STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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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 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** 46687 Based on interview and record review, the facility failed to promptly (quickly/timely) notify the physician for, one of 16 sampled residents (Resident 1), who experienced a change of condition (COC, a sudden clinically important deviation in the resident's health or functioning that requires further assessments and interventions) in accordance with the facilities policies and procedures (P&P) titled, Change in a Resident's Condition or Status, Resident Assessment and Examination, and Resident 1's Care Plan (CP) titled, Constipation (difficulty in emptying the bowels), by failing to: 1. Ensure Registered Nurse (RN) 2 and RN 3 notified Resident 1's primary care physician/Medical Doctor (MD) 1 of Resident 1's COC, on [DATE] at 8 am, when Resident 1 experienced abdominal distension (bloating and swelling in the belly area), abdominal firmness (abdomen feeling hard or tight to the touch), and complained of (unspecified/unrated) abdominal pain. 2. Ensure RN 4 notified MD 1 on [DATE] when Resident 1's constipation (a problem with passing stool, hard stools, generally means passing fewer than three stools a week or having a difficulty passing stools), abdominal distension, and abdominal firmness did not improve after Resident 1 received magnesium citrate (medication used to treat occasional constipation and usually results in a bowel movement [BM, an act of defecation (expelling feces)/movement of feces] within 30 minutes from the time of medication administration) on [DATE] at 4:38 pm. 3. Ensure RN 4,and Licensed Vocational Nurse (LVN) 4 notified MD 1 on [DATE] at 11:10 pm when Resident 1 was noted to have shortness of breath (SOB, sensation of not being able to breathe enough air, or the feeling of suffocating or struggling to breathe), required supplemental oxygen (O2, colorless odorless gas, medical treatment that provides additional oxygen to individuals with breathing difficulties or have low blood oxygen levels), had abdominal distension with hypoactive bowel sounds (decreased/reduced sound made by the movement of the intestines/bowel [long tubed shaped organ in the abdomen that completes the process of digestion (the breakdown of food)] as the intestines push food through, indicating?slowed intestinal activity), and had a hard abdomen. 4. Ensure RN 4, and LVN 4 notified MD 1 on [DATE] at 12:15 am, when Resident 1 complained of acute (fast/sudden) onset (beginning of something unpleasant) of 8 out of 10 pain (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt, 7 to 9 indicates severe pain) to Resident 1's abdomen. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	As a result of these failures, on [DATE] at 1:09 am, LVN 4 found Resident 1 unresponsive (a state in which an individual is unconscious and does not respond to stimuli such as voice, touch, or pain) in Resident 1's bed. Resident 1 had coffee ground emesis (act of vomiting, appears dark brown, coffee-ground-like substance). Resident 1 was not breathing and did not have a pulse (heartbeat). LVN 4 asked Certified Nursing Assistant (CNA) 5 to called [DATE] (phone number used to contact Emergency Medical Services [EMS, a system that responds to emergencies in need of highly skilled prehospital clinicians, also known as ambulance services] in the event of a medical emergency) and began cardio-pulmonary resuscitation (CPR - emergency lifesaving procedure performed when the heart stops or breathing is inadequate). Resident 1 was pronounced dead by Emergency Medical Technician (EMT, a person who is specially trained and certified to administer basic emergency services to victims of trauma or acute illness) at the facility on [DATE] at 1:42 am. On [DATE] at 5:57 pm, while at the facility, the State Survey Agency (SSA) identified an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The IJ was called in the presence of the Administrator (ADM) and the Director of Nursing (DON) due to the facility's failure to notify MD 1 when Resident 1 had a COC. On [DATE], while onsite at the facility, the facility provided an acceptable IJ Removal Plan (IJRP, a detailed plan that includes interventions to immediately correct the deficient practices of the IJ) for the facility's failure to notify MD 1 of Resident 1's COC. While onsite, the SSA verified and confirmed the facility's full implementation of the IJRP through observations, interviews, and record reviews, and determined the IJ situation, under Federal Code of Regulation (CFR) 483.10: Resident Right - Notify of Changes, was no longer present. The SSA removed the IJ on [DATE] at 5:29 pm in the presence of the ADM and the DON. The acceptable IJRP included the following immediate corrective actions: 1. On [DATE], an in-service (training session) was initiated by the DON and the Assistant DON (ADON) to all licensed nursing staff (all RNs and LVNs). The facility employed a total of 84 LVNs and 20 RNs. On [DATE] and on [DATE] a total of 45 of 84 LVNs and 11of 20 RNs were in-serviced (trained) on COCs. The DON and the