

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Rainbow Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 8119 Memphis Arlington Road Bartlett, TN 38133	
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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, incontinent brief manufacturer directions, medical record review, hospital record review, facility investigation review, observation, and interview, the facility failed to protect the Residents' right to be free from neglect when they failed to provide necessary care and services to meet the needs of the Resident for 1 of 6 (Resident #1) sampled residents reviewed for a change of condition and altered mental status. Resident #1, a vulnerable Resident who was cognitively intact, with a full code status was found with an acute change in condition on 7/10/2024 at approximately 10:56 AM. The facility failed to notify the physician and the family at that time. The facility failed to document a nursing assessment, vital signs, or neurological assessment until approximately 3:00 PM, which was 4 hours later. Resident #1 experienced lethargy, changes in speech pattern, gurgling respirations, and subsequently became unresponsive to verbal and tactile stimulation. The facility notified Emergency Medical Services (EMS) more than 4 hours after the change in condition, and Resident #1 was transferred to the emergency room of Hospital #1 on 7/10/2026 at approximately 4:00 PM. Resident #1 was diagnosed with an acute cerebrovascular accident ((CVA)-stroke) and carotid artery stenosis (narrowing of the carotid arteries in the neck which carry blood and oxygen to the brain). In the emergency room a urinalysis was performed which identified semen in the Resident's urine. Resident #1 was transferred to Hospital #2 for a higher level of care on the evening of 7/10/2026, where a forensic nurse conducted a rape kit and examination on 7/11/2026 and found bruising on the inside of the Resident's right thigh and a tear on the lower part of the Resident's vagina. The facility's failure to identify an acute change in condition, protect the Resident from neglect, and transfer to the hospital timely, resulted in Immediate Jeopardy for Resident #1. Immediate Jeopardy (IJ) (a situation in which the provider'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) was identified related to the facility's failure to use its resources effectively to attain and maintain the highest practicable well-being of a vulnerable resident, and to ensure systems and processes were implemented to provide supervision and assistance to ensure the resident environment was free of neglect. The Administrator and the Regional Nurse Consultant were notified of the Immediate Jeopardy (IJ) at F-600 on 7/17/2026 at 7:42 PM, in the conference room. The facility was cited at F-600 at a scope and severity of J which is Substandard Quality of Care. The IJ began on 7/10/2026 through 7/18/2026, the IJ was removed on 7/19/2026. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-600, was received on 7/19/2026 at 2:11 PM. The Removal Plan was verified and validated onsite by the surveyor on 7/20/2026 through 7/22/2026 through review of the in-service training records and audits, review of the facility's policy, observations, and staff interviews. A partial extended survey was conducted on 7/19/2026 through (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 445283	Facility ID: 445283 If continuation sheet Page 1 of 18

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/22/2026. The facility's non-compliance at F-600 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility policy titled, Abuse, Neglect and Exploitation, dated 10/24/2022, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercation .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse and mental abuse .Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .Criminal sexual abuse is serious bodily injury/harm .serious bodily injury includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident .The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written .Existing staff will receive annual education through planned in-services and as needed .Training topics will include .Prohibiting and preventing all forms of abuse, neglect, misappropriation of resident property, and exploitation .Identifying what constitutes abuse, neglect .Recognizing signs of abuse, neglect .Reporting process for abuse, neglect .including injuries of unknown sources .Establishing a safe environment . to the extent possible .for preventing sexual abuse .The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse . Review of the undated facility policy titled, TENNESSEE STATE SPECIFIC RESIDENT RIGHTS, revealed .The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed, and documentation shall be maintained in the resident's file of the following rights.To be free from mental and physical abuse. Review of the facility policy titled, Incontinence, dated 10/26/2023, revealed, .Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services .The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain .Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible . 2. Review of (Named Incontinent Briefs) manufacturer directions dated 2026, revealed .The wetness indicator strip.is designed to help staff identify if a resident has urinated.The indicator will detect urine, perspiration, and loose stool but will not be activated by solid bowel movements.Staff should change.in accordance with their facility practices, along with proper peri care [cleaning of the genital and anal area] procedures. 3. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Hypertension, Fracture of Superior Rim of Right Pubis (pelvic fracture), Encounter for Fracture with Routine Healing, Osteoarthritis, and Overactive Bladder. Review of the facility's Nursing admission Evaluation, dated 7/8/2026, revealed .Arrived at facility via [by way of] [Named medical transport] at 1722 [5:22 PM]. Awake, alert and oriented x [time] 4 [a person is fully conscious and aware of person, place, time, and situation].Noted bruising (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	room air. Review of the medical record showed no additional vital signs were obtained during Resident #1's change of condition. Review of the medical record revealed no documentation of additional vital signs or assessment of Resident #1 following the documentation on 7/10/2026 at 10:56 AM, There was no documentation the physician or family was notified until 3:33 PM. Review of the Transfer Form for Resident #1 dated 7/10/2026 at 3:40 PM, revealed .alert, disoriented, but cannot follow simple instructions.Code Status Full.Transfer is.unplanned.Altered Mental Status. Most Recent Blood Pressure: 140/60 Date: 7/10/2026 10:56 [AM].Most Recent Pulse 64 Date: 7/10/2026 10:56 [AM].Most Recent Respiration 17.0 Date: 7/10/2026 10:58 [AM].Most Recent O2 sat [oxygen saturations] 98 % [percent] Date: 7/10/2026 10:58[AM].room air.Most Recent Temp 97.0.route.forehead.Date: 7/10/2026 10:58 [AM]. There was no documentation on the facility's Transfer Form, dated 