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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPIRUS TIVOLI COMMUNITY	2805 HUNTERS TRAIL PORTAGE, WI 53901

(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 09/08/2026 to 09/15/2026, Surveyor conducted a complaint investigation and verification visit at Aspirus Tivoli Community. One deficiency was identified. The deficiency was a repeat violation. See Statement of Deficiency (SOD) BPUN11, dated 10/16/2025 and SOD JFHZ12, dated 09/29/2022. The previous deficiencies from SOD BPUN12, dated 04/30/2026 were substantially corrected. The complaint was substantiated. Under statutory provisions of Wis. Stat. Chapter 50, a $200 revisit fee is being assessed. Census: 28	{N 000}		
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 each resident received prompt and adequate treatment appropriate to the resident's needs. Resident 11 had 10 occurrences from 05/18/2026 to 06/10/2026 in which his/her blood sugar was over 450 and there was no evidence of staff	N 353		

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

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notifying his/her physician.

Resident 11 missed 2 doses of his/her Lantus insulin on 06/09/2026 and 06/10/2026 resulting in hospitalization. Additionally, Resident 11 missed a dose of Humulin insulin on 06/16/2026.

From 06/18/2026 to 06/21/2026, Resident 11 experienced 6 occurrences of his/her blood sugars over 450, including 2 occurrences over 600, and there was no evidence of staff notifying his/her physician until 06/22/2026 when Resident 11 was hospitalized.

From 07/09/2026 to 07/10/2026, Resident 11 experienced 3 occurrences of his/her blood sugars over 450 and there was no evidence of staff notifying hospice. Resident 11 passed away on 07/11/2026.

This is a repeat deficiency. See Statement of Deficiency (SOD) BPUN11, dated 10/16/2025 and SOD JFHZ12, dated 09/29/2022.

Findings include:

The Mayo Clinic Website defines hyperglycemia as, "High blood sugar, also called hyperglycemia, affects people who have diabetes ...Skipping doses or not taking enough insulin or other medication to lower blood sugar also can lead to hyperglycemia ... Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL) ...Long-term complications Keeping blood sugar in a healthy range can help prevent many diabetes-related complications. Long-term complications of hyperglycemia that isn't treated include: ... Kidney damage (diabetic nephropathy) or kidney failure ...Feet problems

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caused by damaged nerves or poor blood flow that can lead to serious skin infections, ulcerations and, in some severe cases, amputation ..." (Source: The Mayo Clinic Website, Hyperglycemia, 1998-2026, https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631 (retrieval date - September 15,2026).)

On 07/13/2026, the Department received a complaint alleging concerns with a resident's diabetes management.

On 09/08/2026, Surveyor reviewed Resident 11's record and identified the following:

Resident 11 is over 90 and has multiple diagnoses including type 2 diabetes, anxiety, dementia, and restlessness/agitation. Resident 11 had an activated healthcare power of attorney (Legal Representative L). Resident 11 was admitted to hospice services on 06/26/2026 until s/he passed away on 07/11/2026. Resident 11's individual service plan (ISP) dated 06/12/2026 documented: "Medication: Services ALF to provide: Nursing staff med administration, I receive diabetic related medicine as ordered. Update my MD as needed. Check my blood sugars as ordered and as needed. Staff should report indicators of hypo/hyperglycemia to the nurse-dry mouth, extreme thirst, drowsiness, frequent urination, stomach pain, sweating, trembling, dizziness, mood changes, hunger, headaches, blurred vision, fast heart beat, extreme tiredness, paleness, I have diabetes. Endocrine: fluctuating blood sugars, Persons to provide service: staff."

