STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0019004	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN BAY II AL OPERATIONS LLC	289 E SAINT JOSEPH ST GREEN BAY, WI 54301

(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 03/19/2026, Surveyor conducted a complaint investigation at Green Bay II AL Operations LLC. Additional information was gathered through 04/01/2026. The complaint was substantiated, and 2 deficient practices were identified. Census: 61	N 000		
N 214	83.15(3)(a) Administrator shall supervise daily operation The administrator shall supervise the daily operation of the CBRF, including but not limited to, resident care and services, personnel, finances, and physical plant. The administrator shall provide the supervision necessary to ensure that the residents receive proper care and treatment, that their health and safety are protected and promoted and that their rights are respected. This Rule is not met as evidenced by: Based on record review and interview, the administration did not ensure the necessary supervision was provided to ensure Resident 1 received proper care and treatment or that his/her health was protected. Lack of oversight and failure to follow through led to Resident 1 not receiving his/her life dependent medication and subsequently having a significant medical decline over the 4 days s/he was present at the facility. The administrators did not effectively intervene, ensure the resident's right to receive medication, provide oversight of employees to ensure health monitoring and follow-through, recognize	N 214		

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

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N 214	Continued From page 1	N 214		

limitations of their roles, communicate Resident 1's condition to responsible and required parties, initiate an internal investigation into the system failures that led to Resident 1's decline or submit the required report to the Department.

Findings include:

The provider is licensed to serve up to 69 residents who may have diagnoses including advanced age, irreversible dementia/ Alzheimer's disease, and/ or be terminally ill.

On 03/14/2026, the Department received a complaint alleging the provider did not provide oversight of medication management resulting in resident harm.

Administrative Team
On 03/19/2026 at 12:00 PM, Surveyor interviewed some of the administrative team including Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D.) The administrators stated DON B was the registered nurse for the facility and s/he and Regional Director of Operations (RDO K) were the direct supervisors of Administrator A. Administrator A held the title of Administrator, was a Licensed Practical Nurse (LPN,) and his/her job responsibilities matched that of Chapter 83 code requirements. DOW C was a LPN and was the lead administrator at the facility when Administrator A was not present, though Administrator A was usually on call or available for staff to communicate with. Both Administrator A and DOW C provided oversight for all of the staff while Administrator A was the direct supervisor of DOW C and MCD D. MCD D was the director/ manager of the memory care wing

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N 214	Continued From page 2	N 214		

where Resident 1 resided. DOW C was the direct supervisor of Assistant Director of Wellness (ADOW G.) Additionally, there was Marketing and Admissions Director E (MA E.) MA E's responsibilities were related to sales and business including admissions and coordinating preliminary admission paperwork. DON B and RDO K were responsible for regional oversight of multiple facilities. Administrator A, DOW C, ADOW G, and MCD D were referred to as the "clinical team" noting they were responsible for admission assessments, Individual Service Plans, medication management including medication orders, reviewing the admission paperwork once MA E submitted it, and day-to-day supervision of employees to ensure resident's care needs were met. Administrator A, DOW C and Human Resources Director (HRD L) were in charge of conducting any internal investigations while Administrator A was responsible for submitting required self-reports to the Department.

Resident 1
On 03/19/2026 at 10:45 AM, Surveyor reviewed Resident 1's records including the Medication Administration Record (MAR,) progress notes, emails, and the Individual Service Plan (ISP.) Resident 1 was admitted to the facility on 02/24/2026 with diagnoses including type 1 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with other specified complications, unspecified dementia, congestive heart failure, peripheral vascular disease, and a history of transient ischemic attack and cerebral infarction. Resident 1 had an activated Power of Attorney for Health Care (POA F.) Resident 1 had orders on 02/24/2026 for sliding scale insulin to be given after a blood sugar check for mealtimes and at bedtime (4X daily.) The insulin and blood

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N 214	Continued From page 3	N 214		

sugar check orders (diabetic orders) were not signed.

