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	0012042	A. BUILDING: _____ B. WING _____	C 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 000	Initial Comments On 04/16/2025, a standard survey, complaint investigation and review of one self-report was conducted at Maple Ridge of Plover. Additional information was gathered through 04/29/2025. As a result of this survey the complaint was substantiated. Three deficiencies were identified. Two of the three deficiencies were repeat violations. Census: 16	N 000		
N 352	83.32(3)(h) Rights of Residents: Receive medication In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Receive medication. Receive all prescribed medications in the dosage and at intervals prescribed by a practitioner. The resident has the right to refuse medication unless the medication is court ordered. This Rule is not met as evidenced by: Based on record review and interview, the provider did not allow each resident to receive all prescribed medications in the dosage and at the intervals prescribed by a practitioner for 1 of 1 resident reviewed. Resident 1 had a physician's order for twenty (20) units of Basaglar insulin once daily at bedtime. The facility transcribed the order twice, to be administered at 6 PM and again at 8 PM on the January 2025 and February 2025 eMARs (electronic medication administration records). Resident 1 received twenty (20) extra units of Basaglar insulin at bedtime, 19 out of 47 days from 01/01/2025 to 02/16/2025. Additionally, on 02/16/2025, Resident 1 was given twenty (20)	N 352		

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units of Novolog insulin instead of the scheduled twenty (20) units of Basaglar.

This is a repeat deficiency and is being cited for the second time. See Statement of Deficiency (SOD) E21611 dated 05/06/2024.

Findings include:

According to https://www.drugs.com/basaglar.html last updated 08/21/2023 indicated, "Basaglar is the brand name for insulin glargine Basaglar is a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours...Common Basaglar side effects may include: low blood sugar..."

According to https://www.drugs.com/mtm/insulin-aspart.html, last reviewed on 03/27/2025 indicated, "Novolog is the brand name for insulin aspart. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Insulin aspart is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours...

According to https://www.mayoclinic.org/diseases-conditions/hypoglycemia/symptoms-causes/syc-20373685, dated 11/18/2023 indicated, "Hypoglycemia is a condition in which your blood sugar (glucose) level is lower than the standard range. Glucose is your body's main energy source. Hypoglycemia is often related to diabetes treatment...Hypoglycemia needs immediate treatment. For many people, a fasting blood sugar of 70 milligrams per deciliter (mg/dL), or below should serve as an alert for hypoglycemia

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N 352	Continued From page 2 On 04/16/2025, Surveyor reviewed Resident 1's closed medical record. The record indicated Resident 1 was admitted to the facility on 10/16/2024 with diagnoses of Diabetes Type 2. Resident 1 was his/her own person and required staff to administer all his/her medications. Resident 1 had physician's orders dated 12/20/2024, which included, "Insulin Glargine Pen Injector- Inject 20 units under the skin at bedtime and Insulin Aspart Pen Injector- Inject 8 units under the skin once daily as needed." Per Review of Resident 1's eMAR for January 2025, Resident 1 received forty (40) units of Basaglar insulin at bedtime on 01/01/2025, 01/03/2025, 01/09/2025, 01/13/2025, 01/15/2025, 01/17/2025, 01/21/2025, 01/22/2025, 01/23/2025, 01/27/2025, 01/28/2025 and 01/30/2025. The facility transcribed twenty (20) units of Basaglar insulin twice, to be given at 6 PM and 8 PM on the January 2025 eMAR. Surveyor noted the Basaglar insulin order was transcribed incorrectly on the eMAR and Resident 1 received twenty (20) extra units of insulin, 12 out of 31 days during the month of January 2025. Per Review of Resident 1's eMAR for February 2025, Resident 1 received forty (40) units of Basaglar insulin at bedtime on 02/01/2025, 02/04/2025, 02/08/2025, 02/09/2025, 02/10/2025, 02/14/2025, 02/15/2025. The facility transcribed twenty (20) units of Basaglar insulin twice, to be given at 6 PM and 8 PM on the February 2025 eMAR. Surveyor noted the Basaglar insulin order was transcribed incorrectly on the eMAR and Resident 1 received twenty (20) extra units of insulin, 7 out of 16 days during the month of February 2025.	N 352		

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N 352	Continued From page 3 On 04/16/2025, Surveyor reviewed Resident 1's blood sugar check records from 01/01/2025 through 02/16/2025. According to the blood sugar check records Resident 1 experience hypoglycemia (blood sugars under 70 mg/dL) seven times in January 2025 and twice in February 2025. On 04/29/2025 at 11:05 AM, Surveyor spoke with Administrator A regarding the above medication errors. Administrator A verified the above eMAR documentation for January and February 2025 indicated multiple medication errors. On 02/18/2025, the Department received a facility self-report which indicated, "[Resident 1] was found by staff unresponsive in [his/her] bedroom around 9:15 PM on 02/16/2025. Staff immediately took [his/her] vitals and blood sugar. [Resident 1's] blood sugar was 22..Management reviewed all charting and medication documentation from prior to and during the incident. It was documented the med passer, [Caregiver C] administered 20 units of Basaglar per physician order...Upon investigating this possible medication error, management discovered the medication record shows the correct insulin, Basaglar was given and signed off by [Caregiver C], [Resident 1's] other insulin which is called Aspart had a needle left on the pen...The documentation in the resident's eMAR shows the correct insulin was given by [Caregiver C]. Based on this alone, it doesn't appear a medication error occurred. However, we have chosen to treat this as a medication error based on [Caregiver C's] statements about second guessing [her/himself] and the needle found left on the Aspart insulin pen..." Additionally, the facility self-report indicated after this incident	N 352		

