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FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

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F 000	INITIAL COMMENTS Correction date: 4/17/25 The Fort Dodge Health and Rehabilitation Nursing Home is not in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities due to the following deficiencies written during the investigation of complaints #127454-C and #127467-C conducted March 24, 2025 to March 27, 2025. Complaints #127454-C and #127467-C were substantiated. Total census: 56	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, hospital staff interviews, and policy review, the facility failed to provide timely intervention to a resident with a change in condition for 1 of 3 residents reviewed (Resident #1) for assessment and intervention. After the return of Resident #1's return to the facility from the hospital, he continued to have elevated blood sugars. The facility staff failed to provide timely intervention for	F 684	F684 Resident #1 is back at facility and is at prior level of function. All residents are at risk for change of condition and provider to be notified of any changes within 24 hours of assessed change. Change of condition policy reviewed with all nursing staff at nurse meeting on 4/17/25. DNS/designee will audit 24/72 hour report daily and follow up with any changes of condition and family and Dr notification at time of assessed change. This is an ongoing process improvement that will be reviewed and reported on monthly by DNS/designee at QAPI.	

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

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 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.

4/14/25

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F 684	Continued From page 1 Resident #1's elevated blood sugars that had a poor oral intake, only drinking chocolate milk. On 3/21/25, Resident #1 admitted to the hospital with diabetic ketoacidosis (an imbalance of the body's electrolytes due to an inadequate insulin intake that is a medical emergency). The facility reported a census of 56 residents. Findings Include: Resident #1's Minimum Data Set (MDS) assessment dated 12/18/24 identified a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. Resident #1 required staff supervision with eating. The MDS included diagnoses of diabetes, heart failure, renal insufficiency (impaired kidney function), Alzheimer's disease, and malnutrition (inadequate intake of nutrients). Resident #1 received insulin within the lookback period. Resident #1's MDS assessment dated 2/26/25 reflected Resident #1 had an unplanned discharge to the hospital on 2/26/25. Resident #1's Clinical Census List reviewed 3/24/25 listed the following: a. Discharged to the hospital on 2/26/25. b. Returned to the facility on 3/15/25. c. Transferred to the hospital on 3/21/25. The Care Plan Focus updated 1/30/25 identified Resident #1 had diabetes. The Interventions directed the staff the following: a. Monitor blood sugars (BS) b. Give insulin per orders c. Provide a complex carbohydrate snack at 2:00 PM daily.	F 684		

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F 684	Continued From page 2 Resident #1's Order Summary reviewed 3/25/25 included the following active orders as of 2/1/25: a. 11/23/23: A carbohydrate snack daily at 2 PM related to Type 2 Diabetes. b. 11/23/23: Notify provider if BS less than 60 or over 500 four times a day (QID). c. 1/22/25: NovoLog i. 12 units (u) SQ (subcutaneously, "fatty tissue just under the skin") in the morning. ii. 14u in the afternoon iii. 10u SQ in the evening. d. 1/22/25: Tresiba 40 units SQ in the AM (morning). e. 3/15/25: Check BS as needed per nursing judgment as needed. f. 3/15/25: Humalog KwikPen (Insulin Lispro) inject SQ before meals as per sliding scale if: i. 150 - 199 = 3u ii. 200 - 249 = 4u iii. 250 - 299 = 7u iv. 300 - 349 = 10u v. 350 - 399 = 12u vi. 400 - 449 = 15u vii. 450 - 500 = 20u An After-Visit Summary dated 3/15/25 reflected Resident #1 had a hospital stay from 2/26/25 to 3/15/25. The summary included the following orders: a. Discontinue i. Novolog vial and flex pen ii. Tresiba. b. Start i. Humalog (lispro) 20 units TID before meals. ii. Amoxicillin - clavulanate (Augmentin, Antibiotic). Take 1 tablet by mouth twice a day for 3 days. iii. Levofloxacin (antibiotic). Take 1 tablet (500 mg) by mouth daily.	F 684		

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F 684	Continued From page 3 c. BS checks before meals and at bedtime, notify physician if BS less than 70 or greater than 350. d. FreeStyle Libre 14-day sensor (continuous glucose monitor) use as directed. The Condition Follow-up Note dated 3/17/25 at 12:31 AM, reflected Resident #1 readmitted to the facility for skilled level of care with dual antibiotic therapy for a urinary tract infection (UTI), pneumonia, sepsis (severe infection in the blood), and postoperative partial left second toe amputation. The eMAR - Medication Administration Note dated 3/17/25 at 12:03 PM, identified Resident #1's BS registered as high. The EHR Weights and Vitals section recorded the following blood sugars over 350: a. 3/17/25 at 5:40 AM = 360 b. 3/18/25 at 7:28 AM = 410 c. 3/18/25 at 11:13 AM = 372 d. 3/18/25 at 5:19 PM = 427 e. 3/19/25 at 8:39 AM = 452 f. 3/19/25 at 11:35 AM = 432 g. 3/20/25 at 11:37 AM = 378 h. 3/20/25 at 6:44 PM = 355 Resident #1's March 2025 MAR identified an order for Humalog scheduled for 7:00 AM - 10 AM. Staff documentation reflected he received it outside the scheduled time frame on 3/17/25 at 10:42 AM and 3/19/25 at 8:39 AM. The eMAR-Medication Administration Note dated 3/17/25 at 10:42 AM indicated Resident #1's BS registered as high and he didn't eat. The nurse indicated she would give insulin at the time and notify the provider.	F 684		