Resident 11's physician orders documented: "-Insulin Glargine Solostar 100Unit/ML Solution

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N 353	Continued From page 3 Pen-injector sub-Q, Dose: (25unit) daily Breakfast, with a start date of 02/09/2026 and end date of 06/15/2026. -Lantus SoloStar Insulin Glargine 100Unit/ML Solution Pen-injector Dose (10unit), sub-Q at bedtime, with a start date of 05/14/2026 and end date of 06/15/2026. HOLD if blood sugar less or equal to 120 and if has eaten less than 50% of food for the day. -Blood Glucose Check: twice a day Breakfast and HS. Notify physician if blood glucose >300x2 or over 450 update MD. Notify physician if blood glucose <60 with symptoms update MD. If less than 120 HOLD INSULIN if eats less than half during day, HOLD HS insulin. Entry date 03/13/2026 and end date of 06/26/2026. -Humulin 70/30 KwikPen Insulin NPH Isophane & Regulat (70Unit/ML-30) 100Unit/ML Suspension Pen-injector, Dose: (14unit), sub-Q twice per day Breakfast & Midday, with a start date of 06/16/2026 and end date of 06/26/2026. - Humulin 70/30 KwikPen Insulin NPH Isophane & Regulat (70Unit/ML-30) 100Unit/ML Suspension Pen-injector, Dose: (8unit), sub-Q twice per day Breakfast & Midday, with a start date of 06/27/2026. -Blood Glucose Check: four times a day before meals and bedtime 0730, 1130, 1630, HS. Notify physician if blood glucose >300x2 or over 450 update MD. SEE SPECIAL INSTRUCTIONS. IF SUGAR IS BELOW OR ABOVE PARAMETERS CALL [HOSPICE PROVIDER M] AND RN FROM FACILITY. Notify physician if blood glucose <60 with symptoms update MD. Hold Insulin if eats less than half during the day HOLD HS insulin.	N 353		

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N 353	Continued From page 4 Start date 06/26/2026." Example 1: Blood sugars over 450 not reported from 05/18/2026 to 06/10/2026. Surveyor reviewed Resident 11's May and June 2026 medication administration records (MARs). Surveyor observed 10 occurrences in which Resident 11's blood sugar was within notification parameters, there was no evidence in which Resident 11's physician was notified of the high blood sugar readings: -5/18 HS (493) -5/19 HS (569) -5/29 HS (452) -6/1 HS (457) -6/2 HS (588) -6/3 HS (532) -6/4 HS (588) -6/5 HS (565) -6/6 HS (556) -6/10 HS (469) Example 2: Missed doses of insulin Surveyor reviewed Resident 11's June 2026 MAR and progress notes. The following 3 missed doses of insulin were observed: -06/09/2026: Bedtime Blood Glucose Check: 122, Lantus SoloStar Insulin Glargine (HS)-Held-Reason: medication unavailable. -06/10/2026: AM Blood Glucose Check: 126, Insulin Glargine Solostar (AM)-Held-Reason: medication unavailable. -06/16/2026: Humulin 70/30 (midday dose) was missing staff initials on the MAR indicating the medication was administered. Resident 11's progress notes documented: "06/18/2026: 1 dose of insulin was missed on	N 353		

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noon 6/16 as the RA did not go back to check [his/her] mar even though [s/he] was told about the new order."

Resident 11's progress notes documented:
"-06/10/2026 written by [RN I]: Spoke with [Pharmacy N]/[Physician O]/[Legal Representative L]. NPH insulin still not in that was ordered 5/29. They have it on express order and it may be in this afternoon or tomorrow am. Lantus is now run out and there is no remaining script. Humalog pen is available for temporary if needed. Spoke with: call to nurse line x2 for insulin request to [Physician O]. Epic message sent. Comments: For now I would use the Humalog with meals. [His/her] previous dose was 4 units with meals. It will not control the baseline blood sugars but should help with the glucose spikes at mealtimes.

-06/11/2026 written by [RN I]: Spoke with [Pharmacy N]/[Physician O], regarding: insulin, comments: pharmacy sent a request for refill on lantus as they did get a couple of those pens in. The insulin did not come in yet.

-06/12/2026: written by [RN I]: Call placed to [Physician O] regarding: resident returned from overnight stay at hospital due to diabetic ketoacidosis. The paused Lasix and Humulin Kwik Pen which is now in stock at pharmacy."