ADON will continue the in-services until all licensed and registered nurses are trained. Any Licensed Nurses (LNs) that are currently on medical leave or vacation will receive the training before they provide patient care. The in-service included: a. Contacting the physician as soon as possible for any resident's COCs specifically for residents with constipation, abdominal pain, abdominal distention, and abdominal firmness. b. Contacting the resident's physician as soon as possible when there is a delay in medication and when a resident's symptoms do not improve or worsen during a COC. c. Ensure accurate, complete, and timely documentation. d. Complete an accurate assessment of the residents' overall condition and thorough documentation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. License nurses will identify Residents who have not had BMs for 72 hours, with new or worsening symptoms, and other associated abnormal changes but not limited to frequency and consistency of bowel, abdominal pain, abdominal distension, decreased peristalsis (digestion of food), and signs of gastrointestinal (GI, refers to the organs of the body that play a part in food digestion) bleeding. b. Upon identification LNs will utilize the tool and document the notification of the physician. c. LNs will continue documenting the COCs through the Situation, Background, Assessment, and Recommendation (SBAR) in the clinical health records. d. LNs will obtain recommendations from the physicians and will carry [the recommendations] out. e. The tool will be completed daily [during] each shift by the charge nurses, the tool will be collected by medical record staff and retained for review. 7. On [DATE], the medical records team also conducted an audit of the alert system in PCC. The PCC alert notifies the nursing team when a resident does not have BMs for 24 hours or more. Cross Refence: F641, F842 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility initially admitted Resident 1 on [DATE] and readmitted the resident on [DATE] with diagnoses that included psychosis (refers to symptoms that happen when a person is disconnected from reality), muscle wasting, and atrophy (wasting away). During a review of Resident 1's CP titled, Constipation, initiated on [DATE], reevaluated ,d+[DATE], the CP indicated Resident 1 was at risk for constipation due to medication use and decreased mobility (the ability to move or be moved freely and easily). The CP indicated Resident 1 had a history of constipation. The CP's interventions indicated for LNs to monitor medications that may cause constipation and to notify MD 1 if Resident 1 was unable to relieve constipation. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. During a review of Resident 1's Progress Notes (PN), dated [DATE], timed at 7:51 am, the PN indicated on [DATE], at 6:05 am, Resident 1 complained of not having a BM for two days. The PN indicated Resident 1 complained of abdominal pain (unrated), bloating, and feeling uncomfortable during the night shift (11 pm to 7 am, from [DATE] to [DATE]). (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 SBAR form, dated [DATE], timed at 8 am, the SBAR indicated Resident 1 had a COC due to constipation or impaction (hardened stool that is stuck in the rectum [the last section of the large intestine, a long, continuous tube that connects to the colon [the longest part of the large intestine] and the anus [the end of the large intestine] due to long lasting constipation). The SBAR indicated Resident 1's last BM was on [DATE]. The SBAR indicated RN 3 notified MD 1 regarding Resident 1's constipation and received the recommendation to administer magnesium citrate. During a review of Resident 1's Physician Telephone Orders (PO), dated [DATE], timed at 10:20 am, the PO indicated to administer magnesium citrate oral solution, give 296 milliliters (ml- unit of measurement) by mouth, one time only, for constipation until [DATE] at 11:59 pm. The PO indicated RN 2 signed the PO. During a review of Resident 1's Medication Administration Record (MAR, a log initialed and/or signed by the LNs with the date and time a medication was administered to a resident) dated [DATE], timed at 4:38 pm, the MAR indicated LVN 3 administered 296 ml of magnesium citrate oral solution to Resident 1. During a review of Resident 1's SBAR Communication Form, dated [DATE], untimed, the SBAR indicated Resident 1 had a COC. The SBAR indicated on [DATE] at 10:55 pm, Resident 1 was in bed with Resident 1's eyes closed, and Resident 1 had stable vital signs (VS - measurements of the body's most basic functions such as body temperature, heart rate, respiration rate, and blood pressure are within normal limits). The SBAR indicated at 11:10 pm (on [DATE]), Resident 1 was heard, by LVN 4, calling out for O2. The SBAR indicated Resident 1's O2 saturation (sats, percentage of O2 in the blood) was 97 percent (%, unit of measurement) while receiving 3 liters (L, unit of measurement) per minute (LPM, unit of expressed flow rate) of O2 via nasal cannula (NC, a device that delivers extra oxygen through a tube and into the nose). The SBAR indicated Resident 1's abdomen was distended. The SBAR indicated on [DATE] between 12:15 am and 12:30 am, Resident 1 complained of 8 out of 10 pain (severe/intense pain) to Resident 1's abdomen. The SBAR indicated Resident 1 accepted Norco (medication used to treat moderate to severe pain) for abdominal pain. The SBAR indicated MD 1 was notified of Resident 1's expiration (death) on [DATE], at 2 am. During a review of Resident 1's untitled EMS Report (EMSR), dated [DATE], timed at 1:10 am, the EMSR indicated the facility notified the EMS on [DATE] at 1:10 am. The EMSR indicated the EMTs arrived at the facility on [DATE] at 1:17 am and were with Resident 1 at 1:18 am. The EMSR indicated Resident 1 was found supine (face up), unresponsive, and pulseless (without a heart rate). The EMSR indicated the EMTs administered O2, performed CPR, administered two rounds (doses) of one milligram (mg- unit of measurement) of epinephrine (primary drug administered during CPR used to improve blood flow) for cardiac arrest via intraosseous (IO, insertion of a needle into the bone to deliver fluids, medications, and blood products), and a total of 1000 ml of Intravenous [IV, soft, flexible tube placed inside a vein used to administer fluids and medication directly into the bloodstream] fluids were administered to Resident 1. The EMSR indicated Resident 1 did not have a return of spontaneous circulation (ROSC, when the heart begins to beat on its own and blood circulates after CPR is performed) after 20 consecutive minutes [of CPR]. The EMSR indicated Resident 1's time of death was on [DATE] at 1:42 am. (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 PN, dated [DATE], time at 8:25 am, LVN 4 documented (on [DATE]) between 1:06 am and 1:09 am, LVN 4 made rounds (visually checking residents) to assess the effectiveness of Resident 1's pain medication (Norco), and LVN 4 found Resident 1 unresponsive. The PN indicated the RN [RN 4] was notified and [DATE] was called. The PN indicated resuscitative efforts were immediately initiated while waiting for EMS. The PN indicated (on [DATE]), between 1:16 am and 1:42 am, the EMTs arrived, presumed care, and [continued] resuscitative efforts for Resident 1. The PN indicated the EMTs pronounced Resident 1's time of death on [DATE], at 1:42 am. During a telephone interview on [DATE] at 3:37 pm, with LVN 4, LVN 4 stated on [DATE] at 11:10 pm, Resident 1 asked for an increase in O2 because Resident 1, felt like it was hard to breathe. LVN 4 stated LVN 4 increased Resident 1's O2 from 2 LPM to 3 and a half LPM via NC. LVN 4 stated, on [DATE] at 12:15 am, Resident 1 complained of 8 out of 10 abdominal pain and Resident 1 had abdominal distension. LVN 4 stated Resident 1 received Norco for the abdominal pain. LVN 4 stated, 30 minutes after administering Norco, LVN 4 went to reassess Resident 1's pain, but Resident 1 was found unresponsive. LVN 4 stated Resident 1 had emesis coming out of Resident 1's nose and mouth and went down the sides of Resident 1's face. LVN 4 stated, the emesis was thick, watery, chunky, burgundy and black in color. LVN 4 stated there was, A lot of emesis mixed with blood. LVN 4 stated, It smelled like blood. LVN 4 stated LVN 4 checked Resident 1's carotid (artery [blood vessel that carries blood from the heart to the tissues and organs in the body] located on each side of the neck) and radial (artery located in the wrist) pulses and both pulses were missing. LVN 4 stated Resident 1's eyes did not respond to light. LVN 4 stated LVN 4 immediately started CPR and called a code blue (activation of an alert during a medical emergency such as cardiac arrest). LVN 4 stated LVN 4 informed RN 4 when LVN 4 increased Resident 1's O2 (on [DATE] at 11:10 pm) and when Resident 1 complained of ,d+[DATE] abdominal pain, on [DATE] at 12:15 am, because these situations were COCs for Resident 1. LVN 4 stated when Resident 1 experienced a COC, LVN 4 was supposed to assess Resident 1 and notify MD 1. LVN 4 stated LVN 4 only informed RN 4 but did not notify MD 1 of Resident 1's COC. During an interview on [DATE] at 7:50 am, with CNA 5, CNA 5 stated, on [DATE] at 11 pm, Resident 1 complained Resident 1's whole stomach was hurting. CNA 5 stated CNA 5 touched Resident 1's stomach and it was, rock hard. CNA 5 stated CNA 5 asked LVN 3 and LVN 4 when Resident 1 was going to be sent to the hospital because Resident 1 was requesting to be sent to the hospital. CNA 5 stated LVN 4 responded by stating LVN 4 needed to speak to RN 4 to see what RN 4's opinion was. CNA 5 stated Resident 1 continued to complain of stomach pain throughout the night. CNA 5 stated CNA 5 attempted to make Resident 1 as comfortable as possible within CNA 5's scope of practice (activities and duties that a healthcare professional is permitted to undertake). CNA 5 stated CNA 5 also went to the nurses' station to talk to LVN 4 and RN 4. CNA 5 stated CNA 5 asked LVN 4 and RN 4 if they were going to send Resident 1 out [to the hospital] because Resident 1 did not look like Resident 1 was in good condition. CNA 5 stated LVN 4 told CNA 5 they needed to wait for RN 4's instruction. CNA 5 stated LVN 4 went to check on Resident 1 after administering the pain medication (Norco) and LVN 4 came out of Resident 1's room asking