kidney problems or dehydration. The resident's blood glucose was 312 at 10:37 PM on 8/31/25 and 251 at 3:49 AM on 9/1/25. There was no other treatment noted related to hyperglycemia. The final diagnosis was hyperglycemia without ketosis (a metabolic state where the body burns fat for energy instead of glucose due to a lack of enough carbohydrates in the body resulting in ketone bodies in the blood or urine). Resident #1 was discharged home on 9/1/25. An interview was conducted with the DON on 9/24/25 at 11:15 AM. She stated that Resident #1 was admitted on 8/29/25 by Nurse #1. The DON stated she became aware that Resident #1 did not receive insulin while he was admitted at the facility after Resident #1's RP contacted her on 9/1/25 and informed her that Resident #1 had been sent to the ED after he was discharged from the facility. The DON indicated that the admitting orders were on Resident #1's FL2 form which included 5 units Lantus at bedtime and continuous monitoring of blood glucose. She indicated that when she interviewed Nurse #1, the nurse told her (the DON) that Resident #1's RP brought his medications to the facility on admission (8/29/25), but the medications did not include Lantus or the device that read his blood glucose level. She stated that the application that linked to the resident's blood glucose monitoring sensor was on the RP's phone. The DON reported that if the admitting nurse had verified the orders in the EHR with the orders on the FL2 and realized they did not have a way to check the resident's blood glucose she (the admitting nurse) should have reached out to the provider and the provider would probably have given an order to use a glucometer to ensure the resident's blood glucose was being monitored. The DON stated that Nurse #2 was initially supposed to admit the resident on 8/28/25 and when she entered the orders on 8/28/25 she omitted the orders for Lantus and blood glucose monitoring when she entered the orders from the FL2 form into the electronic record so the blood glucose was not monitored, and the Lantus was not administered. The DON stated that the admitting nurse was supposed to enter orders into the EHR, verify the written orders to make sure they were entered correctly, and was supposed to contact the provider if anything needed to be clarified. She indicated that once the admitting nurse verified the orders with the medications brought from home, a second nurse would not have necessarily checked behind the admitting nurse unless there was a problem. An interview was conducted on 9/24/25 at 4:45 PM with the Medical Director. She indicated that she did not	F0684		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0684 SS = SQC-J	Continued from page 10 get to see Resident #1 because he was at the facility for only 2 days and that the nursing staff did not reach out to her to clarify any of the resident's orders. The Medical Director indicated that nurses were supposed to contact her if they had any questions with an order or if a resident's blood glucose was too high or too low. She indicated that the blood glucose parameters that required reporting to the provider varied for different residents. She stated that normally the high parameters that would require notification to the provider would be greater than 400 – 450 and the low parameters would be less than 60 -70. She stated that if Resident #1's blood glucose had been monitored and it was above the high parameter she would have ordered insulin and intravenous fluids. She indicated that she expected nurses to transcribe orders correctly and call for clarification if there were any discrepancies or if they had any questions. The Medical Director stated that she did not expect Resident #1 to develop diabetic ketoacidosis [DKA] (a life-threatening condition due to insufficient insulin in the body that can lead to high blood glucose levels) because he had diabetes type 2. She stated that elevated blood glucose could lead to lethargy, extra thirst, dehydration and vascular problems. She further stated that unmonitored blood glucose could lead to hyperglycemia or hypoglycemia (low blood glucose) and can result in loss of consciousness, seizures and coma. During an interview on 9/24/25 at 5:29 PM with the Administrator he indicated that the nurses should have looked at the FL2 form and put the orders in correctly and if they had any questions they should have called the provider to clarify. The Administrator was notified of Immediate Jeopardy on 9/24/25 at 8:41 PM. The facility provided the following corrective action plan: 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #1 was admitted to the facility on August 29th, 2025, for a 2-day respite stay. Resident #1discharged on Sunday August 31st, 2025. Resident #1's RP contacted the administrator on Monday September 1st, 2025, stating that Resident #1 did not receive any of his medications. The administrator informed Resident #1's RP that the Director of Nursing (DON) would investigate her concern and call her back. The DON completed an investigation by interviewing staff,	F0684		