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F 684	Continued From page 4 Resident #1's clinical record lacked interventions taken for the BS of 360 at 5:40 AM. The clinical record lacked follow-up until 10:42 AM when he BS registered high. The eMAR-Medication Administration Note dated 3/17/25 at 3:10 PM identified the nurse gave Resident #1 20u of insulin due to blood sugar registering high and notified the provider. The Condition Follow-up Note dated 3/17/25 at 5:44 PM indicated Resident #1 refused meals but took 2 glasses of chocolate milk. He was reluctant to get out bed at lunch, blood sugar registered high numerous times. The Advanced Registered Nurse Practitioner saw him that morning and gave a half dose of sliding scale insulin due to him not eating. The nurse discussed hospice with Resident #1's wife, who told the nurse she needed to discuss it with her daughter. The Daily Skilled Note dated 3/18/25 at 3:38 PM reflected the staff monitored Resident #1's BS due to it not at his baseline or well controlled. The nurse didn't provide education regarding his BS levels. He ate less than 25% of his meals. The Condition Follow-up Note dated 3/18/25 at 4:19 PM described Resident #1's appearance as under the weather but with stable vital signs. A Physician's Progress Notes dated 3/19/25 indicated the provider saw Resident #1 following his hospitalization from 2/26/25 to 3/15/25. The note listed the reason for the hospitalization as multifactorial sepsis related to osteomyelitis (infection in the bone) of the left foot, MRSA	F 684		

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(methicillin resistant staphylococcus aureus) (a bacterial infection) pneumonia, and urinary tract infection (UTI). Resident #1 had his left second toe amputated on 3/6/25 due to osteomyelitis. His BS's varied even prior to his hospitalization. Nephrology managed his care and staff are to notify the clinic with new or worsening symptoms. Resident #1 didn't eat well and had very poor oral intake. The staff reported most of his intake included chocolate milk.

The Daily Skilled Note dated 3/19/25 at 10:48 AM reflected Resident #1 had a BS of 452, which is not baseline or well controlled. The nurse didn't provide education regarding his BS levels. He ate less than 25% of his meals.

The Daily Skilled Note dated 3/20/25 at 4:43 PM reflected Resident #1 had a BS of 378 at 11:37 AM, which is not baseline or well controlled. The nurse didn't provide education regarding his BS levels. He ate less than 25% of his meals.

The Condition Follow-up dated 3/20/25 at 6:45 PM identified Resident #1 wanted to attend karaoke, an activity he loves. The nurse described him as subdued but able to move his arms and legs.

The Condition Follow-up dated 3/20/25 at 7:05 PM described Resident #1 as too fatigued to remain up in his wheelchair at the end of the day. The staff assisted him back to bed.

The Condition Follow-up Note dated 3/20/25 at 8:09 PM identified the nurse visited with Resident #1's wife about his general weakness and decline since his return from the hospital. His wife reported she desired all interventions done

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F 684	Continued From page 6 possible to prolong his life as he told her that he desire that. The Nursing Note dated 3/20/25 at 8:10 PM reflected the nurse visited with Resident #1's wife about his decreased appetite, more fatigue, and less active. The nurse relayed his status and that he had an order to do cardiopulmonary resuscitation (CPR). The nurse reviewed what that entailed and told his wife she called her to follow-up with her about their wishes due to his current status. The wife reported she understood and reiterated she desired all interventions done possible to prolong his life because he told her he desired that. The Transfer / Discharge Report dated 3/21/25 reflected Resident #1's chief complaint (reason for transfer) as recent readmit from hospital on 3/15/25 after an extensive stay in the intensive care unit. The report described Resident #1 as unresponsive at times with blood sugars high for several days. Resident #1 had no intake as he couldn't swallow. He depended on staff for all cares. He had a recent amputation of his left foot's second digit with no-weight bearing to that foot. The Nursing Note dated 3/21/25 at 8:46 AM identified Resident #1 went to the ED via ambulance. The ambulance staff (EMTs) couldn't get a blood pressure or a pulse ox (level of oxygen in the blood) on the resident. A Hospital Admission History and Physical (H & P) dated 3/21/25 revealed Resident #1 went to the Emergency Department (ED) on 3/21/25 for an altered mental status, increased lethargy, and being less responsive than his normal, with his	F 684		

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BS's also running high. A workup in the ED showed Resident #1 had DKA (diabetic ketoacidosis, a medical emergency caused by inadequate amount of insulin), glucose of 951 (normal BS: 70 100), bicarb 8 (normal: 22 28) and potassium 6.8 (normal: 3.5 - 5.2). A Hemoglobin A1C (HgbA1C, measures BS over time) on 1/20/25 revealed a result of 9.2 (normal HgbA1C is less than 7%).