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N 352	Continued From page 4 occurred written statements from staff involved were obtained. On 04/17/2025, Surveyor reviewed the written statement signed and dated by Caregiver C on 02/19/2025. Caregiver C's written statement indicated, "This is how I, [Caregiver C], caregiver and medication passer, remember the events from 02/16/2025...At 5:15 PM, [Resident 1] used [his/her] call light to request [his/her] scheduled medications so [s/he] could then go to sleep for the night. I finished my current task before gathering [Resident 1's] medications...I prepped an insulin pen to the correct dosage of 20 units but failed to realize it was not the correct insulin pen (2 pens were present in resident's medication box, despite only one of them being used daily; the other is as needed...Around 5:40 PM, or just before, medications were administered to the resident. [Resident 1] took the insulin pen and self-administered the insulin into [his/her] abdomen. Immediately after doing so, [Resident 1] mentioned [s/he] usually takes Basaglar, not Novolog. I confirmed [Resident 1's] claim and informed [him/her] that I would have to come back to take [his/her] blood sugar reading again soon...I failed to realize the gravity of the situation at the time. I did not realize the insulin [Resident 1] injected was short-acting, whereas [s/he] is actually prescribed long-acting insulin. The Basaglar was signed out on the eMAR, as I did not notice an option to sign out Novolog and failed to realize there was a PRN option under a different label "Insulin Aspart."...Upon realizing management and the hospital might need to know [Resident 1] was given a different insulin medication than what was prescribed, I called management at 1:00 AM, but they did not answer, and no message was left. Management was made aware of the full situation the next day	N 352		

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N 352	Continued From page 5 around 11:20 AM..." On 04/17/2025 at 2:42 PM, Surveyor interviewed Caregiver C via telephone regarding the above written statement. Caregiver C confirmed s/he wrote the above statement, and the above events occurred. Surveyor asked Caregiver C if s/he notified anyone after [s/he] was aware the wrong insulin was administered to [Resident 1]. Caregiver C indicated s/he did not tell anyone. Surveyor pointed out to Caregiver C [s/he] documented twenty (20) units of Basaglar insulin as being administered to Resident 1 on 02/16/2025 at 6 PM on Resident 1's February 2025 eMAR. Caregiver C acknowledged s/he documented twenty (20) units of Basaglar insulin as being administered on 02/16/2025 at 6 PM to Resident 1 on the eMAR and stated, "I shouldn't have signed out the Basaglar insulin because that was not the insulin [Resident 1] received..." On 04/16/2025 at 3:30 PM, Surveyors interviewed Licensee B and Administrator A regarding the above incident with Resident 1 on 02/16/2025. Administrator A stated, "[Caregiver C] didn't tell us about the insulin med error until the next day. [Caregiver C] didn't know why [s/he] didn't check the pen for the correct insulin." Cross Reference N0353 DHS 83.32(3)(i) Rights of Residents: Adequate Treatment	N 352		
N 353	83.32(3)(i) Rights of Residents: Adequate treatment In addition to the rights under s. 50.09, Stats., each resident shall have all of the following rights: Prompt and adequate treatment. Receive prompt and adequate treatment that is appropriate to the resident ' s needs.	N 353		

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N 353	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview the provider did not ensure Resident 1 received prompt and adequate treatment. Resident 1 had a diagnoses of diabetes with a history of hypoglycemia (low blood sugar). Resident 1 had a physician order for a scheduled dose of twenty (20) units of Basaglar insulin (long-acting) to be given at bedtime. In addition to this scheduled dose, Resident 1 had an order for 8 units of Aspart insulin (fast-acting) to be given according to results of blood sugar checks over 450 milligrams per deciliter (mg/dL). On 02/16/2025 at 4:15 PM, Resident 1's BS (blood sugar) was 136 mg/dL. Resident 1 refused the supper meal and requested his/her bedtime medications. Around 5:40 PM, Caregiver C mistakenly gave Resident 1 twenty (20) units of Aspart insulin instead of the scheduled twenty (20) units of Basaglar. Caregiver C was aware Resident 1 did not eat supper and the wrong insulin was administered. Caregiver C failed to notify other staff, on-call staff, the physician, EMS (Emergency Medical Services), or monitor Resident 1 specifically for signs and symptoms of hypoglycemia. Around 9:15 PM, three (3) and a half hours later, Caregiver C found Resident 1 in his/her bedroom unresponsive with a BS reading of 22 mg/dL. Staff did not immediately call EMS, instead staff attempted to locate Resident 1's emergency hypoglycemic medication, with no success and then attempted to provide orange juice and jelly to Resident 1 who was unresponsive. At 9:45 PM, thirty (30) minutes after staff found Resident 1 unresponsive, EMS was called. When EMS was contacted there was confusion if Resident 1 was receiving hospice services and the call to EMS was canceled. At	N 353		

