STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165274	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Mahaska Specialty Care	2401 Crestview Drive Oskaloosa, IA 52577

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, diet spreadsheet/menu review, resident diet type report, staff interviews, policy review, and the Simplified Diet Manual the facility failed to serve the appropriate portions for 3 of 3 residents who received pureed diets (Resident #19, #33 and #49) and 1 of 1 resident served only pureed meat (Resident #29). The facility staff also failed to serve the appropriate portion size of meat for 10 of 11 residents on a mechanical soft diet (Resident #7, #8, #27, #30, #37, #38, #42, #55, #58, #67 and #68). The facility reported a census of 78 residents. Findings include:1. The facility's Cycle Day 4 Diet Spreadsheet identified one (1) serving of a deviled pork chop, 1 serving of squash, and 1 serving of a wheat roll to be served as part of the planned pureed textured diet for the lunch meal served on 9/24/25.The facility's Cycle Day 4 Diet Spreadsheet identified a 3 ounce (oz.) of deviled pork chop to be served as part of the planned mechanical soft textured diet for the lunch meal served on 9/24/25.The facility's Diet Type Report revealed three (3) residents on a pureed texture diet, 1 resident on pureed meat, eleven (11) residents on a mechanical soft textured diet plus two (2) residents on a regular diet with ground meat. During observations on 9/24/25 at 11:31 AM, Staff B, Dietary Cook, placed six pork chop patties and some broth into a Robot Coupe container and blended the contents together. Staff B added more broth and continued to blend the contents together. At 11:35 AM, Staff B poured the pureed contents into a metal pan, covered the pan with foil, and placed the pan into a steam oven. On 9/24/25 at 12:03 PM, Staff B placed six 4 oz. scoops of squash into a Robot Coupe container, added broth and blended the contents together. Staff B poured the pureed squash into a measuring cup and reported there was a total of 4 cups. Staff B checked the pureed serving chart located on the wall. Staff B reported since she made six servings and with the total amount of pureed contents pureed, she would use a #6 scoop (the equivalent of 5 1/3 oz.) when she served the pureed entree to the residents on a pureed diet. Observation of the lunch meal service on 9/24/25 starting at 12:11 PM revealed 10 of 11 residents on a mechanical soft diet received the ground pork chop and 3 of 3 residents received the pureed pork chop and pureed squash. The residents on a pureed diet did not receive a wheat roll (or bread) as indicated on the Diet Spreadsheet. On 9/24/25 at 1:24 PM, Staff B reported food plated for the last resident. Staff B checked the scoop handles and reported the scoop size used for each entree served: a. One green (#12) scoop of pureed squash, the equivalent of 2 1/2 to 3 oz. b. One gray (#8) scoop of pureed pork, the equivalent of 4 to 5 oz. c. One blue (#16) scoop of ground pork, the equivalent of 2 oz. In an interview on 9/24/25 at 1:31 PM, Staff B, Cook, reported she looked at the Diet Spreadsheet and checked the entrees and scoop sizes to determine what size scoop to serve the residents. Staff B reported she looked at the pureed serving chart posted on the wall (in the kitchen) to determine the scoop size to serve for the pureed entrees. Staff B reported she also checked the ounces listed on the scoop handle. In an interview 09/24/25 at 4:30 PM, the Dietary Manager (DM) reported staff used the Therapeutic Diet Spreadsheet to know what serving size to serve to the residents. If the serving size showed 1/2 cup, then she looked at the bottom of the therapeutic spreadsheet to look for 1/2 cup and determined the proper scoop size to use. For example, 1/2 cup would be a 4 oz ladle or scoop. The DM looked at the Diet Spreadsheet for Cycle Day 4 for the Lunch meal and reported a pureed pork serving equaled one (continued on next page)

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	serving. The DM reported staff needed to check the pureed portion serving chart posted in the kitchen to know the scoop size to serve for pureed entrees. The DM explained the process for determining the scoop size for pureed entrees. Staff pureed the entree, poured the contents into a measuring cup, then matched the amount in the measuring cup and the number of portions to determine the scoop size to use and serve for that entree. The DM reported three residents on a pureed diet and one resident got only the pureed meat. The DM reported she expected bread added to the meat whenever the entree was pureed. The DM reported there were about 13 residents on a mechanical soft diet but she added 2 extra portions so they had enough. The mechanical soft serving size was the same as the residents on a regular diet. The facility's undated Pureed Food Preparation Policy and Procedure revealed a resident on a pureed diet will receive the same items as the regular diet. All residents on a pureed diet shall receive the correct portions of pureed meat, starch, fat and vegetable. The policy revealed the following steps: a. The correct number of portions (plus 1-2 extra servings) are added into the Robot-Coupe. b. Liquids of nutritive value such as broth are added when pureeing.c. Bread and butter as planned on the menu may be added to the mixture. 