STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455554	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of McGregor	414 Johnson Dr MC Gregor, TX 76657

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility to immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is a significant change in the resident's physical status for 1 (Resident #1) of 5 residents reviewed for resident rights. The facility failed to ensure the MD and Hospice were notified when Resident #1 had a change of condition on [DATE] with blood in his foley catheter (a medical device, a thin flexible, sterile tube that is inserted through the urethra into the bladder to drain urine). Resident #1 was sent to the ER on [DATE] for further evaluation and treatment and was diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) without acute organ dysfunction, Acute urinary retention (a sudden and often painful inability to empty the bladder, which can develop rapidly and may require immediate medical attention. Symptoms may include suprapubic pain, bloating, urgency, and distress), Complicated Urinary tract infection (a UTI with a higher risk of treatment failure) associated with indwelling urethral catheter, Dehydration (occurs when your body loses more fluids than it takes in, leading to insufficient water for normal bodily functions). Resident #1 later died in the hospital on [DATE]. This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 2:02 p.m. and an IJ template was given. While the IJ was removed on [DATE] at 5:03 p.m., the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for pain, hospitalization, and death. Findings included: (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident # 1's face sheet dated [DATE] reflected an [AGE] year-old male admitted on [DATE] with diagnoses that included: Parkinson's disease (a movement disorder that affects the nervous system and cause tremor, stiffness, slowing of movement and other problems), Acute Kidney failure (also known as acute renal failure is a condition where your kidneys stop working suddenly), obstructive and reflux uropathy (occurs when urine flow is blocked, either partially or completely through the ureter, bladder, or urethra.), BPH (Benign prostatic Hyperplasia occurs when the cells of the prostate gland begin to multiply. These additional cells cause your prostate gland to swell, which squeezes the urethra and limit urine flow) with lower urinary tract symptoms, and history of Urinary Tract Infections (UTI -occurs when bacteria get in the urinary system, often through the urethra, and begin to multiply in the bladder). Review of Resident #1's significant change MDS dated [DATE] indicated the Staff assessment of Mental Status reflected Resident #1 had short-term and long-term memory problems. Section H- Bladder and Bowel reflected Resident #1 had an indwelling catheter. Section J-Pain Assessment Interview reflected Resident #1 experience pain almost constantly. Review of Resident #1's care plan dated [DATE] reflected Resident #1 needed staff participation with ADLs due to weakness, Resident #1 required the use of indwelling catheter related to urinary retention with intervention to observe for signs and symptoms for UTI and notify charge nurse and physician for further assessment, medication as ordered, irrigate catheter per physician orders. It was noted that Resident #1 was at risk for pain related to disease process End Stage Parkinson with intervention to Administer analgesia as per orders. Give 1/2 hour before treatments or care. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Review of Resident #1's progress notes from [DATE] through [DATE] did not indicate Resident #1's family, his Hospice nurse or the MD were notified of the change of condition. Review of Resident #1's hospital records dated [DATE] reflected he was diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) without acute organ dysfunction, Acute urinary retention (a sudden and often painful inability to empty the bladder, which can develop rapidly and may require immediate medical attention. Symptoms may include suprapubic pain, bloating, urgency, and distress), Complicated Urinary tract infection (a UTI with a higher risk of treatment failure) associated with indwelling urethral catheter, Dehydration (occurs when your body loses more fluids than it takes in, leading to insufficient water for normal bodily functions). Review of Resident #1's hospital records dated [DATE] reflected, Resident [#1] was admitted to inpatient Hospice services, symptoms were managed with IV medication. He expired peacefully on [DATE] while in the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at about 9:46 a.m., Resident #1's family stated blood was noted in Resident #1's catheter tubing with no urine in the drainage bag on [DATE] and LVN B was made aware. Family also stated Blood was again noted in Resident #1's catheter on [DATE], about half a cup of fluid and LVN A was notified. Family stated they told LVN A that the last time there was blood in Resident #1's catheter, he had to be sent to the ER immediately and was told by LVN A that hospice do not work on the weekend and would be notified later. Resident #1's family stated Resident #1 was not sent to the ER until [DATE], was septic by the time he got to the hospital, was placed on inpatient hospice because of the severity of the infection. During an interview on [DATE] at 11:33 a.m., Resident #1's Hospice nurse stated she was made aware by LVN B on [DATE] of Resident #1 having blood in his foley catheter with urine output of 25cc. She stated she asked LVN B to irrigate the catheter and call back it there was no changes. She stated she was not made aware that Resident #1 had blood in his catheter since [DATE], she would have sent Resident #1 to the hospital sooner to replace his catheter. Resident #1's hospice nurse stated when she saw Resident #1 on [DATE] he was uncomfortable. During an interview on [DATE] at about 12:00 p.m., CNA F stated she worked with Resident #1 during the night shift on 5/16, 5/17 and [DATE]. CNA F stated Resident #1 had blood in his foley catheter and LVN C was aware. CNA F stated Resident #1 had pain all over but mainly his stomach and LVN C was aware of that. During an interview on [DATE] at about 12:13 p.m., CNA E, stated she worked with Resident #1 during the day shift on 5/16/, 5/17 5/18 and [DATE].CNA E stated Resident #1 started to have blood in his foley catheter bag from [DATE]. CNA E stated Resident #1 urine output was never over 50 cc and was all blood. CNA E stated it was brought to the attention of LVN A and B and they both stated they knew. CNA E also stated Resident #1 was pulling on the catheter like there was discomfort and he didn't want the catheter in., he was fidgeting. During an interview on [DATE] at about 12:39 p.m., LVN C stated he worked with Resident #1 on the weekend of 5/16 through [DATE] overnight. LVN C stated he got in report on [DATE] that Resident #1 had blood in his foley catheter. LVN C also stated Resident was making the AHHH sound while moaning and he gave Resident #1 pain medication on 5/17 and [DATE]. LVN C stated he did not document Resident #1's change in condition because Resident #1 was on hospice, and everyone was aware that there was blood in Resident #1's catheter and that Resident #1 was noted for pulling his catheter out. LVN C stated he did not notify the MD or Hospice. LVN C also stated they just pass it on in report from shift to shift each day the entire weekend. During an interview on [DATE] at 2:13 p.m., the DON stated If it was blood, I expect the staff to irrigate the catheter, make sure it was clear or clearer with documentation to say that. They are not ever supposed to wait for few days before notifying the hospice or the Doctor. During an interview on [DATE] at 3:22 p.m., the MD stated she was familiar with Resident #1. The MD stated, The patient was on hospice, PO intake was poor, enlarge prostate and the urine will not flow. The staff are supposed to check for output every shift, within 24 hours, if there was no output they should have notified someone. The MD stated the protocol was for staff to notify Hospice on-call nurse and MD, if unsuccessful, notify her team. The MD stated she was not notified. Review of facility's policy titled Change of Condition dated [DATE] reflected: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Purpose To provide a standardized process for identifying, assessing, and responding to changes in the physical, cognitive, or emotional condition of nursing home residents, ensuring timely and appropriate notification to the physician, responsible party, and hospice care team (if applicable). Scope This policy applies to all nursing home staff, including nursing, medical, and administrative personnel, involved in the care and communication of residents' health status. Definitions o Change of Condition: A significant and noticeable alteration in a resident's health, behavior, or physical functioning. This can include changes in vital signs, cognitive function, mobility, skin integrity, or overall mental or emotional well-being. o Responsible Party: The individual designated by the resident or their legal representative (e.g., family member, legal guardian) who is responsible for making healthcare decisions or being notified of the resident's health status. o Physician: The attending or primary physician responsible for the overall medical care of the resident. o Hospice Care: Specialized care provided to terminally ill residents, focusing on comfort, pain management, and quality of life at the end of life. Physical Changes Cognitive Function: Sudden confusion, agitation, delirium, or memory decline. o Pain: Increased reports or signs of pain (verbal or non-verbal), requiring reassessment or pam management. Appetite _ or Fluid Intake: significant changes in eating or drinking patterns including refusal to eat or drink. 