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N 353	Continued From page 7 9:50 PM, four (4) minutes later staff discovered Resident 1 was not on hospice and called EMS back, at that time an ambulance was dispatched. Subsequently, Resident 1 was transferred to the ED (Emergency Department) for hypoglycemia and expired in the hospital two days later from anoxic brain injury likely due to prolonged hypoglycemia. Findings include: According to https://www.mayoclinic.org/diseases-conditions/hypoglycemia/symptoms-causes/syc-20373685, dated 11/18/2023 indicated, "Hypoglycemia is a condition in which your blood sugar (glucose) level is lower than the standard range. Glucose is your body's main energy source. Hypoglycemia is often related to diabetes treatment...Hypoglycemia needs immediate treatment. For many people, a fasting blood sugar of 70 milligrams per deciliter (mg/dL), or below should serve as an alert for hypoglycemia...If blood sugar levels become too low, hypoglycemia signs and symptoms can include: looking pale, shakiness, sweating, headache, hunger or nausea, an irregular or fast heartbeat, fatigue, irritability or anxiety, difficulty concentrating, dizziness or lightheadedness, tingling or numbness of the lips, tongue or cheek. As hypoglycemia worsens, signs and symptoms can include: confusion, unusual behavior or both, such as the inability to complete routine tasks, loss of coordination, slurred speech, blurry vision or tunnel vision, nightmares, if asleep. Severe hypoglycemia may cause: unresponsiveness (loss of consciousness) and seizures...Seek emergency help for someone with diabetes or a history of hypoglycemia who has symptoms of severe hypoglycemia or loses	N 353		

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consciousness...Hypoglycemia occurs when your blood sugar (glucose) level falls too low for bodily functions to continue. There are several reasons why this can happen. The most common reason for low blood sugar is a side effect of medications used to treat diabetes...too much insulin or other diabetes medications may cause your blood sugar level to drop too much, causing hypoglycemia. Hypoglycemia can also occur if you eat less than usual after taking your regular dose of diabetes medication...Hypoglycemia usually occurs when you haven't eaten...Untreated hypoglycemia can lead to: seizure, coma and death...Immediate treatment of severe hypoglycemia: ...If you're helping someone who is unconscious, don't try to give the person food or drink. If there's no glucagon kit available or you don't know how to use it, call for emergency medical help..."

According to https://www.drugs.com/mtm/insulin-aspart.html, last reviewed on 03/27/2025 indicated, "Novolog is the brand name for insulin aspart. Insulin is a hormone that works by lowering levels of glucose (sugar) in the blood. Insulin aspart is a fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours...Common side effects of insulin aspart may include: low blood sugar...After using Novolog, you should eat a meal within 5 to 10 minutes...What happens if I overdose? Seek emergency medical attention or call the Poison Help line...Insulin overdose can cause life-threatening hypoglycemia. Symptoms include drowsiness, confusion, blurred vision, numbness or tingling in your mouth, trouble speaking, muscle weakness, clumsy or jerky movements, seizure (convulsions), or loss of consciousness...Avoid medication errors by

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always checking the medicine label before injecting your insulin..."

According to https://www.drugs.com/basaglar.html last updated 08/21/2023 indicated, "Basaglar is the brand name for insulin glargine Basaglar is a long-acting insulin that starts to work several hours after injection and keeps working evenly for 24 hours...Common Basaglar side effects may include: low blood sugar..."

On 02/18/2025, the Department received a facility self-report which indicated, "[Resident 1] was found by staff unresponsive in [his/her] bedroom around 9:15 PM on 02/16/2025. Staff immediately took [his/her] vitals and BS. [Resident 1's] BS was 22. Staff immediately attempted to give [him/her] jelly and orange juice. When [s/he] showed little to no improvement, staff called 911...During this call, another caregiver stated [s/he] thought [Resident 1] was on hospice. This was relayed to dispatch and the call ended without the ambulance being sent. Shortly thereafter, the caregiver reviewed [Resident 1's] chart and discovered [s/he] was not on hospice. 911 was called again and the ambulance was dispatched...When EMS arrived, [Resident 1's] BS was 42. [Resident 1] was transported to the hospital where [s/he] remained until [his/her] death on 02/18/2025...Management reviewed all charting and medication documentation from prior to and during the incident. It was documented [Resident 1] had [his/her] BS checked around 4:15 PM on 02/16/2025. The reading was 136. It was then documented the med passer, [Caregiver C] administered 20 units of Basaglar per physician order...Upon investigating this possible medication error, management discovered the