1/2 of the bread and butter in the meat and 1/2 in the vegetable is suggested if the bread is not pureed separately. d. Scrape the pureed mixture from the Robot-Coupe into a measuring device to determine the total volume. e. Determine the scoop size. 2. The Electronic Health Record (EHR) Medical Diagnoses list revealed Resident #84 had diagnoses of Gastroesophageal Reflux Disease (GERD), diabetes, and postprocedural complications and disorders of the digestive system. The Care Plan revised 6/12/25 revealed the resident was at risk of altered nutritional status related to GERD and diabetes. The care plan directed staff to provide meals that are within his diet. The EHR under the Orders section revealed a clear liquid diet for abdominal distention. An order for clear liquid diet until x-ray results were received and evaluated started on 9/24/25 at 8:00 AM and had an end date of 9/26/25. The Progress Notes revealed the following: a. On 9/23/25 at 11:30 PM, resident said he wanted to go to the hospital because he believed his bowels are shutting down like the last time he was here (at the facility). Abdomen (ABD) slightly firm. He had a small emesis after supper. Spoke with ARNP (nurse practitioner). New order received for a mobile ABD x-ray in the morning. b. On 9/24/25 at 9:05 AM, new order for a two-view abdominal x-ray for constipation. Clear liquid diet ordered until the results were received and evaluated. During observation on 9/24/25 at 12:27 PM, Staff B, Cook, began to plate food for the 100 Hall room trays. Staff B reported Resident #84 was on a clear liquid diet. This was a new order that started today and it was not listed on the diet report yet. At the time, Staff C, dietary aide, asked Staff B if it was ok to give applesauce to the resident on a clear liquid diet. Staff B said yes. Staff C placed the container of applesauce on the tray for Resident #84. During observation on 9/24/25 at 12:45 PM, a surveyor observed a tray that contained beverages and a container of applesauce on Resident #84's bedside table. The resident's meal ticket indicated he was on a clear liquid diet. At 12:46 PM, Staff L, certified nursing assistant, stated Resident #84 was on a clear liquid diet. The surveyor inquired if applesauce was on a clear liquid diet. Staff L stated she was not sure if applesauce was ok to give to a resident on a clear liquid diet. The surveyor requested Staff L to double check whether applesauce could be given to someone on a clear liquid diet. In an interview on 9/24/25 at 1:31 PM, Staff B, Cook, reported the nurse brought a sheet with items that could be given to a resident on a liquid diet so dietary staff knew what to serve. Staff B relayed she knew what could be given to a resident on a liquid diet and didn't need to look at the list because she had worked as a cook for a couple of years. In an interview 9/24/25 at 4:30 PM, the DM reported they had received an order for a clear liquid diet for a resident today (9/24/25). The nurses provided dietary staff a list of items of what could be provided for a resident on a clear liquid diet. She had a list of things that could be given but couldn't find it. The DM confirmed that applesauce would not be considered a clear liquid. The DM reported she referred to the Simplified Diet Manual on page 69-70 for a list of clear liquid items that could be provided to someone on a clear liquid diet. The Daily Menu for a Clear Liquid Diet revealed beef or chicken broth, apple juice, gelatin, popsickles, and hot or iced (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tea. The clear liquid diet did not list applesauce. The Simplified Diet Manual 13th Edition used by healthcare facilities to assist in planning meals modified to meet current science-based diet recommendations for individuals with special health needs. The manual revealed recommendations for a clear liquid diet. A clear liquid diet focused on see-through liquids like water, clear fruit juices (apple, white grape), clear broths, sports drinks, and gelatin. The clear liquid diet prohibited pulp such as all juices and beverages with pulp.