The undated American Diabetes Association article titled Carb Counting and Diabetes found on the website https://diabetes.org/food nutrition/understanding carbs reflected the body breaks down food or drinks with carbohydrates into glucose which raises the level of glucose in the blood. The increase in glucose should cause the pancreas to release insulin to help cells in the body absorb the glucose. For people with diabetes, the insulin doesn't function properly to process the blood glucose. The carbohydrates consumed impact the blood sugar so balance is key. Meals are usually a mix of carbohydrate, protein, and fat. A meal high in protein and fat can change how quickly the body absorbs carbohydrates, which impacts blood sugar levels.

The American Heart Association article titled How Much Sugar is Too Much? Last reviewed 9/23/24, found on the following website https://www.heart.org/en/healthy living/healthy eating/eat smart/sugar/how much sugar is too much instructed men shouldn't consume more than 9 teaspoons (36 grams or 150 calories) of sugar per day and women shouldn't consume more than 6 teaspoons (25 grams or 100 calories) per day.

In an interview on 3/25/25 at 11:30 AM, Staff A,

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F 684	Continued From page 8 Registered Nurse (RN), described Resident #1 as a brittle diabetic (difficult to manage due to large fluctuations in blood sugars). Resident #1 went to the hospital on 3/21/25 because he had high BS's, they got up to 900. He didn't eat and only consumed chocolate milk. He came back from the hospital on 3/15/25 and started on sliding scale insulin. Staff A reported if a resident's BS registered high, they needed to enter a number (code) on the MAR or enter "N/A" and enter a nurse's notes. When asked how much time they allowed for administering medication when insulin scheduled, Staff A responded it depends. The sliding scale insulin popped up on the screen at 7:00 AM If Resident #1 had an order to receive insulin, but the facility had open breakfast from 7:00 AM - 9:00 AM. She checked Resident #1's BS before he went to the dining room but she didn't give the insulin right away because she wanted to make sure he ate some food. If he wasn't eating, she didn't want to give his insulin. She used her nursing judgement on whether to give him insulin or not. She always heard to wait to give Resident #1 insulin until she knew he ate, for his safety. Most of the time, the insulin times are set up in a window of time such as 7:00 AM - 10:00 AM, but after software updates, the system had some quirks. Resident #1's MAR is red most of the days she explained, because she wanted to feel him out to see what he was going to do. She wanted to make sure he ate. Staff A said it scared the crap out of her when a resident had a hypoglycemic reaction. It terrified both her and Resident #1. Staff A reported the CMA's (certified medication aides) give the supplements, and the CMAs MAR includes the supplements. Staff A stated she didn't know if the CMA gave him a sugar free house supplement or the regular house supplement.	F 684		

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In an interview on 3/25/25 at 2:55 PM, Staff B, RN, reported he called the physician if Resident #1's BS got out of parameters. The parameters could be different depending on the physician or the resident. Some residents did fine with a BS above 70. Staff B confirmed he cared for Resident #1, but he was currently in the hospital. Resident #1 always had issues with his BS's even before he went to the hospital. Staff B reported he called the nephrologist to request BS parameters because the physician had Resident #1 on a set amount of insulin. Resident #1's BS's would dip really low. It was easier to bring down Resident #1's BS's versus if his BS's dipped down low. If his BS's got low, it was really hard to bring his BS's back up. Resident #1 had behaviors. He chose if he would eat or drink anything. The nurse had to think about the situation before they gave him any insulin. Resident #1 didn't eat at all, he let the physician know and held his insulin. Staff B reported the nephrologist is not a diabetic physician or specialist but he was the one staff were supposed to call for Resident #1's BS's. Staff B explained they made many attempts to reach the nephrologist but he didn't respond back. Staff B reported the computer automatically put in the timeslots for insulin and when it needed given. Staff couldn't edit the times for insulin administration. Staff need to document if they give the insulin outside of the designated timeframes in the MAR.

In an interview on 3/26/25 at 10:45 AM, Staff F, Nurse Practitioner (NP), reported he saw Resident #1 for a while. He had hard diagnoses to manage. He described him as a brittle Type 2 diabetic, as his BS's ran up and down, and his HgbA1C always ran high. Resident #1 had

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dementia, he didn't eat, and he only drank chocolate milk. The Nephrologist and Staff G, Nephrology NP, managed Resident #1's BS's, CKD (chronic kidney disease), and his blood pressure. Staff F took care of any other medical issues that came up along with his other diagnoses. Staff notify him of resident BS's and he tells them to notify Nephrology because the Nephrologist wanted to manage his blood sugars. Staff F reviewed Resident #1's EHR and confirmed Resident #1 admitted to the hospital twice. He had an acute hypoxic respiratory failure, then they diagnosed him with a UTI, pneumonia, and osteomyelitis in his foot. The hospital put on IV antibiotics. Staff F discussed the impact of giving insulin if Resident #1 didn't eat or drink, as well as if he received his insulin later than the scheduled time. Resident #1 had BS's that fluctuated so Staff F stated he wouldn't give Resident #1 as much insulin when he didn't eat. Staff F added that giving long acting insulin later does not make much of a difference as the short acting insulin given later than the scheduled time. Staff F stated he would be more concerned with short acting insulin and if they gave one late.

