STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065431	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Centerplace, Llc, The	4356 24th St Rd Greeley, CO 80634

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50315

Based on record review and interviews, the facility failed to honor resident choices for one (#7) of three residents reviewed out of eight sample residents.

Specifically, the facility failed to provide Resident #7 a shower schedule based on her preferences.

Findings include:

I. Facility policy and procedure

The Showers policy and procedure, revised 2/9/23, was received from the nursing home administrator (NHA) on 2/14/25 at 3:13 p.m. It documented in pertinent part, Patient preferences must be initiated and complied with. Showers are to be completed on the designated shower schedule or patient modified shower schedule. Patient refusals must be progress noted, educated, family notified if indicated and care planned.

II. Resident #7

A. Resident status

Resident #7, age 79, was admitted on [DATE]. According to the February 2025 computerized physician orders (CPO), diagnoses included pneumonia (infection in the lungs), respiratory failure, muscle weakness and atrial fibrillation (abnormal heart rhythm).

The 2/3/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) score of nine out of 15. The resident required maximal assistance with toileting and dressing and partial assistance for transfers.

B. Resident interview

Resident #7 was interviewed on 2/11/25 at 3:05 p.m. She said she had been at the facility for a couple weeks and was only getting one shower a week. She said showers made her feel refreshed. She said she mentioned to a staff member that she would like to shower more often, but nobody followed up. She said she would like a shower at least twice a week.