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N 353	Continued From page 10 medication record shows the correct insulin, Basaglar was given and signed off by [Caregiver C], [Resident 1's] other insulin which is called Aspart had a needle left on the pen...The documentation in the resident's eMAR shows the correct insulin was given by [Caregiver C]. Based on this alone, it doesn't appear a medication error occurred. However, we have chosen to treat this as a medication error based on [Caregiver C's] statements about second guessing [her/himself] and the needle found left on the Aspart insulin pen..." Additionally, the facility self report indicated after this incident occurred the following action steps were completed: *[Caregiver C] was taken off med pass duties, suspended from work and terminated as a result of this suspected medication error. *Written statements from staff involved were obtained. *A mandatory staff meeting was held on 02/17/2025 to review policies and procedures on how to handle resident emergencies including when to call 911. *Diabetic policies and procedures were reviewed. A simplified high/low blood sugar policy was developed and all staff were trained on. *Facility Registered Nurse scheduled one to one training with all medication passers to review practices and specialty care including insulin administration. *Resident rooms were tagged with a large "H" on the backside of the resident's bedroom door if the resident is on hospice to prevent future delays in contacting either 911 or hospice during an emergency. *A bright red folder was created for each resident with their face sheet and advance directives for ease when EMS arrives. Current medication records are printed and added to the folder before handing off to EMS.	N 353		

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*Insulin pens were separated by color coded baggies for each resident to further separate and draw attention to the different medications.
*A review of the internal medication protocols and staffing to determine if "Med Tech" position(s) will be created.

On 03/04/2025, the Department received a concern regarding resident care and medication administration.

On 04/16/2025, Surveyor reviewed Resident 1's closed medical record. The record indicated Resident 1 was admitted to the facility on 10/16/2024 with diagnoses of type 2 diabetes. Resident 1 was his/her own person and required staff to administer all his/her medications.

On 04/16/2025, Surveyor reviewed Resident 1's BS check records from 01/01/2025 through 02/16/2025. According to the BS check records Resident 1 experience hypoglycemia (blood sugars under 70 mg/dL) seven times in January 2025 and twice in February 2025.

On 04/16/2025, Surveyor reviewed Resident 1's medication list dated 12/20/2024, which included blood sugar checks three times daily before meals and the following medications:
*Insulin Glargine Pen Injector- Inject 20 units under the skin at bedtime
*Insulin Aspart Pen Injector- Inject 8 units under the skin once daily as needed. Call physician if blood sugar is greater then 450.
*Glutose 15 GEL- If BS less than 70, give 1 tube and wait 15 minutes. Recheck BS, if less than 70, give 2 more tubes. Recheck BS in 15 minutes, if less than 70 call 911.
*Trueplus Glucose 4 gram tablet- Chew and swallow 1 tablet as needed for BS less than 70

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*Dextrose 4 gram tablet-Chew and swallow four tablets by mouth as needed for BS less than 70.

On 04/16/2025, Surveyor reviewed Resident 1's most recent ISP (Individual Service Plan) dated 12/19/2024. The ISP indicated, Resident 1 required partial assistance with bathing, dressing, grooming, ambulation, toileting and was independent with eating. Additionally, the ISP indicated, "Diabetes Management: Resident requires staff to manage diabetes per physician orders. Resident is on insulin and blood sugar checks." On 04/16/2025 at 1:30 PM, Administrator A verified the above ISP dated 12/19/2024 was Resident 1's most current ISP. ****Surveyor noted Resident 1's ISP did not identify the resident's signs and symptoms of hypoglycemia and hyperglycemia or a treatment plan to manage hypoglycemia and hyperglycemia incidents.

Review of Resident 1's "Incident Report" dated 02/16/2025 at 9:15 PM indicated, "Staff was doing rounds and found resident unresponsive. Vitals were taken. Blood sugar was very low...Blood sugar 22. Resident transferred to hospital by EMT's."

On 04/16/2025, Surveyor reviewed Resident 1's observation notes from 01/12/2025-02/19/2025 and the following was noted:
*01/12/2025- "Resident had low blood sugar at 4:30 PM (BS 43)..."
*02/14/2025- "Resident blood sugar was extremely low around 11 PM. Resident was given snacks and juice."
*02/16/2025- "Resident was found unresponsive during rounds around 9:15 PM. Resident is usually fatigued after having [his/her] PM medications, but this seemed abnormal. Vitals

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were taken and staff found [s/he] has very low blood sugar. Staff attempted to give [him/her] sugar via jelly and juice, but [s/he] was not swallowing. An ambulance was called and [his/her] POA (Power of Attorney) was notified as well as a supervisor from the center."
*02/17/2025- "Resident is still in the hospital at this time. The hospital called for an update at midnight. Resident is still unresponsive, but blood sugar is now 217..."
*02/19/2025- "Resident POA called last night around 7:15 PM to update writer resident had passed away in the hospital."

On 04/16/2025, Surveyor requested Resident 1's meal charting and safety checks from 01/01/2025 through 02/16/2025. No documentation was located or provided. Administrator A confirmed there was no documentation for Resident 1 regarding meal intakes or safety checks/rounds for Resident 1 during the above timeframe.