Staff H, Nephrology NP, failed to respond to a voicemail left on 3/26/25 at 12:10 PM from the surveyor.

In an interview on 3/26/25 at 3:45 PM, the Vice President (VP) of Clinical Operations reported the nephrologist and Staff G, NP, gave orders for residents in the nursing home. They didn't have a policy or procedure for the residents in the nursing home though. The physician or NP put instructions in their orders on what they needed done by the facility's staff. Typically, a sliding scale is according to the facility's policy. The VP

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F 684	Continued From page 11 of Clinical Operations stated the staff should call the nephrologist or call the facility's provider who conducted rounds at the facility. She described the facility Provider as Staff F or another provider. The facility staff call the clinic or enter a note in the inbox in EPIC if the staff had a question about an order or something. The facility had the ability to see things through EPIC because they had access to the EPIC program. The VP of Clinical Operations stated if the nephrologist or nephrology NP weren't available, the facility staff could call and request the on-call provider. The facility provider's company would connect staff the providers' team to discuss the resident's care and address their questions. In an email correspondence with the Senior Clinic Administrator dated 3/26/25 at 4:39 PM reported insulin is most effective when administered as prescribed. The provider expected the facility to notify or call the physician and follow the facility's policy if the resident had a change in diet or fluid intake. The Senior Clinic Administrator reported the insulin lowered blood sugar. Giving insulin to a resident who didn't eat or drink could further lower their blood sugar. She expected the facility staff to notify or call the nephrologist's office based on orders given or per their facility policy about the resident's blood sugars. In a follow up email 3/28/25 at 12:53 PM regarding the following questions: a. If it mattered if insulin was given later than the scheduled times, if it mattered if the nutritional supplement was sugar free or diabetic friendly b. If the afternoon snack should be held if Resident #1 had an elevated BS? The Senior Clinic Administrator responded to the emailed questions that the provider would expect	F 684		

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F 684	Continued From page 12 the facility to follow any order given or the facility's protocol. In an interview on 3/26/25 at 4:15 PM, the DON reported staff documented calls to the physician in the progress notes. The DON reported they also used EPIC to communicate via an email with Staff F. On 3/27/25 at 8:40 AM, the DON checked the computer EPIC system to see if the staff sent notifications to the provider about Resident #1. The DON confirmed the system didn't have notifications found for 1/18/25, 1/24/25, or dates in February 2025 when they held his insulin. In addition, they couldn't find notifications to the physician or NP about when they held his snacks due to Resident #1's high blood sugar. The DON stated she talked with the nephrologist about giving Resident #1 a snack if his blood sugars were elevated. The nephrologist wanted them to give the snack, especially in the afternoon, because otherwise Resident #1's blood sugar could drop. She was told it's better to provide a snack in between the meals to help keep the blood sugar readings at a more even level. In an interview on 3/27/25 at 8:55 AM, Staff E, CMA, reported the facility used a generic brand house supplement. They kept the supplement in the kitchenette refrigerator, they documented them on the CMA tab. At the time, Staff E obtained the supplement to show the surveyor. Staff E showed the surveyor the Mighty Shake and stated Resident #1 had the option of chocolate or strawberry flavor. Staff E acknowledged she took care of Resident #1 for quite a while. He only drank the chocolate shakes, as he didn't like the strawberry flavor. He	F 684		

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would dump the strawberry supplement on the floor or the table. She realized the chocolate Mighty Shakes had more sugar and carbohydrates but he wouldn't drink the strawberry, so she gave him chocolate.

In an interview on 3/27/25 at 9:10 AM, Staff D, Licensed Practical Nurse (LPN), reported Resident #1's BS's ran high but he also had his BS's bottom out. Resident #1's BS's went up and down. Staff D stated the facility gave a Mighty Shake as the house supplement to residents but they also had one with less sugar for diabetics. Staff D stated the MAR would have the type of house supplement Resident #1 received, along with Resident #1's preference on which flavor they liked. Staff D reported they offered to give Resident #1 things to eat but he clenched his lips shut. She offered him a snack but if when she checked his BS and it had high result, she told the staff to not give him the snack or give him something not as sugary. The order for a snack came because he had real low BS's at night. His BS didn't have a pattern. His BS's went up and down at the drop of a hat. Staff D reported the facility's protocol was if the resident had a BS less than 60 or greater than 400, then she called the physician unless they had other parameters ordered. She documented in the progress note whenever she contacted the physician. Staff entered a code on the MAR or TAR if she held his insulin due to the BS reading and entered a note that she notified the physician. Staff D explained Resident #1 didn't get up right away so they put his insulin on the block schedule, which meant the AM dose could be administered between 7 10 AM. They checked his BS before meals but if he refused to get out of bed, she waited to give him insulin. She wanted to make sure he ate

