STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW PERSPECTIVE SUN PRAIRIE	LIGHTHOUSE OF SUN PRAIRIE SUN PRAIRIE, WI 53590

(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) COMPLETE DATE
N 000	Initial Comments On 05/08/2024, and with information gathered through 05/15/2024, Surveyors conducted 2 complaint investigations and 4 verification visits at New Perspective Sun Prairie, a CBRF located in Sun Prairie, WI. As a result of the survey, 4 violations of Chapter DHS 83 were issued. Both complaints were substantiated. Under statutory provisions of Wis. Stat. Ch. 50, a $200 revisit fee is being assessed.	N 000		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure that the community-based residential facility (CBRF) implemented and followed Resident 4's individual service plan (ISP) with regards to his/her transfer and mobility needs as written. This is a repeat deficiency. See Statement of Deficiency (SOD) ND1D11, dated 06/24/2022. Findings include: On 05/08/2024, from approximately 11:35 - 11:50 a.m., Surveyor observed residents in the memory care unit eating lunch, including Resident 4. As residents left the dining area upon finishing lunch, Surveyor observed some residents in wheelchairs being manually pushed by caregiving staff.	N 388		

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

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Residents who were ambulatory were observed to walk with independence or modified independence (use of a walker). Surveyor did not observe any residents leaving the dining area with contact guard assistance.

At approximately 11:56 a.m., Surveyor observed a whiteboard in the staff room located in the memory care unit. The whiteboard appeared to have different notes regarding resident updates and care needs. On it, Surveyor observed the following note: "[Resident 4] Contact assist walk w/ gaitbelt to + from meals. Catheter please check and empty bag every 2 hours."

At approximately 1:53 p.m., Surveyor interviewed Resident 4 in his/her room. During the interview, Resident 4 was observed walking around his/her apartment with a front wheeled walker but otherwise independently. Resident 4 reported that s/he typically walked with his/her walker and didn't need staff assistance for ambulation.

On 05/08/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the provider on 04/05/2024 with diagnoses including major neurocognitive disorder. Within Resident 4's observation notes, reviewed from 04/01/2024 - 05/08/2024, Surveyor observed the following:

- Staff documented that Resident 4 experienced a fall on 04/25/2024 at 12:07 a.m.

- 04/25/2024 (2:50 p.m.): Staff documented that Resident 4 was hospitalized

- 04/30/2024 (3:00 p.m.): Staff documented communication with hospital staff, who informed them that Resident 4 was ambulating with a walker and contact guard assistance of one staff

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N 388	Continued From page 2 - 05/01/2024 (1:13 p.m.): Staff documented that the provider's re-assessment of Resident 4 found that his/her "changes in condition are the foley catheter & contact guard with gait belt and one staff for all mobility." Surveyor reviewed Resident 4's current ISP, which was dated for 04/05/2024 with some sections updated on 05/03/2024, and observed the following: - Under the mobility section: "Caregivers will provide a contact guard assist with gait belt and walker for [Resident 4]. One staff must be walking with [him/her], hand on gait belt when moving about community with [his/her] walker. Care staff will report any changes, issues such as refusals, slips/falls, injuries, increased weakness to nurse. Report complaints of pain, decreased or changes in mobility status." - Under the transfers section: "Caregivers will assist [Resident 4] up in the am and back to bed in pm. A gait belt will be used for all transfers. Caregivers will provide assistance in between am & [night] if [s/he] chooses to nap during the day or go to an activity. Caregivers will report any refusals, slips/falls, increased weakness to nursing. Use a transfer belt when assisting resident to transfer...observe for and report changes in transfer assistance needs, balance or mobility to supervisor." At approximately 3:20 p.m., Surveyor interviewed Caregiver L about Resident 4's mobility. Caregiver L reported that s/he wasn't sure if contact guard assistance was used with Resident 4 when ambulating. Caregiver L reported that Resident 4 seemed steady with his/her walker	N 388		