On 04/16/2025, Surveyor reviewed the staff schedule for 02/16/2025 and noted Caregiver C, D an E were working in the facility during the above incident involving Resident 1.

On 04/17/2025, Surveyor reviewed the written statement signed and dated by Caregiver C on 02/19/2025. Caregiver C's written statement indicated, "This is how I, [Caregiver C], caregiver and medication passer, remember the events from 02/16/2025 that led to the hospitalization of [Resident 1]: At about 4:00 PM or a bit later, [Resident 1's] blood sugar was checked before dinner. [Resident 1's] blood sugar was within normal range (136 mg/dL). The resident refused the dinner provided by Maple Ridge, and it's uncertain if [s/he] ate anything from [his/her] mini-fridge in [his/her] room, which [s/he] usually

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prefers. At 5:15 PM, [Resident 1] used [his/her] call light to request [his/her] scheduled medications so [s/he] could then go to sleep for the night. I finished my current task before gathering [Resident 1's] medications...I prepped an insulin pen to the correct dosage of 20 units but failed to realize it was not the correct insulin pen (2 pens were present in resident's medication box, despite only one of them being used daily; the other is as needed...Around 5:40 PM, or just before, medications were administered to the resident. [Resident 1] took the insulin pen and self-administered the insulin into [his/her] abdomen. Immediately after doing so, [Resident 1] mentioned [s/he] usually takes Basaglar, not Novolog. I confirmed [Resident 1's] claim and informed [him/her] that I would have to come back to take [his/her] blood sugar reading again soon. [Resident 1] told me [s/he] would be sleeping, but I insisted that I needed to come back to make sure [s/he] was okay.
I failed to realize the gravity of the situation at the time. I did not realize the insulin [Resident 1] injected was short-acting, whereas [s/he] is actually prescribed long-acting insulin. The Basaglar was signed out on the eMAR, as I did not notice an option to sign out Novolog and failed to realize there was a PRN option under a different label "Insulin Aspart." Work continued as usual and remained busy until around the 9:00 PM rounds. Around 9:00 PM, I went to check on [Resident 1] to see if [s/he] needed help in the bathroom and to check [his/her] blood sugar. Upon entering [his/her] room, [Resident 1] was unresponsive but breathing deeply...[Resident 1's] blood sugar was taken and read 22 mg/dL. I tried to rouse the resident, but [s/he] remained unresponsive. I ran to the medication cart to search for emergency glucose, which I could not find. I then ran to the kitchen to grab a cup of

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juice with sugar and some jelly and a spoon. I used a straw to drop some juice into the resident's mouth, but then realized this was unsafe as [s/he] was not cognizant enough to swallow. I then called for help from my co-workers, including the lead worker from next door. Vitals were taken, which were all within normal ranges except for his blood pressure, which was a bit high...I grabbed the phone in case 911 needed to be called but decided to wait for the supervisor's instruction.
The supervisor attempted similar tactics with the sugary drink and jelly. As the supervisor was getting these items ready, I asked if an ambulance should be called. [S/he] told me [s/he] didn't think it was necessary right at that moment and suggested we try to get [Resident 1's] blood sugar back up. Meanwhile, another co-worker had called 911 on their personal phone. The supervisor, who was not as familiar with the residents, was unsure if [Resident 1] was on hospice. There was some confusion as staff tried to log into ECP to figure out which hospice provider [Resident 1] uses. The ambulance was called off. Staff confirmed [Resident 1] was not a hospice patient and [s/he] was not a DNR. 911 was called a second time, and an ambulance arrived. EMTs got a blood sugar reading of about 44 mg/dL...Upon realizing management and the hospital might need to know [Resident 1] was given a different insulin medication than what was prescribed, I called management at 1:00 AM, but they did not answer, and no message was left. Management was made aware of the full situation the next day around 11:20 AM..." On 04/17/2025 at 2:42 PM, Surveyor interviewed Caregiver C via telephone regarding the above written statement. Caregiver C confirmed s/he wrote the above statement and the above events occurred. Surveyor asked Caregiver C if s/he notified

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anyone after [s/he] was aware the wrong insulin was administered to [Resident 1]. Caregiver C indicated s/he did not tell anyone. Surveyor then asked if s/he checked on Resident 1 or monitored [him/her] more frequently after the wrong insulin was administered. Caregiver C verified s/he did not monitor or check on [Resident 1] until sometime around 9:15 PM and stated, "I really regret not monitoring [Resident 1] closer...I knew it was the wrong insulin because [Resident 1] told me [her/himself]." Surveyor pointed out to Caregiver C s/he documented twenty (20) units of Basaglar insulin as being administered to Resident 1 on 02/16/2025 at 6 PM on Resident 1's February 2025 eMAR. Caregiver C acknowledged s/he documented twenty (20) units of Basaglar insulin as being administered on 02/16/2025 at 6 PM to Resident 1 on the eMAR and stated, "I shouldn't have signed out the Basaglar insulin because that was not the insulin [Resident 1] received..."