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F 684	Continued From page 14 something before she gave him insulin. Staff D stated Resident #1 had dementia and the staff had to just go with the flow with him. On 3/27/25 at 12:15 PM, the Clinical Market Leader reported the facility didn't have a policy for nutritional supplements. An Administration of Drugs policy reviewed September 2022 instructed to administer all medications as prescribed by the attending physician. Scheduled medications must be administered within the facility's time frame. If they withheld a medication, a resident refused, or they gave it outside the scheduled time, the documentation will be reflected in the clinical record. A Change of Condition Reporting policy reviewed July 2021 directed to communicate all changes in a resident's condition to the physician. Notify the Medical Director for follow up if they can't contact the attending physician or alternate physician timely. The physician will be notified whenever there are changes in Resident #1's physical condition and if they have any abnormal labs. The nurse in charge is responsible for notifying the physician prior to the end of their assigned shift whenever they note a significant change in the resident's condition. All calls to the physician or communication exchanges requesting callbacks need documented in the nursing progress notes. If the physician didn't return the call by the end of the shift, the on coming nurse will be notified for follow up. A change in Resident #1's condition and response shall be documented in the nursing progress notes and updated the resident's Care Plan as indicated. All attempts to reach the physician and responsible party, along with the	F 684		

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F 684	Continued From page 15 time and response will be documented in the nursing progress notes.	F 684		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy review the facility staff failed to notify the physician in a timely manner of changes in a resident's status, failed to ensure the physician collaborated with the facility staff on the care and treatment of a diabetic resident, and failed to ensure the provider / specialist followed up in a timely manner for a resident's care and needs for 1 of 4 residents reviewed diabetes care and treatment and/or had a change in condition (Resident #1). The facility reported a census of 56 residents.	F 710	F710 Resident #1 has returned to the facility and is currently at prior level of functioning. All other residents in facility are at risk for change of condition lack of follow up care from provider if ongoing communication is not completed in a timely manner. New process in place for any nurse to provider communication to be placed at front nurses station that has not been responded to within 24 hours. Night nurse will review these communications and resubmit via EPIC or fax. Oncoming day nurse will contact DNS/designee if no response is received by EOD, so that provider/office can be contacted until order is	

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F 710	Continued From page 16 Findings: Resident #1's Minimum Data Set (MDS) assessment dated 12/18/24 identified a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. Resident #1 required staff supervision with eating. The MDS included diagnoses of diabetes, heart failure, renal insufficiency (impaired kidney function), Alzheimer's disease, and malnutrition (inadequate intake of nutrients). Resident #1 received insulin within the lookback period. Resident #1's MDS assessment dated 2/26/25 reflected Resident #1 had an unplanned discharge to the hospital on 2/26/25. Resident #1's Clinical Census List reviewed 3/24/25 listed the following: a. Discharged to the hospital on 2/26/25. b. Returned to the facility on 3/15/25. c. Transferred to the hospital on 3/21/25. The Care Plan Focus updated 1/30/25 identified Resident #1 had diabetes. The Interventions directed the staff the following: a. Monitor blood sugars (BS) b. Give insulin per orders c. Provide a complex carbohydrate snack at 2:00 PM daily. The eMAR - Medication Administration Note dated 1/18/25 at 8:14 AM, reflected Resident #1 had a BS of 122. Insulin held per nursing judgement due to Resident #1 had a history (hx) of easily going hypoglycemic (blood sugar lower than average of 70-150). The eMAR - Medication Administration Note	F 710		

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dated 1/24/25 at 12:21 PM identified the nurse held Resident #1's Novolog per nursing judgement for low BS's and Resident #1's refusal to eat lunch.

The Nursing Note dated 1/24/25 at 8:35 PM, indicated the nurse sent a list of BS's to Staff G, Nurse Practitioner (NP) at the nephrologist's office with a request for them to review and possibly decrease his Tresiba and order Novolog on a sliding scale. In addition, they notified the provider Resident #1 often had a poor appetite. He received his snacks frequently with insulin held per nursing judgement at times.

The eMAR - Medication Administration Note dated 2/7/25 at 5:08 PM, reflected the nurse held Resident #1's Novolog 10 units SQ per nursing judgement due to a BS of 99.

The eMAR - Medication Administration Note dated 2/8/25 at 4:01 PM, indicated the nurse held Resident #1's Novolog 10 units SQ per nursing judgement.

The eMAR - Medication Administration Note dated 2/10/25 at 8:24 PM, identified to notify the provider for a BS under 60 or over 500. Resident #1's BS registered high, the nurse gave fluids as he allowed.

The eMAR - Medication Administration Note dated 2/14/25 at 12:19 PM, reflected the nurse couldn't give Resident #1 his house supplement due to it being frozen.