On 03/19/2026 at 12:00 PM, Surveyor continued to review Resident 1's record while interviewing Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D.) The interviews and records provided a timeline of events. The administrators confirmed they had access to Resident 1's record at all times, including his/her preadmission assessment conducted on 02/09/2025 that included information on Resident 1 being an insulin dependent diabetic. The resident's progress notes showed inconsistent attempts by the administration to obtain the signed diabetic orders over the 4 days the resident was present at the facility and showing signs of decline such as refusing all meals, having falls, and episodes of emesis. The residents' declining health was not recognized as a change in condition that required consistent health monitoring. Blood sugar checks were occasionally performed but not documented, inconsistent shift notes were made noting the residents' falls, refusals of meals, lack of diabetic orders and episodes of emesis. The administration had access to the records and did not provide consistent oversight of the documented concerns until resolved. Resident 1's POA F was told all necessary paperwork was in order for the resident to be admitted on 02/24/2026 when the diabetic orders were not enacted. POA F was not notified that no orders were received during the 4 days Resident 1 was at the facility. The resident moved into the facility on 02/24/2026 and did not eat or receive insulin while at the facility until s/he was found in a diabetic coma on 02/28/2026 and had to be emergently sent to the hospital.

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N 214	Continued From page 4 Administrators: Actions and Oversight While reviewing the timeline during the invterview on 03/19/2026 at 12:00 PM, the administrators recognized there was a breakdown in their system of assigned responsibilities that led to Resident 1's care needs not being met and a lack of clear accountability. Tasks such as reviewing the medical records to ensure accuracy, procuring medication orders, notification of the POA, and follow-up communication with providers were delegated to multiple administrators causing confusion as to who was ultimately responsible for which task's oversight and completion. Administrators delegated tasks to each other and their employees between shift changes and without follow-up. -Per reord review of an e-mail sent on 02/23/2026, MA E informed POA F that all the necessary paperwork was in order for the admission on 02/24/2026 when the orders for insulin were not complete. No administrator was able to say who on the clinical team was responsible for reviewing the orders after MA E gathered them to ensure they were correct prior to the resident's admission. -Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D): Administrator A stated s/he was not at the facility on 02/24/2026-02/28/2026 but was on-call and was informed on 02/25/2026 by MCD D that Resident 1 did not have insulin orders. Administrator A encouraged MCD D to call the endocrinologist office but did not follow-up with his/her employees to ensure the issue came to a	N 214		

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N 214	Continued From page 5	N 214		

resolution. Administrator A stated the next call s/he received was on 02/28/2026 when Resident 1 was found unresponsive and s/he directed staff to call emergency services. Administrator A stated s/he did not report the incident to his/her supervisors, did not conduct an investigation into the incident or root cause, and did not submit a self-report to the Department as was required. After the Department investigation identified a self-report was required, a self-report was submitted By Administrator A on 03/20/2026. Administrator A noted in the self-report that POA F was informed by MCD D on 02/26/2026 that the signed insulin orders had not yet been received. The statement was contradicted by interviews with MCD D on 03/19/2026, POA F on 03/25/2026, and a written statement by MCD D on 03/20/2026. Additionally, Administrator A was aware POA F had not been informed of the lack of diabetic orders as Administrator A informed him/her that the provider never received signed diabetic orders in an e-mail to POA F on 03/13/2026 (text included below) after POA F requested to review the Medication Administration Record (MAR) and found there were no diabetic orders to review.

MCD D did not call when s/he first noticed the diabetic orders were incomplete on the morning on 02/24/2026. MCD D stated s/he called the endocrinologist office on 02/25/2026 and handed off the report to DOW C on 02/25/2026 at the end of his/her shift. MCD D was present at the facility on 02/26/2026 and did not follow-up to get the insulin order and did not inform POA F when s/he was present that no insulin orders were in place. MCD D stated s/he reached out on the morning of 02/27/2026 tell ADOW G to call the endocrinologist office as s/he was aware Resident 1 still did not have insulin orders.