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, policy review, and guidance from the Centers for Disease Control and Prevention (CDC), the facility failed to implement infection control practices consistent with CDC guidelines pertaining to COVID precautions and Enhanced Barrier Precautions to prevent cross contamination by staff failing to wear proper Personal Protective Equipment (PPE) during routine cares for 2 out of 4 halls (Residents #16, #23, #29 and #44). The facility also failed to perform hand hygiene after catheter care for 1 of 2 residents with catheters (Resident #44). The facility reported a census of 78 residents.Findings include:1. The Care Plan initiated 09/8/25 for Resident #16 indicated she was in isolation for COVID-19 infection. The Care Plan lacked information on the type of isolation. The Care Plan also indicated to follow CDC guidelines and recommendations. The Care Plan initiated 07/30/25 for Resident #29 indicated he was in isolation for COVID-19 infection that resolved on 09/23/25. The Care Plan lacked information on the type of isolation. The Care Plan initiated on 02/14/25 for Resident #23 indicated she was in isolation for COVID-19 infection. The Care Plan lacked information on the type of isolation. The Care Plan also indicated to follow CDC guidelines and recommendations. The Electronic Health Record (EHR) revealed that Resident #16 had an order dated 09/21/25 for droplet isolation precautions 09/21/25-10/1/25. The Electronic Health Record (EHR) revealed that Resident #29 had an order dated 09/15/25 for contact isolation precautions 09/23/25. The Electronic Health Record (EHR) revealed that Resident #23 had an order dated 09/18/25 for droplet isolation precautions 09/18/25-09/28/25. During an observation on 09/22/2025 at 12:21 PM a room tray delivery to room [ROOM NUMBER] showed Certified Nursing assistant (CNA) dons gown, gloves, and surgical mask and receives a room tray from nursing students. She then knocks and enters resident's room and closed the door behind her. At 09/22/2025 12:26 PM the CNA exits room and had removed her PPE removed. During observation on 09/22/25 at 2:20 PM, a Droplet Precautions and an EBP sign was posted on the wall outside Resident #16's room. A plastic bin with drawers had gowns, surgical masks, and gloves inside. At 2:24 PM, the lid of the red trash bin in Resident #16's room was propped open and the red trash bin was overflowing with used PPE (gowns, gloves and masks). One gown and mask were lying on the floor by the trash bin. At 2:30 PM, a male CNA reported Resident #16 had COVID. During an observation on 09/22/2025 at 3:15 PM room [ROOM NUMBER] was noted to have an EBP sign and a Droplet precaution sign outside of the door. A plastic 3 drawer container was also outside the room containing CaviWipes 2.0, surgical masks, gowns, face shields and gloves. No N95 masks were noted in the container. The Droplet precaution sign indicated that everyone must: Clean their hands, including before and entering and when leaving the room. Additionally, make sure their eyes, nose and mouth are fully covered before room entry and remove face protection before exiting the room. During an observation on 09/22/2025 at 3:18 PM Staff K, CNA entered room [ROOM NUMBER] (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wearing surgical mask, face shield, gown and gloves. An EBP sign and a Droplet precaution sign were noted outside of the door. The Droplet precaution sign indicated that everyone must: Clean their hands, including before and entering and when leaving the room. Additionally, make sure their eyes, nose and mouth are fully covered before room entry and remove face protection before exiting the room. There was also a plastic container outside the door containing gloves, gowns, face shields and surgical masks. No N95 masks were noted to be in container. During on observation on 09/22/2025 at 3:52 PM room [ROOM NUMBER] had a droplet precautions sign outside of the door. The Droplet precaution sign indicated that everyone must: Clean their hands, including before and entering and when leaving the room. Additionally, make sure their eyes, nose and mouth are fully covered before room entry and remove face protection before exiting the room. There was also a plastic container outside door containing gloves, gowns, face shields and surgical masks. No N95 mask were noted to be in container. During observation on 09/23/25 at 12:47 PM, Staff D, certified medication aide (CMA) wore a white hair covering and carried a beverage cup down the hall to Resident #16's room. Staff D sat the cup down and donned a gown, a face shield, and gloves and entered the room. At 1:05 PM, Staff D left Resident #16's room. Staff D no longer wore the gown, face shield or gloves but continued to wear the white hair