On 04/17/2025 at 1:33 PM, Surveyor interviewed Caregiver D regarding the above incident involving Resident 1. Caregiver D stated, "On 02/16/2025 around 9:30 PM, [Caregiver C] approached me and asked me, "What do you do if somebody's blood sugar is 22?" That's when [Caregiver C] told me [Resident 1's] blood sugar was 22. I responded with concern and asked [Caregiver C] if [s/he] called or told anyone. [Caregiver C] told me "No," [s/he] came to me first. I went running into [Resident 1's] room and on the way to [his/her] room I grabbed some jelly to try and raise [his/her] blood sugar. [Resident 1] was unresponsive but breathing heavy. I told [Caregiver C] we needed to call on-call, next door and 911. [Supervisor F] came over from the building next door and wasn't sure if [Resident 1] was on hospice so we canceled the ambulance..."

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N 353	Continued From page 17 Surveyor then asked Caregiver D is s/he was aware Resident 1 received the wrong insulin on 02/16/2025. Caregiver D stated, "I didn't know anything until 9:30 PM when [Caregiver C] told me [Resident 1's] blood sugar was 22. I never checked on [Resident 1] during the shift because [Caregiver C] was tending to [Resident 1]...The last time I saw [Resident 1] awake and alert was around 4:30 PM on 02/16/2025." On 04/17/2025 at 2:15 PM, Surveyor interviewed Caregiver E regarding the above incident involving Resident 1. Caregiver E confirmed s/he worked the PM shift with Caregiver C and D on 02/16/2025 and stated, "I was not aware of any medication mix-up or concern with [Resident 1] during the shift on 02/16/2025...I was never told to keep a closer eye on [Resident 1] during the shift." Caregiver E could not recall the last time s/he seen Resident 1 on 02/16/2025. Caregiver E went on to say, "I didn't know anything was wrong until we called 911...[Caregiver C] went to [Caregiver D] before me to ask for help...I was told [Resident 1's] BS was 22. When I walked into [Resident 1's] room [s/he] was not responding to anything and looked dead to me. I was confused why we didn't call 911 sooner when we knew [Resident 1's] BS was 22. Once we called 911 there was a lot of confusion if [Resident 1] was on hospice so we canceled the call, then we found out [Resident 1] wasn't on hospice and we called 911 again." On 04/17/2025, Surveyor reviewed the written statement signed and dated by Supervisor F on 02/18/2025. Supervisor F's written statement indicated, "On 02/16/2025, while I was working in the sister building I received a call at 9:39 PM from [Caregiver C]...[S/he] told me [s/he] had an emergency and asked if I could come	N 353		

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over...When I got there I was told [Resident 1] had a really low blood sugar of 22. I went towards [Resident 1's] room and was shocked to see [Resident 1] very pale in color and [his/her] mouth open with juice running out of [his/her] mouth. At this point I asked [Caregiver C] if [s/he] had tried to bring up [Resident 1's] blood sugar or not and [s/he] indicated [s/he] did but [Resident 1] is not responsive too much. I confirmed this by trying to wake the resident with no luck. I asked [Caregiver C] if [s/he] checked any other vitals and [s/he] said the only thing wrong was [Resident 1's] blood sugar...I went to the kitchen to start and get orange juice and sugar to try and bring up this resident's blood sugar...[Caregiver D] was calling an ambulance...When [Caregiver D] was on the phone with the ambulance dispatcher, [Caregiver C] mentioned the resident might be on hospice. I indicated if [s/he] is, we can not call 911 unless hospice tells us to. [Caregiver D] handed me [her/his] cell phone and I advised we needed to confirm if the resident is on hospice care and the dispatcher asked if [s/he] should cancel the ambulance. I said yes because at this point we were all by the resident's room. We had to go back by the med carts to a laptop and look into this resident's file to confirm if [Resident 1] is or is not on hospice. I called [Administrator A] to ask [her/him] if [Resident 1] is on hospice instead of waiting for staff to log into the computer. I went back in by [Resident 1] as I talked to [Administrator A]. [Administrator A] indicated [Resident 1] is not on hospice. At this point I advised we need an ambulance as [Resident 1] is not on hospice and we need to call 911 back."