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N 214	Continued From page 6 ADOW G did not call the endocrinologist office until the afternoon on 02/27/2026. DOW C stated s/he did not call for an after-hours order on 02/25/2026 when MCD D informed him/her that Resident 1's insulin orders were not enacted even though the resident had been at the facility for over 24 hours without insulin. On the afternoon of 02/26/2026 Caregiver J reported Resident 1's blood sugar to be 408 to DOW C. DOW C was aware Resident 1 still did not have insulin orders and told Caregiver J not to call the physician or intervene as s/he believed because the resident was not eating the blood sugar would self-correct. (LPN's are not licensed to assess residents, or make assessments or medical decisions based on reported values or observations.) DOW C did not follow-up to get insulin orders or report the blood sugar to the physician, pharmacy, POA F, endocrinologist office, or notify his/her supervisors. DON B stated s/he had not been made aware of the situation until on 03/19/2026 when in the course of investigation the Department survey revealed there had been a compliant regarding Resident 1. DON B stated his/her expectation that his/her employees inform him/her about resident situations of concern as they arise. DON B stated in internal investigation would immediately begin. Administration Communication and Post Survey Investigation Findings On 03/25/2026, Surveyor reviewed e-mail correspondence between POA F, MCD D and Administrator A. On 03/12/2026 at 12:26 PM, POA F asked for the MAR including all documented blood sugar checks. On 03/12/2026	N 214		

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N 214	Continued From page 7 at 3:35 PM, MCD D sent POA F Resident 1's February MAR. POA F responded noting what was sent did not include the insulin or blood sugar checks as s/he had still not been informed that Resident 1 did not receive insulin or regular blood sugar checks while s/he was at the facility. On 03/13/2026 at 10:25 AM, Administrator A responded: "Good morning, We received the physician plan of care on 2/23/26 and the medication list had all [his/her] diabetic medications crossed out, but they were signed by the NP. On 2/24/26, the day of move-in, we received another med list with [his/her] diabetic medications on it, however, it was not signed and was not accepted by the pharmacy. There was an issue at Streu's because they initially uploaded [his/her] orders to our RCAC and we were unable to just transfer them to the CBRF, so we had to wait until early evening until we could verify the orders. On 2/25/26, we reached out to endocrinology and explained that the orders that we received were not signed and they need to have them signed and fax them back to us asap . On 2/27/26, we still had not received anything from endocrinology, so we called and followed up and requested the signed medication list again. We did not have signed orders for blood sugar checks but knew [s/he] was diabetic, so we were occasionally checking [his/her] blood sugars, when [s/he] would allow, and the highest [his/her] blood sugar ever got was 290 and [MCD D] did report that reading to you. [S/he] was not eating, drinking normally, and refusing to allow staff to check [his/her] blood sugar.	N 214		

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N 214	Continued From page 8 On 2/28/26, in the morning, [s/he] was sent out. I have attached the initially orders that we received from [his/her] primary care provider as well as the endocrinology orders that we finally received on 3/3/26 but were still not signed and not accepted by the pharmacy ..." On 04/01/2026 at 12:05 PM, DON B e-mailed Surveyor a copy of the investigation that was completed after the allegations were brought to DON B's attention on 03/19/2026. The investigation included a summary of their findings including: "-Failure to obtain sign practitioner orders prior to or immediately upon admission resulting in missed insulin administration. -Failure to ensure the residents right to receive prescribed medications. inadequate health monitoring including failure to respond appropriately to decreased oral intake. -Failure to notify and involve primary care provider or covering provider regarding missing orders, changing condition, nutritional concerns. -Breakdown in provider continuity during transition from Sequoia to Bluestone physician group. -Lack of consistent follow up after initial physician contact on 2/25 and delayed recontact until 2/27. -No escalation process for high-risk medications or declining condition. -Incomplete and insufficient communication and documentation with the POA. -Absence of a formal admission medication reconciliation and order verification process." The provider took immediate steps to reeducate the clinical staff. The training outlined admission orders and communication compliance, physician	N 214		