7/10/2026 at 3:40 PM, of a current nursing assessment or current vital signs. Review of the Nurses Note for Resident #1 dated 7/10/2026 at 4:00 PM, revealed .Resident noted with a change in condition noted very lethargic, not able to communicate, Resident noted very weak not able to keep eyes open, head up. Or talk.VSS [vital signs stable].This nurse call [Named Doctor] and doctor gave order to send resident out. Review of Resident #1's medication administration record dated July 2026, revealed the following medications were documented as given on 7/11/2026 and 7/12/2026: Amlodipine Besylate 10 mg (milligrams) one tablet by mouth one time a day Bupropion 300 mg one tablet by mouth one time a day Lovastatin 40 mg one tablet by mouth one time a day Omeprazole 20 mg 2 tablets by mouth one time a day Oxybutynin Chloride ER (extended release) 15 mg one tablet by mouth one time a day Calcium 600+ D plus Minerals one tablet by mouth two times a day Carvedilol 6.25 mg one tablet by mouth every 12 hours Review of the medical record revealed Resident #1 was discharged from the facility on 7/10/2026 and was not present in the facility to receive the scheduled medications on 7/11/2026 and 7/12/2026. 4. Review of the (Named Hospital #1) Emergency/Urgent Care Emergency Department (ED) Physician ED note dated 7/10/2026 at 5:27 PM, revealed .DATE/TIME PATIENT SEEN.7/10/2026 16:29 [4:29 PM] PT [patient/Resident #1] arrived via [Named emergency service] from [Named Facility] for AMS [Altered Mental Status], last known well 1200 [12:00 PM] today, patient non-verbal on arrival, not moving right arm and appears to have a facial droop on right side, will not follow commands.Contraindications [circumstance where a particular medication could be harmful] to Thrombolytic Therapy [IV medications to stop blood clots].Thrombolytic and Endovascular Stroke Treatment Exclusion/ Delay.Time last known well unknown or greater than 4.5 hours prior to treatment initiation [treatment window for initiating Thrombolytic Therapy].Impression.Acute CVA [cerebrovascular accident] and Carotid artery stenosis. Review of Hospital #1's Emergency/Urgent Care lab report for Resident #1 dated 7/10/2026 at 6:30 PM, revealed .UA [urinalysis].Turbid [cloudy, hazy, or milky] (abnormal) UA Sperm Rare (abnormal).UA Blood 2+ [plus]. Resident #1 was transferred to Hospital #2's Neurological (neuro) Intensive Care Unit (NICU) for a higher level of care by the ambulance service on 7/10/2026 at 8:02 PM. 5. Review of Hospital #2's Nursing Narrative, for Resident #1 dated 7/11/2026 at 3:47 AM, revealed .During in and out catheterization this am [morning], 2 tears around pt's [patient's/Resident #1] vagina noted. This was done after seeing results of pt's UA from [Named City (Hospital #1)] showing sperm present. Calls to nursing management made to determine how to proceed and/or report to authorities [authorities]. Review of Hospital #2's Nursing Narrative for Resident #1 dated 7/11/2026 at 6:16 PM, revealed .At approximately 0800 [8:00] [Named Police Department] @ [at] bedside for report of possible sexual assault @ [Named Facility].At approximately 1330 [1:30 PM] Forensic [Named Nurse Practitioner] arrived at bedside to perform sexual assault exam; exam concluded @ approximately 15:30 [3:30 PM] [Named Police Department] arrived at bedside to (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	collaborate. Review of Hospital #2's Consultation Note, for Resident #1 dated 7/13/2026 at 12:17 PM, revealed .Chief Complaint: lethargy, AMS [altered mental status.seen at [Named Hospital #1] and sent here.The patient is. female admitted on [DATE], for an acute cerebrovascular accident (CVA) presenting with altered mental status, aphasia, facial droop, and right hemiparesis [injury to the left side of the brain].The primary diagnoses for this admission were acute CVA due to severe bilateral carotid artery stenosis, expressive aphasia [partial loss of the ability to produce language], and right hemiparesis.Thrombolytic therapy was not administered due to the patient being outside the treatment window, and neurointerventional procedures were not indicated.The patient was NPO [nothing by mouth] until a dysphagia screen [swallow exam] could be passed, and a NG [nasogastric tube is a tube placed in the nose and down into the stomach] was placed for medication administration.PHYSICAL EXAM.BLE [bilateral lower extremities] responds to painful stimuli, BUE [bilateral upper extremities] moves on commands, weak RUE [right upper extremity].Non-verbal.Follows commands slowly with prompting. 6. During an interview on 7/17/2026 at 4:26 PM, the facility Administrator was asked what was being done to protect the residents to ensure a safe environment (after the incident with Resident #1). The Administrator stated, .started our abuse in-service, we interviewed all residents with a BIMS of 8 or higher.did skin checks on all people with a BIMS of 7 or lower.interviewed all the staff to see if they had any concerns of other staff members or any residents.all staff were making rounds.viewed visitor logs.reviewed all the video.we kind of narrowed it down based on the warrant that it was a male. The Administrator was asked if anything had been implemented (since the incident with Resident #1) to ensure residents were kept in a safe environment. The Administrator stated, .We've been through our normal process, interviewed the residents, went back and asked some of the residents close by those rooms if they heard anything and they did not.other than our normal process to keep people safe.I don't know what else I could have done at this point. The Administrator was asked if there was a process for changing the exit door codes to prevent entry of unauthorized persons. The Administrator stated, .no, just change the code as needed. The Administrator was asked when the last time the door code was changed. The Administrator stated, .I would have to ask when they were changed. The Administrator was asked if there were any residents currently in the facility who are sexually aggressive. The Administrator stated, Not that I'm aware of. The Administrator was asked how he was made aware of the alleged sexual misconduct with Resident #1. The Administrator stated, .around 2 o'clock, the staff told me a police officer had shown up and wanted to look in [Named Room where Resident #1 resided].possible crime scene.I left here around 6 [6:00 PM].then I got a call from [Named Police Officer] who said he was leaving the search warrant processing in the room.I showed up at 7:45 PM, and they were finishing up, he handed me a copy of the search warrant. The Administrator was asked if he left while the police were in his building. The Administrator stated, .yes.just that one officer was here at that time.nobody told me the forensic team showed up.my Assistant Director of Nursing [ADON] was here.but she may have left.I'm not sure. The Administrator stated he reviewed the video of the hall outside of Resident #1's room in its entirety from start to finish on the following Wednesday (7/15/2026). The Administrator was asked if any new processes