STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44443 Based on interview and record review, the facility failed to notify the physician when a resident experienced a change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember], behavioral, or functional status) for one of three sampled residents (Resident 1) when Resident 1 had a temperature of 103.8 degrees Fahrenheit (F-unit of measurement [normal body temperature can range from 97 F to 99 F]), heart rate (HR) of 130 beats per minute (bpm normal resting heart rate is between 60 and 100 beats per minute) on [DATE] at 11:43 p.m., and hematuria (blood in the urine) that started on [DATE]. The facility failed to: 1. Ensure licensed nurses notified Resident 1's physician when Resident 1 had a temperature greater than (>) 99 F, heart rate > 90 beats per minute (bpm), and systolic blood pressure (SBP- pressure exerted when the heart beats and blood is ejected into the arteries [blood vessels that distribute oxygen-rich blood to your entire body]) less than (<) 100 Millimeters of mercury (mmHg a unit of measurement for pressure) as ordered by Resident 1's physician for sepsis (a life threatening condition in which the body's reaction to an infection) prevention dated [DATE] The licensed nurses did not notify Resident 1's physician as follows: a. On [DATE] 10:12 pm for Resident 1's temperature 99.8 F b. On [DATE] 11:25 am for Resident 1's HR 96 bpm c. On [DATE] 11:31 pm for Resident 1's HR 91 bpm d. On [DATE] 2:31 pm Resident 1's temperature 99.1 F e. On [DATE] 10:32 pm Resident 1's temperature 99.8 F f. On [DATE] 11:43 pm Resident 1's temperature 103.8 F g. On [DATE] 2:31 p.m., for Resident 1's HR 98 bpm h. On [DATE] 11:43 p.m., for Resident 1's HR 130 bpm (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER The Springs Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 10625 Leffingwell Road Norwalk, CA 90650	

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This failure resulted in Resident 1 had a blood pressure of ,d+[DATE] mmHg with HR of 112 and had an altered level of consciousness (ALOC a change in a person's state of awareness and alertness, where they are not fully conscious or responsive to their surroundings) on [DATE] at 6 a.m. Resident 1 was transferred to general acute care hospital (GACH) on [DATE] via 911. Resident 1 was admitted to GACH where he was diagnosed with septic shock (life threatening condition when an infection spreads throughout the body and causes a dangerously low blood pressure) and he expired on [DATE], (13 hours after he was admitted to the GACH. On [DATE], at 2:34 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and Director of Nursing (DON) due to the facility's failure to follow Resident 1's physician order to notify physician of temperature > 99 F, heart rate > 90 bpm, and SBP <100 mmHg as ordered by Resident 1's physician for sepsis prevention. On [DATE], at 2:30 p.m., the facility submitted an acceptable IJ removal plan ([IJRP]- an intervention to immediately correct the deficient practices). After verification the IJRP was implemented through observation, interview, and record review, the IJ was removed while onsite on [DATE] at 2:30 p.m., in the presence of the ADM, DON, and the Regional Director of Operations (RDO). The IJRP included the following: 1.License Nurse 1 was educated by the DON regarding Change of Condition policy and procedure focusing on immediate notification of the physician as it relates to quality of care. 2. In-service education was commenced by the DON and Quality Staff Registered Nurse (QS RN) to all licensed nurses on [DATE] regarding physician notification of the change of condition (COC) including but not limited to vital signs (measure the basic functions of the body which include temperature, blood pressure, pulse and respiratory [breathing] rate) that are out of range for the sepsis prevention (that is [i.e.] temperature< 96.8 F or >99 F or, HR <60 bpm or >90 bpm, respiratory rate <12 or > 20, systolic blood pressure (SBP- pressure exerted when the heart beats and blood is ejected into the arteries) < 100 mmHg. If base line SBP is < 100 mmHg, plus (+) 5 mmHg than the baseline, Oxygen saturation (O2 Sat a measure of how much oxygen the blood is carrying as a percentage) of < 90% and any change of change of condition. 3. In-service education was commenced by the DON and/or designee on [DATE] regarding initiation, review, and revision of resident-centered care plan of residents with a diagnosis of neuromuscular dysfunction of the bladder (neurogenic bladder-impaired bladder control and difficulty emptying the bladder) with interventions to prevent the resident from developing urinary tract infection (UTI- an infection in the bladder/ urinary tract), /sepsis and other areas that accurately reflects resident's conditions and care. 4.Competency Skills Check for licensed nurses was commenced on [DATE] by DON and QS RN regarding (1) assessing residents' change in conditions (2) identifying symptoms of infection/sepsis and of change of condition, (3) assess, monitor and implement needed interventions based on residents' change in condition (4) recognizing symptoms of urinary tract infection and including elevated temperature, hematuria, abdominal pain, and low back pain, and (5) compliance with recognizing, evaluating and monitoring. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5.The facility checked Situation, Background, Assessment, Recommendation (SBAR a technique that can be used to facilitate prompt and appropriate communication) /COC from [DATE] to [DATE]. All 161 SBAR/COC showed that medical doctor (MD) was notified on a timely manner. 6.In-service education was commenced by the DON and/or designee on [DATE] regarding initiation, review, and revision of resident-centered care plan of residents with a diagnosis of neuromuscular dysfunction of the bladder with interventions to prevent the resident from developing UTI/sepsis and other areas that accurately reflects resident's conditions and care. 7.In-service education was commenced on [DATE] regarding Physician Notification of the COC including but not limited to vital signs that are out of range for the sepsis prevention. As of [DATE] at 10 a.m., 50 out of 50 Registered Nurses (RNs)/Licensed Vocational Nurses (LVN) staff (100%) received the in-service on Physician Notification of the COC including but not limited to vital signs that are out of range for the sepsis prevention. 