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N 214	Continued From page 9 orders prior to admission, medication availability at move in, medication administration compliance for when orders are delayed or not obtained, recognizing and responding to change in condition, high risk medications not available, communication documentation requirements, refusal of care/treatment, admission audits, and 24-hour report review. Cross Reference: N0353 DHS 83.32(3)(i) Rights Of Residents: Adequate Treatment	N 214		
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. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure Resident 1 had prompt and adequate treatment to manage his/her chronic medical condition. Resident 1's Type 1 insulin dependent diabetes was not managed by the provider, resulting in Resident 1 entering a diabetic coma and requiring hospitalization where s/he passed away. Findings include: The provider is licensed to serve up to 69 residents who may have diagnoses including advanced age, irreversible dementia/ Alzheimer's disease, and/ or be terminally ill.	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 353	Continued From page 10 On 03/14/2026, the Department received a complaint alleging the provider did not provide oversight of medication management resulting in resident harm. On 03/19/2026 at 10:45 AM, Surveyor reviewed Resident 1's records including the Medication Administration Record (MAR,) progress notes, emails, and the Individual Service Plan (ISP.). Resident 1 was admitted to the facility on 02/24/2026 with diagnoses including type 1 diabetes mellitus with hyperglycemia, type 2 diabetes mellitus with other specified complications, unspecified dementia, congestive heart failure, peripheral vascular disease, and a history of transient ischemic attack and cerebral infarction. Resident 1 had an activated Power of Attorney for Health Care (POA F.) Resident 1 had orders on 02/24/2026 for sliding scale insulin to be given after a blood sugar check for mealtimes and at bedtime (4X daily.) The order included: "Inject under skin four times daily with meals and at bedtime inject just after finishing the meal. Base dose: breakfast: 6 units (hold of skipping meal) lunch: 6 units (hold if skipping meal) supper: 6 units (hold of skipping meal.) Plus sliding scale (based on pre meal blood sugars) <80: treat low with fast acting carbs; then eat meal. Once blood sugar >80 and dose base dose 80-149: base dose only, 150 -250: 1 unit, 251-350: 2 units, 351-450: 3 units, > 450: 4 units. Bedtime sliding scale <200: consume protein-based snack; no insulin 200- 300: 1 unit, 301 to 400: 2 units, >400: 3 units and call provider's office." The diabetic orders were not completed as they were not signed by the physician. On 03/23/2026 at 11:00 AM, Surveyor interviewed	N 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 353	Continued From page 11	N 353		

POA F. POA F stated prior to Resident 1's arrival s/he received an e-mail from Marketing and Admissions staff E (MA E) stating all paperwork including medications were in order and ready for Resident 1 to move in on 02/24/2026. POA F stated s/he came to visit Resident 1 on 02/26/2026 at around lunchtime and found Resident 1 had not eaten lunch, that the provider had accidentally washed Resident 1's blood sugar monitor and it was not functioning. POA F stated s/he requested the facility use one of their spare blood sugar monitors to check Resident 1's blood sugar and it came back reading 295. POA F stated Resident 1's blood sugars tended to "run high ...usually around 200" so while believing there were current orders and insulin medication to give Resident 1 at the facility, s/he encouraged Resident 1 to eat. POA F stated, "They told me they washed the blood sugar meter. That's it. No one told me the orders hadn't come through. No one told me there wasn't insulin at the facility to give to (him/her.) I didn't know (s/he) hadn't received insulin yet or eaten anything yet. I am also diabetic. Someone with diabetes cannot live without insulin. You can die without it in just 48-72 hours. Its not a question of if you will die, but when. Had I known there was no insulin there I never would have encouraged (him/her) to eat. I would have demanded they bring (him/her) to the emergency department to get insulin or I would have given (him/her) some myself ...[his/her] endocrinology office is just down the street I would have helped and gone there and waited until I received the orders." POA F stated on 02/28/2026 the provider found Resident 1 unresponsive in a diabetic coma, and Resident 1 had to be emergently transported to the hospital where Resident 1 was found to be in diabetic ketoacidosis that damaged his/her kidneys leading to encephalopathy and to him/her passing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 353	Continued From page 12	N 353		