Surveyor reviewed communication between the provider and Physician O's clinic. The following was documented:
"-06/10/2026 at 10:21 AM: Took at batline call. [RN I] from [provider name] calling. Pt is out of insulin. Pt was on Lantus 25 units in the am and 10 units at bedtime. Pt's blood sugars were very labile and so [s/he] was switched to NPH &

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regular insulin. [Pharmacy N] ordered the NPH and put a rush on it They said that it will not come in tomorrow. Pt used the last of [his/her] lantus yesterday morning 6/9/26 25 units. [His/her] blood sugar last night was 122 and this morning 126. [S/he] is not having any symptoms of concern. [RN I] is not sure what to do. Called [RN I] ...They have glargine multi dose vial available in stock and Humalog multi dose vials in stock if [Physician O] is wanting to try bridging with something else until the NPH can be delivered. 2:43 PM: [RN I] called again and stated that [Legal Representative L] is getting a little upset that about this not being addressed faster. Patient is out of insulin. 3:52 PM: ...called [RN I] at [provider name], ok to do Humalog only at current dosing until NPH is available."

Resident 11's hospital records dated 06/11/2026 to 06/12/2026 documented:
"Hospital Course: [Resident 11] with history of dementia, aortic stenosis, hypertension, diastolic heart failure, and poorly controlled type 2 diabetes mellitus (most recent A1c 10.5%) who presents due to hyperglycemia and lack of insulin ...The [Legal Representative L] reported that [his/her] facility had run out of the patient's insulin glargine for the last several days. An attempt was made to cover the patient with short-acting insulin instead while more glargine could be obtained. However, the patient's blood sugars has continued to rise. Patient was then brought to the emergency department. Outside of mild tachycardia, vitals were stable. Labs showed a blood glucose of 744, elevated beta hydroxybutyrate at 4.1, bicarb of 15, anion gap of 24, and potassium of 5.5. Patient received a fluid bolus and 10 units of regular insulin and was then admitted to the hospital for further management. Attempt was made to manage the patient with

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subcutaneous insulin alone. [S/he] received [his/her] normal dose of insulin glargine, 5 more units of regular insulin, and further IV fluids to treat an AKI. Patient received a total of 2.5 liters of IV fluids. Within 12 hours, the patient's blood sugar had improved to 162, anion gap had closed, bicarb was up to 24, sodium had normalized, and [his/her] creatinine was improving. The patient was also able to tolerate a diet. It was confirmed with the patient's facility that they did have the insulin glargine available now. Patient was then discharged back to [his/her] facility."

Example 3: Blood sugars over 450 not reported prior to 6/21-6/26 hospitalization

Surveyor reviewed Resident 11's June 2026 MAR. Surveyor observed 6 occurrences in which Resident 11's blood sugar were within notification parameters, there was no evidence in which Resident 11's physician was notified of the high blood sugar readings until Resident 11 was hospitalized on 06/22/2026:
-6/18 PM (455)
-6/19 AM (471)
-6/19 PM (499)
-6/20 AM (488)
-6/20 PM (over 600)
-6/21 AM (over 600)

Resident 11's hospital records dated 06/21/2026 to 06/26/2026 documented:
"-[Resident 11] ...admitted on account of generalized weakness, fatigue. Vital signs upon arrival to the emergency room temperature was 97° pulse was 116, respiratory was 20 blood pressure was 82/51, saturation was 90% on room air. Patient received 2 liters of normal saline bolus with improvement in blood pressure with systolic

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improving to 125/61. Basic Metabolic Panel (BMP) revealed blood sugar of 800, creatinine of 1.28 lactic acid 7.9 WBC 22.34 K, H&H 12.1/38.0 likely hemoconcentrated. UA was abnormal, blood culture was obtained and patient was started on insulin and Rocephin. Patient was ultimately found to be in Diabetic ketoacidosis (DKA) and subsequently admitted to the ICU. DKA protocol was initiated. Blood glucose on anion gap by subsequently within optimal range. However, patient was noted to be persistently lethargic and had episodes of hypoglycemia presumably due to poor oral intake. Seroquel and benzodiazepines was subsequently discontinued. Mental status subsequently improved with patient is more responsive on communicative ...Blood sugar remains stable on NPH 8 units in the daytime, on 5 units at bedtime. Patient was started on antibiotics on account of urinary tract infection with cultures growing Candida, Enterobacter faecalis, lactobacillus. [S/he] is stable for discharge and will discharge back to assisted living facility. Hospice has been consulted for follow up. Recommended blood sugar checking regimen has been documented in the discharge instruction in the after visit summary."