2. Assessment of Change of Condition (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Once a change of condition is identified, the responsible nursing staff member must perform a thorough assessment to determine the severity of the change and its potential causes. This includes: o Reviewing the Resident's Medical History: Consider any chronic conditions or known issues that might be exacerbated. o Monitoring Vital Signs: Repeat vital signs if necessary to confirm a significant change. o Assessment Tools: Use appropriate clinical assessment tools (e.g., Braden Scale for pressure ulcers, pain scales, delirium assessment tools) to measure and document the change. o Documentation: Thoroughly document all findings, including changes in symptoms, assessment details, interventions, and the time the change was first noted. 3. Notification Protocol Once a change in condition has been identified and assessed, the following notification protocols should be followed to ensure that all relevant parties are informed promptly and appropriately. 3.1 Notification of the Physician Immediate Notification: The attending physician must be notified of an) significant change in the resident's condition that could impact their health or require changes to their care plan. This should be done within one hour of identifying the change. Documentation: Document the time of the notification. the person contacted. and the physician's response or instructions in the resident's medical record. Critical Changes: If the change in condition is life-threatening or requires urgent intervention, notify the physician immediately. and follow up with any necessary interventions (e.g., emergency medication. transfer to the hospital). 3.3 Notification of Hospice (If Applicable) o (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Hospice Involvement: If the resident is under hospice care, the hospice care team must be notified promptly of any changes in condition, especially if the change indicates a worsening or imminent decline in the resident's health. o Timely Communication: Hospice care providers should be contacted immediately if the change of condition is related to end-of-life issues, such as increased pain, difficulty breathing, or changes in consciousness. o Collaboration: The nursing home staff should collaborate with the hospice team to discuss the next steps in care, including adjusting the hospice care plan, symptom management, and family support. Review of facility's policy titled Resident Rights dated [DATE] reflected: Policy Statement-- Employees shall treat all residents with kindness, respect, and dignity. I. equal access to quality of care regardless of source of payment. Review of facility's policy titled Hospice Program dated [DATE] reflected: Policy Statement Hospice services are available to residents at the end of life. In generally, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: a. Twenty-four-hour room and board care, b. Administering prescribed therapies, incl a. b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	c. Notifying the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. The Administrator and ADON were notified on [DATE] at 2:02 p.m., that an IJ had been identified and an IJ template was provided. The following POR was approved on [DATE] at 10:25 a.m. Plan of Removal for F580 - Notification of Changes Regulatory Tag: F580 On [DATE], an abbreviated survey was initiated at the facility. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to ensure the MD and Hospice were notified when Resident #1 had a change of condition on [DATE] with blood in his foley catheter. Resident #1 was sent to the ER on [DATE] for further evaluation and treatment where Resident #1 was diagnosed with Sepsis without acute organ dysfunction, Acute urinary retention, Complicated Urinary tract infection associated with indwelling urethral catheter, Dehydration, and Retention of urine. 1. Immediate Protection for Resident #1 and Related Residents: Resident #1 expired in the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Physician was contacted by DON/ADON and updated on the two other residents that have a indwelling catheter or are on Hospice services. The responsible parties for the indwelling catheter residents and Hospice residents were notified by DON/ADON and documentation completed showing if there were any significant changes noted. Residents with indwelling catheter and/or on Hospice had their treatment plan reviewed and updated by the interdisciplinary team. These efforts will be documented on a facility-developed audit tool. Completed by: DON/ADON 0n [DATE]. 