had been implemented since the allegation of sexual misconduct. The Administrator stated, .I don't think so.we had a good process in place. The Administrator was asked to explain what the process was for transferring a resident with an altered mental status. The Administrator stated, .I would have to defer to nursing. The Administrator was asked whether they would call 911 if a patient had altered mental status. The Administrator stated, I would have to defer to nursing. During an interview at Hospital #2 on 7/18/2026 at 9:31 AM, Registered Nurse (RN) H said he was the house supervisor at Hospital #2 and (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the brain controls speech, language and understanding. RN K said Resident #1 was aphasic and wasn't speaking. RN K reported she had to put in a NG tube to give aspirin and plavix (a medication that prevents blood clots). RN K was asked did she assess Resident #1's perineal area (the area located between the thighs that extends from the genital region to the anus). RN K stated, Yeah, at one point the [Forensic] NP doing sexual assault exam asked me to send some lab work.straight cath [(catheter) insertion of a straight cath to empty the bladder].when I [was] getting ready to urine cath, the [Forensic NP] was also there and she had what appeared to be a vaginal tear right at the base [of the vagina].bruising in her inner thigh, I hate to speculate but about the size of a thumb print maybe. During an interview on 7/20/2026 at 12:03 PM, Certified Nursing Assistant (CNA) A was asked if she cared Resident #1 (while she was in the facility) and what assistance was provided. CNA A confirmed Resident #1 was alert and oriented, incontinent of bowel and bladder, wore incontinent briefs during the day, and required assistance of staff to turn and reposition. CNA A was asked how often she would check for incontinence care and did Resident #1 have skin issues such as wounds or bruises. CNA A stated, .I'm not sure if she had skin issues or wounds, I may have changed her once that night.we are supposed to check incontinence every 2 hours and reposition then. CNA A was asked if she charted residents' incontinence episodes. CNA A stated, Yes, we should chart in her POC [PLAN OF CARE]. CNA A was asked did she chart the incontinent care provided to Resident #1. CNA A stated, .yes . During an interview on 7/20/2026 at 12:40 PM, facility CNA B was asked if she took care of Resident #1 (while she was in the facility). CNA B stated, .She was very nice, alert to everything.she was incontinent and wore incontinent briefs.we had to help her with turning in the bed. CNA B was asked how Resident #1 felt on her last day at the facility (7/10/2026). CNA B stated, .she seemed good early that morning, but was different after about 1030 AM. CNA B was asked if she told anyone about the change in Resident #1. CNA B stated, I told the charge nurse she was hard to wake up and seemed different. CNA B was asked if she seen any bruising or wounds on Resident #1 and how often she performed incontinent care. CNA B stated, .I didn't notice bruising.don't recall skin issues either, but I checked her once that day that I remember.I just changed her brief around 10:30 while she was in bed, then she was sent out that afternoon by the nurse. CNA B was asked if she charted the incontinent care she provided. CNA B stated, Yes, I document incontinent care in the charting system. During an interview on 7/20/2026 at 1:19 PM, RN D was asked if she did a nursing assessment on Resident #1 on admission to the facility. RN D stated, Yes, I assessed her skin on 7/9/2026, she had moisture associated skin damage to her right buttock, I looked at her whole body and seen small bruises on her arms where she had IV's and scabbing to her left and right toes.she was alert, cheerful, her goal was for therapy.she needed help with bed mobility and incontinence care.she stated she had been incontinent for years. RN D was asked how often Resident #1 required changing of her brief for incontinence. RN D stated, she required every 2 hours or more if needed.especially with her MASD on her buttock.I didn't see her the day she was discharged . During an interview on 7/20/2026 at 4:22 PM, Certified Occupational Therapist Assistant (COTA) E was asked if she cared for Resident #1 on the day she was discharged (7/10/2026). COTA E stated, .yes, she participated well before breakfast, she was talking alert and oriented.I split my time with her and was going back later in the day.At 11:00 AM I was trying to arouse her, but she wasn't arousing.the Unit Manager was there and said they were going to send her out. During a phone interview on 7/20/2026 at 7:27 PM, Physical Therapist Assistant (PTA) C was asked if she provided therapy to Resident #1 on 7/10/2026. PTA C stated, Yes, I tried to arouse her prior to lunch it was somewhere around 11 [11:00] AM, she was out of it.the Unit Manager assisted me getting her in the wheelchair, it was maximum assist, took both of us to get her to the chair.the nurse said they would check her out (continued on next page)		

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	when I brought her back.I took her to the therapy room, but I noticed her right arm was stiff, and she had excessive leaning to her right side.her eyes were barely open looking up. I took her straight back to her room sitting in her wheelchair I knew the Unit Manager was aware she wasn't acting the same as the day before, I told the CNA as I left the room, that she was in her wheelchair and to check on her.as I passed the charge nurse, I told her the same, to check on her. During a phone interview on 7/21/2026 at 12:06 PM, the Doctor of Nursing Practice (DNP) was asked if she was Resident #1's Primary Care DNP. The DNP stated, .I never met her but was planning to see her on Friday.the only thing I know is that she had a change of condition.the facility called me after 3:00 PM [7/10/2026]. The DNP was asked did the facility notify you when the change of condition first started occurring. The DNP stated, .no.no one contacted me regarding any changes for that resident.the unit manager called me sometime after 3 [3:00] PM.I instructed her to send the patient to the ER [emergency room].the facility takes it upon themselves if she is having symptoms and should have called 911 [emergency telephone number]. The DNP was asked when should the facility do timely nursing assessments. The DNP stated, .when the change of condition is starting to occur.I would hope they would call the Physician or NP immediately and document their findings. During a phone interview on 7/22/2026 at 9:08 AM, the ADON was asked if she had been notified on 7/10/2026 by the unit manager of Resident #1's change of condition and a suspected bruise to the Resident's right cheek. The ADON stated, I don't recall. The ADON was asked was she awar		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the 2026 American Heart Association/American Stroke Association (AHA/ASA) Guidelines, facility policy review, hospital record review, medical record review, facility documentation review, emergency