cover. Staff D walked down the hall toward the dining room. At 1:08 PM, Staff D stood by the medication cart and looked at the computer and continued to wear the white hair covering. At 1:10 PM, Staff D removed white hair covering and threw it in the trash. During an observation on 09/23/25 at 12:54 PM the surveyor noted no signage on the front door indicating the facility was in outbreak status for COVID-19. During observation on 9/23/25 at 1:47 PM, a Droplet Precautions and an EBP sign were posted on the wall outside Resident #16's room. A plastic bin with drawers had gowns, surgical masks, and gloves inside. Staff E, Licensed Practical Nurse donned a gown, surgical mask, and gloves and entered the resident's room. Staff E did not wear an N95 mask or faceshield. At 1:56 PM, Staff E opened the door to the resident's room, removed the gown and gloves, then walked to the treatment cart and removed her surgical mask. During an observation on 09/25/25 at 7:43 AM room [ROOM NUMBER] and 215 had a new sign on the door indicating that it is a hot room and before entering the room to wear N95 mask, face shield or goggles, gloves and gown. During an observation on 09/25/25 at 8:16 AM the surveyor noted signage on the front door indicating COVID-19 outbreak. In an interview on 09/23/25 at 4:10 PM Staff F, CNA stated they found out Resident #16 had tested positive for COVID-19 on 09/22/25. Stated she was exposed as she took care of her. Added that she had not been asked about exposure, being tested or wearing source control. In an interview on 09/24/2025 at 7:32 AM Staff G, CNA stated she was not sure why the EBP sign on room [ROOM NUMBER] today but stated [NAME] tested positive for COVID on 09/18/25. Stated her roommate tested negative and is still testing negative. Added that she has not tested positive in the last 3 months. When questioned if she took care of Resident #23 without a mask for more than 15 minutes, Staff G, CNA stated she helped transfer at least twice and believed it was 15 minutes. Stated she was talked to about exposure and told to be wary of any symptoms. She was not advised (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to wear a mask for 10 days or to get tested. In an interview on 09/24/2025 at 12:01 PM Staff H, CNA stated resident in room [ROOM NUMBER] is COVID positive. Stated with COVID PPE needed would be glove, gown and surgical mask. Asked about eye protection and she stated they do not have face shields or goggles. Added that she has not been in that room or this hall before. When looking at signage outside of door, she stated she just knows to wear a gown but admitted it should probably be on the sign. In an interview on 09/24/2025 at 2:45 PM the Assistant Director of Nursing (ADON) stated that residents who have symptoms of COVID-19 should be placed in isolation, notify the physician and tested for COVID-19. She added that if a resident is positive for COVID, the doctor and family will be notified. The kitchen will also be notified. The ADON then stated they would be placed in isolation. Stated not sure what isolation sign is on the doors of the 3 positive residents as she did not put them up. When informed that droplet isolation signs were on the doors she stated they have a COVID sign that should have been used. Added that N95 masks should be worn in those rooms. Informed that no N95 masks are in the plastic containers. Stated they might have run out but should be using. Will restock with N95 masks as they are in the storage room. When questioned about contact tracing, the ADON stated she did not contact trace this time as Staff J, Corporate Nurse said to only test symptomatic staff and residents. Staff can wear masks if they want and are encouraged to wear face masks if they are negative. Stated not sure how long to wear and they cannot make the staff wear them. No contact tracing for residents or staff completed. In an interview on 09/25/25 at 11:11 AM with the ADON and Staff I, PA, the ADON stated they no longer follow the CDC guidelines on testing and masking as the CDC recommends and they do not have to adhere to recommendations. Also stated that this was a change in November of 2023. The surveyor reviewed that their policy dated November of 2023 indicated they should do testing and masking. The policy actually is almost verbatim to the CDC guidance. The surveyor pointed out that Quality Safety and Oversight (QSO)-20-39-Nursing Home (NH) revised 5/8/23 indicated that the CDC guidance on the core principles of COVID-19 should be adhered to at all times. Staff, I, PA stated that if Centers for Medicare & Medicaid Services (CMS) stated that they should then the need to follow the CDC guidance. In an interview on 09/25/25 at 12:35 PM with Staff J, Corporate Nurse and the Administrator, the