2. Education/Re-Education: The nurse(s) involved in the failure to notify were immediately re-educated on change of condition, notifying responsible Hospice entities, medical personnel, and responsible party by DON/ADON. Audit sheets will be made by ADON that address return knowledge. All licensed nurses and nursing staff were re-educated by DON/ADON on: o F580 regulatory requirements o Facility policy for significant change notifications o Timeframe expectations per policy o Proper documentation procedures o DON was reeducated by the Regional Nurse on [DATE]. In-service Completion Date: The DON/ADON will in-service and train each nursing staff member before their next assigned shift or they will not be allowed to work by [DATE]. Audit sheets will be made by ADON that address return knowledge. 3. Policy and Process Reinforcement: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility policy regarding change in condition notifications was reviewed and updated by the DON/ADON. Standardized notification form/checklist was implemented requiring: o Date/time of physician/family notification. o Name of person notified. o Reason for notification o Signature of staff completing the communication o This form will be maintained at the nurses 24 report station. All nursing staff will be educated by DON/ADON (who were reeducated by the Regional Nurse on [DATE]) by [DATE] on the new form and required documentation prior to their next assigned shift or they will not be allowed to work. 4. Monitoring Plan for Continued Compliance: Beginning [DATE] DON or designee will review: o 5 resident charts per week for 4 weeks o Then 5 charts weekly for the next 8 weeks Random staff interviews conducted weekly to validate understanding of notification policy. Audit sheets will be made by ADON that address return knowledge. Results reported weekly to Standards of Care for ongoing tracking and follow-up will be managed by the DON or designee. These will flow to the monthly QAPI review for management. The Surveyor monitored the POR on [DATE] from 10:26 a.m. to 5:30 p.m. as follows: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on [DATE] from 1:55 PM - 3:03 PM revealed four CNAs, one MA, one LVN, and one RN from different shifts all stated they were in-serviced before their shifts by the DON on catheter care, pain, and notifying the MD. The CNAs stated they were responsible for emptying the catheter bag before the end of their shift, making sure it was clean, and that peri care was provided. The CNAs stated they were responsible for charting the input and output of urine and notifying the nurse if there was anything abnormal such as blood in the urine, cloudiness, or if the resident was in pain. The nurses all stated it was their responsibility to set eyes on residents' catheters every shift to monitor if it was in place, if there was any sediment in the tubing, and that it was draining properly. The nurses stated if there was blood in the bag or if the resident was in uncontrolled pain, they would contact the MD immediately. Review of facility's in-services dated [DATE] and [DATE] reflected the following: Facility had an QAPI for identification of deficient practice on [DATE] at 7:20 pm Nurses and CMA checkoff on Foley Catheter Insertion, Hand hygiene, PPE/EBP with posttest. DON completed an audit on all Resident with foley Catheter. MD review all resident with catheter and were on hospice, reviewed their documents and there were no concerns. Review of facility's in-serviced dated [DATE] titled Completion and accuracy of charting - MD and families to be notified of all events/changes in condition/new onset of symptoms and charted. Accuracy of intake and output is paramount in coordinating care between all disciplines. Nurses stated they were in-serviced on making sure to chart any changes and notify the family and/or the MD. Review of facility's Change of condition and notification policy reflected it was updated on [DATE] and was approved by DON, and the , Regional Nurse Consultant. It reflected the purpose was to provide a standardized process for identifying assessing, and responding to changes in the physical, cognitive or emotional condition of nursing home residents, ensuring timely and appropriate notification to the physician, responsible party and hospice care team (if applicable.) Review of facility's in-service dated [DATE] reflected the DON was in-serviced by the Regional Nurse on the following topics: change of condition, significant change of conditions, pain and suffering management, pain management assessment, catheter care / management policy. Review of facility's in-services reflected LVN B and D were in-serviced on notification on [DATE]. LVN B confirmed verbally that she was in-serviced. Review of the facility's matrix dated [DATE] reflected there were 2 other residents with indwelling catheter in the facility. Both Residents progress notes dated [DATE] reflected care plan meeting was held with residents and their RPs regarding indwelling catheter and pain management. Review of Residents with indwelling catheter care plans reflected their care plans were updated on [DATE] by the MDS nurse. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility's audit tools reflected all residents with indwelling catheter and were on hospice were listed and kept in the 24-hour report binder and there were no issues with their catheter and hospice care. On [DATE] at 05:03 p.m., the Administrator was informed the immediacy was removed. While the IJ was removed on [DATE] at 05:03 p.m., the facility remained out of compliance at a severity of no actual harm and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections for 1 (Resident #1) of 3 residents review for catheter care. The facility failed to assess and intervene with Resident #1's foley catheter (a medical device, a thin flexible, sterile tube that is inserted through the urethra into the bladder to drain urine) when Resident #1's foley catheter was draining all blood from [DATE] until 3 days later on [DATE]; Resident #1 was sent to the local ER for further evaluation and treatment and was diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) without acute organ dysfunction dated [DATE], Acute urinary retention (a sudden and often painful inability to empty the bladder, which can develop rapidly and may require immediate medical attention. Symptoms may include suprapubic pain, bloating, urgency, and distress), Complicated Urinary tract infection (a UTI with a higher risk of treatment failure) associated with indwelling urethral catheter, Dehydration (occurs when your body loses more fluids than it takes in, leading to insufficient water for normal bodily functions). This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 2:02 pm and an IJ template was given. While the IJ was removed on [DATE] at 05:03 pm, the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for hospitalization, Sepsis, and death. Findings included: Review of Resident # 1's face sheet dated [DATE] reflected an [AGE] year-old male admitted on [DATE] with diagnoses that included: Parkinson's disease (is a movement disorder that affects the nervous system and cause tremor, stiffness, slowing of movement and other problems), Acute Kidney failure (also known as acute renal failure is a condition where your kidneys stop working suddenly), obstructive and reflux uropathy (occurs when urine flow is blocked, either partially or completely through the ureter, bladder, or urethra.), BPH (Benign prostatic Hyperplasia occurs when the cells of the prostate gland begin to multiply. These additional cells cause your prostate gland to swell, which squeezes the urethra and limit urine flow) with lower urinary tract symptoms, history of Urinary Tract Infections (UTI -occurs when bacteria get in the urinary system, often through the urethra, and begin to multiply in the bladder). Review of Resident #1's significant change MDS dated [DATE] indicated Staff assessment of Mental Status reflected Resident #1 had short-term and long-term memory problems. Section H- Bladder and Bowel reflected Resident #1 had an indwelling catheter. Section J-Pain Assessment Interview reflected Resident #1 experience pain almost constantly. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan dated [DATE] reflected Resident #1 needed staff participation with ADLs due to weakness, Resident #1 required the use of indwelling catheter related to urinary retention with intervention to observe for signs and symptoms for UTI and notify charge nurse and physician for further assessment, medication as ordered, irrigate catheter per physician orders. It was noted that Resident #1 was at risk for pain related to disease process End Stage Parkinson with intervention to Administer analgesia as per orders. Give 1/2 hour before treatments or care. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Review of Resident #1's progress notes reflected no documentation of change of condition on 5/16, 5/17 and [DATE]. Review of Resident #1's Hospice nurse notes dated [DATE] written by Hospice nurse reflected: Received call from facility, nurse [LVN A]. She stated pt had clotted blood in foley bag. States he's not showing sign or symptoms of UTI. Instructed to flush foley with sterile water and to call back it not better. Verbalized understanding. Updated family. Review of Resident #1's Hospice nurse notes dated [DATE] at 7:39 pm reflected: called [LVN A] back. Foley cath flushed without difficulty and had good return. Instructed to call back for any other concerns or questions. Review of Resident #1's progress notes dated [DATE] written by LVN D at 10:15 am reflected: RN with hospice attempted to replace foley catheter at this time due to concerns with current foley and not voiding. Upon inserting new foley, nurse hit resistance and noted large amounts of blood upon attempt to insert foley. Due to difficulty with inserting new catheter hospice is sending out to ER for catheter replacement. Review of Resident #1's interact form dated [DATE] reflected Resident #1 went to the ER for foley catheter re-insertion. Review of Resident #1's urine output reflected: [DATE] 01 :38 AM---800 cc [DATE] 13:54 (1:54 PM)---50 cc [DATE] 05:55 AM---0 cc [DATE] 05:59 AM-----0 cc [DATE] 13:59 (1:59 PM)----25 cc [DATE] 04: 11 AM-----0 cc (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's hospital records dated [DATE] reflected: chief complaint-Hematuria- is an 80 y.o. male patient presenting to the ED via EMS from hospice with c/o urination changes. EMS reports that the nurse checked on the pt this morning, who was not producing urine even with a foley catheter. EMS states that the nurse pulled out the foley catheter and found a clot after trying to flush out the catheter. EMS states that the pt's nurse was unable to put the catheter back in afterwards. Review of Resident #1's hospital records dated [DATE] reflected he was diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) without acute organ dysfunction, Acute urinary retention (a sudden and often painful inability to empty the bladder, which can develop rapidly and may require immediate medical attention. Symptoms may include suprapubic pain, bloating, urgency, and distress), Complicated Urinary tract infection (a UTI with a higher risk of treatment failure) associated with indwelling urethral catheter, Dehydration (occurs when your body loses more fluids than it takes in, leading to insufficient water for normal bodily functions). Final Diagnoses as of [DATE] at 11:26 am Acute urinary retention Complicated UTI (urinary tract infection), Dehydration, End of life care. Review of Resident #1's hospital records dated [DATE] reflected, Resident [#1] was admitted to inpatient Hospice services, symptoms were managed with IV medication. He expired peacefully on [DATE] while in the hospital. During an interview on [DATE] at about 9:46 a.m., Resident #1's family stated blood was noted in Resident #1's catheter tubing with no urine in the drainage bag on [DATE] and LVN B was made aware. Family also stated Blood was again noted in Resident #1's catheter on [DATE], about half a cup of fluid and LVN A was notified. Family stated they told LVN A that the last time there was blood in Resident #1's catheter, he had to be sent to the ER immediately and was told by LVN A that hospice do not work on the weekend and would be notified later. Resident #1's family stated Resident #1 was not sent to the ER until [DATE], was septic by the time he got to the hospital, was placed on inpatient hospice because of the severity of the infection. During an interview on [DATE] at about 10:46 a.m., LVN B stated she worked with Resident #1 on [DATE] and it was brought to her attention by Resident #1's family that there was blood in the Resident #1's foley catheter. LVN B stated Resident #1 was pulling on his foley catheter that is why there was blood in the catheter. LVN B stated she explained to Resident #1's family that there was a balloon in the catheter that would prevent the catheter from coming outside and it was causing trauma that is why there was blood in the catheter drainage bag. LVN B stated she gave Resident #1 fluids and checked placement and his catheter cleared out. LVN B stated she did not document any interventions, maybe she forgot. LVN B stated she should have documented change of condition. During an interview on [DATE] at about 11:52 a.m., LVN D stated she worked with Resident #1 on [DATE] the morning he was transferred to the ER. LVN B stated she got a verbal report that Resident #1 did not have urine output all night. LVN D stated she did not assess Resident #1 or provide any interventions. LVN D stated what she documented was what was done by Resident #1's Hospice nurse. LVN D stated when Resident #1's Hospice nurse got in the building at about 10:00 a.m., she told Resident #1's Hospice nurse that she got in report that Resident #1 did not have urine output during the night shift (12 hours shift). (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at about 12:35 p.m., Resident #1's Hospice nurse stated she was made aware by LVN A on [DATE] at about 2:00 p.m. of Resident #1 having blood in his foley catheter with urine output of 25 cc. Resident #1's Hospice nurse stated