medical transportation review, and interview, the facility failed to provide treatment and care in accordance with professional standards of practice for 1 of 6 (Resident #1) sampled residents reviewed for physical injuries, timely assessments, and emergency transfer for a change in condition. Resident #1, a vulnerable Resident who was cognitively intact, with a full code status, was found with an acute change in condition and altered mental status on the morning of 7/10/2022 at approximately 10:56 AM. The facility failed to call 911 (emergency phone number) immediately upon noticing the Resident's change of condition. Resident #1 was transferred to the hospital for evaluation between 4:00 PM and 4:30 PM, approximately 5 hours later. During her transfer to Hospital #1 emergency room (ER) on the afternoon of 7/10/2026, emergency medical services (EMS) personnel identified a contusion to Resident #1's right cheek that the facility staff were unaware of. The facility's failure to respond to the Resident's acute change in condition and altered mental status and provide timely assessments resulted in a delay in treatment which prevented the ER from administering clot busting medications (medications that dissolve blood clots that cause strokes). Resident #1 was diagnosed with an acute cerebrovascular accident (CVA-stroke) and carotid stenosis (narrowing or blockage of the carotid arteries in the neck which carry blood and oxygen to the brain). Resident #1, who was admitted to the facility as awake, alert and oriented times (x) 4 (a person who is fully conscious and aware of person, place, time, and situation), was nonverbal at this time and had a nasogastric (NG) tube per hospital records and family interviews. At the time of the survey no written incident report was provided, and the facility investigation was incomplete. The facility should take immediate action to ensure timely identification and notification of changes in residents' condition, and timely assessments to protect residents from serious injury, serious harm, serious impairment, or death. The facility's failure to provide care and services to Resident #1 resulted in Immediate Jeopardy (IJ), (a situation in which the provider'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) for Resident #1. The Administrator and the Regional Nurse Consultant were notified of the Immediate Jeopardy (IJ) at F-689 on 7/17/2026 at 7:42 PM, in the conference room. After supervisory review on 8/4/2026, the deficiency was changed to F-684, and the deficiency number was amended on the IJ template and provided to the facility. The facility was cited at F-684 at a scope and severity of J which is Substandard Quality of Care. The IJ began on 7/10/2026 through 7/18/2026, the IJ was removed on 7/19/2026. An acceptable Removal Plan, which removed the immediacy of the Jeopardy identified for the facility's failure to provide timely assessments and emergency transfers for a change in condition, was received on 7/19/2026 at 12:50 PM. The Removal Plan was verified and validated onsite by the surveyor on 7/20/2026 through 7/22/2026 through review of the in-service training records and audits, review of the facility's policy, observations, and staff interviews. The Removal Plan provided covered the areas cited in F-684. A partial extended survey was conducted on 7/19/2026 through 7/22/2026. The facility's non-compliance at F-684 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the AHA/ASA 2026 Guidelines published 1/26/2026, revealed. This updated guideline is intended to provide a comprehensive, up-to-date, evidence-based set of recommendations from prehospital evaluation (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	through acute treatment.Clinical practice guidelines for stroke provide recommendations applicable to patients with or at risk of developing cerebrovascular disease.Stroke is a leading cause of death and disability.This guideline aims to cover the full course of the emergency evaluation and early management of the patient with AIS [Acute Ischemic Stroke].Lack of awareness of stroke warning signs and the need to call 9-1-1 [emergency number] in the case of stroke symptoms contributes to delays to hospital arrival and has the potential to reduce patients' eligibility for reperfusion therapies [methods of restoring blood flow].IVT [(Intravenous thrombolytics) administration of medications through an IV line to stop blood clots] is proven to benefit.patients.when administered within 4.5 hours of symptom onset. Data from RCTs [Randomized Clinical Trials] and the AHA Get With the Guidelines (GWTG)-Stroke registry show that the earlier the treatment, the greater the benefit, which diminishes over time.Prompt clinical assessment by trained professionals is essential to determine whether presenting neurological deficits are disabling. 2. Review of the facility policy titled, Notification of Changes, dated 8/29/2024, revealed .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification.Circumstances requiring notification include.Significant change in the resident's physical, mental, or psychological condition such as deterioration in health, mental or psychosocial status. This may include Life- threatening conditions, or Clinical complications. Review of the facility policy titled, Incidents and Accidents Reporting dated 8/11/2022, revealed .It is the policy of this facility for staff to utilize electronic and/or approved forms to report, investigate, and review any incidents or accidents that occur, on facility property and may involve or allegedly involve a resident. Accident refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident.An incident is defined as an occurrence or situation that is not consistent with the routine care of a resident or with the routine operation of the organization.The purpose of incident reporting is.Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care.Incidents that rise to the level of abuse, misappropriation, or neglect, will be managed and reported according to the facility's abuse prevention policy.In the event of an incident or accident, immediate assistance will be provided or securement of the area will be initiated unless it places one at risk of harm.Any injuries will be assessed by the licensed nurse or practitioner and the affected individual will not be moved until safe to do so.The supervisor or other designee will be notified of the incident/accident, report any injuries or other findings, and obtain orders, if indicated, which may include transportation to the hospital dependent on the nature of the injury.The resident's family or representative will be notified of the incident/accident and any orders obtained or if the resident is to be transported to the hospital.Documentation should include the date, time, nature of the incident, location, initial findings, immediate interventions, notifications and orders obtained or follow-up interventions.If an incident /accident was witnessed by other people, the supervisor or designee will obtain the witnesses' account. 