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N 388	Continued From page 3 when walking but that s/he thought staff walking with Resident 4 was needed. At approximately 3:23 p.m., Surveyor interviewed Life Engagement Coach M regarding Resident 4's mobility. During the interview, a group of residents that included Resident 4, were observed sitting around a table engaging in an activity. Life Engagement Coach M reported that Resident 4 walked without staff assistance. Life Engagement Coach M reported that Resident 4 sometimes participated in activities and s/he walked to/from the activities without any staff assistance. While interviewing Life Engagement Coach M, Surveyor observed Resident 4 get up from his/her chair at the table, and ambulate with his/her walker from the activity area to his/her room approximately 30 feet away. No staff were observed assisting Resident 4. At approximately 3:42 p.m., Surveyor interviewed Administrator A. Administrator A reported that ever since Resident 4 returned from the hospital that s/he was to ambulate with contact guard assistance. Administrator A reported that the provider phones that staff used for resident information did not notify staff when changes were made to the ISPs and so they may not have known to look in his/her ISP for this change.	N 388		
{N 389}	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from	{N 389}		

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{N 389}	Continued From page 4 the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the provider did not ensure that Resident 3's individual service plan (ISP) was updated to reflect the change in his/her needs with regards to his/her residual limb management after his/her right foot was amputated. This is a repeat deficiency. See Statement of Deficiency (SOD) 9PKX12 dated 09/05/2023 and SOD ZZI811, dated 10/23/2023. Findings include: On 05/08/2024, at approximately 12:20 p.m., Surveyor observed Caregiver I administer Resident 3 his/her lunchtime medications. Resident 3 was sitting in his/her wheelchair listening to an audiobook. Resident 3 was observed to have his/her right foot amputated, with wraps observed around the residual limb. On 05/08/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 09/25/2023 with diagnoses including type 2 diabetes mellitus and personal history of diabetic foot ulcer. Surveyor reviewed Resident 3's ISP which was dated 09/25/2023 with one section having been updated on 04/05/2024. There was no information regarding Resident 3 having an	{N 389}		

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amputated foot, any information regarding current wound care needs, or any information about precautions for the healing residual limb (such as avoiding standing pressure on it). Under Resident 3's transfer needs, in one section it was documented that Resident 3 required the assistance of 1 to transfer, but in another section it documented that Resident 3 required the assistance of 2 to transfer. Surveyor reviewed Resident 3's observation notes from 04/01/2024 - 05/08/2024, and observed the following:

- 04/05/2024 (11:23 a.m.): "[Registered Nurse] completed a comprehensive assessment for resident on 4/4/2024 at [local rehabilitation facility]. [S/he] will be discharged back to community on 4/5/2024 around 4:30 p.m. [His/her] comprehensive assessment found no need for Bcam or changes in services except staff need to watch for changes in [complaints of] pain and report to Nursing. Staff will continue to provide toileting and dressing assistance as well as transferring to and from bed..."

- 04/11/2024 (8:35 a.m.): "Received new orders today from podiatry: Change dressing on stub daily. Use Iodosorb paste on wound...Nursing staff will complete dressing change every Wednesday. [Family member] will change it all the other days."

- 04/15/2024 (12:47 p.m.): "Late Entry for 4/12/2024 3:00 PM: Writer unwrapped dressing to resident's right leg. Cleansed the bottom of the stub with normal saline and then applied betadine, There [sic] is no infection, minimal pain for [Resident 3]. Wound measures 2.5 inch by 2 inches. Covered wound with abd binder and then wrapped with kling. [Resident 3] tolerated it well. Nursing will change dressing on Wednesdays

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and [his/her] [family member] does it all other days of the week."

- 04/16/2024 (9:35 p.m.): "Triage call 20:52: Team notes that resident is ambulating on recently amputate [sic] foot, serosanguinous fluid noted on the floor. Team to reinforce dressing. Elevate resident's foot. Ensure resident uses wheelchair with foot elevated until nursing can reassess wound. May not ambulate. Community nurse to follow."

- 04/17/2024 (4:04 p.m.): "Writer completed wound/dressing change. Bandage was sticking badly to the bottom of the stump. Used normal saline to get it off. Painful for [Resident 3]. I continued to cleanse with normal saline. I skipped the betadine as it is drying it out too much and then it makes it bleed when removing the bandage. Redressed with abd pad and kling. Brace applied. [Resident 3] tolerated it well."

- 04/24/2024 (11:13 a.m.): "Writer unwrapped dressing to wound. Cleansed with Normal Saline [sic]. New medication Idosorb paste applied to wound bed. No [signs or symptoms] of infection. Minimal pain to [Resident 3]. Redressed with abd pad and kling and brace put back on. [Resident 3] tolerated well."