(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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Record review Resident #7's shower care plan, revised 2/9/25, identified that she preferred showers and her bathing frequency was twice weekly on Tuesdays and Fridays during day shift. The shower documentation from 1/15/25 to 2/12/25 revealed Resident #7 did not receive a shower on her scheduled shower days on 1/28/25, 1/31/25, 2/7/25 and 2/11/25. She received a shower on four out of eight opportunities. D. Staff interviews Occupational therapist (OT) #1 was interviewed on 2/13/25 at 11:09 a.m. She said sometimes the occupational therapy department gave residents their showers. She said the occupational therapy department had not given Resident #7 any of her showers. She said physical therapy did not give resident showers. The assistant director of nursing (ADON) and the regional clinical director (RCD) were interviewed on 2/13/25 at 11:38 a.m. The ADON said the facility tried to accommodate the resident's shower preferences as best as they could. She said the facility assigned showers on the residents preferred shower days under tasks for the certified nurse aides (CNA). She said if a shower was not given, the nursing staff needed to reproach the resident later in the day and offer the shower again. She said if the resident refused or was out of the building, the staff should offer a shower the next day. She said it was expected to be charted if a shower was given or missed. CNA #2 was interviewed on 2/13/25 at 1:45 p.m. CNA #2 said if a resident refused a shower and the staff were not able to give the resident a shower, she would talk to the resident and try to convince them to take the shower. She said if the resident still refused, she said she would tell the nurse and the nurse would provide education to the resident. She said she would chart that the resident refused a shower.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43950 Based on record review and interviews, the facility failed to ensure residents received treatment and care consistent with professional standards of practice. This affected five (#1, #2, #5, #6 and #7) of six residents out of eight total sample residents. RESIDENT #1 Resident #1 was admitted to the facility from the hospital on [DATE]. His diagnoses included long-term use of anticoagulants (blood thinner). Orders included the anticoagulant Lovenox by injection, started [DATE] and discontinued [DATE], and Apixaban (Eliquis) an oral anticoagulant for deep vein thrombosis, started [DATE], discontinued [DATE], and ordered again on [DATE] to [DATE]. A review of the treatment administration record (TAR) revealed the November orders, starting [DATE], read in part, Anti-coagulation medication monitoring: monitor every shift for signs and symptoms of bleeding (black tarry stools, increased or new bleeding of gums, blood in urine, etc). If complications notify MD . -However, this order was discontinued on [DATE], and there was no documentation of anticoagulant monitoring on the resident's TAR from [DATE] to [DATE] - 26 shifts over 13 days. There was no documentation explaining why monitoring was discontinued and, the resident's care plan did not address anticoagulant therapy - the risks, signs/symptoms of bleeding, or monitoring expectations found on the TAR. In addition, the resident's record did not contain consent for the use of the anticoagulant medication Eliquis. On [DATE] at around 6:00 p.m., a certified nurse aide (CNA) found the resident with coffee-colored emesis and a dark bowel movement. The CNA reported the findings to the licensed practical nurse (LPN #1) who worked the night of [DATE] and the early morning of [DATE]. In an interview, the LPN stated Resident #1 had not previously had a dark bowel movement or coffee-colored emesis. The LPN called the assistant director of nursing (ADON) (the interim DON at the time). The ADON requested the registered nurse (RN) do a full assessment. After receiving the RN's report, the ADON contacted the physician around 10:30 p.m. and a decision was made to monitor the resident. -However, there was no documentation of the RN's full assessment in the electronic medical record or a change of condition assessment form. Per the nursing home administrator (NHA), no RN assessment note was completed. Further, there was no documentation explaining why the resident was not sent to the hospital which was the expectation for evidence of a new bleed per the ADON. Moreover, although the resident's primary care physician (PCP) documented the resident's MOST form (Medical Orders for Scope of Treatment) was revised on [DATE] and record review revealed an order entered that day for do not resuscitate (DNR), the revised MOST form could not be located during the survey, and the resident's care plan still read full code, initiated [DATE]. Resident #1 expired at the facility early in the morning on [DATE]. According to a note dated [DATE] at 4:47 a.m., the resident was checked at 4:00 a.m. and found without respirations or heart tones. The cause of death, according to the death certificate, was a presumed gastrointestinal bleed. RESIDENTS #2, #5, #6, AND #7 (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review and interviews revealed the facility failed to complete a change in condition assessment form when Resident #2 experienced low oxygen levels and was unresponsive; failed to care plan Resident #5, #6, and #7's anticoagulant use, and failed to have physician orders monitoring their anticoagulant use. Further, the facility failed to have documentation that consent was obtained for Resident #6's anticoagulant medication. SUMMARY The facility failed to properly address Resident #1's significant change of condition when the resident, who was receiving anticoagulant medication, began bleeding internally. The facility's failure to assess and monitor the resident's anticoagulant medication use and change in condition, failure to document changes, and failure to seek medical treatment, contributed to serious harm for Resident #1. The failures also created the potential for further serious resident harm if the facility's system for assessing, monitoring, and communicating changes was not immediately corrected. Findings include: I. Immediate jeopardy A. Findings of immediate jeopardy A review of Resident #1's anticoagulant use, monitoring records, and staff interviews revealed the facility failed to take steps, consistent with professional standards of practice, to promote Resident #1's well-being both before and upon the discovery of the resident's coffee-colored emesis and dark bowel movement on [DATE]. There was no evidence the facility thoroughly investigated the [DATE] incident to uncover and address why the nurses did not recognize the resident's change in condition, complete accurate assessments, and seek appropriate treatment. -Record review revealed no documentation of anticoagulant monitoring on Resident #1's treatment administration record (TAR) from [DATE] to [DATE] - 26 shifts over 13 days. Further, the resident's care plan did not address anticoagulant therapy - the risks, signs/symptoms of bleeding, or monitoring expectations found on the TAR. -Record review revealed no documentation of the RN's full assessment in the electronic medical record or a change of condition assessment form. Per the nursing home administrator (NHA), no RN assessment note was completed. There was no documentation explaining why the resident was not sent to the hospital which was the expectation for evidence of a new bleed per the assistant director of nursing (ADON). The facility's failure to implement an immediate and comprehensive review of the facility's system of anticoagulation management and of response to resident changes in condition, including the response to Resident #1's coffee-colored emesis and dark bowel movement, placed residents at risk for serious harm if the situation was not immediately corrected. B. Facility notice of immediate jeopardy (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On [DATE] at 4:30 p.m., the NHA, chief operating officer (COO), and director of nursing (DON) were notified that the facility's failure to identify and respond to Resident #1 change in condition created an immediate jeopardy situation. C. Facility plan to remove immediate jeopardy On [DATE] at 11:04 a.m. the facility submitted a final plan for removal of the immediate jeopardy situation. The plan read: The facility immediately completed the following: 1. Resident-centered care plan was created on [DATE] for all residents who currently received anticoagulant medications and will be completed by [DATE]. 2. Orders for on-going monitoring for anticoagulant medications were obtained from the providers on all residents who do not have orders on [DATE]. 3. An in-service was completed on [DATE] by the DON/designee to all licensed nursing staff who were in the building (phone call education for staff who were not in the building) to ensure that the facility performs adequate physical assessments for change of conditions, recognize changes and how to accurately and timely communicate the assessment findings to the physician on call. 4. An in-service was completed on [DATE] by the DON/designee to all licensed nursing who were in the building (phone call education for staff who were not in the building) to ensure that they analyze the situations for when to send residents to the hospital, with background information, assessments and recommendations with a timely, consistent and accurate process. 5. Education will be provided to all nursing staff prior to the start of their shift. All residents have the potential to be affected by this alleged deficiency. All residents in the building were reviewed for change of condition and none of the other residents were affected by this deficient practice. The DON or their designee will oversee the compliance with the resident-centered care plan and ensure continuous monitoring of anticoagulant therapy. This monitoring will include staff performance of thorough physical assessments for changes in resident conditions, timely recognition of these changes, and the accurate and prompt communication of assessment findings to the on-call physician. Additionally, the monitoring process will ensure that nursing staff appropriately analyze situations where hospitalization may be necessary, including completing timely and accurate background information, assessments, and recommendations. Monitoring will start on [DATE] and will follow the schedule below: Daily for one week, Weekly for four weeks, Monthly for two months, or until substantial compliance is achieved. (continued on next page)