3. Review of Hospital #1's admission H&P [History and Physical] dated 7/2/2026 at 10:56 AM, revealed .CHIEF COMPLAINT.Pt [patient/Resident #1] arrived.from home for a fall that she had yesterday and injured right hip and she also has bruising to right side of face.she fell onto her right side she reports no dizziness.she did slightly hit her head but denies any loss of consciousness. 4. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], for rehabilitation following hospitalization at Hospital #1 with diagnoses including Hypertension, Fracture of Superior Rim of Right Pubis (pelvic fracture), Encounter for Fracture with Routine Healing, Osteoarthritis, and Overactive Bladder. Review of the facility's Nursing admission Evaluation, dated (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/8/2026, revealed Resident #1 arrived at the facility at 5:22 PM. Resident #1 was awake, alert and oriented x 4, and bruising was documented to the inside bend of her elbows bilaterally. Resident #1 experienced pain with movement and could not sit or stand without increased pain. The admission Evaluation did not document bruising to the right side of Resident #1's face. Review of the Care Plan for Resident #1 dated 7/8/2026, revealed .Resident is at risk for falls/injury related to bladder incontinence, decreased strength and endurance, functional problems, generalized weakness, high risk for falls, history of falls.Resident has an impaired musculoskeletal status related to osteoarthritis, fracture of R [right] pubic ramus [crack or break in the pelvis], muscle weakness, unsteadiness on feet, abnormalities of gait and mobility. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was not coded. Review of the medical record revealed Resident #1 experienced an acute change in condition on 7/10/2026 at approximately 10:56 AM. Review of the facility's SBAR [Situation, Background, Assessment, Recommendation] Communication Form and progress note dated 7/10/2026 at 3:33 PM, revealed Resident #1 experienced a change in condition including lethargy, decreased consciousness, and decreased mobility. Further review revealed Resident #1's vital signs were obtained at 10:56 AM and documented in the note at 3:33 PM. Resident #1's vital signs were as follows: Blood pressure (BP)-140/60 Pulse-64 Respirations-17 Oxygen saturation-91 percent (%) on room air Temperature-97 degrees Fahrenheit Review of the facility's Transfer Form, dated 7/10/2026 at 3:40 PM, revealed Resident #1 could not follow simple instructions and experienced an altered mental status (AMS). There was no documentation of a bruise or contusion to Resident #1's right cheek. Review of a Nurses' Note dated 7/10/2026 at 4:00 PM, revealed Resident #1 was observed with lethargy, weakness, inability to communicate, and was unable to hold her eyes open and keep her head up. The Doctor of Nursing Practice (DNP) was notified and orders were given to send the Resident to the Emergency room. The vital signs documented at 4:00 PM were from 10:56 AM. There were no current vital signs documented. Review of Resident#1's medical record revealed no documentation a head-to-toe nursing assessment was completed, no documentation of vital signs in the medical record after 10:56 AM, and no documentation that 911 was called related to Resident #1's altered mental status or her change of condition. 5. Review of the (Named Ambulance service) Patient Care Record for Resident #1 dated 7/10/2026, revealed .Clinical Impression.Provider's Primary.Altered mental status.Provider's Secondary.weakness.Chief Complaint Altered mental status.Vitals stable.16:01 [4:01 PM] BP [blood pressure] 97/39.HR [heart rate] 69.RESP [respirations] 18.Unable to complete.stroke scale.responded immediately to nursing home with no lights and sirens.upon arrival.found patient semi-Fowlers [patient lies on back with head and body elevated at an angle of 30-45 degrees].in facility bed.patient's chief complaint is altered mental status.nursing staff stated patient's baseline mental status was A [alert] & [and] O[oriented] x 4.nursing staff state they had minimal information about patient due to patient being a new admit [admitted [DATE]].nursing staff stated they were unaware of contusion on face. Nursing staff stated patient had not had any recent falls.Patient noted to have no facial droop.contusion noted to right cheek.IV [intravenous-inside a vein] attempted and unsuccessful.patient was successfully transferred to stretcher via [by way of] drawsheet method and properly secured with all straps and rails.[by] 2 in a semi-Fowler's position.patient was transported to ambulance and loaded without incident or complaint.Patient was transported with no lights and sirens to [Named Hospital #1] Upon arrival patient was unloaded and transferred to facility via draw sheet method by EMS [emergency medical services] without incident.patient left in care of [Named Nurse]. 6. Review of the (Named Hospital #1's) Emergency/Urgent Care Emergency Department (ED) Physician progress note dated (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/10/2026 at 5:27 PM, revealed Resident #1 arrived at the ED via ambulance for AMS with a last known well time of 12:00 PM (time prior to hospital arrival that the patient was at their current baseline state of health). Resident #1 was non-verbal, was not moving her right arm, appeared to have right-sided facial droop, and would not follow commands. ED staff were unable to treat Resident #1 with Thrombolytic Therapy (medications to dissolve blood clots inside arteries and veins) due to the time that had lapsed since she was at her baseline. Resident #1 was diagnosed with an acute stroke and carotid artery stenosis. 7. During an interview on 7/20/2026 at 11:25 AM, the Chief Operating Officer of the (Named Ambulance Service) confirmed after reviewing Resident #1's 7/10/2026 transportation log, the facility should have called 911 during this emergency transportation to the local emergency room. During an interview on 7/20/2026 at 12:03 PM, Certified Nursing Assistant (CNA) A confirmed she had provided care to Resident #1 while in the facility. CNA A was unable to recall any bruising to Resident #1's skin. During an interview on 7/20/2026 at 12:40 PM, CNA B confirmed she provided care to Resident #1 on 7/10/2026. CNA B stated, .she seemed good early that morning, but was different after about 10:30 AM. CNA B was asked if she told anyone about the change in Resident #1. CNA B stated, I told the charge nurse she was hard to wake up and seemed different. CNA B was unable to recall if Resident #1 had any bruising to her skin. During an interview on 7/20/2026 at 1:19 PM, Registered Nurse (RN) D was asked if she performed a nursing assessment on Resident #1 on admission. RN D stated, Yes, I assessed her skin on 7/9/2026, she had moisture associated skin damage [MASD] to her right buttock, I looked at her whole body and seen small bruises on her arms where she had IVs and scabbing to her left and right toes. RN D was asked if there was bruising on any other parts of the Resident's body. RN D stated, .I was focused on her right buttock.I didn't see her the day she was discharged . During