- 05/01/2024 (10:13 a.m.): "Writer took off old dressing and cleansed heel with normal saline. Wound measures 2.5 inches by 2 inches. No [signs or symptoms] of infection. The wound is dark in color but it has been this way. Applied betadine paste to wound on non-adhesive pad, followed by an abdominal pad and kling. Brace put back on. Resident tolerated it well. Wound may never heal due to poor circulation to this leg. Resident is being followed by podiatry."

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{N 389}	Continued From page 7 At approximately 3:20 p.m., Surveyor interviewed Caregiver L. Caregiver L reported that there was a brace staff were instructed to put on Resident 3 whenever s/he left his/her room for the day. Regarding transferring, Caregiver L reported that Resident 3 required the assistance of 1 staff to pivot transfer. Caregiver L reported that Resident 3 was supposed to not be putting pressure on his/her stump during transfers and that s/he had been able to do this pretty well. Caregiver L reported that both facility nursing staff and Resident 3's family member, who is in the medical field, were managing Resident 3's residual limb cares. At approximately 3:42 p.m., Surveyor interviewed Administrator A. Administrator A acknowledged Surveyor's concern that Resident 3's ISP was not updated to include information regarding his/her residual limb care needs, but said nothing further.	{N 389}		
N 396	83.36(1)(a) Adequate staff to meet resident needs. The CBRF shall provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure adequate staffing to meet resident needs. Resident call light responses exceeded 26 minutes on 38 occasions from 05/02/2024 through 05/08/2024. Findings include: Facility is able to serve up to 50 individuals with	N 396		

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primary diagnoses that include but are not limited to: irreversible dementia/Alzheimer's and advanced age. Current census on day of survey was 33.

On 01/05/2024 and 05/03/2024, the Department received a complaint that staff were not responding to resident call lights in a timely manner.

On 05/08/2024 at 10:00 AM, Surveyor reviewed the call light response records for the facility and found that there was a total of 38 occurrences from 05/02/2024 through 05/08/2024 that call light response times exceeded 26 minutes.

The call light response dates and times are as follows:

Example 1: Resident 3

On 05/08/2024, Surveyor reviewed Resident 3's medical record. Resident 3 was admitted 09/25/2023 with diagnoses that include but are not limited to: hypertension, COPD, aortic stenosis, congestive heart failure, diabetes, history of diabetic foot ulcers.

According to Resident 3's Individual Service Plan (ISP) dated 09/25/2023, Resident 3 requires 1 staff assist with transfers, is a fall risk and uses a call light to request staff assistance.

Date	Time	Response time
05/05/2024	11:20 AM	38 minutes
05/07/2024	3:35 PM	134 minutes
05/07/2024	8:41 PM	37 minutes
05/08/2024	6:08 AM	37 minutes
08/08/2024	8:47 AM	44 minutes

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Example 2: Resident 4

On 05/08/2024, Surveyor reviewed Resident 4's medical record. Resident 4 was admitted 04/05/2024 with diagnoses that include but are not limited to: major neurocognitive disorder and osteoarthritis

According to Resident 4's ISP dated 04/05/2024, Resident 4 requires 1 staff assistance with transfers, is a fall risk and uses a call light to request staff assistance.

Date	Time	Response time
05/08/2024	2:02 PM	34 minutes

Example 3: Resident 5

On 05/08/2024, Surveyor reviewed Resident 5's medical record. Resident 5 was admitted 12/30/2018 with diagnoses that include but are not limited to: restless leg syndrome, GERD, atrial fibrillation, osteoarthritis, hemiplegia, obesity, urinary incontinence, history of leg fracture, urinary tract infection (UTI).

According to Resident 5's ISP dated 01/24/2024, Resident 5 requires 1 staff assist with transfers, is a fall risk and uses a call light to request staff assistance.

Date	Time	Response time
05/02/2024	5:01 AM	35 minutes
05/02/2024	11:06 AM	75 minutes
05/03/2024	1:35 PM	29 minutes
05/03/2024	4:20 PM	27 minutes
05/04/2024	1:47 PM	119

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minutes
05/05/2024 6:42 AM 128 minutes
05/06/2024 6:25 AM 52 minutes
05/06/2024 8:49 AM 26 minutes

Example 4: Resident 6

On 05/08/2024, Surveyor reviewed Resident 6's medical record. Resident 6 was admitted 09/30/2021 with a primary diagnosis of Parkinson's Disease.