away at the hospital on 03/15/2026. On 03/12/2026 POA F was still uninformed by the provider that they had not been completing regular blood sugar checks and did not have the diabetic orders to administer insulin. POA F e-mailed the provider requesting a copy of the documented blood sugars and medications given from the 03/25/2026-03/28/2026. On 03/13/2026 Administrator A wrote back explaining a general timeline and informing POA F that there had not been diabetic orders or regular blood sugar monitoring. During the interview on 03/23/2026 POA F questioned why no orders were received or followed through with by the provider, no medication was given, no meals were eaten, no continuous health monitoring occurred, and no one notified him/her from 02/24/2026 through 02/28/2026 of the resident's most significant needs and changes despite POA F having been present at the facility on 02/24/2026, 02/25/2026, and 02/26/026.

On 03/19/2026 at 12:00 PM, Surveyor continued to review Resident 1's record while interviewing Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D.)

DON B stated s/he had not been made aware of the concerns regarding Resident 1 and was just learning about the situation as the interviews were being conducted during the state investigation.

Administrator A, DON B, DOW C, and MCD D all confirmed they were aware physicians have after hours physicians on-call that are available for urgent needs such as procuring orders for insulin. The providers confirmed they were aware if DON B (registered RN) was not available to take the

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	0019004	A. BUILDING: _____ B. WING _____	C 04/01/2026

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N 353	Continued From page 13	N 353		

orders after hours, emergency services were also available. The providers confirmed they were all medication trained, including diabetic management and were aware Resident 1 was dependent on insulin to live. The providers confirmed they were aware significant harm including coma and/ or death could occur within days if person with insulin dependent diabetes did not receive insulin.

Administrator A stated s/he was not working at the facility from 02/24/2026 through 02/28/2026 but was available by phone for his/her staff to contact in the event of an emergency or if guidance is needed. Administrator A stated s/he was first made aware the provider did not have the signed diabetic orders and that the resident "wasn't feeling good" from all call made to him/her by MCD D on 02/25/2026. Administrator A stated Resident 1 was a "fragile diabetic" and that his/her blood sugars were reported to normally be "around 200."

The interviews and record review (including hospital records from 02/28/2026-03/215/2026) provided a timeline of events:

02/09/2026
Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of the admission assessment dated 02/09/2026:

Administrator A and MCD D conducted an admission assessment of Resident 1 at his/her previous place of residence. It was noted that Resident 1 was an insulin dependent diabetic.

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N 353	Continued From page 14 02/23/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of email records dated 02/23/2026: 2:04 PM- Marketing and Admissions Director E (MA E) assured POF A that all records, including medical orders, were received and in order. MA E e-mailed POA F, "Paperwork should be taken care of shortly. [sic] And [sic]we should be good to go for move in tomorrow!" 2:36 PM- MA E emailed POA F, "We are good to go with paperwork - [sic] fax just came through ..." Resident 1's physician plan of care was received, and the provider observed the orders for insulin, blood sugar checks, and supplies (diabetic orders) were struck out. The physician's plan of care and signed medication list was sent to the pharmacy. 02/24/2024 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of email records dated 02/24/2026: 8:30 AM- The previous home e-mailed the provider a copy of the diabetic orders from Resident 1's endocrinology office. The provider observed the orders were not signed by the physician. 11:30 AM- Resident and his/her medications arrived at the facility. The medication included	N 353		