8.Competency Skills Check regarding COC was commenced on [DATE] by DON and QS RN. As of [DATE] at 10 a.m., Competency Skills Check regarding COC was conducted to 50 out of 50 RNs/LVNs staff (100%). What measures will be put into place or what systemic changes will make to ensure that the deficient practice does not recur? 1.The facility nursing staff will notify the DON or designee at the time of a change of condition. The DON or designee (i.e. Assistant Director of Nursing (ADON) and RN Supervisor) will ensure that MD/Nurse Practitioner (NP- a nurse who has advanced clinical education and training) and Physician Assistant (PA- a licensed medical professional who works with physicians to provide patient care) notification has been completed (i.e. MD notified of the COC, MD responded, and carry out physician order, if with physician order) or the DON or designee will call the MD/NP/PA on call personally. In the event the resident's MD/NP/PA on record may not be reached at the time of the residents COC, the RN Supervisor will obtain orders from a doctor on the medical panel (i.e. other medical doctors) obtain the order to send the resident to the acute care hospital if needed in real time as to prevent any delay in resident care. 2.COC of the previous day will be reviewed by the clinical team (such as but not limited to DON, ADON, Director of Staff Development (DSD), Infection Preventionist (IP) on the following day in the Clinical Meeting to ensure that all change of conditions have been checked for compliance such as but not limited to (1) assessing any residents' change in condition (1) symptoms of infection/sepsis and of change of condition were identified, (2) appropriate assessment, monitoring and needed interventions were implemented (3) symptoms of UTI including elevated temperature, hematuria, abdominal pain, and low back pain were identified and (4) compliance with recognizing, evaluating, monitoring. 3.The License Nurse will follow the process of MD notification: a. The attending physician will be notified promptly (i.e. within 30 minutes) for any change of conditions including but not limited to out-of-range vital signs, cardiovascular (heart) changes, neurological changes (brain/mental), genitourinary (bladder), etc. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. If no response from the attending physician within 30 minutes, the Medical Director will be notified of any change of conditions including but not limited to out-of-range vital signs, cardiovascular changes, neurological changes, genitourinary, etc. c. If no response from the Medical Director and the resident is manifesting a significant change of condition (such as decrease level of consciousness, unresponsiveness, critical labs level, out of range vital sign, etc. [used at the end of a list to indicate that further, similar items are included.]) registered nurse will refer Physician Orders for Life-Sustaining Treatment (POLST form is a written medical order that specifies a patient's end-of-life care preferences) if to be sent out to emergency room (ER) for further evaluation. Then, attending physician will be notified thereafter. 4. In-service education was commenced to Licensed Nurses by the DON and/or designee on [DATE] regarding timely Physician Notification of the COC including but not limited to vital signs that are out of range for the sepsis prevention and any change of change of condition. 5.In-service education was commenced by the DSD to CNAs on [DATE] regarding identification and reporting to License Nurse in-charge and/or the RN Supervisor in a timely manner of any change of condition. 6.The DSD or designee (i.e. QS RN, RN Supervisor) will do random verbal quiz to CNAs on different shifts regarding identification and reporting to License Nurse in-charge and/or the RN Supervisor in a timely manner of any change of condition. CNAs will be immediately re-in serviced by the DSD for those CNAs needing further education. DSD will present the findings and progress status to the Monthly Quality Assessment Assurance (QAA- responsible for identifying and responding to quality deficiencies that are identified in the facility) meeting for recommendations/suggestions. a. Four CNAs weekly for four weeks then; b.Three CNAs weekly for two weeks then; c.Two CNAs a month for two months. 7.In-service education was commenced by the DON and/or designee on [DATE] regarding initiation, review, and revision of care plan of residents with a diagnosis of neuromuscular dysfunction of the bladder with interventions to prevent the resident from developing urinary tract infection (UTI) and sepsis and other care plan that accurately reflects the residents' conditions and care. 8.Competency Skills Check for Licensed Nurses (Registered Nurses and Licensed Nurses [LN]) on COC by DON, QS RN and was commenced on [DATE]. 9.The DON, or designee will do random verbal quiz to licensed nurses (LN) on different shifts re regarding (1) Verbalize/name change of condition such as symptoms of infections/sepsis, (2) name the process of timely Physician Notification of the Change of Condition (COC) including but not limited to out-of-range vital signs which is an early sign of infection and change of condition, (3) name symptoms of UTI and including elevated temperature, hematuria, abdominal pain, and low back pain, and (4) able to name/recognize, evaluate, monitor, and assess any residents' change of condition: a. Four LNs weekly for four weeks then; (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Three LNs weekly for two weeks then; c. Two LNs a month for two months. 10.The DON or designee (i.e. ADON, QS RN) will conduct random chart audits on SBAR/Change of Conditions. The DON or designee (i.e. ADON, QS RN) will further investigate for findings (such as but not limited to MD was not notified on a timely manner, or other missing information in the SBAR). An in-service education will immediately be provided to the RN/LN involved. Findings and progress status will be presented in the Monthly QAA Meeting for suggestions/recommendations. d. Three residents weekly for four weeks then; e. Two residents weekly for two weeks then; f. Two residents a month for two months. 11.Licensed Nurse staff who are not present during the In-service education (such as those who are on leave, per-diem, or part-time status), in-service education will be provided on day-1 return to work prior to start of shift. 