According to Resident 6's ISP dated 09/06/2023, Resident 6 requires 1 staff assist with transfers, is a fall risk and uses a call light to request staff assistance.

Date	Time	Response time
05/03/2024	2:16 PM	33 minutes
05/05/2024	3:19 AM	26 minutes
05/08/2024	1:42 AM	27 minutes
05/08/2024	5:26 AM	36 minutes
05/08/2024	8:28 AM	27 minutes

Example 5: Resident 7

On 05/08/2024, Surveyor reviewed Resident 7's medical record. Resident 7 was admitted 11/28/2016 with diagnoses that include but are not limited to: osteoarthritis, seizures, UTI.

According to Resident 7's ISP dated 07/07/2023, Resident 7 requires 2 staff assistance with transfers with a hoyer lift, is a fall risk and uses a call light to request staff assistance.

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Date	Time	Response time
05/03/2024	12:33 AM	34 minutes
05/03/2024	3:07 AM	26 minutes
05/03/2024	7:00 AM	27 minutes
05/06/2024	4:28 AM	32 minutes
05/06/2024	6:35 AM	30 minutes
05/07/2024	1:55 PM	44 minutes
05/08/2024	12:35 AM	58 minutes
05/08/2024	4:12 AM	26 minutes

Example 6: Resident 8

Resident 8

On 05/08/2024, Surveyor reviewed Resident 8's medical record. Resident 8 was admitted 04/25/2015 with diagnoses that include but are not limited to: Parkinson's Disease, pulmonary embolism, fall risk, Alzheimer's, osteoarthritis, GERD, atrial fibrillation.

According to Resident 8's ISP dated 06/30/2023, Resident 8 requires 2 staff assistance with transfers using a sit to stand lift, is a fall risk and uses a call light to request staff assistance.

Date	Time	Response time
05/04/2024	11:20 AM	26 minutes
05/05/2024	5:26 PM	91 minutes
05/08/2024	1:55 PM	27 minutes

Example 7: Resident 9

On 05/08/2024, Surveyor reviewed Resident 9's medical record. Resident 9 was admitted 11/25/2020 with diagnoses that include but are not limited to: macular degeneration bilateral eyes, abnormal gait, osteoporosis, dementia, GERD.

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According to Resident 9's ISP dated 11/30/2023, Resident 9 uses a walker for ambulation, is a fall risk and uses a call light to request staff assistance.

Date	Time	Response Time
05/02/2024	7:57 AM	58 minutes
05/02/2024	6:44 PM	48 minutes
05/03/2024	7:14 AM	62 minutes
05/07/2024	7:03 PM	32 minutes
05/07/2024	8:32 PM	30 minutes

Example 8: Resident 10

On 05/08/2024, Surveyor reviewed Resident 10's medical record. Resident 10 was admitted 04/08/2024 with diagnoses that include but are not limited to: Alzheimer's, history of rib/sternum fracture from artificial resuscitation, arthritis.

According to Resident 10's ISP dated 04/08/2024, Resident 10 is a fall risk and uses a call light to request staff assistance.

Date	Time	Response time
05/03/2024	8:41 AM	36 minutes
05/03/2024	11:16 AM	91 minutes

Example 9: Resident 11

On 05/08/2024, Surveyor reviewed Resident 11's medical record. Resident 11 was admitted 04/17/2023 with diagnoses that include but are not limited to: coronary artery disease, HTN, memory loss, Dementia, diarrhea, UTI.

According to Resident 11's ISP dated 04/17/2023, Resident 11 is a fall risk and uses a call light to request staff assistance.

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N 396	Continued From page 13 Date Time Response Time 05/07/2024 7:07 PM 28 minutes INTERVIEWS: On 05/08/2024 at 9:00 AM, Surveyor interviewed Resident 5. Resident 5 stated that s/he has a hard time getting out of bed and needs staff to assist when transferring. Resident 5 stated s/he has had to wait over an hour after pressing his/her call light button and there is a usual wait time of about 15-20 minutes. On 05/08/2024 at 9:45 AM, Surveyor interviewed Resident 9. Resident 9 stated s/he doesn't see well and needs help at times. Resident 9 stated that s/he has had to wait long periods of time for help when pressing his/her call light. On 05/08/2024 at 10:20 AM, Surveyor interviewed Resident 3. Resident 3 stated s/he needs help with transfers to prevent falls. Resident 3 stated s/he had to wait over 2 hours on 05/07/2024 for help after pressing his/her call light button. On 05/08/2024 at 3:30 PM, Surveyor discussed the above concern with Administrator A. Administrator A acknowledged that the memory care unit residents do require more help from staff and most residents use a call light pendant to request that help. Administrator A acknowledged that call light response times are fairly good, but there are times that residents do have to wait a significant amount of time. Administrator A stated that the facility is working on responding more timely to resident call lights	N 396		