CNA 5 to call [DATE]. CNA 5 stated CNA 5 called [DATE]. CNA 5 stated after the EMTs pronounced Resident 1 dead, RN 4 asked CNA 5 to clean Resident 1. CNA 5 stated as soon as CNA 5 walked into Resident 1's room, CNA 5 observed Resident 1's skin was pale, and there was, Black sludge [thick, soft, wet mixture of liquid and solid components], all around Resident 1's head area, bed railing, and all over the floor. CNA 5 stated, It [the emesis] looked like black bean chunks. CNA 5 stated, It [the emesis] smelled rotten [bad smelling]. CNA 5 stated CNA 5 finished cleaning Resident 1, but Resident 1 continued to bleed out of Resident 1's nose. (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 telephone interview on [DATE] at 12:57 pm with MD 1, MD 1 stated MD 1 was informed by facility nursing staff (unable to identify) on [DATE] at 7:44 am, Resident 1 was constipated. MD 1 stated MD 1 was notified Resident 1 continued to be constipated even after Resident 1 had received lactulose (synthetic, non-absorbable sugar used primarily as a laxative to treat constipation) and a water enema (procedure where water is introduced into the rectum to cleanse the bowel and treat constipation). MD 1 stated staff requested a KUB (Kidney/Ureter [thin tubular structure that connects the kidneys to the urinary bladder [hollow muscular organ that acts as a reservoir for urine]/Bladder) X-ray (imaging study that takes pictures of the bones and soft tissues), but MD 1 recommended the administration of magnesium citrate first. MD 1 stated facility staff did not inform MD 1 Resident 1 had abdominal distension, severe abdominal pain, and abdominal firmness/hardness. MD 1 stated staff (unidentified) notified MD 1 again on [DATE] at 6:26 am that Resident 1 was found unresponsive, EMS could not achieve ROSC, and Resident 1 passed away (on [DATE] at 1:42 am). MD 1 stated when magnesium citrate was not effective in relieving constipation, pain, abdominal distension, and hardness, LNs needed to contact MD 1 so MD 1 could provide additional orders. MD 1 stated MD 1 would have ordered a KUB X-ray for Resident 1. MD 1 stated when Resident 1 experienced SOB and needed an increase in O2, had severe abdominal pain, and had a distended abdomen, LNs needed to notify MD 1 because Resident 1 needed higher level care. MD 1 stated LNs did not notify MD 1 of Resident 1's symptoms and this [not notifying MD 1 of Resident 1's COC] stopped Resident 1 from receiving higher level care and being treated for those symptoms. MD 1 stated MD 1 was not notified about Resident 1 having coffee ground emesis when Resident 1 was found unresponsive. MD 1 stated coffee ground emesis indicated Resident 1 may have had GI bleeding. MD 1 stated signs and symptoms of GI bleeding included, abdominal distension and pain, decreased bowel sounds, nausea, vomiting, decreased O2 sats, or an increased need for O2. During a telephone interview on [DATE] at 2:40 pm, with RN 2, RN 2 stated, on [DATE] before 10 am, Resident 1 informed RN 2 Resident 1 did not have a BM for two days. RN 2 stated RN 2 assessed Resident 1 and Resident 1 had hypoactive bowel sounds, abdominal distension, and firmness. RN 2 stated Resident 1 complained of abdominal pain, but RN 2 did not ask/assess Resident 1's pain level. RN 2 stated based on RN 2's assessment of Resident 1, Resident 1 had ,d+[DATE] pain (severe pain). RN 2 stated RN 2 did not relay RN 2's assessment to MD 1 because Resident 1's main complaint was constipation. RN 2 stated RN 2 was supposed to inform MD 1 of Resident 1's full assessment because Resident 1's situation could worsen. During an interview on [DATE] at 4:44 pm with the DON, the DON stated when Resident 1 complained of constipation, LNs were supposed to assess Resident 1's abdomen by listening to bowel sounds, checking for dehydration, (state of having too little water in the body), distension, bloating, and pain. The DON stated the assessment could determine the next steps/interventions to be taken and escalating the assessment findings to MD 1 for new orders. The DON stated if LNs did not relay Resident 1's full assessment and symptoms to MD 1, It could affect Resident 1's treatment and outcome. The DON stated Resident 1's condition may not improve and could worsen. The DON stated when Resident 1 had new symptoms or when symptoms became more severe, MD 1 needed to be notified immediately (instantly) so MD 1 could decide the best course of treatment, provide more medication, or send Resident 1 to the hospital. The DON stated when MD 1 ordered the medication (magnesium citrate) and the medication was not effective, or did not relieve symptoms of constipation, MD 1 needed to be notified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056431	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Inland Valley Care and Rehabilitation Center	250 W. Artesia Street Pomona, CA 91768