Resident 11's progress notes documented: "-06/22/2026 written by [RN I]: Call placed to [Physician O] and [hospital] case worker, regarding: resident is currently at [hospital] after resident had blood sugar over 600 pm 6/20 but was alert, then 6/21 was still over 600 so was sent to hospital due to not being alert. Resident was on lantus 25 at breakfast, and 10 units at HS which was stopped 6/15 due to sugars being high then crashing, and was switched to Humulin 70/30 14 units twice daily which started on 06/16. Resident was to follow up with MD on 6/26 in

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N 353	Continued From page 9 office. Sugars 6/16 0400 44, breakfast 137, HS 122, 6/17 0400 172, breakfast 170 HS 326, 6/18 0400 434, breakfast 447, and HS 455, 6/19 0400 420, breakfast 471, and HS 499, 6/20 0400 480, breakfast 488, and HS Over 600. Now is in hospital." There was no other evidence in the record to show Resident 11's physician was notified of his/her spike in blood sugars from 6/18 to 6/21 until s/he was hospitalized. Example 4: Blood sugars over 450 not reported to hospice Surveyor reviewed Resident 11's July 2026 MAR. Surveyor observed 3 occurrences in which Resident 11's blood sugar was within notification parameters, there was no evidence in which Resident 11's hospice team was notified of the high blood sugar readings: -07/09 PM (525) -07/09 HS (571) -07/10 AM (479) Resident 11's progress notes documented: "-07/10/2026 written by [RN I]: Spoke with [Hospice Provider M], regarding: at 1530 staff felt resident did not appear well. Resident did not eat very much all day. [S/he] had spit up on [his/her] shirt. Asked RN if they should check [his/her] sugar and RN said yes. Blood sugar machine said over 600. RN went with RA for retest. Machine read over 600. Hospice RN called. There is no PRN insulin and RN would not be able to get order from MD advised to send to ER for blood sugar stabilization. [Legal Representative L] bedside in agreement but upset."	N 353		

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N 353	Continued From page 10 Resident 11's hospice notes documented: "07/10/2026: Writer called [RN I] following triage call about blood sugars ....[RN I] states that [Legal Representative L] is upset with [him/her] and staff due to the blood sugars being so elevated. [RN I] reports that blood sugars were in the 500s last evening and staff did not call [him/her] or [Legal Representative L]. [Hospice Provider M] did not receive a call ...Writer spoke with [RN I] as well as [Legal Representative L] via speaker phone. Patient's blood sugar has continued to rise throughout the day. Patient is less alert and drooling per [Legal Representative L]. Last blood sugar was in the 600s. Writer suggested that [Legal Representative L] transfer patient to the ED as there are no insulin orders for this situation. Patient has insulin orders for scheduled doses but no as needed or sliding scale. [Legal Representative L] expresses that [s/he] is upset that this has happened again and is audibly upset. Writer reassured [Legal Representative L] that this is what is best as patient is uncomfortable and there is no treatment for [his/her] blood sugar where [s/he] is." Resident 11's hospital records dated 07/10/2026-07/11/2026 documented: "-Patient was diagnosed with diabetic ketoacidosis. Patient presented to the emergency Upon arrival to the department patient was completely obtunded and nonverbal. Blood pressure was soft upon arrival. Upon chart review, patient is enrolled in hospice through [Hospice Provider M]. EKG was obtained and demonstrated sinus tach without any evidence of ST segment changes, ectopy, or ischemia. Head CT was initially ordered due to altered mental status and [Legal Representative L], has declined advanced imaging. [Legal Representative L] reported that she only wants hyperglycemia	N 353		

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treated at this time. Initial blood glucose was greater than 600. Initial labs show a glucose of 797, potassium of 5.2, sodium of 131, carbon dioxide of 13, and gap of 31. Beta hydroxybutyrate was 8.1. Patient was started on an insulin drip. 2 liters of normal saline have been infused. Urine sample was obtained and is infectious. Urine culture and blood cultures are pending at this time. Patient was given 2 grams of IV Rocephin. Blood pressure remains soft at 89/54 but is responding to fluids. Attempted to admit at this facility, but due to bed availability and nursing staffing we are unable to accommodate this admission. Patient will be transferred to bearable [sic] hospital ...Arrangements are currently being made to admit transfer patient."