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N 396	Continued From page 14 and another review will occur at the next team meeting.	N 396		
N 432	83.38(1)(h) Medication administration. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Medication administration. The CBRF shall provide medication administration appropriate to the resident ' s needs. This Rule is not met as evidenced by: Based on record review, observation, and interview, the provider did not ensure that insulin administration was provided to Resident 3 appropriate to his/her needs. During the lunchtime medication pass on 05/08/2024, Resident 3's insulin administration was based on his/her post-meal blood sugar reading as opposed to a pre-meal blood sugar reading as instructed from his/her medication administration record (MAR) and his/her medical provider's staff. His/her Humalog that day was administered at least 11 minutes after s/he had eaten lunch. On 2 occasions from 04/01/2024 - 05/08/2024, Resident 3 received the incorrect dosage of insulin. On 6 of 7 occasions from 04/01/2024 - 05/08/2024 when Resident 3's blood sugar levels exceeded 300, the maximum level from his/her prescribed sliding scale, staff	N 432		

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administered him/her 6 units of insulin (in accordance with his/her 251-300 blood sugar range) but there was no evidence that this was based on guidance from a medical provider.

This is a repeat deficiency. See Statement of Deficiency (SOD) 5DNC11, dated 07/24/2019.

Findings include:

According to the U.S. Food and Drug Administration (FDA), when Humalog was administered subcutaneously, it "should be given within 15 minutes before a meal or immediately after a meal" (Source: FDA, Highlights of Prescribing Information, March 2013, https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/020563s115lbl.pdf (retrieval date - May 10, 2024).).

On 05/08/2024, at approximately 11:35 a.m., Surveyor observed residents eating lunch in the memory care section of the facility. The main dish consisted of meat loaf.

On 05/08/2024, at approximately 12:10 p.m., Surveyor began observing Caregiver I during the lunchtime medication pass. Caregiver I clarified that this medication pass was for the non-memory care residents. During the medication pass and while at the computer on the medication cart, Caregiver I reviewed the lunchtime medications due to Resident 3. Surveyor also observed the medication list on the computer, which showed an order for Resident 3's blood sugars to be checked before meals. Surveyor also observed an order for sliding scale insulin, with different parameter ranges documented. Caregiver I and Surveyor walked to the courtyard where Resident 3 was sitting in

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his/her wheelchair listening to an audiobook. At approximately 12:21 p.m., Caregiver I tested Resident 3's blood sugar, which was 283. Caregiver I was then observed to administer Resident 3 6 units of insulin from his/her insulin pen. While Caregiver I administered Resident 3's insulin, Surveyor interviewed Resident 3. Resident 3 reported that s/he already ate lunch and had meat loaf. Upon returning to the medication cart, Surveyor interviewed Caregiver I about Resident 3's blood sugar checks and subsequent insulin administration. Caregiver I confirmed that the instructions read for Resident 3's blood sugar to be tested before meals, but stated that Resident 3 "didn't eat lunch today." When reviewing Resident 3's earlier comments about having eaten lunch with Caregiver I, s/he replied that s/he didn't think Resident 3 had lunch because s/he didn't see him/her getting assisted to lunch and that staff typically helped with that. Upon being asked if Resident 3 typically receives mealtime insulin even without eating meals, Caregiver I replied that s/he did.

A few minutes later, Surveyor walked with Caregiver I to the cafeteria in the provider's residential care apartment complex (RCAC), where Caregiver I administered medications to a resident who was eating lunch. There, Surveyor observed a few tenants eating lunch, where the main dish appeared consistent with meat loaf.

At approximately 12:43 p.m., Surveyor interviewed Resident 3. Resident 3 confirmed that s/he ate lunch and that as part of this s/he ate meatloaf.

At approximately 12:50 p.m., Surveyor interviewed Caregiver J. Caregiver J confirmed that Resident 3 ate lunch at the provider's main

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dining area (over in the RCAC).