On 04/22/2025, Surveyor reviewed "Village of Plover/EMS Prehospital Care" reports for Resident 1, which indicated, "On 02/16/2025 at

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N 353	Continued From page 19 9:45 PM, Plover EMS received a call for service to respond to the CBRF for report of [Resident 1] with a blood sugar of 22. EMS was canceled prior to responding, with dispatch advising that the facility stated the resident was on hospice...On 02/16/2025 at 9:49 PM, Plover EMS received a call for service to respond to the CBRF for the report of [Resident 1] who they could not find the hospice paperwork for (EMS had prior been paged for [Resident 1] with a blood sugar of 22, was canceled as the facility had believed [s/he] was on hospice). EMS responded immediately, dispatch information was repeated. Upon arrival on scene [Resident 1] was found to be laying in a recliner chair, not responding to EMS presence. Resident is noted to not respond to verbal or painful stimuli. Resident does not appear to be in respiratory distress, and appears to have a patent airway with adequate respiratory drive. Vitals are obtained, and blood glucose was obtained. While vitals and blood glucose were obtained, facility staff were interviewed, stating they had found [Resident 1] unconscious and they had checked a blood sugar and it was 22. Facility staff state they do not know of any medical history for the resident, other than [s/he] is a diabetic. Facility states they do not know a last known well time. During a physical assessment of the resident, pin-point pupils are noted, facility is asked if the resident takes narcotics, facility states the resident does take narcotics. Facility is asked how resident receive prescribed medications, facility states they administer prescribed medications and watch the resident take medications, when asked about the resident's narcotic medications along with if the resident had taken any or too much, the facility staff state they do not know. [Resident 1] is moved to the stretcher...During this process, the resident is noted to have a red substance coming	N 353		

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out of [his/her] mouth, this substance is noted to be brighter red in color, and appears to be thicker in nature. [Resident 1's] mouth is assessed and no visible bleeding sources are found. [Resident 1] is moved to the ambulance. Once in ambulance, vitals are re-obtained. An NPA (Nasopharyngeal airway) is placed and an end-tidal nasal cannula flowing oxygen at a rate of 4 LPM is placed on the resident, end tidal is monitored. IV access is obtained. [Resident 1] is started on a D10 infusion. Mouth is re-assessed, no additional red substance is noted, and mouth still appears to be free of obstructions...Transport began to the hospital..."

On 04/29/2025, Surveyor reviewed the ED report for Resident 1 dated 02/16/2025 which indicated, "[Resident 1] presents for evaluation after an unresponsive episode. History limited, resident unable to provide any direct history. Per report, nursing facility staff was checking up on [him/her] and [s/he] appeared sweaty, they could not wake [him/her], and checked a blood sugar which was in the 20s. Called 911, and tried to provide oral glucose but [s/he] was unable to swallow. On EMS arrival, blood sugar in the 30s, IV access obtained and was provided EF of D50 and D10. [Resident 1] was also noted to have pinpoint pupils and they did provide a milligram of Narcan, however no improvement in mental status on the way to the hospital. Last was seen well approximately 6:00 PM when [s/he] was given [his/her] nighttime medications and helped to bed. No recent signs of illness, no complaints of pain, no known falls or injuries. No recent changes in medications. On evaluation of the resident, [s/he] was breathing spontaneously but does not respond to any verbal or painful stimuli...On presentation, vital signs within normal limits. Blood sugar greater than 200...[Resident 1] was

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unresponsive, with minimal flickers of movement with painful stimuli, new nail bed pinch. ECG nonischemic, no evidence of dyshythmia. Labs obtained, notable for no CO2 retention, no acidosis, remainder of electrolytes within normal limits, troponin undetectable. CT head negative for evidence of intracranial hemorrhage. Prior records and medications reviewed, does have an extensive list of sedating medications, which may be contributory however no new change in medication. Repeat blood sugars are stable without hypoglycemia. Family presented to the bedside, results of testing, differential diagnosis discussed extensively with the family. [Resident 1] continues to be unresponsive to verbal or painful stimuli. Plan of care made for admission for further evaluation monitoring. Case discussed with hospitalist, who accepted for admission...Impression: Final diagnoses: Hypoglycemia, Unresponsive, Hypothermia. Disposition:
Admit..."

On 04/29/2025, Surveyor reviewed the Hospital Discharge report for Resident 1 dated 02/18/2025 which indicated, "Admission Date: 2/16/2025, Death Date: 2/18/2025, Time of Death: 1900, Cause of Death: Anoxic brain injury likely due to prolonged hypoglycemia...Hospital Course: [Resident 1] with history of COPD, pulmonary hypertension, type 2 diabetes, GERD, hypertension, anxiety and depression, chronic back pain, BPH, and alcohol abuse who was brought in from [his/her] facility on account of altered mental status. The resident was seen in [his/her] normal state around 5:45 PM when [s/he] was given [his/her] medications. Around 9 PM, resident was checked again for [his/her] blood sugar and was noted to be unresponsive. [Resident 1's] blood sugar was in the 20s. Then

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911 was called and IV access was obtained. [Resident 1] was given an ampule of D50 and D10. [S/he] was noted to have pinpoint pupils and was given Narcan without any improvement. [S/he] did not have any improvement in [his/her] mental status following dextrose infusion as well. At that point, [s/he] was brought over to the ED for evaluation. [His/her] blood sugar in the ED was noted to be 217. [Resident 1] was still obtunded. At that point, [s/he] was referred for admission to the inpatient service. 1. Acute metabolic encephalopathy secondary to hypoglycemia. [Resident 1] was admitted to the hospital on account of acute metabolic encephalopathy. [S/he] remained obtunded during the hospital stay. [S/he] was continued on dextrose infusion without any improvement in [his/her] mental status. ABG was essentially unremarkable. The resident was able to maintain [his/her] airway. Because of [his/her] altered mental status, [his/her] POA (power of attorney) was activated. The resident's family did not want [him/her] to live like this and family opted comfort care for [him/her]. At that point, comfort cares were initiated. The resident later passed away peacefully on the evening of February 18, 2025, at 1900. The cause of that is likely anoxic brain injury secondary to prolonged hypoglycemia."