Surveyor indicated the QSO-20-39-NH revised on 5/8/23 indicated that the CDC guidance on the core principles of COVID-19 should be adhered to at all times. The Administrator stated she wished it was easier to find then with all the links. Staff J, Corporate Nurse stated that she had no questions and that they would be looking at it. 2. The admission MDS assessment dated [DATE] revealed Resident #44 had diagnoses of renal insufficiency and diabetes. The MDS revealed the resident had an indwelling catheter. The Care Plan initiated on 8/20/25 revealed the resident had a urinary catheter and at risk for infection related to the catheter. The Care Plan directed staff to use Enhanced Barrier Precautions (EBP) whenever high-contact care activities were performed. The Electronic Health Record (EHR) under the Orders revealed an order created 9/11/25 for EBP's due to the catheter. During observation on 9/23/25 at 1:12 PM, Staff A, certified nursing assistant (CNA), entered (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and policy review, the facility failed to develop a comprehensive person-centered care plan to include pain for one of three residents reviewed (Resident #44). The facility reported a census of 78 residents. Findings include: The admission Minimum Data Set (MDS) comprehensive assessment dated [DATE] revealed Resident #44 admitted to the facility on [DATE]. The MDS revealed the resident had diagnoses of spinal stenosis, neuropathy and diabetes. The MDS recorded the resident took pain medication but had no pain in the past 5 days during the look-back period. The Care Area Assessment (CAA's) revealed pain not triggered. The MDS assessment was completed on 8/28/25. The Care Plan initiated 8/20/25 lacked information regarding the resident's pain and staff directives for pain management interventions. The admission Evaluation dated 8/20/25 revealed under Section F /Conclusion was marked no to the statement about the resident had new acute and/or chronic pain, used medication and/or non-pharmacological interventions for pain management. The Electronic Health Record (EHR) under the Orders section revealed the following: a. Check pain level every shift started on 8/20/25.b. Gabapentin 100 milligrams (mg) by mouth (PO) three times a day for pain started on 8/20/25. c. Lidocaine External Patch 5 % to bilateral lower extremities every shift for muscle spasms started on 8/20/25.d. Biofreeze Cool (topical analgesic)) to the back, abdomen, and thighs every 6 hours as needed (PRN) for muscle spasms. e. Orphenadrine Citrate Extended Release 100 mg PO two times a day for muscle spasms started on 9/3/25. f. Oxycodone 5 mg PO two times a day for spinal stenosis and give one tablet PO every 6 hours PRN for spinal stenosis started on 9/15/25. g. Diazepam 5 mg every 6 hours PRN for spasms started on 9/22/25.The Progress Notes revealed the following: a. On 8/28/25 at 3:52 AM, resident complained of muscle spasms in bilateral legs and abdomen. Diazepam given for muscle spasms. b. On 9/1/25 at 8:15 PM, resident rates pain to low back at 5. PRN APAP (Tylenol) given. c. On 9/9/25 at 1:16 AM, resident complained of intense sharp pain in lower back that traveled down her left leg. Pain medication requested at this time. d. On 9/13/25 at 9:03 PM, resident stated pain 10 out of 10. e. On 9/13/25 at 10:19 PM, follow up pain level was 7.f. On 9/15/25 at 12:00 AM, the resident had neuropathy, spinal stenosis and muscle spasms. She experienced severe spinal stenosis (back) pain that was particularly intense first thing in the morning. She also reported bilateral knee pain. The resident now used an electric wheelchair due to pain with ambulation. The resident expressed a desire to start on a pain pill. g. On 9/16/25 at 5:53 AM, resident complained of muscle spasms in her lower back. Diazepam PRN given h. On 9/17/25 at 8:29 PM, resident reported pain at 7. Scheduled oxy (oxycodone) given for pain. In an interview 09/24/25 at 5:10 PM, the MDS Coordinator reported she completed the residents' MDS assessments and care plans. She did an assessment, asking residents questions, and then developed the resident's care plan based on the assessment. She also looked at the orders to obtain additional information to determine things that were applicable to put on the care plan such as medications. The MDS Coordinator confirmed a focus area for pain should be included on the care plan. The facility's Comprehensive Person-Centered Care Plan policy revised 12/2016 revealed a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's needs is developed and implemented for each resident. The care plan will incorporate identified problem areas and describe the services to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The care plan is developed within seven days of completion of the comprehensive MDS assessment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northern Mahaska Specialty Care	2401 Crestview Drive Oskaloosa, IA 52577