On 05/08/2024, Surveyor reviewed Resident 3's record. Resident 3 was admitted to the provider on 09/25/2023 with diagnoses including type 2 diabetes mellitus and personal history of diabetic foot ulcer. Surveyor reviewed Resident 3's individual care plan (ISP) which was dated 09/25/2023 with one section having been updated on 04/05/2024. There was no information regarding Resident 3's blood sugar monitoring needs in the ISP.

Surveyor reviewed Resident 3's observation notes from 04/01/2024 - 05/08/2024, and observed an entry on 04/12/2024 (9:19 p.m.), which documented: "Triage call 18:05: Resident with blood sugar 314-- [electronic MAR (eMAR)] only has sliding scale instructions to 300. Resident is asymptomatic. Administer insulin for blood sugar of 300. Encourage resident to drink extra fluids (water) and discourage starches and sugars with dinner. Notify triage of any changes in resident status or ongoing hyperglycemia. Community nurse to follow." There were no other notes about this entry. Within Resident 3's prescriptions, Surveyor observed an order for "insulin lispro 100 units/mL (Humalog)" with instructions to, "Inject three times daily per sliding scale: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units subcutaneously." Surveyor did not observe any guidance in Resident 3's prescription list indicating guidance for insulin administration when his/her blood sugars were >300.

Surveyor reviewed Resident 3's MARs from 04/01/2024 - 05/08/2024 and observed the following:

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N 432	Continued From page 18 - A standalone set of entries for Resident 3's blood sugar checks, which documented the following instructions: "Chedk [sic] blood sugars before meals and before bedtime." Entries were made for morning, mid-day, evening, and bedtime values to be recorded. - Two discrepancies in the amount of insulin s/he was supposed to be versus was administered. For his/her mid-day dose on 04/12/2024 his/her blood sugar was documented as 281 (within the 6 unit range), however, 4 units were documented as administered. For his/her mid-day dose on 05/04/2024, his/her blood sugar was documented as 264 (within the 6 unit range), however, 4 units were documented as administered. - Six of 7 occasions that Resident 3's blood sugar exceeded the sliding scale maximum level of 300 set by his/her prescribing medical provider, but nothing was documented about guidance sought or follow up actions taken by caregiving staff for addressing the blood sugar other than staff documenting administering 6 units of insulin (in accordance with the 251-300 range in his/her sliding scale). These included: 04/08/2024 mid-day blood sugar of 354, 04/13/2024 mid-day blood sugar of 350, 04/18/2024 mid-day blood sugar of 339, 04/20/2024 mid-day blood sugar of 322, 05/04/2024 evening blood sugar of 428, and 05/05/2024 evening blood sugar of 352. Surveyor did not observe anything regarding the management of these blood sugars documented in the MAR, in Resident 3's observation notes, or an overall plan for management in his/her ISP. On 05/08/2024, at approximately 3:42 p.m., Surveyor interviewed Administrator A. Administrator A acknowledged Surveyor's concern regarding the process of testing	N 432		

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N 432	Continued From page 19 Resident 3's blood sugar, and reported that s/he believed the blood sugar should have been tested prior to meals. Administrator A reported s/he would talk with staff further. Administrator A acknowledged Surveyor's concern about the insulin administration errors and reported s/he would follow up with staff. Regarding the management of Resident 3's diabetes when his/her blood sugars exceeded the range from his/her medical provider, Administrator A reported s/he would have to follow up with nursing staff. Administrator A reported that it was possible the medication passers on those occasions called health and wellness staff but did not document these conversations. On 05/09/2024, at approximately 3:48 p.m., Surveyor interviewed Nurse K from Resident 3's medical provider office. Nurse K reported that Resident 3's blood sugar should be tested before s/he starts eating meals because his/her glucose levels will increase as s/he eats. Nurse K reported that the administering of Resident 3's sliding scale should be based on what the pre-meal blood glucose value was. Nurse K reported that Resident 3's Humalog could be administered shortly prior to the meal or even while s/he was eating if staff had concerns that about Resident 3's eating. Nurse K reported that for most sliding scales, orders instructed staff to call the medical provider when blood sugars exceeding the maximum listed range. Nurse K reported that in this case, it would be recommended to contact Resident 3's medical provider clinic or have a documented protocol set by a clinician for staff to follow to manage Resident 3's high blood sugar values.	N 432		