12.New hires (licensed nurses) and Registries (provides nursing personnel to facility in need of temporary staff) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly in orientation by the DON and/or DSD 13.The DON implemented a Quality Assurance Performance Improvement (QAPI data-driven approach to improving the quality of care and services in nursing homes) Performance Improvement Project (PIP) with a focus on physician notification of significant changes. 14.The PIP resulted in implementation of daily ADON/designee audits of the Clinical Alerts Listing audit to monitor timely notification of MD for residents with vital signs that are out-of-range and other change of conditions. 15.The QS RN/consultant nurse will visit the facility at least once a week to provide general oversight and monitoring of the PIP. How the facility plans to monitor performance to make sure that solutions are sustained. 1.Under the supervision of the Administrator, DON or Designee will be responsible and accountable to submit audit findings utilized the Quality Assurance (QA) monitoring/audit tool to QAA committee member monthly for 3 months until 100% compliance. 2.The Administrator and DON shall be responsible for the implementation, monitoring, and evaluation of this Plan of Correction. Findings: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a serious condition that occurs when your lungs cannot get enough oxygen into your blood or remove carbon dioxide), bronchopneumonia (an inflammation of the lungs that affects the small airways and the surrounding lung tissue, seizures (a sudden uncontrolled change in behavior or body movement caused by abnormal electrical activity in the brain), hemiplegia (paralysis on the same side of the body) and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), encounter for tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe, and neuromuscular dysfunction of bladder. During a review of Resident 1's History and Physical (H&P), dated [DATE], indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], indicated, Resident 1 had severe impairment in cognitive skills for daily decision making. Resident 1 was dependent with bed mobility, chair/ bed to chair transfer, and tub/ shower transfer. During a review of Resident 1's Physician Order Summary report dated [DATE], the Physician Order Summary indicated to notify Medical Doctor (MD) if Resident 1 have any of the following symptoms: 1. Temperature less than 96.8 F or greater than 99 F. 2. Heart rate greater than 90 beats per minute 3. Respiratory (breathing) rate greater than 20 4. Acute change in mental status 5. O2 sat. less than 90 percent (%) 6. Systolic blood pressure (SBP- pressure exerted when the heart beats and blood is ejected into the arteries [blood vessels that distribute oxygen-rich blood to your entire body]), if baseline less than 100 millimeters of mercury (mmHg a unit of measurement for pressure), more than 5 mmHg lower than the baseline, every shift for sepsis prevention. During a review of Resident 1's SBAR and Initial Change of Condition/ Alert Charting and Skilled Documentation, dated [DATE] timed at 6:19 a.m., the SBAR/ initial COC indicated, Resident 1 had moderate amount of hematuria (blood in the urine) in Resident 1's incontinent pad (diaper) and elevated temperature (temperature not indicated). During a concurrent interview and record review on [DATE], at 4:24 p.m., with Registered Nurse Supervisor (RNS 1), Resident 1's Weight and Vital Sign Summary and Situation, Background, Assessment, Recommendation (SBAR a communication tool used by healthcare workers when there is change of condition among the residents) / Change of Condition (COC) dated [DATE] and [DATE] were reviewed. The Weight and Vital Sign Summary indicated, Resident 1 had the following temperature and heart rate readings: a. On [DATE] 10:12 pm for Resident 1's temperature 99.8 F (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. On [DATE] 11:25 am for Resident 1's HR 96 bpm c. On [DATE] 11:31 pm for Resident 1's HR 91 bpm d. On [DATE] 2:31 pm Resident 1's temperature 99.1 F e. On [DATE] 10:32 pm Resident 1's temperature 99.8 F f. On [DATE] 11:43 pm Resident 1's temperature 103.8 F g. On [DATE] 2:31 p.m., for Resident 1's HR 98 bpm h. On [DATE] 11:43 p.m., for Resident 1's HR 130 bpm RNS 1 stated Resident 1's physician should be notified of Resident 1's vital signs as ordered for sepsis prevention. RNS 1 stated the physician orders should have been followed so Resident 1's physician could have given physician orders to address Resident 1's COC. RNS 1 stated physician notification should be documented to Resident 1's medical record to ensure licensed nurses would know what treatment was ordered for Resident 1. During an interview on [DATE], at 4:40 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 physician was not notified of Resident 1's temperature of 103.8 F and HR 130 bpm on [DATE] at 11:43 p. m. LVN 1 stated nonpharmacological (healthcare strategies that do not involve the use of medications) interventions including cooling measures such as removing blankets, put a fan on, and placing cold towels on Resident 1's forehead and under the arms were initiated. LVN 1 stated Resident 1's physician was not called because Resident 1 had a COC on [DATE] at 10:12 p.m. when Resident 1 had temperature of 99.8 F. LVN 1 stated she failed to inform Resident 1's physician when the resident had a temperature of 103.8 F. LVN 1 stated she did not think it was an infection as Resident 1's temperature went down to 99 F. LVN 1 stated she did not recall the exact time Resident 1's temperature was taken and she did not document it. LVN 1 stated she did not notify Resident 1's Physician of Resident 1's HR of 130 bpm on [DATE] at 11:43 p. m., as Resident 1's heart rate came down. LVN 1 stated Resident 1's physician should have been notified as interventions (cooling measures) were not working. LVN 1 stated no other temperatures or heart rates were documented after it was taken and documented on [DATE] at 11:43 p.m. LVN 1 stated the next vital signs was taken on [DATE] at 6 a.m., (after 6 hours). LVN 1 stated Resident 1 was sent to the GACH on [DATE]. During an interview on [DATE], at 5:10 p.m., with RNS 3, RNS 3 stated on [DATE] at 11:43 p.m., Resident 1 had a temperature of 103.8 F, but Resident 1's physician was not notified. RNS 3 stated looking back Resident 1's physician should have been notified as Resident 1 had previous elevated temperature of 99.8 F on [DATE]. RNS 3 stated Resident 1 could have had a urinary tract infection (UTI- an infection in the bladder/ urinary tract), pneumonia (an infection/ inflammation in the lungs), or sepsis (a life-threatening blood infection). RNS 3 stated on [DATE] when Resident 1 had an altered level of consciousness (a change in a person's state of awareness and alertness, where they are not fully conscious or responsive to their surroundings) and low blood pressure of ,d+[DATE] mmHg, it could have been sepsis. RNS 3 stated Resident 1 was transferred to GACH via 911 on [DATE] at 6 a.m. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 9:35 a.m., with Resident 1's Primary Care Physician (PCP)1, PCP 1 stated on [DATE] he was not informed of Resident 1's temperature of 103.8 F and HR of 130 bpm. PCP 1 stated he could have ordered for Resident 1 to be transferred to a GACH especially when Resident 1 was exhibiting signs of infection. PCP 1 stated on [DATE] at 11:43 p.m., Resident 1 could have had a septic shock (a life-threatening condition that occurs when an infection spreads throughout the body and causes a dangerously low blood pressure) when his temperature increased to 103.8 F and HR 130 bpm. PCP 1 stated Resident 1 should have been transferred to the GACH. During an interview on [DATE], at 1:57 p.m., with RN 3, RN 3 stated, on [DATE] Resident 1 had altered level of consciousness as Resident 1's eyes were closed, the resident was not responding to tactile stimuli (any form of touch or physical contact perceived by the skin such as a sternal rub [a painful stimulus to the chest that is used to assess a patient's responsiveness]), and when called by his name. RN 3 stated Resident 1's temperature was checked every 30 minutes to one hour but was not documented. RN 3 stated if it was not documented it was not done. RNS 3 stated he should have called Resident 1's PCP 1 or called 911 when Resident 1 had a COC. During a concurrent interview and record review on [DATE] at 11:13 a.m., with the Director of Nursing (DON), Resident 1's COC, Physician's Orders, Nurse Notes, Medication Administration Record (MAR) for the month of ,d+[DATE] were reviewed. The DON stated the Physician Order dated [DATE] for sepsis prevention indicated to notify MD if any vital signs were abnormal such as temperature < 96.8 F or > 99 F and HR > 90 bpm. The DON stated there was no documentation indicating on [DATE], Resident 1's physician was notified when Resident 1 had a temperature of 99.8 F. The DON stated, on [DATE] at 11:43 p.m., when Resident 1 had a temperature of 103.8 F and HR of 130 bpm, licensed staff should have called PCP 1. The DON stated when there was a change of condition for any resident, licensed nurses were expected to complete an assessment, notify the physician and resident representative. The DON stated sepsis was a complication of an infection that could be fatal. During a review of Job Description LVN, ([undated]), the Job Description LVN indicated, LVN is responsible for demonstrating the ability to assign meaning to a resident symptoms and initiating appropriate action and consistently monitoring resident condition, initiating appropriate nursing action, consistently documenting resident care and reports pertinent clinical observations and reactions to the appropriate individual, and documenting nursing interventions and resident responses including physical and psychological response. During a review of the Job description Registered Nurse (RN), ([undated]), the Job Description RN indicated, The RN is responsible for making supervisory decisions, demonstrating the ability to assign meaning to resident symptoms and initiating appropriate action, consistently monitoring resident condition and initiates appropriate nursing intervention, consistently documenting resident care and reports pertinent clinical observations and reactions to the appropriate individual, and documenting nursing interventions, consistently and accurately performs reassessments during each shift and when the resident condition changes, and documenting nursing interventions and resident responses including physical and psychological response. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems, dated ,d+[DATE], the P&P indicated, These guidelines are to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's P&P titled, Change in a Resident's Condition or Status, dated ,d+[DATE], the P&P indicated, The nurse will notify the resident's Attending Physician or physician on call when there has been a(an) specific instruction to notify the Physician of changes in the resident's condition. Cross Reference F684

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44443

Based on interview and record review, the facility failed to ensure residents, with a change in condition (COC- a sudden, clinically important deviation from a patient's baseline [a minimum or starting point used for comparisons] in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) manifested by temperature of 103.8 degrees Fahrenheit (F-unit of measurement [normal body temperature can range from 97 F to 99 F]), heart rate of 130 beats per minute (bpm normal resting heart rate is between 60 and 100 beats per minute), hematuria (blood in the urine) was transferred to a general acute care hospital (GACH) without a delay for one of three sampled residents (Resident 1).

The facility failed to:

1. Ensure Licensed Vocational Nurse (LVN 1) assessed and monitored Resident 1's condition, including vital signs, when the resident had a change in condition as follows:

a. On [DATE] at 10:12 p.m. Resident 1 had body temperature of 99.8 F

b. On [DATE] 10:57 a.m., Resident 1 had hematuria (blood in urine).

c. On [DATE] at 11:43 p.m. Resident 1 had an elevated body temperature of 103.8 F and heart rate of 130 bpm.

2. Develop a care plan for Resident 1's diagnosis of neuromuscular dysfunction of the bladder (neurogenic bladder-impaired bladder control and difficulty emptying the bladder) with interventions to prevent the resident from developing a urinary tract infection (UTI- an infection in the bladder/ urinary tract) and sepsis (a life-threatening condition in which the body's reaction to an infection).

3. Ensure licensed nurses, transferred Resident 1 to GACH on [DATE] at 11:53 p.m., without a delay of up to 6 hours, when Resident 1 had an elevated temperature of 103.8 F and heart rate of 130 bpm.