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F 0684

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

D. Removal of immediate jeopardy

Based on the facility's plan above and evidence of its implementation, the immediate jeopardy situation was removed on [DATE] at 12:40 p.m. However, the deficient practice remained at a G level, isolated actual harm.

II. Professional references and facility expectations

A. Professional references - Anticoagulant risks

1. The National Library of Medicine, Anticoagulant Safety, updated [DATE], retrieved on [DATE] at Amaraneni A, Chippa V, [NAME] J, et al. Anticoagulation Safety. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK519025/, read in pertinent part:

Millions of patients rely on oral anticoagulants to decrease the risk of ischemic stroke and other thromboembolic events, underscoring the importance of understanding their safety profiles. However, these medications rank among the leading causes of emergency department visits and hospital admissions among older adults, prompting classification as high-alert medications by the Institute of Safe Medication Practices and a focus on harm reduction in The Joint Commission's National Patient Safety Goals. Still, the benefits outweigh the overall risks for most patients. The initial weeks of oral anticoagulant use pose the highest risk of adverse effects, particularly during transitions from hospital to home care, necessitating careful management as patients recuperate.

Despite their efficacy in preventing and treating thromboembolism, all anticoagulants elevate the risk of bleeding. Clinicians must carefully assess each agent's risks and benefits, tailoring medication choices accordingly.

Adverse effects often stem from concurrent use of antiplatelet medications, dosing errors, or inadequate monitoring, underscoring the importance of healthcare professionals' knowledge about potential complications like intracranial and gastrointestinal bleeding, hematoma formation, and available reversal agents. Accurate assessment of bleeding risks and prescribing appropriate doses is essential for maximizing clinical benefit.

Symptoms of significant bleeding vary by site, and early symptoms include epistaxis, gum bleeding, heavy menstrual bleeding, or excessive bruising. Airway-related hematomas may cause sore throat, painful or difficult swallowing, nosebleeds, shortness of breath, or hemoptysis. Extremity involvement may manifest as pain, swelling, weakness, or limited motion. Intraabdominal bleeding can lead to pain and distension, while intracranial bleeds may cause severe headaches, vomiting, dizziness, or seizures. Ocular bleeding may result in vision changes. Gastrointestinal bleeding may present as melena, hematochezia, or hematemesis. Gastrointestinal signs: Patients may have evidence of hypovolemia manifesting as tachycardia and hypotension, visible or occult blood in the stool, and pain on abdominal examination.

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Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Healthcare professionals must swiftly determine the severity and location when assessing bleeding complications in patients taking oral anticoagulants. A comprehensive history and medication review are crucial, documenting the anticoagulant regimen, last dose timing, and potential overdose risk. In addition, exploring the history of renal or hepatic disease, bleeding disorders, thrombocytopenia, and medications affecting hemostasis is necessary. Understanding the anticoagulation indication and thrombosis risk aids treatment decisions.