A summary of Resident 11's hospital records once transferred documented:
-The patient ...who presents with 3rd episode of DKA and ICU admission in month, this time obtunded for 2 days apparently before sent to ED, where was found to have diabetic ketoacidosis and essentially coma.
-On arrival here fingerstick blood sugar was >500, but our lab techs were unable to draw [his/her] blood due to hypovolemia. I completed rapid exam, during which [s/he] briefly opened eyes and loked [sic] around, but was unresponsive. US showed adequate IJ sites to place a central line. Family was in Family Room, so I went and spoke to them for permission with central line so we could get labs and proceed with DKA protocol, which I had ordered. They declined to allow that and wanted to try multiple RNs as well as lab and US guidance. We are not able to provide that every 4 hours, so that was not an option. I suggested either we do Critical Care for critical illness, or Comfort Care ....They did select

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N 353	Continued From page 12 Comfort Care and [Hospice Provider M] accepted them to General Inpatient Care (GIP) Hospice." Record Review: On 09/09/2026, Surveyor reviewed a document titled "Resident Concern: [Resident 11], Family Meeting Date: July 24, 2026." The following was summarized: "- ...The meeting provided the family with an opportunity to discuss concerns related to diabetic management, ...communication, and their overall perception of [Resident 11's] care team. ...On May 29, 2026, a new physician order was received to transition [Resident 11] to Humulin 70/30 insulin. The pharmacy initially required clarification of the order before processing. Once clarification was obtained, [provider name] was informed that the medication would need to be ordered and could take approximately one week to arrive. The physician directed staff to continue administering Lantus until the new insulin became available ....By the evening of June 11, [Resident 11's] available supply of Lantus had been exhausted. On June 12, staff contacted both physician and pharmacy multiple times regarding the situation. The pharmacy advised that the previous Lantus prescription was no longer valid while the new ordered insulin remained unavailable. As a result, [Resident 11] did not receive [his/her] scheduled morning Lantus dose ...Throughout this period, [provider name] staff maintained ongoing communication with the pharmacy and prescribing provider regarding medication availability and sought guidance regarding insulin management while awaiting delivery of the new medication. The delay involved multiple factors, including medication ordering, pharmacy processing, and changing	N 353		

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physician orders. Leadership recognizes that additional escalation strategies may have been beneficial as the delay continued and medication unavailability became increasingly urgent.

-On June 21, 2026, [Resident 11] was again transferred to the hospital due to blood glucose readings exceeding 600.

-Despite hospice involvement, challenges with diabetic management continued.
-July 9-10 Blood Glucose Concerns:
-July 9, 4:11 p.m.: Blood glucose 525. [Provider staff] administered the routine dose of 5 units of insulin but did not notify hospice.
-July 9, 8:15 p.m.: Blood glucose 571. Insulin was not administered, and hospice was not notified.
-July 10, 7:44 a.m.: Blood glucose 479. Routine insulin was administered, but hospice was not notified.

-Leadership identified concerns regarding this sequence of events. Regardless of hospice involvement, significantly elevated blood glucose readings should have prompted immediate clinical communication escalation. Staff did not consistently recognize that these values requires urgent notification to nursing and/or hospice. Leadership also discussed whether clearer insulin-management parameters or PRN orders could have been established through hospice given [Resident 11's] history of unstable blood glucose levels. However, the absence of standing parameters did not eliminate [provider name] staff's responsibility to recognize abnormal findings, communicate concerns, and seek clinical direction. This event highlights the need for continued caregiver education regarding diabetic management, recognition of abnormal blood glucose levels, timely escalation of clinical