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N 353	Continued From page 15 bubble packaged medications but no insulin. 1:30 PM- MCD D contacted the pharmacy and discovered the orders had not been uploaded to the correct provider electronic system and there was still no signed medication order. MCD D reported the situation to DOW C prior to leaving in the afternoon. 4:00 PM- DOW C reviewed the electronic medication charting system and observed no diabetic orders were present. 5:00-6:00 PM- The provider did not document checking his/her blood sugar but (during the interview on 03/19/2026) DOW C recalled a blood sugar was taken "around dinner time" and was approximately 225. Despite not having insulin available, Resident 1 was offered dinner. Per interview on 04/01/2026 at 4:35 PM with Caregiver J and record review of Resident 1's progress notes, Caregiver L noted in Resident 1's progress notes that s/he "refused supper" and when s/he asked why, Resident 1 stated, "because of my diabetes." Caregiver J questioned DOW C about the insulin orders and was told the provider was waiting for clarification. No calls to POA F or an after-hours physician to procure an order and access to medication was made. 02/25/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of Resident 1's progress notes dated 02/25/2026:	N 353		

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N 353	Continued From page 16 8:00 AM- Caregiver H noted in Resident 1's progress notes, " ... I tried encouraging [Resident 1] to eat [his/her] breakfast. [S/he] started to eat from the fruit cup and threw up after 2 pieces. I asked if [s/he] was OK. [S/he] said [his/her] sugar must be sky high. I informed the Med tech. The Med tech tested [his/her] sugar and encouraged [him/her] to eat. Resident said if [s/he] ate [s/he] would get sick again..." There was no documentation of the results of the blood sugar check. No call to POA F or the resident's physician was made. 10:00 AM- MCD D called Resident 1's endocrinology office to report Resident 1 still needed signed orders sent to the pharmacy and that Resident 1 had not yet eaten or had insulin since arriving on 02/24/2026. MCD D stated s/he could not recall the name of the nurse s/he spoke with at the office. MCD D stated s/he called Administrator A to inform him/her that the resident was not feeling well, and the signed diabetic orders were still not received. MCD D stated s/he called and left a voice message for POA F to call him/her back but did not receive a return call. (During the interview on 03/19/2026, MCD D stated to Surveyor on 02/26/2026 POA F was present at the facility and during this encounter s/he did not update him/her about the lack of diabetic orders and insulin.) 6:00 PM- Resident 1 fell out of bed and his/her blood sugar was reported to be "around 200" 02/26/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) interview with	N 353		

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N 353	Continued From page 17 POA F on 03/23/2026 at 11:00 AM, and record review of Resident 1's progress notes dated 02/26/2026: 5:45 AM- DOW C called POA F to notify him/her about the fall from the previous evening and did not inform POA F about the diabetic orders not being completed. 7:52 AM- Resident 1 refused breakfast. MCD D noted in the progress notes, "Writer did attempt to contact APOA [sic] yesterday [sic] awaiting call back." 12:30 PM- Resident 1 did not eat lunch. POA F came to visit and was informed by MCD D that Resident 1 had an emesis, was not feeling well, had been refusing meals and that the provider had accidentally run the resident's blood sugar monitor through the laundry on 02/25/2026 and it was no longer functioning. POA F asked the provider to check a blood sugar using one of their blood sugar meters. Resident 1's blood sugar was 295. POA F encouraged Resident 1 to eat and s/he took 2 bites of oatmeal. MCD D did not inform POA F that the diabetic orders were not completed, and no insulin was available for the resident. No follow-up contact was made with the resident's physician, endocrinology office, or pharmacy. Administrator A, DOW C, and MCD D stated no further efforts were made on 02/26/2026 to address the lack of diabetic orders or Resident 1 going over 48 hours without food or receiving insulin. The administrators stated all employees were needed on 02/26/2026 to address an urgent community situation in the basement of the facility.	N 353		