Enhancing patient-centered care, outcomes, safety, and team performance in anticoagulation management requires a multifaceted approach involving physicians, advanced practitioners, nurses, pharmacists, and other healthcare professionals. Physicians and advanced practitioners should demonstrate strong clinical skills in risk assessment, medication selection, and dosage determination while effectively communicating with patients to involve them in treatment decisions. Nurses play a crucial role in monitoring patients, educating them about adherence and lifestyle changes, and promptly recognizing and managing complications. Pharmacists contribute by conducting medication reviews, assessing drug interactions, and ensuring appropriate care transitions.

Effective interprofessional communication, supported by clear documentation, is essential for coordinating care and minimizing errors. Care coordination involves developing standardized protocols, guidelines, and pathways for anticoagulation management across various settings, ensuring seamless transitions and optimizing patient outcomes. By leveraging their skills, communication, and coordination, healthcare teams can collectively enhance anticoagulation safety and improve patient care and outcomes.

2. Eliquis package insert ([DATE]) was retrieved on [DATE] from chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.accessdata.fda.gov/drugsatfda_docs/label/,d+[DATE]s034lbl.pdf. It revealed in pertinent part,

Eliquis increases the risk of bleeding and can cause serious, potentially fatal bleeding. Advise patients of signs and symptoms of blood loss and to report them immediately or go to an emergency room .

B. Facility expectations

The facility's Change of Condition policy, reviewed [DATE], was provided by the NHA on [DATE] at 12:36 p.m. It read in pertinent part:

As part of the evaluation the nurse will help identify individuals for having any changes of condition during their stay or if a patient has a fall.

In addition, the nurse shall evaluate and document/report the following: Vital signs; Difficulty speaking; Difficulty understand(ing) speech; neurological abnormalities; recent labs; all active diagnoses; cognitive and emotional status; change in mental status and LOC (level of consciousness).

Direct care staff to notify nurse if they notice subtle, but significant changes in the patient: For example: Decrease in food intake; Increase confusion/agitation; Change in vital signs etc; Change in balance; Injury from fall; Change in neuro's (neurological findings).