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a review of the facility's undated P&P titled, Resident Examination and Assessment, the P&P indicated The purpose of the P&P was to examine and assess the resident for any abnormalities in health status, which provided a basis for the CP. The P&P indicated The GI assessment included to assess for: abdominal distension and hardness, constipation, and bowel sounds in all four quadrants (four sides of the abdomen); hypoactive (reduced bowel sounds, can indicate the intestines are not working properly), normal, or hyperactive (increased bowel sounds) sounds. The P&P indicated Notify the physician of any abnormalities such as, but not limited to abnormal vital signs, labored breathing (struggle to breathe), distended, hard abdomen, or absence of bowel sounds, and worsening of pain, as reported by the resident. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised ,d+[DATE], the P&P indicated The facility promptly notified the resident, his or attending physician, and the resident's representative of changes in the resident's medical/mental condition and/or status. The P&P indicated The nurse will notify the resident's attending physician or physician on-call when there has been a(an) significant change in the resident's physician/emotional/mental condition, a need to alter the resident's medical treatment significantly, need to transfer the resident to a hospital or treatment center, and/or specific instructions to notify the physician of changes in the resident's condition. The P&P indicated Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted on the Interact SBAR Communication Form. The P&P indicated The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46687 Based on interview and record review, the facility failed to examine and assess one of 16 sampled residents (Resident 1) according to the facility's policy and procedure (P&P) titled, and Resident Assessment and Examination, by failing to: 1. Ensure when Resident 1 experienced a change of condition (COC- a change in the resident's health or functioning that requires further assessment and intervention) on [DATE] at 8 am, Registered Nurse 2 (RN 2) and RN 3 assessed Resident 1's abdominal distension (bloating or swelling), abdominal firmness (abdomen feeling hard or tight to the touch) rebound or guarding (physical signs that can indicate inflammation of the abdominal lining or other acute abdominal issues), bowel sounds (sound produced by the movement of fluid and air in the intestines) for hyperactivity (increased bowel sounds), hypoactivity (reduced bowel sounds) and pain. 2. Ensure RN 5 and Licensed Vocational Nurse (LVN) 3 assessed Resident 1's abdomen and pain on [DATE] between 3 pm and 11 pm when Resident 1's abdominal pain, abdominal distension and abdominal firmness did not after receiving magnesium citrate (laxative) [DATE] at 4:38 pm. Resident 1 was on monitoring for constipation (less frequent bowel movement [BM]). 3. Ensure LVN 3 and LVN 4 assessed Resident 1's oxygen (O2- colorless gas) saturation (sats- percentage of oxygen in the blood) before increasing Resident 1's oxygen to be increased from two liters per minute (LPM- unit of measurement) to three and a half LPM, on [DATE] at 11:10 pm when Resident 1 has shortness of breath. As a result of these failures, Resident 1 was not provided with a full assessment and had the potential to result in adverse consequences for Resident 1. Cross Reference: F580 and F842 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility admitted Resident 1 on [DATE] and readmitted on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD, group of diseases that cause airflow blockage), chronic respiratory failure (a long lasting condition when the lungs cannot get enough oxygen)and muscle wasting and atrophy (thinning of muscle mass). During a review of Resident 1's care plan (CP) titled, COPD, initiated on [DATE] and reevaluated on , d+[DATE], the CP indicated Resident 1 was at risk for discomfort, shortness of breath, and exacerbation (worsening) secondary (due to) COPD. The CP interventions indicated Resident 1 to receive O2 at two liters (unit of volume) per minute (LPM) via nasal canula (NC- tube which on one end splits into two prongs which are placed in the nostrils to deliver oxygen). (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. The MDS indicated Resident 1 was always incontinent (inability to control urination and bowel movement [BM]). During a review of Resident 1's Progress Notes (PN) dated [DATE], timed at 7:51 am, the PN indicated at 6:05 am, Resident 1 complained of not having a BM for two days. The PN indicated Resident 1 complained of abdominal pain (unrated), bloating, and feeling uncomfortable during the night shift (11 pm to 7 am). The PN indicated Resident 1 was on two LPM of O2 via NC. During a review of Resident 1's eINTERACT SBAR form dated [DATE], timed at 8 am, the SBAR indicated Resident 1 had a COC due to constipation or impaction (hardened stool). The SBAR indicated Resident 1 had constipation and Resident 1 had not had a BM in two to three days. The SBAR indicated RN 3 notified MD 1 and MD 1 ordered magnesium citrate first, before a Kidney Ureter Bladder (KUB-imaging test) and X-ray (imaging study that uses radiation and takes pictures of the inside of the body) were taken. The SBAR form did not indicate Resident 1 had abdominal distention, firmness, or pain. During a review of Resident 1's SBAR Communication Form dated [DATE], timed at 1:06 am, the SBAR