These failures resulted in a six-hour delay transferring Resident 1 to the GACH from the time Resident 1 had a change in condition, where he was diagnosed with septic shock (life threatening condition when an infection spreads throughout the body and causes a dangerously low blood pressure) and he expired on [DATE], (13 hours after he was admitted to the GACH.

On [DATE], at 2:34 p.m., an Immediate Jeopardy ([IJ] a situation in which the facility's noncompliance with one or more requirements of participation had cause, or is likely to cause serious injury, harm, impairment, or death to a resident) was called in the presence of the Administrator (ADM) and Director of Nursing (DON) due to the facility's failure to transfer Resident 1 to GACH) timely, when he had a COC on [DATE].

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055297	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Springs Post-Acute	10625 Leffingwell Road Norwalk, CA 90650

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], at 2:30 p.m., the facility submitted an acceptable IJ removal plan ([IJRP]- an intervention to immediately correct the deficient practices). After verification the IJRP was implemented through observation, interview, and record review, the IJ was removed while onsite on [DATE] at 2:30 p.m., in the presence of the ADM, DON, and the Regional Director of Operations (RDO). The IJRP included the following: 1.License Nurse 1 was educated by the DON regarding Change of Condition policy and procedure focusing on immediate notification of the physician as it relates to quality of care. 2. In-service education was commenced by the DON and Quality Staff Registered Nurse (QS RN) to all licensed nurses on [DATE] regarding physician notification of the change of condition (COC) including but not limited to vital signs that are out of range for the sepsis prevention (that is [i.e.] temperature< 96.8 F or >99 F or, HR <60 bpm or >90 bpm, respiratory rate <12 or > 20, systolic blood pressure (SBP- pressure exerted when the heart beats and blood is ejected into the arteries) < 100 mmHg. If base line SBP is < 100 mmHg, + 5 mmHg than the baseline, Oxygen saturation (O2 Sat a measure of how much oxygen the blood is carrying as a percentage) of < 90% and any change of condition. 3. In-service education was commenced by the DON and/or designee on [DATE] regarding initiation, review, and revision of resident-centered care plan of residents with a diagnosis of neuromuscular dysfunction of the bladder with interventions to prevent the resident from developing UTI/sepsis and other areas that accurately reflects resident's conditions and care. 4.Competency Skills Check for licensed nurses was commenced on [DATE] by DON and QS RN regarding (1) assessing residents' change in conditions (2) identifying symptoms of infection/sepsis and of change of condition, (3) assess, monitor and implement needed interventions based on residents' change in condition (4) recognizing symptoms of urinary tract infection and including elevated temperature, hematuria, abdominal pain, and low back pain, and (5) compliance with recognizing, evaluating and monitoring. 5.The facility checked Situation, Background, Assessment, Recommendation (SBAR a technique that can be used to facilitate prompt and appropriate communication) /COC from [DATE] to [DATE]. All 161 SBAR/COC showed that medical doctor (MD) was notified on a timely manner. 6.In-service education was commenced by the DON and/or designee on [DATE] regarding initiation, review, and revision of resident-centered care plan of residents with a diagnosis of neuromuscular dysfunction of the bladder with interventions to prevent the resident from developing UTI/sepsis and other areas that accurately reflects resident's conditions and care. 7.In-service education was commenced on [DATE] regarding Physician Notification of the COC including but not limited to vital signs that are out of range for the sepsis prevention. As of [DATE] at 10 a.m., 50 out of 50 Registered Nurses (RNs)/Licensed Vocational Nurses (LVN) staff (100%) received the in-service on Physician Notification of the COC including but not limited to vital signs that are out of range for the sepsis prevention. 8.Competency Skills Check regarding COC was commenced on [DATE] by DON and QS RN. As of [DATE] at 10 a.m., Competency Skills Check regarding COC was conducted to 50 out of 50 RNs/LVNs staff (100%). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Springs Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 10625 Leffingwell Road Norwalk, CA 90650	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	What measures will be put into place or what systemic changes will make to ensure that the deficient practice does not recur? 1.The facility nursing staff will notify the DON or designee at the time of a change of condition. The DON or designee (i.e. Assistant Director of Nursing (ADON) and RN Supervisor) will ensure that MD/Nurse Practitioner (NP- a nurse who has advanced clinical education and training) and Physician Assistant (PA-a licensed medical professional who works with physicians to provide patient care) notification has been completed (i.e. MD notified of the COC, MD responded, and carry out physician order, if with physician order) or the DON or designee will call the MD/NP/PA on call personally. In the event the resident's MD/NP/PA on record may not be reached at the time of the residents COC, the RN Supervisor will obtain orders from a doctor on the medical panel (i.e. other medical doctors) obtain the order to send the resident to the acute care hospital if needed in real time as to prevent any delay in resident care. 2.COC of the previous day will be reviewed by the clinical team (such as but not limited to DON, ADON, Director of Staff Development (DSD), Infection Preventionist (IP) on the following day in the Clinical Meeting to ensure that all change of conditions have been checked for compliance such as but not limited to (1) assessing any residents' change in condition (1) symptoms of infection/sepsis and of change of condition were identified, (2) appropriate assessment, monitoring and needed interventions were implemented (3) symptoms of UTI including elevated temperature, hematuria, abdominal pain, and low back pain were identified and (4) compliance with recognizing, evaluating, monitoring. 