The eMAR - Medication Administration Note dated 2/14/25 at 6:00 PM, indicated Resident #1 didn't receive his carbohydrate snack at 2:00 PM

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F 710	Continued From page 18 due to his high BS. The eMAR - Medication Administration Note dated 2/15/25 at 3:32 PM identified Resident #1 received 10 units of Novolog due to blood sugar reading high. The eMAR - Medication Administration Note dated 2/20/25 at 8:28 AM listed Resident #1 had a BS of 62. The Skin/Wound Note dated 2/21/25 at 3:07 PM reflected Resident #1 had dry adherent eschar noted to top of his left second toe. The toe appeared slightly red, swollen, and cool to touch. The nurse cleaned the area with soap and water, painted it with betadine, and covered it with a foam dressing. The eMAR - Medication Administration Note dated 2/25/25 at 1:01 AM reflected Resident #1's BS registered high with finger stick as the nurse couldn't locate his monitor for his continuous glucose monitor. The nurse gave several drinks of water as he showed no symptoms. The eMAR - Medication Administration Note dated 2/25/25 at 12:24 PM identified the nurse held Resident #1's house supplement held due to his high BS. The eMAR - Medication Administration Note dated 2/26/25 at 8:49 AM, identified the nurse held the Tresiba and Novolog due to Resident #1 not getting up to eat breakfast. Resident is clammy and tired. The eMAR - Medication Administration Note dated 2/26/25 at 1:26 PM, indicated Resident #1	F 710		

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had high BS's all day, with a BS of 437 after lunch. Resident #1 had a nonproductive wet cough and crackles in his lungs. His oxygen saturation registered at 78 % on room air. The nurse received an order to send Resident #1 to the emergency department (ED) for evaluation.

The Nursing Note dated 3/11/25 at 4:15 PM, the facility received the PFF (Physician Fax Form) from the nephrologist sent by the facility on 1/24/25 regarding Resident #1's low BS's and a request to review his insulin dose. The nephrologist responded the patient is inpatient (at the hospital) so unable to address at this time. They would review insulin dose and BS when Resident #1 returned to the facility.

The Condition Follow-up Note dated 3/17/25 at 12:31 AM, reflected Resident #1 readmitted to the facility for skilled level of care with dual antibiotic therapy for a urinary tract infection (UTI), pneumonia, sepsis (severe infection in the blood), and postoperative partial left second toe amputation.

The eMAR - Medication Administration Note dated 3/17/25 at 12:03 PM, identified Resident #1's BS registered as high.

The eMAR - Medication Administration Note dated 3/19/25 at 8:26 AM, Coreg for atrial flutter held due to low blood pressure (B/P) of 102/58 (expected around 120/80).

The Daily Skilled Note dated 3/20/25 at 4:43 PM reflected Resident #1 had a BS of 378 at 11:37 AM, which is not baseline or well controlled. The nurse didn't provide education regarding his BS levels. He ate less than 25% of his meals.

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F 710	Continued From page 20 The Condition Follow-up dated 3/20/25 at 6:45 PM identified Resident #1 wanted to attend karaoke, an activity he loves. The nurse described him as subdued but able to move his arms and legs. The Condition Follow-up dated 3/20/25 at 7:05 PM described Resident #1 as too fatigued to remain up in his wheelchair at the end of the day. The staff assisted him back to bed. The Nursing Note dated 3/20/25 at 10:01 PM, indicated the facility waited for a return call from the provider to update on Resident #1's decline and general status. Resident #1 had fatigue, declined appetite, and high BS via his Freestyle monitor and glucometer. The Nursing Note dated 3/20/25 at 10:34 PM, reflected the nurse called the on call physician back. The Nursing Note dated 3/20/25 at 10:35 PM, identified the call service paged the physician every 15 minutes. The Condition Follow-up Note dated 3/20/25 at 11:25 PM indicated the nurse updated the on-call physician of Resident #1's decline, decreased appetite, increased fatigue, his diagnoses, antibiotic therapy, and his high blood glucose at that time. The on-call provider gave zero new orders and instructed don't give insulin at that time. Follow-up with the NP in the morning. The hospital's communication program identified messages between the facility staff and the NP on 2/25/25 at 1:15 PM and 3/21/25 at 10:48 AM.	F 710		

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F 710	Continued From page 21 An After-Visit Summary dated 3/15/25 reflected Resident #1 had a hospital stay from 2/26/25 to 3/15/25. The summary included the following orders: a. BS checks before meals and at bedtime, notify physician if BS less than 70 or greater than 350. b. FreeStyle Libre 14-day sensor (continuous glucose monitor) use as directed. A Physician's Progress Notes dated 3/19/25 indicated the provider saw Resident #1 following his hospitalization from 2/26/25 to 3/15/25. The note listed the reason for the hospitalization as multifactorial sepsis related to osteomyelitis (infection in the bone) of the left foot, MRSA (methicillin resistant staphylococcus aureus) (a bacterial infection) pneumonia, and urinary tract infection (UTI). Resident #1 had his left second toe amputated on 3/6/25 due to osteomyelitis. His BS's varied even prior to his hospitalization. Nephrology managed his care and staff are to notify the clinic with new or worsening symptoms. Resident #1 didn't eat well and had very poor oral intake. The staff reported most of his intake included chocolate milk. A Hospital Admission History and Physical (H & P) dated 3/21/25 revealed Resident #1 went to the Emergency Department (ED) on 3/21/25 for an altered mental status, increased lethargy, and being less responsive than his normal, with his BS's also running high. A workup in the ED showed Resident #1 had DKA (diabetic ketoacidosis, a medical emergency caused by inadequate amount of insulin), glucose of 951 (normal BS: 70 100), bicarb 8 (normal: 22 28) and potassium 6.8 (normal: 3.5 5.2). A Hemoglobin A1C (HgbA1C, measures BS over	F 710		