an interview on 7/20/2026 at 4:22 PM, Certified Occupational Therapist Assistant (COTA) E confirmed she treated Resident #1 before breakfast on 7/10/2026 and the resident was alert and participated in therapy. COTA E stated, .I split my time with her and was going back later in the day.At 11:00 AM I was trying to arouse her, but she wasn't arousing.the Unit Manager was there and said they were going to send her out. During a phone interview on 7/20/2026 at 7:27 PM, Physical Therapist Assistant (PTA) C confirmed she provided care to Resident #1 on 7/10/2026. PTA C stated, .I tried to arouse her prior to lunch it was somewhere around 11 [11:00] AM, she was out of it.the Unit Manager assisted me getting her in the wheelchair, it was maximum assist, took both of us to get her to the chair.the nurse said they would check her out when I brought her back.I took her to the therapy room, but I noticed her right arm was stiff, and she had excessive leaning to her right side.her eyes were barely open looking up. I took her straight back to her room sitting in her wheelchair . PTA C confirmed the Unit Manager was aware Resident #1 was not the same as the day before. PTA C stated, .I told the CNA as I left the room, that she was in her wheelchair and to check on her [Resident #1].as I passed the charge nurse, I told her the same, to check on her. During a telephone interview on 7/21/2026 at 12:06 PM, the Doctor of Nursing Practice (DNP) was asked if she was Resident #1's Primary Care DNP. The DNP stated, .I never met her but was planning to see her on Friday.the only thing I know is that she had a change of condition.the facility called me after 3:00 PM [on 7/10/2026]. The DNP confirmed the facility did not call when Resident #1's change in condition first started occurring. The DNP stated, .no.no one contacted me regarding any changes for that resident.the unit manager called me sometime after 3 [3:00] PM.I instructed her to send the patient to the ER [Emergency Room].the facility takes it upon themselves if she is having symptoms and should have called 911 [emergency telephone number]. The DNP confirmed timely assessment should be completed when residents experience changes in condition, the assessment should be documented in the medical record, and the Physician or DNP (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	should be notified immediately. During a telephone interview on 7/22/2026 at 9:08 AM, the ADON was unable to recall if she had been notified of Resident #1's change in condition or of the lack of documentation related to the change in condition on 7/10/2026. The ADON confirmed she was notified about a bruise to Resident #1's cheek. The ADON was asked if she assessed Resident #1 after being told of a bruise to the Resident's right cheek. The ADON stated, .I did not meet her.or see a bruise.but seen it documented on the EMS run report the following week. During an interview on 7/22/2026 at 9:41 AM, the Regional Director of Clinical Services stated the facility was unaware of the bruise to Resident #1's right cheek until Monday (7/13/2026) or Tuesday (7/14/2026), after the Resident was transferred to the hospital on (Friday) 7/10/2026. The Regional Director of Clinical Services was asked if the facility's documentation of Resident #1's change of condition and the nursing assessments documentation were accurate. The Regional Director of Clinical Services stated, No. During an interview on 7/22/2026 at 10:59 AM, the Administrator stated the facility was not aware of the bruising to Resident #1's right cheek until Monday (7/13/2026) or Tuesday (7/14/2026), 3-4 days after Resident #1's transfer to Hospital #1's ER. The Administrator stated, .the bruise is part of our big investigation of the abuse allegation.we seen the [Named Ambulance] report, but our nurses never captured that in our medical record. The Administrator stated, .if the bruise was there, it should have been documented. The Administrator was asked if staff identified a bruise to a resident, while at the bedside during a transfer to the hospital, should Administration have been made aware and should have Administration investigated that. The Administrator stated, Yes. During an interview on 7/22/2026 at 11:58 AM, Paramedic L confirmed the ambulance service transfer did not use lights and sirens during Resident #1's transportation to Hospital #1's emergency room. Paramedic L was asked to describe Resident #1's presenting condition when the Ambulance Service arrived in the Resident's room. Paramedic L stated, .altered mental status.could not follow commands.painful response.yellow bruise the size of a [NAME] to the right upper cheek of her face.nurses couldn't tell me anything.we waited 10 minutes for a nurse to come to the room.she [the nurse] didn't know if she was on blood thinners.stated they [nurses] didn't know much about her [Resident #1] she was a new admit.we were in the room [ROOM NUMBER] to 30 minutes.her [Resident #1] eyes were intermittently moving.she was a full code.vital signs were normal.wasn't critical.seems like they should have called hours ago but for some reason they didn't. Paramedic L was asked should Resident #1's transfer been treated as an emergent transfer with lights and a siren. Paramedic L stated, .it's a judgement call.we base it on different factors. Paramedic L was asked if Resident #1 could have been in a stroke crisis. Paramedic L stated, .yes. During a phone interview on 7/22/2026 at 12:33 PM, the Medical Director (MD) confirmed Resident #1's change of condition and nursing assessments on 7/10/2026 should have been accurately performed and documented in the medical record, and the MD and Nurse Practitioner (NP) should have been notified immediately when the patient's change of condition started occurring. The MD confirmed the 911 emergency ambulance services should have been utilized during Resident #1's change of condition and her transfer to the hospital emergency room. During an interview on 7/22/2026 at 1:00 PM, Licensed Practical Nurse (LPN) F confirmed she provided care to Resident #1 on 7/9/2026 and 7/10/2026. LPN F stated, .the first day I seen her was on Thursday 7/9/2026, she was alert and oriented, needed assistance from staff for turning in the bed, she didn't get up by herself. LPN F confirmed she gave Resident #1 medications on the morning of 7/10/2026 and she was unable to recall any bruising to the resident's skin. LPN F stated, She was hurting some that morning, but she said she was good. LPN F was asked when she saw Resident #1 again. LPN F stated, I saw therapy rolling her back to her room around 11:30 AM.shortly after that, cannot say what time, maybe a few minutes, a CNA called me to her room. I looked at her and she (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	was kind of out of it. LPN F was asked what she observed. LPN F stated, She was sitting in her wheelchair leaning forward with head down tilted to the left. nonverbal and no eye contact, looking in a daze. so I asked the CNAs to lay her down. LPN F was asked if she obtained vital signs or performed an assessment of Resident #1 and