3.The License Nurse will follow the process of MD notification: a. The attending physician will be notified promptly (i.e. within 30 minutes) for any change of conditions including but not limited to out-of-range vital signs, cardiovascular (heart) changes, neurological changes (brain/mental), genitourinary (bladder), etc. b. If no response from the attending physician within 30 minutes, the Medical Director will be notified of any change of conditions including but not limited to out-of-range vital signs, cardiovascular changes, neurological changes, genitourinary, etc. c. If no response from the Medical Director and the resident is manifesting a significant change of condition (such as decrease level of consciousness, unresponsiveness, critical labs level, out of range vital sign, etc. [used at the end of a list to indicate that further, similar items are included.]) registered nurse will refer Physician Orders for Life-Sustaining Treatment (POLST form is a written medical order that specifies a patient's end-of-life care preferences) if to be sent out to emergency room (ER) for further evaluation. Then, attending physician will be notified thereafter. 4. In-service education was commenced to Licensed Nurses by the DON and/or designee on [DATE] regarding timely Physician Notification of the COC including but not limited to vital signs that are out of range for the sepsis prevention and any change of change of condition. 5.In-service education was commenced by the DSD to CNAs on [DATE] regarding identification and reporting to License Nurse in-charge and/or the RN Supervisor in a timely manner of any change of condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6.The DSD or designee (i.e. QS RN, RN Supervisor) will do random verbal quiz to CNAs on different shifts re identification and reporting to License Nurse in-charge and/or the RN Supervisor in a timely manner of any change of condition. CNAs will be immediately re-in serviced by the DSD for those CNAs needing further education. DSD will present the findings and progress status to the Monthly Quality Assessment Assurance (QAA- responsible for identifying and responding to quality deficiencies that are identified in the facility) meeting for recommendations/suggestions. a. Four CNAs weekly for four weeks then; b.Three CNAs weekly for two weeks then; c.Two CNAs a month for two months. 7.In-service education was commenced by the DON and/or designee on [DATE] regarding initiation, review, and revision of care plan of residents with a diagnosis of neuromuscular dysfunction of the bladder with interventions to prevent the resident from developing urinary tract infection (UTI) and sepsis and other care plan that accurately reflects the residents' conditions and care. 8.Competency Skills Check for Licensed Nurses (Registered Nurses and Licensed Nurses [LN]) on COC by DON, QS RN and was commenced on [DATE]. 9.The DON, or designee will do random verbal quiz to licensed nurses (LN) on different shifts re regarding (1) Verbalize/name change of condition such as symptoms of infections/sepsis, (2) name the process of timely Physician Notification of the Change of Condition (COC) including but not limited to out-of-range vital signs which is an early sign of infection and change of condition, (3) name symptoms of UTI and including elevated temperature, hematuria, abdominal pain, and low back pain, and (4) able to name/recognize, evaluate, monitor, and assess any residents' change of condition: a. Four LNs weekly for four weeks then; b. Three LNs weekly for two weeks then; c. Two LNs a month for two months. 10.The DON or designee (i.e. ADON, QS RN) will conduct random chart audits on SBAR/Change of Conditions. The DON or designee (i.e. ADON, QS RN) will further investigate for findings (such as but not limited to MD was not notified on a timely manner, or other missing information in the SBAR). An in-service education will immediately be provided to the RN/LN involved. Findings and progress status will be presented in the Monthly QAA Meeting for suggestions/recommendations. d.Three residents weekly for four weeks then; e.Two residents weekly for two weeks then; f.Two residents a month for two months. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11.Licensed Nurse staff who are not present during the In-service education (such as those who are on leave, per-diem, or part-time status), in-service education will be provided on day-1 return to work prior to start of shift. 12.New hires (licensed nurses) and Registries (provides nursing personnel to facility in need of temporary staff) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly in orientation by the DON and/or DSD 13.The DON implemented a Quality Assurance Performance Improvement (QAPI data-driven approach to improving the quality of care and services in nursing homes) Performance Improvement Project (PIP) with a focus on physician notification of significant changes. 14.The PIP resulted in implementation of daily ADON/designee audits of the Clinical Alerts Listing audit to monitor timely notification of MD for residents with vital signs that are out-of-range and other change of conditions. 15.The QS RN/consultant nurse will visit the facility at least once a week to provide general oversight and monitoring of the PIP. How the facility plans to monitor performance to make sure that solutions are sustained. 1.Under the supervision of the Administrator, DON or Designee will be responsible and accountable to submit audit findings utilized the Quality Assurance (QA) monitoring/audit tool to QAA committee member monthly for 3 months until 100% compliance. 2.The Administrator and DON shall be responsible for the implementation, monitoring, and evaluation of this Plan of Correction. Findings: During a review of Resident 1's Admission Record, the Admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure (a serious condition that occurs when your lungs can't get enough oxygen into your blood or remove carbon dioxide), bronchopneumonia (an inflammation of the lungs that affects the small airways and the surrounding lung tissue, seizures (a sudden uncontrolled change in behavior or body movement caused by abnormal electrical activity in the brain, hemiplegia (paralysis on the same side of the body) and hemiparesis (total paralysis of the arm, leg, and trunk on the same side of the body), encounter for tracheostomy (a surgical procedure that creates an opening in the neck into the windpipe, and neuromuscular dysfunction of the bladder. During a review of Resident 1's History and Physical (H&P), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1's Physician Order Summary report dated [DATE], the Physician Order Summary indicated to notify Medical Doctor (MD) if Resident 1 had any of the following symptoms: 1. Temperature less than (<) 96.8 F or greater than 99 F. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Heart rate greater than (>) 90 beats per minute 3. Respiratory (breathing) rate greater than 20 4. Acute change in mental status 5. Oxygen saturation (O2 sat- a measure of how much oxygen the blood is carrying as a percentage) less than 90 percent (%) 6. Systolic blood pressure (SBP- pressure exerted when the heart beats and blood is ejected into the arteries [blood vessels that distribute oxygen-rich blood to your entire body]), if baseline less than 100 millimeters of mercury (mmHg a unit of measurement for pressure), more than 5 mmHg lower than the baseline, every shift for sepsis prevention. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated [DATE], the MDS indicated, Resident 1 had severe impairment in cognitive (ability to think, understand, learn, and remember), skills for daily decision making. The MDS indicated Resident 1 was dependent on staff with bed mobility, chair/ bed to chair transfer, and tub/ shower transfer. During a record review of Resident 1's COC dated [DATE] timed at 6:19 a.m., the COC indicated Resident 1 had a moderate amount of hematuria in his incontinent pad (diaper). The COC indicated on [DATE] at 6:30 a.m. Resident 1's Primary Care Physician (PCP) 1 was notified., but there was no documentation of recommendations or physician orders. During a record review of Resident 1's COC dated [DATE] timed at 7:10 a.m., the COC indicated Resident 1 was unresponsive to verbal, tactile (any form of touch or physical contact perceived by the skin such as a sternal rub [a painful stimulus to the chest that is used to assess a patient's responsiveness]), and deep stimuli (when a person does not respond to pain, touch, and voice). The COC indicated PCP 1 was notified and facility staff called 911. During a review of Resident 1's Paramedics Run Sheet (a detailed written record that paramedics fill out during each emergency medical call) dated [DATE] timed at 6:33 a.m., the Paramedics Run Sheet indicated Resident 1 was observed with eyes open and unresponsive. The Paramedics Run Sheet indicated Resident 1 had fever for three days and became hypotensive (low blood pressure) with an altered mental status. The Paramedics Run Sheet indicated on [DATE] at 6:46 a.m., Resident 1's blood pressure was ,d+[DATE] mmHg, HR 110 bpm, and respiratory rate of 20. During a review of Resident 1's GACH emergency room (ER) Notes dated [DATE], the GACH ER Notes indicated, Resident 1 was admitted on [DATE] at 7:31 a.m., with diagnoses of UTI, acute kidney injury (a sudden loss of kidney function, that can range from minor to complete kidney failure) and septic shock (a life-threatening condition that occurs when the body's response to an infection causes dangerously low blood pressure). The GACH ER notes indicated on [DATE] was 8:11 a.m., Resident 1 was noted to have severe sepsis. GACH ER notes indicated Resident 1's temperature was 98.7 F, HR 111 bpm, and blood pressure , d+[DATE] mmHg. The GACH ER notes indicated on [DATE] at 6:12 p.m., the first code blue (a hospital emergency code that indicates a patient needs immediate medical attention, usually due to cardiac (heart) or respiratory arrest) was called, and at 7:50 p.m., the second code blue was called. The GACH ER notes indicated on [DATE], at 8:11 p.m., Resident 1 expired. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:14 p.m. with LVN 2, LVN 2 stated she did not assess or monitor Resident 1's vital signs when the resident had a change of condition (temperature of 103.8 F and HR 130 bpm) on [DATE] at 11:43 p.m. LVN 2 stated there was no documentation of Resident 1's temperature and HR after it was last taken on [DATE] at 11:43 p.m. During a concurrent interview and record review on [DATE], at 4:24 p.m., with Registered Nurse Supervisor (RNS 1), Resident 1's Weight and Vital Sign Summary and Situation, Background, Assessment, Recommendation (SBAR a communication tool used by healthcare workers when there is change of condition among the residents) / Change of Condition (COC) were reviewed. The Weight and Vital Sign Summary indicated, Resident 1 had the following temperatures and heart rates: a. On [DATE] 10:12 pm for Resident 1's temperature 99.8 F b. On [DATE] 11:25 am for Resident 1's HR 96 bpm c. On [DATE] 11:31 pm for Resident 1's HR 91 bpm d. On [DATE] 2:31 pm Resident 1's temperature 99.1 F e. On [DATE] 10:32 pm Resident 1's temperature 99.8 F f. On [DATE] 11:43 pm Resident 1's temperature 103.8 F g. On [DATE] 2:31 p.m., for Resident 1's HR 98 bpm h. On [DATE] 11:43 p.m., for Resident 1's HR 130 bpm RNS 1 stated Resident 1's physician order dated [DATE] indicated to notify MD if Resident 1 had any of the following symptoms: Temperature less than 96.8 F or greater than 99 F, Heart rate greater than 99 bpm Respiratory rate greater than 20, Acute change in mental status, O2 saturation less than 90 %, systolic blood pressure, if baseline less than 100 mmHg, more than 5 mmHg lower than the baseline, every shift for sepsis prevention. RNS 1 stated the orders should have been followed for Resident 1's physician to address COC. RNS 1 stated there was no care plan for neuromuscular dysfunction of the bladder to ensure licensed nurses will have specific intervention related to the diagnosis. RNS 1 further stated that there was no re-assessment done by licensed nurses after Resident 1 was noticed to have change of condition (temperature of 103.8 F and HR 130 bpm) on [DATE] at 11:43 p.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE], at 4:40 p.