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N 353	Continued From page 18 2:30-4:00 PM- Caregiver J took Resident 1's blood sugar with a facility monitor and noted it was 408. (Photo 1.) Caregiver J reported the reading to DOW C with MCD D present. Surveyor interviewed Caregiver J at 4:35 PM on 04/01/2026. Caregiver J stated, "I told [DOW C] it was over 400 and [s/he] told me not to do anything about it because [s/he] wasn't eating ... said it would come down on its own ... [Resident 1] had just been drinking those diet rootbeers. [S/he (DOW C)] kind of like chuckled about it ... I was kind of shocked ... normally if its over 400 we have to call the doctor." DOW C is a Licensed Practical Nurse (LPN.) LPN's are not licensed to assess residents, or make assessment or medical decisions based on reported values or observations. 02/27/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of Resident 1's progress notes dated 02/27/2026: 9:31 AM- MCD D texted ADOW G to follow-up with the endocrinology office to get the signed diabetic orders. 2:27 PM- ADOW G called the endocrinology office to request the diabetic orders. ADOW G did not note who s/he spoke with but was told the request would be sent to the endocrinology RN to have the orders faxed to the facility. 11:08 PM- Resident 1 was found on the floor in his/her room yelling out for help and in a confused state as Caregiver H noted when asked	N 353		

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N 353	Continued From page 19 what happened Resident 1 stated s/he "always sleeps on the floor." The confusion along with the unwitnessed fall was not recognized as a potential change in condition and was not reported to the on-call administrator, physician, or POA F. 02/28/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of Resident 1's progress notes dated 02/28/2026: After 9:13 AM- Resident 1 was found unresponsive in his/her room by Caregiver M. Caregiver M noted in a progress note (written at 11:33 AM,) " ... staff took blood sugar it just read HIGH ..." 9:25 AM- Caregiver M called Administrator A who directed the staff to call emergency service to send the resident to the hospital. (Resident 1 was admitted to St. Vincent's hospital via the Emergency Department.) Per record review of hospital records from 02/28/2026: 10:11 AM- The hospital blood glucose meter read >500. A venous blood draw was ordered and the resident was immediately started on treatment. 10:16 AM Resident 1's blood was drawn and results were called in at 10:56 AM as a blood sugar reading of 1016. 10:57 A urine sample was tested and results came noting glucose continued to be >1000 and	N 353		

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N 353	Continued From page 20 Ketones were found to be 40 mg/dl. 03/02/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of Resident 1's progress notes dated 03/02/2026: 8:29 AM- MCD D noted in the progress notes that s/he called the hospital and received an update that the resident was "on an insulin drip, has a heart cath, [sic] monitoring kidneys closely. No plan for discharge, RN stated [s/he] will likely be there for a while." 03/12/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of e-mails dated 03/12/2026: 12:26 PM -POA F e-mailed the provider asking for Resident 1's blood sugar and medication administration records. 03/13/2025 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D,) and record review of e-mails dated 03/13/2026: 10:25 AM- Administrator A informed POA F via e-mail that no blood sugar checks or insulin had been administered and that the diabetic orders had not been completed from admission through discharge to the hospital (02/24/2026-	N 353		

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N 353	Continued From page 21 02/28/2026.) 03/15/2026 Per interview on 03/19/2026 at 12:00 PM with Administrator A, Regional Director of Nursing B (DON B), Director of Wellness C (DOW C), and Memory Care Director D (MCD D)and review of hospital records on 03/15/2026: 8:35 AM- Resident 1 passed away at the hospital. On 03/31/2026 Surveyor received and reviewed Resident 1's hospital records. Surveyor noted: "Hospital Course: [Resident 1] is a 78-year-old [fe/male] with a history of type 1 diabetes mellitus, coronary artery disease status post CABG, ischemic stroke, hypertension, and obstructive sleep apnea who was admitted after being found unresponsive at [his/her] memory care facility, presenting with altered mental status, hypotension, and severe hyperglycemia. During [his/her] hospitalization, [s/he] was diagnosed with diabetic ketoacidosis with coma, multifactorial shock (septic and cardiogenic), acute kidney injury, and acute hypoxic respiratory failure. - [Physician I] 9:01 AM 03/15/2026." During the interview 03/19/2026 DON B stated at 2:15 PM that the provider would begin an investigation including a root cause analysis and take immediate corrective measures. Cross Reference: N0214 DHS 83.15(3)(a) Administrator Shall Supervise Daily Operation	N 353		