where did she document that. LPN F stated, .I completed a skilled assessment around 2:00 PM, I used the vital signs from earlier that day, around 11:00 AM, I think. LPN F confirmed she did not perform a head-to-toe assessment of Resident #1 at that time. LPN F was asked if she should have completed an assessment, documented it in the medical record, and notified the physician. LPN F stated, .I didn't assess the patient and document. but yes, I should have. I was just completing the skilled note before my shift was over. It was a day. was no excuse I was just overwhelmed. nothing I can say. LPN F was asked if Resident #1 had a change in condition with her altered mental status. LPN F stated, Yes. LPN F confirmed her Unit Manager knew the resident had a change, and she (the Unit Manager) called the primary DNP. LPN F confirmed she did not go back into Resident #1's room after the order was received to transfer the resident to the ER. During an interview on 7/22/2026 at 3:10 PM, LPN G confirmed she was the Unit Manager on Resident #1's hall on 7/10/2026. LPN G was asked about Resident #1's condition on 7/10/2026. LPN G confirmed she had assisted therapy in getting Resident #1 dressed and up for therapy on 7/10/2026. LPN G stated she told the Charge Nurse that Resident #1 was less talkative and to follow up with the resident after therapy. LPN G confirmed she did not do an assessment on the resident or document any changes in condition in Resident #1's medical record. LPN G was asked if the charge nurse followed up on Resident #1 and documented her assessment. LPN G stated, .I didn't see it documented in the chart. LPN G was asked if the vital signs on the transfer sheet was a new set of vital signs or vitals gotten earlier in the day. LPN G stated, .not sure. I didn't obtain or document the vital signs in the medical record. I called the [Named DNP] around 3:20 PM. I then went back to the room after the ambulance arrived. I observed a total decline. more lethargic. less responsive. making moaning gurgling noises . LPN G was asked where she documented her nursing assessment of her change of condition. LPN G stated, .I expected the licensed nurse to document the resident's change of condition because she was the nurse for the patient. LPN G confirmed a nursing assessment should have been completed and documented for Resident #1 when the change in condition was identified. LPN G was asked if this (lack of assessment) affected Resident #1's outcome. LPN G stated, .it could have. LPN G confirmed she reported Resident #1's change in condition to the ADON. LPN G was asked when she thought the change of condition occurred. LPN G stated, .probably before noon. we should have reacted sooner. LPN G was asked if she called 911 or an Ambulance Service to transport Resident #1 to the ER. LPN G stated, .I should have called 911. I called [Named Ambulance Service]. LPN G was unaware if the ambulance service came to the facility with lights and sirens on, and if the ambulance service left the facility after picking up the Resident with lights and sirens. LPN G said this was an emergent change of condition. LPN G confirmed she was not aware of a bruise to Resident #1's cheek until paramedics pointed it out during the transfer to the ER and she notified the ADON of the bruise. LPN G was unable to recall the appearance of the bruise at the time of the interview. During an interview on 7/22/2026 at 3:15 PM, the Director of Nursing (DON) confirmed that during an admission physical assessment, the licensed nurse should look at the whole body for any issues or concerns. The DON was asked would an adequate assessment include any type of bruising. The DON stated, Yes. The DON was asked if a bruise was identified during an assessment or an observation of a resident, when should the investigation of how the bruise occurred begin. The DON stated, Immediately. The DON was asked if the bruise was assessed to Resident #1's right cheek, should the licensed nurse have documented it in the medical record. The DON stated, Yes. The DON was asked if staff monitored Resident #1's (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Rainbow Rehab and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 8119 Memphis Arlington Road Bartlett, TN 38133	
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	change of condition (on 7/10/2026). The DON stated, .I expect the nurses to come in and round on the residents.if a change of condition starts to occur.the licensed nurse should document the change of condition immediately. The DON confirmed the nurse should assess and identify the change of condition timely and document their findings, then notify the Physician or Nurse Practitioner (NP) as soon as the change is identified. The DON confirmed she had been involved in discussions about whether or not Resident #1's change in condition was identified timely and if it was documented in the medical record, but she (the DON) had not personally read the documentation. The DON was asked if the facility did not do a timely assessment or document their assessment findings or did not communicate their assessment to the Doctor of Nursing Practice (DNP), or call the DNP for instructions, could this have caused injury or a decline in the outcome of the resident's condition. The DON stated, .it could have caused it. The DON confirmed staff should have called 911 for Resident #1's transfer to the ER on [DATE]. Refer to F600 The Removal Plan was verified and validated onsite by the surveyor on 7/20/2026 through 7/22/2026 through review of the in-service training records and audits, review of the facility's policy, observations, and staff interviews. Identification of Residents~Affected or Likely to be Affected:~ The facility took the following actions to~review and~identify~residents affected or likely to be affected.~ Resident #1~was discharged to~the emergency room on~7/10/26.^ The DON, ADON, SDC, IP nurse, Unit Managers, Nurse Supervisors, Wound Care Nurse, Medical record nurse, admission Nurse or MDS Coordinators~will assess current residents with~BIMS of 7 or less for any injuries that are suspicious in nature or of unknown origin and identified will be reported and investigated per state/federal guidelines.~This will be completed on 7/18/26.~ The DON, Social Services Director, Social service assistant, MDS Nurse, ADON will interview current residents with BIMS scores of 8 and above for potential abuse and/or neglect. Any allegations of abuse and/or neglect will be reported/investigated per state/federal guidelines.~This will be completed on 7/18/26. Residents who are not~interview able~with a BIMS score of 7 or below will have a skin assessment to~identify~any injuries that are suspicious in~nature~ or~of unknown origin.~ The DON, ADON, SDC, IP nurse, Unit Managers, Nurse Supervisors, Social services,~Wound care nurse, Medical record nurse, admission nurse~or MDS Coordinators~will assess for change in condition including vital signs, respiratory assessment,~change in mentality~and overall change in condition, to identify any change to determine if any current resident has a change in condition~with any change in condition being reported to the provider for further instruction. This will be completed on 7/18/26.