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F 710	Continued From page 22 time) on 1/20/25 revealed a result of 9.2 (normal HgbA1C is less than 7%). In an interview on 3/25/25 at 11:30 AM, Staff A, Registered Nurse (RN), described Resident #1 as a brittle diabetic (difficult to manage due to large fluctuations in blood sugars). Resident #1 went to the hospital on 3/21/25 because he had high BS's, they got up to 900. He didn't eat and only consumed chocolate milk. He came back from the hospital on 3/15/25 and started on sliding scale insulin. Staff A reported if a resident's BS registered high, they needed to enter a number (code) on the MAR or enter "N/A" and enter a nurse's notes. When asked how much time they allowed for administering medication when insulin scheduled, Staff A responded it depends. The sliding scale insulin popped up on the screen at 7:00 AM if Resident #1 had an order to receive insulin, but the facility had open breakfast from 7:00 AM - 9:00 AM. She checked Resident #1's BS before he went to the dining room but she didn't give the insulin right away because she wanted to make sure he ate some food. If he wasn't eating, she didn't want to give his insulin. She used her nursing judgement on whether to give him insulin or not. She always heard to wait to give Resident #1 insulin until she knew he ate, for his safety. Most of the time, the insulin times are set up in a window of time such as 7:00 AM - 10:00 AM, but after software updates, the system had some quirks. Resident #1's MAR is red most of the days she explained, because she wanted to feel him out to see what he was going to do. She wanted to make sure he ate. Staff A said it scared the crap out of her when a resident had a hypoglycemic reaction. It terrified both her and Resident #1. Staff A reported the CMA's (certified medication aides) give the supplements, and the	F 710		

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F 710	Continued From page 23 CMAs MAR includes the supplements. Staff A stated she didn't know if the CMA gave him a sugar free house supplement or the regular house supplement. In an interview on 3/25/25 at 2:55 PM, Staff B, RN, reported he called the physician if Resident #1's BS got out of parameters. The parameters could be different depending on the physician or the resident. Some resident did fine with a BS above 70. Staff B confirmed he cared for Resident #1, but he was currently in the hospital. Resident #1 always had issues with his BS's even before he went to the hospital. Staff B reported he called the nephrologist to request BS parameters because the physician had Resident #1 on a set amount of insulin. Resident #1's BS's would dip really low. It was easier to bring down Resident #1's BS's versus if his BS's dipped down low. If his BS's got low, it was really hard to bring his BS's back up. Resident #1 had behaviors. He chose if he would eat or drink anything. The nurse had to think about the situation before they gave him any insulin. Resident #1 didn't eat at all, he let the physician know and held his insulin. Staff B reported the nephrologist is not a diabetic physician or specialist but he was the one staff were supposed to call for Resident #1's BS's. Staff B explained they made many attempts to reach the nephrologist but he didn't respond back. Staff B reported the computer automatically put in the timeslots for insulin and when it needed given. Staff couldn't edit the times for insulin administration. Staff need to document if they give the insulin outside of the designated timeframes in the MAR. In an interview on 3/26/25 at 10:45 AM, Staff F, Nurse Practitioner (NP), reported he saw	F 710		

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Resident #1 for a while. He had hard diagnoses to manage. He described him as a brittle Type 2 diabetic, as his BS's ran up and down, and his HgbA1C always ran high. Resident #1 had dementia, he didn't eat, and he only drank chocolate milk. The Nephrologist and Staff G, Nephrology NP, managed Resident #1's BS's, CKD (chronic kidney disease), and his blood pressure. Staff F took care of any other medical issues that came up along with his other diagnoses. Staff notify him of resident BS's and he tells them to notify Nephrology because the Nephrologist wanted to manage his blood sugars. Staff F reviewed Resident #1's EHR and confirmed Resident #1 admitted to the hospital twice. He had an acute hypoxic respiratory failure, then they diagnosed him with a UTI, pneumonia, and osteomyelitis in his foot. The hospital put on IV antibiotics. Staff F discussed the impact of giving insulin if Resident #1 didn't eat or drink, as well as if he received his insulin later than the scheduled time. Resident #1 had BS's that fluctuated so Staff F stated he wouldn't give Resident #1 as much insulin when he didn't eat. Staff F added that giving long acting insulin later does not make much of a difference as the short acting insulin given later than the scheduled time. Staff F stated he would be more concerned with short acting insulin and if they gave one late.

Staff H, Nephrology NP, failed to respond to a voicemail left on 3/26/25 at 12:10 PM from the surveyor.