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N 353	Continued From page 14 concerns, and effective communication with nursing and hospice providers. Leadership has already implemented enhanced diabetic-management education through annual skills training and competency review processes." Interviews: On 09/08/2026 at 9:10 AM, Surveyor interviewed Legal Representative L via phone. Legal Representative L reported Resident 11's insulin was not available for administration for several doses starting on 6/9 after s/he ran out. Legal Representative L reported the facility did not refill his/her long-acting insulin (glargine) timely while waiting for a new short acting insulin ordered from the pharmacy. Legal Representative L reported s/he was frustrated with the provider for not having a plan to order more glargine insulin while waiting for the new script and not taking more urgent action until Resident 11 ran out of his/her insulin. Legal Representative L reported the pharmacy had glargine insulin available, but the facility just let Resident 11's supply run out. Legal Representative L reported Resident 11 was admitted to the hospital on 06/11 with a blood sugar over 700 and contributed the hospitalization to the missed insulin. Legal Representative L reported Resident 11 was hospitalized again on 6/21-6/26 due to DKA and stated staff were not mixing Resident 11's short acting insulin correctly. Legal Representative L reported upon discharge Resident 11 started hospice services and they included specific notification parameters on Resident 11's plan of care regarding elevated blood sugars. Legal Representative L reported the provider did not notify hospice of blood sugars values over 450 on at least 2 occasions before Resident 11 passed away on 07/11. Legal Representative L reported the medication errors	N 353		

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and not reporting elevated blood sugars led to Resident 11's decline.

On 09/08/2026 at 11:15 AM, Surveyor interviewed Administrator A. Administrator A stated the provider completed an investigation into Resident 11's family concerns and met with Legal Representative L after the resident's passing. Administrator A acknowledged Resident 11 missed insulin doses on 6/9 and 6/10. Administrator A reported RN I was in frequent contact with the pharmacy and was told they did not have anymore Lantus available but told Legal Representative L they did have more. Administrator A reported s/he thought staff had told RN I that Resident 11's insulin supply was getting low, so s/he was not sure what happened. Administrator A reported Resident 11's diabetes was hard to manage for staff. Administrator A reported once the new short acting insulin was started, staff were educated on how to mix insulin and the provider had placed instructions in Resident 11's room. Administrator A denied any concerns with mixing of Resident 11's insulin. Administrator A reported when Resident 11's glargine insulin ran out, the provider was still waiting for the new short acting insulin, and the glargine insulin script ended which caused further delays and miscommunication occurred.

On 09/08/2026 at 11:35 AM, Surveyor interviewed Caregiver P. Caregiver P reported s/he was a med passer and had administered Resident 11's insulin during his/her admission. Caregiver P reported Resident 11 had notification parameters in place with his/her blood sugars and staff were expected to document in the record if anyone was contacted.

On 09/11/2026 at 12:59 PM, Surveyor interviewed

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Hospice Nurse Q via phone. Hospice Nurse Q confirmed hospice was not notified of high blood sugars on 7/9 and 7/10. Hospice Nurse Q reported s/he thought Resident 11 could have gone to the emergency room sooner on 7/10 as s/he did not go until the late afternoon. Hospice Nurse Q reported s/he had observed staff perform insulin administration and did not have any concerns with mixing of insulin.

On 09/11/2026 at 12:11 PM, Surveyor sent the following email to Administrator A: " ...
Here are my additional questions:
-For the following dates I need to verify if [Physician O] was notified about blood glucose levels over 450. I reviewed progress notes and communications in the portal given to me and could not locate these dates were reported: 05/18 (AM), 5/19 (AM), 5/29 (HS), 6/1 (HS), 6/2 (HS), 6/3 (HS), 6/4 (HS), 6/5 (HS), 6/6 (HS), 6/10 (HS).
Please send any evidence the physician was notified for the above dates?
-I noticed when reviewing [Resident 11's] record, [his/her] BS's started to spike on 6/18 PM (455), 6/19 AM (471)/PM (499), 6/20 AM (488)/PM (over 600), 6/21 AM (over 600). I did not see in [his/her] record the physician was notified regarding the above dates. I saw record of [RN I] notifying the hospital and the physician on 6/22, but nothing sooner. Please send evidence the physician was notified for the above dates prior to hospitalization?
I will need the above information and answers to my earlier email by Monday (9/14) at 11am, so I can have time to review prior to our exit."