indicated Resident 1 had a COC. The SBAR form did not indicate an abdominal/GI evaluation (assessment). The SBAR indicated on [DATE] at 10:55 pm, Resident 1 was in bed with eyes closed. The SBAR form indicated at 11:10 pm, Resident 1 was heard, by LVN 4, needing O2. The SBAR indicated Resident 1's O2 sat was 97 percent (%) while receiving three LPM of O2 via NC. The SBAR indicated Resident 1's abdomen was distended. The SBAR indicated on [DATE] between 12:15 am and 12:30 am, Resident 1 complained of eight out of 10 pain (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt) to the abdomen. The SBAR indicated Resident 1 received Norco (brand name for hydrocodone-acetaminophen-used to treat moderate to moderate to severe pain). During a review of Resident 1's PN dated [DATE], time at 8:25 am, LVN 4 documented (on [DATE]) between 1:06 am and 1:09 am, LVN 4 made rounds (visually checking residents) to assess the effectiveness of Resident 1's pain medication (Norco), and LVN 4 found Resident 1 unresponsive. The PN indicated the RN [RN 4] was notified and [DATE] was called. The PN indicated resuscitative efforts were immediately initiated while waiting for EMS. The PN indicated (on [DATE]), between 1:16 am and 1:42 am, the EMTs arrived, presumed care, and [continued] resuscitative efforts for Resident 1. The PN indicated the EMTs pronounced Resident 1's time of death on [DATE], at 1:42 am. During a telephone call on [DATE] at 1:02 pm, [DATE] at 11:47 am, and [DATE] at 12:59 pm, an attempt was made to reach LVN 3, but LVN 3 could not be reached. During a telephone call on [DATE] at 1:03 pm and on [DATE] at 11:43 am, an attempt was made to reach RN 5, but RN 5 could not be reached. During a telephone interview on [DATE] at 1:11 pm, with RN 4, RN 4 stated RN 5 did not endorse to RN 4 that Resident 1 had abdominal distension or pain when RN 4 started RN 4's shift on [DATE] at 11 pm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056431	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 3:37 pm, with LVN 4, LVN 4 stated on [DATE] at 11:10 pm, Resident 1 asked for an increase in O2 because Resident 1, felt like it was hard to breathe. LVN 4 stated LVN 4 increased Resident 1's O2 from 2 LPM to 3 and a half LPM via NC. LVN 4 stated LVN 4 documented the O2 administration as three LPM. LVN 4 stated LVN 4 did not know what Resident 1's O2 sats were before increasing the O2, and did not assess Resident 1's O2 sats until after increasing Resident 1's O2. LVN 4 stated LVN 3 did not endorse to LVN 4 that Resident 1 had abdominal distension and pain when LVN 4 started the shift on [DATE] at 11 pm. LVN 4 stated LVN 4 informed RN 4 that Resident 1's O2was increased. LVN 4 stated, on [DATE] at 12:15 am, Resident 1 complained of 8 out of 10 abdominal pain and Resident 1 had abdominal distension. LVN 4 stated Resident 1 received Norco for the abdominal pain, and 30 minutes after administering Norco, LVN 4 went to reassess Resident 1's pain, but Resident 1 was found unresponsive. LVN 4 stated LVN 4 informed RN 4 when LVN 4 increased Resident 1's O2 (on [DATE] at 11:10 am) and when Resident 1 complained of ,d+[DATE] abdominal pain, on [DATE] at 12:15 am, because these situations were COCs for Resident 1. LVN 4 stated when Resident 1 experienced a COC, LVN 4 was supposed to assess Resident 1 and notify MD 1. LVN 4 stated LVN 4 only informed RN 4 but did not notify MD 1 of Resident 1's COC. During an interview on [DATE] at 7:30 am, with CNA 5, CNA 5 stated on [DATE] at 11 pm, Resident 1 complained Resident 1's whole stomach was hurting. CNA 5 stated CNA 5 touched Resident 1's stomach and it was, rock hard. CNA 5 stated LVN 3 and LVN 4 increased Resident 1's supplemental O2. CNA 5 stated LVN 3 and LVN 4 did not assess Resident 1's O2 sat level before increasing the O2. CNA 5 stated CNA 5 asked LVN 3 and LVN 4 if Resident 1 was going to be sent to the hospital because Resident 1 was asking to be sent. CNA 5 stated LVN 4 told CNA 5 they needed to wait for RN 4's instruction. CNA 5 stated Resident 1 continued to complain of stomach pain. During a telephone interview on [DATE] at 11:48 am, with RN 4, RN 4 stated, on [DATE] around 11:10 pm, LVN 4 informed RN 4 that Resident 1 needed an increase in O2. RN 4 stated at around 11:30 pm (on [DATE]), RN 4 assessed Resident 1 and Resident 1's abdomen was distended and hard to touch. RN 4 stated RN 4 did not auscultate (examination of the resident by listening to bowel sounds to assess for intestinal function) Resident 1's abdomen. RN 4 stated Resident 1 had distension, and a Hard to touch, abdomen even after receiving magnesium citrate. RN 4 stated when RN 4 arrived at Resident 1's code (blue), RN 4 observed a moderate amount of coffee-ground emesis on Resident 1's gown and body. RN 4 stated coffee-ground emesis indicated GI bleeding. During a telephone interview on [DATE] at 12:36 pm, with RN 3, RN 3 stated on [DATE] at, around 4 am, Resident 1 complained of not having a BM, feeling bloated, and pain in the abdomen. RN 3 stated Resident 1 had a distended abdomen. RN 3 stated RN 3 did not assess Resident 1's abdomen, listen to bowel sounds, nor ask Resident 1 the pain level Resident 1 felt in Resident 1's