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 1 physician was not notified of Resident 1's temperature of 103.8 F and HR 130 bpm on [DATE] at 11:43 p. m. LVN 1 stated nonpharmacological (healthcare strategies that do not involve the use of medications) interventions including cooling measures such as removing blankets, put a fan on, and placing cold towels on Resident 1's forehead and under the arms were initiated. LVN 1 stated Resident 1's physician was not called because Resident 1 had a COC on [DATE] when Resident 1 had temperature of 99.8 F and hematuria. LVN 1 stated she failed to inform Resident 1's physician when he spiked a temperature of 103.8 F. LVN 1 stated she did not think it was an infection as Resident 1's temperature went down to 99 F. LVN 1 stated she does not recall the exact time Resident 1's temperature was taken and was not documented. LVN 1 stated she did not notify the doctor of Resident 1's HR of 130 bpm, as Resident 1's heart rate came down but failed to document. LVN 1 stated Resident 1's physician should be notified as interventions (cooling measures) were not working. LVN 1 stated no other temperatures or heart rates were documented after it was taken on [DATE] at 11:43 p.m. LVN 1 stated the next vital signs was taken on [DATE] at 6 a.m., (6 hours after). LVN 1 stated Resident 1 was sent to the GACH on [DATE] at 6 a.m. During an interview on [DATE], at 5:10 p.m., with RNS 3, RNS 3 stated Resident 1's physician was not notified of the resident's temperature of 103.8 F, as Resident 1 was already on monitoring for elevated temperatures and hematuria. RNS 3 stated primary care physicians get upset when called so nonpharmacological interventions were initiated for Resident 1. RNS 3 stated looking back Resident 1's physician should have been notified of Resident 1's temperature of 103.8 F as Resident 1 had previous elevated temperature of 99.8 F on [DATE]. RNS 3 stated Resident 1 could have had a UTI, pneumonia (an infection/ inflammation in the lungs), or sepsis (a life-threatening blood infection). RNS 3 stated on [DATE] when Resident 1 had altered level of consciousness (a change in a person's state of awareness and alertness, where they are not fully conscious or responsive to their surroundings) and low blood pressure of , d+[DATE] mmHg, it could have been sepsis. RNS 3 stated Resident 1 was transferred to GACH via 911 on [DATE] at 6 a.m. During an interview on [DATE], at 9:35 a.m., with Resident 1's Primary Care Physician (PCP)1, PCP 1 stated on [DATE] he was not informed of Resident 1's temperature of 103.8 F and HR of 130 bpm. PCP 1 stated he could have ordered for Resident 1 to be transferred to a GACH especially when Resident 1 was exhibiting signs of infection. PCP 1 stated on [DATE] at 11:43 p.m., Resident 1 could have had a septic shock (a life-threatening condition that occurs when an infection spreads throughout the body and causes a dangerously low blood pressure) when his temperature increased to 103.8 F and HR 130 bpm. PCP 1 stated Resident 1 should have been transferred to the GACH. During an interview on [DATE], at 1:57 p.m., with RN 3, RN 3 stated, on [DATE] Resident 1 had altered level of consciousness (ALOC-a change in a person's state of awareness and alertness, where they are not fully conscious or responsive to their surroundings) as Resident 1's eyes were closed, the resident was not responding to tactile stimuli (any form of touch or physical contact perceived by the skin such as a sternal rub [a painful stimulus to the chest that is used to assess a patient's responsiveness]), and when called by his name. RN 3 stated Resident 1's temperature was checked every 30 minutes to one hour but was not documented. RN 3 stated if it was not documented it was not done. RNS 3 stated he should have called Resident 1's PCP 1 or called 911 when Resident 1 had a COC. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a concurrent interview and record review on [DATE] at 11:13 a.m., with the Director of Nursing (DON), Resident 1's COC, Physician's Orders, Nurse Notes, Medication Administration Record (MAR) for the month of ,d+[DATE] were reviewed. The DON stated the Physician Order dated [DATE] for sepsis prevention indicated to notify MD if any vital signs were abnormal such as temperature less than 96.8 F or greater than 99 F and HR greater than 90 bpm. The DON stated there was no documentation indicating on [DATE] Resident 1's physician was notified when Resident 1 had a temperature of 99.8 F. The DON stated, on [DATE] at 11:43 p.m., when Resident 1 had a temperature of 103.8 F and HR of 130 bpm, licensed staff should have transfer Resident 1 to a GACH for evaluation and treatment and not wait until the next day [DATE] at 6 a.m., (6 hours later). The DON stated there was no care plan to address Resident 1's diagnosis of neuromuscular dysfunction of the bladder. The DON stated it was important to have a plan of care with interventions needed for Resident 1's diagnosis. The DON stated when there was a change of condition for any resident licensed nurses were expected to complete an assessment, notify the physician and resident representative. The DON stated sepsis was a complication of an infection that could be fatal. During a review of Job Description LVN, ([undated]), the Job Description LVN indicated, the LVN is responsible for demonstrating the ability to assign meaning to a resident symptoms and initiating appropriate action and consistently monitoring resident condition, initiating appropriate nursing action, consistently documenting resident care and reports pertinent clinical observations and reactions to the appropriate individual, and documenting nursing interventions and resident responses including physical and psychological response. During a review of the Job description Registered Nurse (RN), ([undated]), the Job Description RN indicated, The RN is responsible for making supervisory decisions, demonstrating the ability to assign meaning to resident symptoms and initiating appropriate action, consistently monitoring resident condition and initiates appropriate nursing intervention, consistently documenting resident care and reports pertinent clinical observations and reactions to the appropriate individual, and documenting nursing interventions, consistently and accurately performs reassessments during each shift and when the resident condition changes, and documenting nursing interventions and resident responses including physical and psychological response. During a review of the facility's policy and procedure (P&P) titled, Guidelines for Notifying Physicians of Clinical Problems, dated ,d+[DATE], the P&P indicated, These guidelines are to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient, and effective manner and 2) all significant changes in resident status are assessed and documented in the medical record. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, dated ,d+[DATE], the P&P indicated, The nurse will notify the resident's Attending Physician or physician on call when there has been a(an) specific instruction to notify the Physician of changes in the resident's condition. Cross Reference F580