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Resident #1's hospitalization history: admitted to the hospital on [DATE] with global weakness and dysarthria. The patient was then discharged from the hospital to the skilled nursing facility on [DATE]. The patient transferred to the emergency room (ER) on [DATE] for concerns of developing sepsis, diagnosed with COVID, and sent back to the facility. The resident transferred to theER on [DATE] for liver function testing, increasing lethargy, and worsening pulmonary symptoms. Urinary tract infection (UTI) diagnosed in the ED (emergency department). The resident was transferred to theER on [DATE] and [DATE] due to feeding tube issues. The feeding tube was unclogged and the patient was sent back to the facility. -Goals of care discussion held [DATE] with the resident and his wife through an interpreter over the phone who speaks Chuukese (arranged per facility administration). Explained in detail numerous medical issues that the patient was currently dealing with. Explained in detail that given the multitude of issues as well as progressive worsening in weakness and failure to improve with therapy that it was unlikely that patient will improve from a therapeutic standpoint in regards to his stroke. Explained that he will likely never swallow again, he will likely never walk again, and will be dependent on others for the remainder of his life. Also explained given the multitude of issues affecting multiple organ systems that further worsening of such is likely to occur and that rehospitalization was certain in his future. -We discussed CPR (cardiopulmonary resuscitation) at length, what it entails, what that would look like for Resident #1 and possible outcomes of such. After answering questions, the wife decided that CPR/intubation would not likely be in the patient's best interest and instead DNR would be more appropriate. New MOST form filled out and filed. A bedside nurse was present in the room for the entire discussion. All questions answered. 2. Events [DATE] and [DATE] An [DATE] nursing progress note revealed Resident #1 was changed at the beginning of the shift (6:00 p.m.) by a certified nurse aide (CNA). When Resident #1 was rolled to his right side, the resident had vomited coffee ground emesis. Resident #1 was cleaned up and the nurse was notified. Resident #1's brief was changed and found to have a dark bowel movement. A call was made to the DON. A full assessment was completed by the registered nurse (RN) in the building and notified the DON of the results. The DON called the provider and he gave the following orders: One time order of 30ML of first-lansoprazole oral suspension 3 MG/ML (Lansoprazole) (a medication that reduces acid in the stomach). Vital signs every four hours and if systolic blood pressure was less than 100 or heart rate greater than 100 to call the provider. The [DATE] at 4:47 a.m. death note revealed the DON had called the provider at approximately 10:30 p.m. and he gave the following orders: One time order of 30ML of First-Lansoprazole Oral Suspension 3 MG/ML (Lansoprazole.) Vital signs every four hours. If Systolic is less than 100 or HR (heart rate) is greater than 100 call the provider. Vitals just after midnight: Blood pressure ,d+[DATE], Temperature 98.1, Pulse 100, Respirations 19, O2 (oxygen saturation) 90%. The resident was checked on at 2:00 a.m. and had no changes to note. At 4:10 a.m. the staff went in to check on the resident and complete vital signs and the patient had no respirations or heart tones. Eyes were fixed and dilated. RN assessed patient for the final outcome. The patient was a DNR. Time of pronouncement of death: 4:10 a.m. per on-call physician. Body not sent anywhere at this time. Wife in room and would gather belongings. Skin condition upon death: intact. Responsible party notification: Wife in attendance in room. MD Notification: On-call notified at 4:20 a.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	C. Record review and interviews revealed the facility failed to ensure Resident #1 received treatment and care consistent with professional standards of practice. The DON was interviewed on [DATE] at 5:28 p.m. The technician at the local county coroner's office was interviewed on [DATE] at 10:08 a.m. Resident #1's PCP was interviewed on [DATE] at 10:19 a.m. The ADON was interviewed on [DATE] at 1:11 p.m. The NHA was interviewed on [DATE] at 2:47 p.m. and LPN #1 was interviewed on [DATE] at 5:42 p.m. 1. Failure to properly manage Resident #1's anticoagulant therapy a. Record review Although the resident's TAR revealed an order for anti-coagulation medication monitoring every shift for signs and symptoms of bleeding (see above), this order was discontinued on [DATE]. There was no explanation for discontinuing monitoring for evidence of bleeding, and a review of the TAR and the resident's electronic medical record revealed no documentation of anticoagulant monitoring from [DATE] to [DATE] - 26 shifts over 13 days. Although there are significant risks to resident safety from anticoagulants (see references above), a review of the resident's care plan revealed it did not address anticoagulant therapy - the risks, signs/symptoms of bleeding, or monitoring expectations found on the TAR. Finally, the resident's record did not contain consent for the use of the anticoagulant medication Eliquis. b. Interview ADON: The assistant director of nursing (ADON) said if a resident is on an anticoagulant, the nurses should be monitoring for signs and symptoms of bleeding, evaluating the resident if signs of bleeding are reported by staff, and documenting the evaluation. The ADON said it was important to monitor if a resident uses anticoagulant medication for the very reason with Resident #1 of a gastrointestinal bleed. The ADON said without monitoring, there could be abnormal labs, leading up to and including death. The ADON said there should be a care plan for all residents using an anticoagulant medication so that staff providing care were aware. PCP: The PCP said if a resident was on an anticoagulant medication such as Eliquis, there should be monitoring and documentation of symptoms of bleeding. The PCP said it went without saying how important it was because healthcare providers worry about the ongoing risk of hemorrhage. 