abdomen. RN 3 stated RN 3 informed MD 1 Resident 1 was constipated. RN 3 stated RN 3 did not inform MD 1 of Resident 1's abdominal distension, feeling bloated, or the unrated abdominal pain. RN 3 stated providing all [pertinent] information helped MD 1 determine the treatment needed for Resident 1. During a telephone interview on [DATE] at 12:57 pm, with MD 1, MD 1 stated MD 1 was informed by facility nursing staff (unable to identify) on [DATE] at 7:44 am, Resident 1 was constipated. MD 1 stated MD 1 was notified Resident 1 continued to be constipated even after Resident 1 had received lactulose (synthetic, non-absorbable sugar used primarily as a laxative to treat constipation) and a water enema (procedure where water is introduced into the rectum to cleanse the bowel and treat constipation). (continued on next page)

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 2:40 pm, with RN 2, RN 2 stated, on [DATE] before 10 am, Resident 1 informed RN 2 Resident 1 did not have a BM for two days. RN 2 stated RN 2 assessed Resident 1 and Resident 1 had hypoactive bowel sounds, abdominal distension, and firmness. RN 2 stated Resident 1 complained of abdominal pain, but RN 2 did not ask/assess Resident 1's pain level. RN 2 stated based on RN 2's assessment of Resident 1, Resident 1 had severe pain. RN 2 stated RN 2 did not relay RN 2's assessment to MD 1 because Resident 1's main complaint was constipation. RN 2 stated RN 2 was supposed to inform MD 1 of Resident 1's full assessment because Resident 1's situation could worsen. During an interview on [DATE] at 4:44 pm, with the DON, the DON stated when Resident 1 complained of constipation, licensed nurses were supposed to assess Resident 1's abdomen by listening to bowel sounds, checking for dehydration, distension, bloating, and pain. The DON stated the assessment could determine the next steps to be taken, interventions needed, and escalating the assessment findings to MD 1 for new orders. The DON stated if LNs did not relay Resident 1's full assessment and symptoms to MD 1, It could affect Resident 1's treatment and outcome. The DON stated Resident 1's condition may not improve and could worsen. During a review of the facility's P&P titled, Resident Examination and Assessment, revised ,d+[DATE], the P&P indicated the purpose of the P&P was to examine and assess the resident for any abnormalities in health status, which provided a basis for the CP. The P&P indicated the GI assessment included to assess for: abdominal distension and hardness, constipation, and bowel sounds in all four quadrants (four sides of the abdomen); hypoactive, normal, or hyperactive sounds. The P&P indicated to notify the physician of any abnormalities such as, but not limited to abnormal vital signs, labored breathing, distended, hard abdomen, or absence of bowel sounds, and worsening of pain, as reported by the resident.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 46687 Based on interview and record review, the facility failed to ensure accurate and complete documentation for one of one sampled resident (Resident 1), in accordance with the facility's policies and procedures (P&P) titled, Charting and Documentation and Change in a Resident's Condition or Status. This deficient practice resulted in no documentation of Resident 1's full assessments during a Change of Condition (COC, a sudden clinically important deviation in the resident's health or functioning that requires further assessments and interventions) on 5/6/2025 and had the potential to result in complications leading to a physical decline to Resident 1. Cross Reference: F580 and F641 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility initially admitted Resident 1 on 10/24/2022 and readmitted the resident on 1/25/2023 with diagnoses that included psychosis (refers to symptoms that happen when a person is disconnected from reality), muscle wasting, and atrophy (wasting away). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 4/7/2025, the MDS indicated Resident 1 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 1 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. During a review of Resident 1's Medication Administration Record (MAR, a log initialed and/or signed by the licensed nurse with the date and time a medication was administered to a resident) dated 5/5/2025 to 5/7/2025, the MAR did not indicate Resident 1 had pain. During a review of Resident 1's Progress Notes (PN), dated 5/6/2025, timed at 7:51 am, the PN indicated at 6:05 am, Resident 1 complained of not having a BM for two days. The PN indicated Resident 1 complained of abdominal pain (unrated), bloating, and feeling uncomfortable during the night shift (11 pm to 7 am). The PN indicated Resident 1 was on two LPM of O2 via NC. During a review of Resident 1's eINTERACT SBAR form dated 5/6/2025, timed at 8 am, the SBAR indicated RN 3 documented Resident 1 had a COC due to constipation. The SBAR form did not indicate Resident 1 had abdominal distention, firmness, bloating, or pain. During a review of Resident 1's PN dated 5/6/2025 between 3 pm and 11 pm, the PN did not indicate an abdominal/GI evaluation (assessment) was completed. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 1's SBAR Communication Form, dated 5/7/2025, timed at 1:06 am, the SBAR indicated Resident 1 had a COC. The SBAR indicated on 5/6/2025 at 10:55 pm, Resident 1 was in bed with eyes closed. The SBAR indicated at 11:10 pm, Resident 1 was heard, by LVN 4, calling out for O2. The SBAR indicated Resident 1's O2 sats was 97 percent (%, unit of measurement) while receiving 3 LPM of O2 via NC. The SBAR indicated Resident 1's abdomen was distended. The SBAR indicated on 5/7/2025 between 12:15 am and 12:30 am, Resident 1 complained of 8 out of 10 pain (severe pain) to the abdomen. The SBAR indicated a GI (gastrointestinal, refers collectively to the organs of the body that play a part in food digestion [breakdown of food]) evaluation was not done for Resident 1 (section left blank). The SBAR did not indicate Resident 1 was found with coffee-ground emesis (vomiting). During a telephone interview on 5/7/2025 at 3:37 pm, with LVN 4, LVN 4 stated on 5/6/2025 at 11:10 pm, Resident 1 asked for an increase in oxygen [O2, colorless, odorless gas] because Resident 1, felt like it was hard to breathe. LVN 4 stated LVN 4 increased Resident 1's O2 from 2 liters per minute (LPM, unit of expressed flow rate) to 3 and a half LPM via nasal canula ([NC] a device-lightweight flexible plastic tubing used to deliver supplemental oxygen, tubing ending is placed in the nostrils and is fitted over the patient's ears). LVN 4 stated LVN 4 documented 3 LPM instead of 3 and a half LPM. LVN 4 stated LVN 4 was supposed to document Resident 1's oxygen saturation (measurement that indicates what percentage of blood saturated with oxygen) accurately, so it reflected Resident 1's condition correctly. During a telephone interview on 5/8/2025 at 9:29 am, with LVN 4 stated LVN 4 forgot to document Resident 1's 8 out of 10 pain (pain scale 0 to 10, 0 means no pain and 10 means the worst possible pain felt) in Resident 1's MAR and document Resident 1 had coffee-ground emesis. LVN 4 stated it was important to ensure all LVNs documented accurately to reflect Resident 1's condition. During a telephone interview on 5/8/2025 at 12:36 pm, with RN 3, RN 3 stated on 5/6/2025 at, around 4 am, Resident 1 complained of not having a BM, feeling bloated, and feeling pain (unrated) in the abdomen. RN 3 stated Resident 1 had a distended abdomen. RN 3 stated RN 3 did not document Resident 1 feeling bloated and feeling pain (unrated) in Resident 1's SBAR form dated 5/6/2025, timed at 8 am. RN 3 stated documenting in the medical record helped physicians determine the treatment needed for Resident 1, and the physician orders needed. During a telephone interview on 5/8/2025 at 2:40 pm, with RN 2, RN 2 stated, on 5/6/2025 before 10 am, Resident 1 informed RN 2 Resident 1 did not have a BM for two days. RN 2 stated RN 2 assessed Resident 1 and Resident 1 had hypoactive bowel sounds, abdominal distension, and firmness. RN 2 stated Resident 1 complained of abdominal pain. RN 2 stated based on RN 2's assessment of Resident 1, Resident 1 had severe pain. RN 2 stated, RN 2 did not document the assessment, including Resident 1's pain, performed on Resident 1 in Resident 1's medical record. During an interview on 5/8/2025 at 4:44 pm, with the DON, the DON stated when Resident 1 complained of constipation, licensed nurses were supposed to assess Resident 1's abdomen. The DON stated the importance of documenting the full assessment when Resident 1 had a COC (5/6/2025) was so that all staff were aware of what [treatment] was done for Resident 1. The DON stated if documentation was missing it affected the residents' care. The DON stated that clinical documentation can greatly impact care because of the feedback in assessment and how that information is relayed to the physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Charting and Documentation, revised 7/2017, the P&P indicated that all services provided to the resident, progress towards the CP goals, or changes in the resident's medical, physical, functional pr psychosocial condition, shall be documented in the resident's medical record. The P&P the medical record should facilitate communication between the Interdisciplinary Team (IDT, a team of health care professions who work together to establish plans of care for residents) regarding the resident's condition and response to care. The P&P indicated objective (not opinionated or speculative) observations, medications administered, treatments or serviced performed, changes in the resident's condition, events, incidents or accidents involving the resident, and progress toward or changes in the CP goals and objectives were to be documented in the medical record. The P&P indicated documentation in the medical record will be objective, complete, and accurate. The P&P indicated documentation of procedures and treatments would include care-specific details including the assessment data and/or any unusual findings obtained during the procedure/treatment and how the resident tolerated the procedure/treatment. During a review of the facility's P&P titled, Change in a Resident's Condition or Status, revised 2/2021, the P&P indicated the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.