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F0684 SS = SQC-J	Continued from page 11 reviewing surveillance footage and completing a chart audit. The DON determined during Resident #1 respite stay that an insulin order for Lantus 5 units at bedtime and an order for continuous blood glucose monitoring was omitted from the EHR. The DON identified that B-hall nurse transcribed orders on Thursday August 28th, 2025; however, Resident #1 did not admit to facility until Friday August 29th, 2025, and was admitted to a-hall. A-hall nurse reviewed orders transcribed into the EHR according to medications brought into facility by Resident #1's RP. A-hall nurse reported no insulin or blood glucose monitoring sensor being provided by Resident #1's RP. The lack of communication between the A Hall Nurse and B Hall nurse resulted in the omission of orders. The facility's provider was not contacted by the admitting nurse for clarification of orders. As a result, Resident #1 did not receive Lantus 5 units at bedtime on Friday August 29th, 2025, and on Saturday August 30th, 2025. Resident #1 did not have any blood glucose monitoring performed on Friday August 29th, Saturday August 30th, or Sunday August 31st, 2025. The DON contacted Resident #1's RP on 9/1/25 and informed her of the investigation findings and that a plan of correction would be implemented to prevent any further issues with order omissions upon admission of respite residents. The DON educated Resident #1's RP of signs and symptoms of hypo / hyperglycemia and to notify emergency services via 911 if Resident #1 exhibited any signs or symptoms. Resident #1s RP reported to DON that Resident #1 was taken to the emergency room on Sunday August 31st, 2025, and was admitted in ICU with a blood glucose of 700 (this was not confirmed with hospital records). 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The DON performed an audit on all respite residents that admitted to the facility beginning August 1st, 2025. The DON compared orders transcribed in the EHR with FL2's to identify any discrepancies with order transcription. The audit revealed that Resident #2 admitted on Friday August 8th, 2025, with no discrepancies noted to FL2 and orders transcribed into the EHR. Resident #3 was admitted on August 21st, 2025, and discrepancies with FL2 and home medications were identified. Home medications were verified with the responsible party, and the provider was made aware of the discrepancy between home medications and FL2. An order was obtained to hold primidone (medication used to treat seizures), administer metoprolol (medication used to lower blood pressure and heart rate) once a day, and administer 20 milliequivalents of potassium	F0684		

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F0684 SS = SQC-J	Continued from page 12 chloride daily. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The DON initiated staff education verbally to all nurses on Wednesday September 3rd, 2025, regarding omission of admission orders in regard to respite residents. The facility will continue to obtain an FL2 prior to providing an offer of respite admission to the facility. The facility Admissions Director will continue to communicate with RPs of each potential respite admission that home medications are required upon the resident's arrival to the facility. All nurses were instructed to utilize the FL2 to transcribe orders into the EHR, once the resident's medications are brought to the facility the assigned nurse will compare the medication bottle label with the orders transcribed into the EHR. If there are discrepancies, the assigned nurse will contact the family to determine the resident's current medication regimen. The assigned nurse will notify the provider of the discrepancies and the current home medication regimen reported by the family. If the family is unable to be reached, the assigned nurse will contact the provider for clarification of orders. In the event that medications are not provided by RP upon admission, the nurse will contact the provider and obtain medications from the facility's contracted pharmacy. All newly hired nurses to include facility hire, agency hire, and/or contract nurses will be provided verbal education regarding transcription of respite resident orders prior to beginning to train on the floor in a nursing role by the DON/designee. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The DON or in the absence of the DON, the designated nursing supervisor will complete audits of respite residents seven days a week in which the nurse will physically observe medications brought from home to ensure accurate transcription of all orders. The DON or designee will compare transcribed orders in the EHR to each resident's FL2 and home medications on day of admission for each respite resident to ensure accuracy of transcription of all orders. The DON or designee will complete the daily audits for 60 days. The audit will be reviewed at the next scheduled Quality Assurance Improvement Plan (QAPI) meeting. ADHOC QAPI was completed by the DON on September 3rd, 2025. Alleged date of immediate jeopardy removal and	F0684		

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F0684 SS = SQC-J	Continued from page 13 compliance: 9/4/25 The corrective action plan was validated on 9/25/25 by reviewing the initial audits, monitoring audits, and the education the licensed nursing staff received which included utilizing the FL2 to transcribe orders for respite care residents into the electronic record, comparing the medication bottle label with the orders transcribed into the electronic record and clarifying any discrepancies with the provider. The licensed nursing staff were able to verbalize the education that was given to them. QAPI review was verified to have been completed on 9/3/25. The immediate jeopardy removal date and compliance date of 9/4/25 was verified.	F0684		