2. Failure to properly manage Resident #1 change of condition a. Interviews DON: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Center at Centerplace, Llc, The		STREET ADDRESS, CITY, STATE, ZIP CODE 4356 24th St Rd Greeley, CO 80634	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The DON, who assumed her position on [DATE], said she did not know why Resident #1 was not sent to the hospital when he had signs and symptoms of a gastrointestinal bleed. ADON: The ADON said she was the nurse on-call and acting as the interim DON during the evening on [DATE] and early morning on [DATE]. She said it was her understanding that Resident #1's bleeding was not new and that he had gone to the hospital multiple times with the same issue. She said this was reported to her from the staff that evening. She said on the night of [DATE], she got a call from LPN #1 and she spoke to the RN in charge who made it sound like, and confirmed, that the resident had gone out to the hospital multiple times for the same issue (coffee ground emesis and dark stool) and it sounded like a recurrent issue in the way it was presented. She said typically, if it was a new bleed, the resident would be sent out immediately and per protocol, a change of condition assessment form completed. The ADON confirmed she did not have an RN assessment for Resident #1 or a completed change of condition assessment form. The ADON said she called the on-call physician and told him it was reported the resident had abdominal distension, that the resident had received both doses of his anticoagulant, and that the resident had coffee-ground emesis and dark-colored bowel movement. She said the physician was made aware of the bleeding, but told it was a frequent event, not a new event. He was informed the resident's status had changed to DNR, the wife was at the bedside and it was reported to her the wife did not push to send the resident to the hospital but did not say either way. The ADON said the action decided on by the physician was to give Prevacid (a medication that reduces acid in the stomach), check vitals every four hours with parameters of when to notify the provider, and ordered a CBC but not stat (right now). It was not obtained before the resident expired. The ADON said at the time of the incident she agreed with the provider, but with what she knew now, that the bleeding was a new issue, her decision would have been different and she would have recommended sending Resident #1 to the hospital. PCP: The PCP said if there was a change in condition, such as increased bleeding, nose bleeds, vomiting blood, or gastrointestinal bleeding, she would want to be notified. The PCP said the facility should know to contact her or call 911. The PCP said if there was no documentation stating otherwise, a resident with new significant bleeding should be sent to the hospital for further monitoring and evaluation. The PCP said she saw Resident #1 on [DATE] before taking time off. When she returned to work, she asked what happened in reference to the resident's death. The PCP said she thought Resident #1 should have been sent to the hospital. She said that although she was not the provider who was covering that day, whenever she heard about a gastrointestinal bleed and the resident was on an anticoagulant medication, they should go to the hospital. NHA: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The NHA said Resident #1 spoke a rare language, Chuukese (a language spoken in the Federated States of Micronesia). The NHA said the resident had been sent out to the hospital a couple of times in [DATE]. The NHA said his understanding about what had occurred with Resident #1 was that the resident's wife had said no - the resident did not want to be sent out. He said the ADON called and told him the resident's clinical indicators were decreasing and told him they were going to send the resident out but the wife said no. The NHA said an interpreter was not present. The resident's wife spoke some English; however, he acknowledged there was no documentation of the resident's wife saying no to hospitalization . He said he found out that Resident #1 had passed away the next morning. LPN #1: LPN #1 said she had worked at the facility for one year and was the nurse who was working on the night of [DATE] and early morning of [DATE] with Resident #1. LPN #1 said that Resident #1 had a lot going on and the doctor during the day came in and that was the report she got. LPN #1 said Resident #1 had a lot of congestion going on and breathing was loud. LPN #1 said when she first checked on him, his tube feeding was going and he was sitting up. LPN #1 said the CNA told her of Resident #1's dark bowel movement and coffee-colored emesis but the CNA did not show it to her. LPN #1 said Resident #1 had not had a dark bowel movement or coffee-colored emesis before. LPN #1 said the RN had come up to the third floor from the second floor to assess him. LPN #1 said the bleeding was new as far as she was concerned. LPN #1 said she did not speak to the doctor. She called the ADON (interim DON at the time) who said to have the RN do a full assessment and call her back and then she (ADON) would call the doctor. LPN #1 said after that, the RN called the ADON back to give her a report. LPN #1 said she did not remember what the RN said after the assessment. LPN #1 said basically, the RN found nothing wrong and she asked the RN if she thought Resident #1 should be sent out and the RN said no, that she had talked with the ADON. LPN #1 said she was told to call the ADON with any change of condition, and before calling a provider or sending a resident out to the hospital. LPN #1 said she had tried to call the daughter but she had not answered. LPN #1 said she felt that Resident #1 should have gone to the hospital but she deferred to the RN and ADON (interim DON at that time). County coroner technician (CCT): The technician at the local county coroner's office said Resident #1's actual cause of death as listed on the death certificate was presumed gastrointestinal bleed caused by gastric ulcers as recorded by Resident #1's PCP. b. Record review (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There was no documentation of the RN's full assessment on [DATE] in the electronic medical record or a change of condition assessment form, and, per the NHA, no RN assessment note was completed. There was no documentation why the resident was not sent to the hospital, which was the expectation for a new bleed per the ADON. On [DATE] at 12:21 p.m., the RN assessment for the [DATE] event was requested. On [DATE] at 1:50 p.m., the NHA responded that an RN assessment note was not completed and the RN had been terminated. The Change of Condition policy (see above) was not reviewed or revised following the events on [DATE] that revealed nursing staff failed to fully evaluate, document, and report Resident #1's change in condition. A review of the policy revealed it was last reviewed [DATE], per the Change of Condition document provided by the NHA. Printed on the Change of Condition policy document was the issuing date ([DATE]), a revised date ([DATE]), a revised date ([DATE]), and a reviewed date ([DATE]). (Department of Nursing) A review of the electronic medical record revealed there were no physician orders to send Resident #1 to the hospital. 3. Failure to take steps to clarify Resident #1 and their representative's goals for care to ensure a response consistent with their goals. a. Record review The [DATE] PCP follow-up visit to discuss goals of care (see above) indicated a new MOST form that documented Resident #1 would be a DNR (do not resuscitate) was filled out and filed. Further, the resident's record revealed an order was written with a start date of [DATE] that read Resident #1 was a DNR (do not resuscitate)/No code. -Notwithstanding the PCP note and order above, the new MOST form (or copy), requested from the NHA on [DATE] at 4:22 p.m., could not be located as of [DATE] according to the NHA. -Notwithstanding the PCP note and order above, a review of Resident #1 care plan was not updated and read the resident was a full code, initiated on [DATE]. b. Interviews DON: The DON said she did not recall anything about Resident #1's MOST form. However, she said it should have been scanned into t[TRUNCATED]