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, policy review, American Heart Association (AHA) and Automated External Defibrillator (AED) Manufacture's Guide, the facility failed to provide sufficient nursing staff with the appropriate competencies and skill sets to provide nursing interventions, including the use of an AED and administering a shock on a conscious, breathing resident, for 1 of 3 residents (Resident #64) reviewed for a change of condition and hospitalizations. The facility reported a census of 78 residents. Findings include:Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #64's Brief Interview for Status (BIMS) of 6, indicating severe cognitive impairment with diagnoses of Coronary Artery Disease, Heart Failure, Non-Alzheimer's Dementia, Chronic Obstructive Pulmonary Disease (COPD), Anxiety, Depression, Schizophrenia, and health conditions of shortness of breath or trouble breathing when lying flat. Resident #64's The MDS also documented Resident #64 receives antipsychotic, antidepressant, anticoagulant (blood thinner) medications. Review of Resident #64's Electronic Health Recorded (EHR), revealed a Nurses Note dated [DATE] at 10:41 PM, by Staff N, LPN, a new order was received to send Resident #64 to Emergency Department (ED) for altered mental status. Temperature 102.9, blood pressure 80/66, pulse 165, oxygen 84% on room air. Review of the Change in Condition Evaluation dated [DATE] at 11:52 PM completed by Staff M, LPN, revealed the following document evaluation for Resident #64:a. Signs and symptoms: abnormal vital signs, fever, and shortness of breath. Most recent vital signs, blood pressure 80/66, pulse 250 beats per minute, regular pulse type. Respirations 24, temperature 102.9 and oxygen saturation 73% on room air. b. Evaluation of systolic blood pressure (top number) below 100, heart rate above 100, temperature above 100, suggested possible sepsis. c. Pertinent diagnoses include CHF, COPD, Dementia, Resident #64 is not on an anticoagulant, and CPR code status. d. Mental Status Evaluation: altered level of consciousness (hyperalert, drowsy but easily aroused, difficult to arouse) with sudden change in level of consciousness or responsiveness, no changes in functional status observed. e. Respiratory status: respiratory changes; shortness of breath, abrupt onset of shortness of breath with pain, fever, or respiratory distress. f. Cardiovascular status: new irregular pulse, resting pulse greater that 100 or less than 50. During assessment, attempted to auscultate (listen/hear) pulse and unable to hear. g. Review of findings and provider notification, since the change in condition occurred the signs and symptoms got worse. From first assessment, second assessment performed, pulse 250, Oxygen 73% on room air. h. Summarization of observations, evaluation and recommendations: Resident #64's pulse continued to jump from 173-250 beats per minute, Staff M, LPN was unable to auscultate apical pulse (chest) or palpate radial (wrist) pulse. Automated External Defibrillator (AED) was applied to detect rhythm, AED stated shock was advised and issued one shock to Resident #64. Staff M, LPN monitored Resident #64 during and post shock and noted tremors slowing, breathing returning to normal, pulse reading down to 135 and oxygen up 89% with 2 liter oxygen via nasal cannula. Resident #64 began to blink his eyes again and was more alert. i. Provider had been notified, with recommendations to send Resident #64 to the Emergency Department (ED). Review of ED Physician's note dated [DATE] at 11:13 PM stated, Resident #64 brought in by ambulance due to altered mental status and fever. Fever began today, he has had some cough. EMS (Emergency Medical Services) reports the staff at the nursing home connected an AED to resident #64 and it said to shock, so they did (he was reportedly not unconscious and had generalized shaking at the time.) On physical exam the Physician noted, Resident #64 has generalized intermittent course shaking and tremors, greatest in the arms bilaterally. Cardiovascular (heart) with regular rhythm, tachycardia (condition where heart beats abnormally fast, typically at a rate over 100 beats per minute) present. Neurological, Resident #64 is alert with intermittent, waxing and waning (coming and going), generalized course tremors that Resident #64 reports he always shakes. Resident #64 admitted to hospital for further observation. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospital records dated [DATE] at 9:56 AM, revealed Resident #64 reportedly febrile (fever) at facility and was found to be tremulous (shaking or quivering) with altered mental status by nursing home staff. Resident #64 was never reported to be pulseless or unresponsive, he was placed on an AED at the facility. AED advised shock and one shock was administered by nursing home staff. EMS was called, Resident #64 was noted to be awake and alert on scene. On exam Resident #64 is asleep but arousable to voice, noted to be oriented to his name, hospital and state. Resident #64 is not oriented to the city, year, or current president. Resident #64 also reports he has tremors at baseline. During an interview on [DATE] at 4:12 PM, Staff N, LPN, stated she had come on at shift change (10:00 PM) and she had heard other staff saying Resident #64 was declining, Staff M, LPN grabbed the crash cart, while Staff N, LPN got the equipment to do an assessment. As Staff N, LPN, entered Resident #64's room, Staff M, LPN was in the room with the AED hooked up to Resident #64 and had shocked him. Upon entering the room Staff N, LPN, Resident #64 was laying in bed and responsive. With in minutes EMS arrived and Resident #64 was transferred to their gurney and report was given to an EMT. The EMT told Staff N, LPN and Staff M, LPN not to shock when they're responsive. Staff N, LPN, was not able to recall the details as to why Staff M, LPN, had placed the AED on Resident #64, but stated it was something related to Resident #64's vitals and Staff M, LPN thought a shock would be the solution. During an interview on [DATE] at 9:47 AM, Staff M, LPN stated she was finishing her charting from her shift (2:00 PM- 10:00 PM) and overheard the CNAs (Certified Nursing Assistants) saying something was not right with Resident #64. Staff M, LPN stated Staff N, LPN, had taken Resident #64's vitals with the facility's equipment. Staff M, LPN, stated she had gotten inaccurate reading in the past using this equipment and had her own manual equipment. Staff M, LPN, with her equipment, went to Resident #64's room to check his vitals, his oxygen was in the low 70's, pulse was in the 200's, and he had a fever. Staff M, LPN, stated she was not able to obtain an apical pulse or blood pressure due to Resident #64's tremors. Staff M, LPN stated she then told Staff N, LPN about the vitals she had obtained for Resident #64 and told the CNAs to get the crash cart. Staff M, LPN stated she was not sure what the resident's pulse was but was told by another CNA that the ED uses an AED to detect patient's pulse. Staff M, LPN stated she then attached the AED to Resident #64, the AED detected a pulse and advised a shock. Staff M, LPN then pressed the button to administer a shock. Staff M, LPN continued by stating, Resident #64 was conscious, the AED was used to detect Resident #64's heart rhythm as she was not able to determine the rhythm herself due to Resident #64's tremors. Further in the interview, Staff M, LPN stated, prior to administering the shock with the AED, Resident #64 was responsive to verbal stimuli, once the AED pads were placed Resident #64 did not seem to be as responsive to verbal stimuli but she did not try to touch, shake, or do a sternal rub for a response. Staff M, LPN stated a couple minutes after the shock was give, EMS arrived, given report and updated on the situation. No further communication was received from EMS crew. Staff M, LPN also stated the reason why the AED had advised the shock was because normally when an AED is put on a conscious person it will detect and know (that the person is conscious) and will not advise a shock. Review of an undated, Facility provided Incident Report and Statement Document, revealed the following:1. Situation: [DATE] around 11pm, Resident #64 was having increased shaking and his vital signs were abnormal (pulse or bottom blood pressure in the 170's and oxygen down to 73). When the nurse, Staff M, LPN, was assessing she got the order from the on call to send to ER. While waiting for paramedics Resident #64's heart went out of rhythm and so due to him being full code, even though he didn't lose consciousness, she put the AED on him to advise her if he was having a heart attack, and if he needed a shock, since she knew it would say shock advised or not. The machine registered his heart out of rhythm and gave a shock. After shock was given his oxygen increased, his tremors calmed down and he seemed to be getting better. The paramedics then arrived and took Resident #64 to the hospital. 2. Staff N, LPN notified facility's Physician of Resident #64's vitals and received an order to send him to ER. 3. No chest compressions or breathing support (other than 2 liters oxygen via nasal cannula) was provided.4. Upon Paramedic's arrival, Resident #64 (continued on next page)

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