On 09/11/2026, additional emails occurred between the Surveyor and Administrator A clarifying the above dates of 5/18 and 5/19 should

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N 353	Continued From page 17 have reflected HS elevated blood sugar readings not reported. On 09/14/2026 at 1:04 PM, Director of Senior Services G replied to the above email: " ...I worked with [RN I] and [Administrator A] to talk through this and see what we could pull memory and here's how we're landing. Thank you for your follow-up questions. We have completed an additional review of [Resident 11's] record, medication administration records, communications, and discussions with staff involved in her care. Physician Notifications for Blood Glucose Levels Over 450 For the dates listed below: -5/18 (AM) -5/19 (AM) -5/29 (HS) -6/1 (HS) -6/2 (HS) -6/3 (HS) -6/4 (HS) -6/5 (HS) -6/6 (HS) -6/10 (HS) We were unable to locate documentation confirming physician notification for each specific occurrence. After speaking with [RN I] and reviewing available records, it is our understanding that communication with the clinic often occurred by telephone, including after-hours contacts. Unfortunately, not all of these communications were consistently documented in the resident record. [RN I] doesn't have access to ECS from home which makes it hard for [him/her] to chart	N 353		

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N 353	Continued From page 18 after hours . Likewise, we cannot verify whether all calls or contacts made to the clinic were documented by the clinic. They also don't always chart every time a call is made to them with a question. Therefore, while staff recall communicating concerns regarding blood glucose trends to the physician's office, we do not have documentation that allows us to verify each individual notification requested above. Elevated Blood Glucose Levels June 18-21 Regarding the elevated blood glucose readings on: -6/18 PM (455) -6/19 AM (471) -6/19 PM (499) -6/20 AM (488) -6/20 PM (over 600) -6/21 AM (over 600) We do have documentation of communication with the physician and hospital on 6/22; however, we do not have documentation confirming physician notification for each of the preceding dates. Based on discussions with [RN I] [s/he] believes [s/he] may have contacted the clinic during this period; however, some communications may have occurred after hours, and in situations where messages were left with the answering service or nursing staff, return calls were not always immediate. They most likely wouldn't document those phone calls either. Additional Clinical Context We would also like to provide additional context regarding [Resident 11's] diabetes management.	N 353		

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N 353	Continued From page 19 [Resident 11] resided in an assisted living setting and retained the right to make [his/her] own choices regarding diet and lifestyle. Prior to hospice enrollment, staff routinely observed fluctuations in [his/her] blood glucose levels that are often correlated with dietary choices, including consumption of sweets and visits with family. Historically, our understanding from [Physician O's] office was that they generally wished to be notified regarding sustained trends or patterns of elevated blood glucose readings rather than isolated elevations believed to be related to dietary intake. This may explain the documented communication that occurred on 6/22, after several consecutive days of significantly elevated readings. However, we acknowledge that our records do not consistently demonstrate when notifications occurred. We recognize that documentation of physician communication should have been more consistent and complete. As part of our review process, we have reinforced expectations with staff regarding timely documentation of all physician notifications, including after-hours communications and messages left with on-call providers." On 09/15/2026 at 2:30 PM, Surveyor conducted an exit conference and shared findings with Administrator A, Director of Senior Services G, and RN I. The management team acknowledged Resident 11 missed insulin doses on 6/9-AM, 6/10-AM, and 6/16-noon. Additionally, the management team acknowledged the above concerns with not consistently reporting elevated blood sugars to the physician or hospice. Surveyor asked for clarification regarding the insulin unavailability starting on 6/9 and no	N 353		

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N 353	Continued From page 20 documentation in Resident 11's record until 6/10. Surveyor noted the provider's investigation included language "additional escalation strategies may have been beneficial." Director of Senior Services G stated s/he was not contacted prior to Resident 11's insulin running out but if s/he had been, we could have escalated the matter potentially to the hospital or clinic director. Surveyor asked for clarification regarding the provider's on-call system after hours. Administrator A stated s/he was on call Friday, Saturday, and Sunday and RN I was on call Monday to Thursday. Surveyor questioned if management was contacted by staff regarding Resident 11's elevated blood sugars from 06/18 to 6/21. Administrator A stated s/he reviewed records and did not have any notification from staff. The management team reported concerns with not having access to their electronic health record when working from home and additional measures were needed to ensure health monitoring was recorded. Director of Senior Services G reported through the providers' investigation and further review of Resident 11's record, identified areas for improvement including communication/documentation and proactive reassessment of the appropriate level of care. Director of Senior Services G reported retraining would be completed with all staff on documentation and empowering them to complete notification requirements.	N 353		