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43950 Based on interviews and record review, the facility failed to ensure an effective quality assurance program to identify and address facility compliance concerns was implemented, in order to facilitate improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life and resident safety. Specifically, the quality assurance performance improvement (QAPI) program committee failed to identify and address concerns related to quality of care by not sending a resident to the hospital when indicated that rose to the level of immediate jeopardy and created a situation where a serious adverse outcome occurred and caused harm. Findings include: I. Facility policy and procedure The Quality Assurance and Performance Improvement (QAPI) policy, revised 2/11/25 (during the survey), was provided by the nursing home administrator (NHA) on 2/13/25 at 1:17 p.m. It read in pertinent part, It is the policy of the facility to develop a QAPI plan in accordance with Federal guidelines to describe how the facility will address clinical care, residents' quality of life and residents' choice and is based on the scope and complexity of services defined by the facility assessment. Objective of the QAPI improvement policy: The objective of this requirement is the completion and implementation of the QAPI plan to identify the high risk, problem prone and high volume areas to evaluate for improvement and identify, collect and use data relevant to the unique characteristics and needs of the residents. II. Cross-reference citation Cross-reference F684: The facility failed to provide quality care by not sending a resident to the hospital when indicated, resulting in the death of the resident. The facility's failure to provide quality of care put residents in a situation where a serious outcome occurred and created an immediate jeopardy situation. III. Staff interviews The medical director (MD) was interviewed on 2/12/25 at 3:53 p.m. The MD said he was not informed of the immediate jeopardy. However he said the NHA was out of the facility last night and today (2/11/25 and 2/12/25). The MD said he was in the facility at least two times per month. The MD said he attended QAPI committee meetings regularly. The MD said he had been the medical director since the facility was initially built. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The MD said he was not aware there was a quality of care issue by not sending residents to the hospital when indicated, resulting in a death due to a GI (gastro-intestinal) bleed. Nor was he aware of any quality of care problems related to anticoagulant monitoring, care plans or obtaining consents for anticoagulant use. The MD said the prior administrators may have discussed the issues before, however he said it had not been discussed in QAPI recently. The MD said he was frustrated with the high turnover rate with staff and leadership at the facility and felt more stability would improve the quality of care for residents. The NHA was interviewed on 2/13/25 at 1:49 p.m. The NHA said the QAPI committee met monthly and included every department. The NHA said he was new to the facility as of October 2024. The NHA said he established a pre-QAPI preparation to talk about follow up from previous QAPI meetings. He said all departments discussed what was going on, such as falls, wounds, grievances, resident council and staffing concerns. The NHA said the QAPI committee included more than all the required members and they all knew if a corrective action had been implemented. The NHA said quality of care with change of condition documentation and when decisions were made to send to the hospital would be discussed moving forward and added to QAPI.