In an interview on 3/26/25 at 3:45 PM, the Vice President (VP) of Clinical Operations reported the nephrologist and Staff G, NP, gave orders for residents in the nursing home. They do not have a policy or procedure for Resident #1s in the

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORT DODGE HEALTH AND REHABILITATION	728 14TH AVENUE NORTH FORT DODGE, IA 50501

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nursing home though. The physician or NP put instructions in their orders on what they needed done by the facility's staff. Typically, a sliding scale is according to the facility's policy. Staff should call the nephrologist or call the Connect provider that made rounds at the facility. The Connect Provider for the facility would be Staff F or another provider. The facility staff called the clinic or entered a note in the inbox in hospital communication program if the staff had a question about an order or something. The VP of Clinical Operations reported the facility had the ability to see things through hospital communication program because they had access to the hospital communication program. When the surveyor asked the VP of Clinical Operations what the turnaround time would be for when staff submitted a question in hospital communication program or called the nephrologist's office. The VP of Clinical Operations said it just depends. She went on to explain that the nephrologist was a single provider with a NP in his office. If the nephrologist or NP was not available because they were out of town or not on call, nobody took over or managed the nephrology faxes or communications back to the facility. The VP of Clinical Operations stated the facility staff could call and reach out and request the provider that was on call, which would then be addressed by the Connect team. She would expect the turnaround time for a provider responding back through hospital communication program or a communication back to the facility within 24 48 hours.

In an interview on 3/26/25 at 4:15 PM, the Director of Nursing (DON) reported the staff contacted Staff F or the Medical Director whenever the nephrologist didn't respond to staff

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calls or communications. The staff waited a day to hear back from the provider. If the issue was more serious or emergent then she expected staff to request the provider call back as soon as possible. the DON reported staff documented calls to the physician in the progress notes. The DON reported they also used a hospital program to communicate via an email with Staff F. Staff F did his best to contact the nephrologist or Staff G, NP, by doing what he could do to reach them and get them what was needed. Staff F had his office in the same office building with the nephrologist. It had been a challenge to get the nephrologist to respond to staff at the facility regarding his BS's and concerns about Resident #1 and what to do. The DON stated the nephrologist yelled at her and told her, she wasn't a doctor.

On 3/27/25 at 8:40 AM, the DON checked the computer EPIC system to see if the staff sent notifications to the provider about Resident #1. The DON confirmed the system didn't have notifications found for 1/18/25, 1/24/25, or dates in February 2025 when they held his insulin. In addition, they couldn't find notifications to the physician or NP about when they held his snacks due to Resident #1's high blood sugar. The DON stated she talked with the nephrologist about giving Resident #1 a snack if his blood sugars were elevated. The nephrologist wanted them to give the snack, especially in the afternoon, because otherwise Resident #1's blood sugar could drop. She was told it's better to provide a snack in between the meals to help keep the blood sugar readings at a more even level. She found correspondence in hospital communication program between the facility staff and the provider on 8/12/24 at 9:38 AM, 10/4/24 at 8:13 AM, and 3/21/25 at 10:48 AM.

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F 710	Continued From page 27 In an interview on 3/27/25 at 9:10 AM, Staff D, Licensed Practical Nurse (LPN), reported Resident #1's BS's ran high but his BS's could also bottom out, his BS's went up and down. Staff D stated they tried to work with the nephrologist to let him know about Resident #1's BS's but it was hard to get him to respond back. The specialist was very good at what he did and he knows it, but he acted like he was better than everyone else. On 3/27/25 at 1:30 PM, the Clinical Market Leader reported the nephrologist used to go through the faxes or communication from the facility staff every 3 months and then addressed things. On 3/27/25 at 1:45 PM, the Clinical Market Leader reported she looked for policies more specific to what to do if the physician doesn't respond back but she couldn't find one. She sent the policy she had for physician notification. A Notification of Physician or Responsible Party revised August 2007 revealed the facility notified the attending physician promptly for any changes in the resident's condition and/or status. A Physician's Visit policy dated August 2019 instructed the resident must see their attending physician at least once every quarter following their admission. The facility must review the resident's total program of care (including medication and treatments) at least every quarter, and revise as necessary. A Change of Condition Reporting policy reviewed July 2021 directed to communicate all changes in	F 710		

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F 710	Continued From page 28 a resident's condition to the physician. Notify the Medical Director for follow up if they can't contact the attending physician or alternate physician timely. The physician will be notified whenever there are changes in Resident #1's physical condition and if they have any abnormal labs. The nurse in charge is responsible for notifying the physician prior to the end of their assigned shift whenever they note a significant change in the resident's condition. All calls to the physician or communication exchanges requesting callbacks need documented in the nursing progress notes. If the physician didn't return the call by the end of the shift, the on coming nurse will be notified for follow up. A change in Resident #1's condition and response shall be documented in the nursing progress notes and updated the resident's Care Plan as indicated. All attempts to reach the physician and responsible party, along with the time and response will be documented in the nursing progress notes.	F 710		