On 04/16/2025 at 3:30 PM, Surveyors interviewed Licensee B and Administrator A regarding the above incident with Resident 1. Administrator A stated, "[Caregiver C] didn't tell us about the med error until the next day. [Caregiver C] didn't know why [s/he] didn't check the pen for the correct insulin." Surveyors asked Licensee B and Administrator A what they would expect staff to do after a medication error. Licensee B stated the expectation is for staff to call on-call, the physician and monitor the resident closely.

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N 353	Continued From page 23 Surveyors pointed out on 02/16/2025 at 5:40 PM, Caregiver C was aware Resident 1 received the wrong insulin and there was no evidence of physician/on-call notification or increased monitoring. Licensee B and Administrator A confirmed Caregiver C did not notify anyone and there was no documentation staff provided increased monitoring. Administrator A went on to say, "[Resident 1] was found unresponsive around 9:00 PM-9:15 PM on 02/16/2025. [Caregiver C] was trying to do interventions for diabetes [her/himself] for about thirty (30) minutes, getting orange juice, jelly, etc. Staff called 911, then the call was canceled thinking [Resident 1] was on hospice. 911 was called back a second time when staff realized [Resident 1] wasn't on hospice." Surveyors questioned Licensee B and Administrator A if they would have expected staff to call 911 right away when they found Resident 1 unresponsive with a BS of 22. Both Administrator A and Licensee B confirmed they would expect staff to call 911 immediately. Licensee B then stated, "We train to call right away. [Caregiver C] should have called 911 when [s/he] found [Resident 1] unresponsive at 9:15 PM, but EMS was not called until 9:45 PM, 30 minutes later." Administrator A and Licensee B also confirmed Resident 1 experienced a further delay in receiving treatment when staff canceled the first call to 911 due to confusion regarding Resident 1's hospice status. In conclusion, the provider's failure to administer the correct insulin to Resident 1 and failure to notify medical professionals and monitor the resident post-insulin administration of the fast-acting insulin resulted in Resident 1 requiring hospitalization for the treatment of a low blood sugar. At the hospital Resident 1 was placed on comfort cares and passed away on 02/18/2025,	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0012042	A. BUILDING: _____ B. WING _____	C 04/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 353	Continued From page 24 two days later from anoxic brain injury likely due to prolonged hypoglycemia.	N 353		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least 140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency. This Rule is not met as evidenced by: Based on observation and staff interview the provider did not ensure water temperatures at sinks in 1 of 2 resident shower rooms were 115 degrees F (Fahrenheit) or less. Temperatures in the west side shower room sink were as high as 165.9 degrees with a potential to scald residents. This deficiency is a re-cite from SOD (Statement of Deficiency) DSV211 dated 05/22/2019 and SOD DSV212 dated 02/25/2020. Findings include: This facility is licensed as a Class CNA (non-ambulatory) and serves residents who are advanced aged, terminally ill, and who have irreversible dementia or Alzheimer's disease. On 04/16/2025 at approximately 9:30 AM, Surveyor tested water temperatures at the sinks in the east and west resident shower rooms with	N 617		

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N 617	Continued From page 25	N 617		

ADM (Administrator) - A. The water temperature at the sink in the west side shower room across from room 17 was 163.7 degrees F, steaming, and too hot to keep Surveyor's hand in it. ADM - A confirmed seeing it was hot from the steam and verified that this shower room is used by the residents on the west side. Surveyor and ADM - A tested the water in the east side shower room which tested at 113.5 degrees F. ADM - A and Surveyor checked the thermometer on the water heater on the west side which was set at 160 degrees F. The thermometer on the east side water heater was set at 142.

On 04/16/2025 at 1:30 PM, Surveyor tested the water temperature at the sink in the west side shower room for a second time. This temperature was 165.9 degrees F.

During the exit with Surveyors on 04/16/2025 at approximately 3:45 PM, ADM - A and LIC (Licensee) - B indicated the plumber had been called to fix the water temperature and all staff were instructed not to use the west side shower room until fixed.

Exposure to hot water is a potential environmental danger for clients. Elderly clients and clients with mental and
physical disabilities may have neurological conditions that prevent instant recoil from hot water. Because these
individuals do not instantly react to dangerous temperature levels, they are at particular risk for injury. Hot water
can cause scalding, e.g., second and third degree burns in which the skin blisters and swells. In such instances,
skin does not return to normal and forms scar tissue upon healing. These burns may lead to

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N 617	Continued From page 26 permanent disability. (DQA publication P-01942, Hot Water Temperatures in Adult Family Homes, 08/2017).	N 617		