^ The RDO/VPO will educate the Administrator and DON on abuse/neglect policy and reporting guidelines on~7/18/26.^ ^ Actions to Prevent Occurrence/Recurrence:~ The facility took the following actions to prevent an adverse outcome from reoccurring.~ ^ The Administrator and Director of Nursing~reviewed the Abuse and Neglect policy and~the Notification of Changes policy~and no further recommendations on 7/18/26.~ The DON, ADON, SDC, IP Nurse, Unit managers,~Medical~record Nurse or Nursing Supervisors~will provide education to all current licensed nurses on notification to provider on significant change in medical conditions to include~completion of documentation,~assessment, notification~and use of the emergency services in cases of medical emergencies.~No licensed staff will be allowed to work after~7/18/26~until they have completed this training. The facility does not~utilize~agency staff, and any new hired licensed nurse will be educated during orientation. All current licensed nurses will be given a posttest to~validate~understanding.~ All current direct care~staff,~~Nurses, Certified Nursing Assistants and Therapy Staff will be educated on the stop and watch program which is~a~evidence based program part of the INTERACT program to alert to early warning signs of change in condition and report to nurse via direct communication or the electronic medical record. No direct care staff will be allowed to work after (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/18/26 until they have completed this training. The facility does not utilize agency staff, and any newly hired direct care staff will be educated during orientation. All current direct care staff will be given a posttest to validate understanding. All current staff will be educated on Abuse and neglect policy to include injuries of unknown origin and/or suspicious in nature with a posttest given with each staff member passing with 100% accuracy. Education will be completed by the Administrator, Director of Nursing, Social Services Director, ADON, Unit Manager, Staff Development Coordinator, or Nurse Supervisor. No staff will be allowed to work after 7/18/26 until they have completed this training. The facility does not utilize agency staff, and any newly hired staff will be educated during orientation. The DON, ADON, SDC, IP Nurse, Unit Managers, or Nursing Supervisors will conduct 5 employee questionnaires weekly x 12 weeks to validate understanding of abuse/neglect policy. The DON, ADON, SDC, IP Nurse, Unit Managers, Medical		

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F 0580 Level of Harm - Minimal harm or potential for actual harm 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** Based on policy review, medical record review, and interview, the facility failed to notify the Doctor of Nursing Practitioner (DNP) and the resident's legal representative of a change of condition that was identified on 7/10/2026 at approximately 10:56 AM for 1 of 6 (Resident #1) sampled resident reviewed for notification of change. Based on policy review, medical record review, and interview, the facility failed to notify the Doctor of Nursing Practitioner (DNP) and the resident's legal representative of a change of condition that was identified on 7/10/2026 at approximately 10:56 AM for 1 of 6 (Resident #1) sampled residents reviewed for notification of change. The findings include: 1. Review of the facility policy titled, Notification of Changes, dated 8/29/2024, revealed .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification.Circumstances requiring notification include.Significant change in the resident's physical, mental, or psychological condition such as deterioration in health, mental or psychosocial status. This may include Life- threatening conditions, or Clinical complications. Review of the facility policy titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 10/30/2023 revealed .Emergency Transfers/ Discharges- initiated by the facility for medical reasons .Notify resident and/or resident representatives . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Hypertension, Fracture of Superior Rim of Right Pubis (pelvic fracture), Encounter for Fracture with Routine Healing, Osteoarthritis, and Overactive Bladder. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was not coded. Review of the facility's Skilled Daily Note for Resident #1 dated 7/10/2026 at 3:33 PM, revealed Resident #1 experienced a change in condition and exhibited decreased consciousness, decreased mobility, and lethargy that began at approximately 10:56 AM, and vital signs were taken at that time. The DNP and RP were not notified of the change in condition when it first occurred. Review of the Nurses' Note for Resident #1 dated 7/10/2026 at 4:00 PM, revealed documentation that Resident #1 experienced a change of condition and an order was received to send the resident out to the emergency room (ER). During a telephone interview on 7/16/2026 at 12:30 PM, Resident #1's Responsible Party (RP) stated he was notified of the Resident's change of condition on 7/10/2026 at 3:30 PM, prior to her being transferred out to the ER. During an interview on 7/20/2026 at 12:40 PM, CNA B confirmed she provided care to Resident #1 on 7/10/2026 and the Resident was different after 10:30 AM. CNA B said she told the charge nurse Resident #1 was hard to awaken and seemed different. During an interview on 7/20/2026 at 4:22 PM, Certified Occupational Therapist Assistant (COTA) E was asked if she cared Resident #1 on the day she was discharged (7/10/2026). COTA E stated, .yes, she participated well before breakfast, she was talking alert and oriented.I split my time with her and was going back later in the day.At 11:00 AM I was trying to arouse her, but she wasn't arousing.the Unit Manager was there and said they were going to send her out. During a phone interview on 7/21/2026 at 12:06 PM, the DNP confirmed she was Resident #1's Primary Care Provider. The DNP said she was notified of Resident #1's change in condition after 3:00 PM on 7/10/2026, but she should have been notified when the change in condition first occurred. During an interview on 7/22/2026 at 1:00 PM, Licensed Practical Nurse (LPN) F was asked if she did a head-to-toe assessment on Resident #1. LPN F stated, No, I didn't. LPN F was asked if staff communicated to her a change in condition. LPN F stated, .not sure . LPN F was asked (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	if she should have completed an assessment, documented it in the medical record, and notified the physician. LPN F stated, .I didn't assess the patient and document.but yes, I should have. LPN F confirmed she did not notify the DNP or Resident #1's family when the change of condition began. During an interview on 7/22/2026 at 3:15 PM, the Director of Nursing (DON) confirmed the facility should have notified Resident #1's DNP and her family, as soon as the change of condition started occurring. Refer to F-600 and F-684		