she asked LVN A to irrigate the catheter and call back if there were no changes. Resident #1's Hospice nurse stated when she saw Resident #1 on the morning of [DATE], there was blood in his catheter drainage bag, she flushed the catheter and there was return of clear fluids, and she knew something was not right because the output should have blood tinge and not clear. Hospice nurse stated she attempted to removed Resident #1's catheter and realized the bulb of the catheter was not in his bladder so his foley catheter was not draining urine. Hospice nurse stated she assessed Resident #1, and his abdomen was distended, she attempted to re-insert the foley catheter but was unsuccessful, so she transferred Resident #1 to the ER. The Hospice nurse stated distended bladder can cause discomfort and infection. She stated Resident #1 might have pull his catheter out, he had history of pulling his catheter out. During an interview on [DATE] at about 1:30 p.m., after the DON reviewed Resident #1's urine output which indicated the resident had no urine output on 5/17 and 25 cc on 5/18. The DON stated not having urine output with distended stomach can cause infection, if bad it can cause sepsis which can lead to death. The DON stated, if a resident was on hospice services, the hospice nurse would help sometimes to change the catheter. The charge nurses, DON, ADONs are responsible to ensure that the catheter is changed. Output for catheter should be document on the TAR by the charge nurses. The aides should get the output and the charge nurses document the output. During an interview on [DATE] at about 2:18 p.m., LVN A stated she worked with Resident #1 on [DATE] and there was blood coming from his catheter. LVN A stated Resident #1's family approached her about the blood in Resident #1's catheter and she called Resident #1's Hospice nurse around 2:00 p.m. and was told to flush the catheter. LVN A stated she flushed Resident #1's foley catheter and there was pinkish output of about 100 cc noted in the drainage bag. LVN A stated she did not tell the family that she would wait for the next day, she stated by the time she got back from calling Resident #1's Hospice nurse, the family had left. LVN A stated that she did not call Resident #1's Hospice nurse back and did not talk to Hospice nurse after. During an interview on [DATE] at 11:33 am, Resident #1's Hospice nurse stated she was not made aware the Resident #1 had blood in his catheter since [DATE], she would have sent Resident #1 to the hospital sooner to replace his catheter. Resident #1's hospice nurse stated when she saw Resident #1 on [DATE] he was uncomfortable. During interviews on [DATE] at about 12:00 p.m., CNA F stated she worked with Resident #1 during the night shift on 5/16, 5/17 and [DATE]. CNA F stated Resident #1 had blood in his foley catheter and LVN C was aware. CNA F stated Resident #1 had at least 100 cc in his foley bag, maybe she forgot to document Resident #1's output for the entire weekend. CNA F stated Resident #1 had pain all over but mainly his stomach and LVN C was aware of that. During an interview on [DATE] at about 12:13 p.m., CNA E, stated she worked with Resident #1 during the day shift on 5/16/, 5/17 5/18 and [DATE].CNA E stated Resident #1 started to have blood in his foley catheter bag from [DATE]. CNA E stated Resident #1 urine output was never over 50 cc and was all blood. CNA E stated it was brought to the attention of LVN A and B and they both stated they knew. CNA E also stated Resident #1 was pulling on the catheter like there was discomfort and he didn't want the catheter in., he was fidgeting. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at about 12:39 p.m., LVN C stated he worked with Resident #1 on the weekend of 5/16 through [DATE] overnight. LVN C stated he got in report on [DATE] that Resident #1 had blood in his foley catheter. LVN C also stated Resident was making the AHHH sound while moaning and he gave Resident #1 pain medication on 5/17 and [DATE]. LVN C stated he did not document Resident #1's change in condition because Resident #1 was on hospice, and everyone was aware that there was blood in Resident #1's catheter and that Resident #1 was noted for pulling his catheter out. LVN C stated he did not notify the MD or Hospice. LVN C also stated they just pass it on in report from shift to shift each day the entire weekend. Later During an interview on [DATE] at 2:13 p.m., the DON stated it was documentation problems, the staff did intervene for Resident #1. The DON stated blood in the urine/catheter was normal for Resident #1. The DON stated, If it was blood, I expect the staff to irrigate the catheter, make sure it is clear or clearer with documentation to say that. You would monitor urine output but if you are not taking in anything, nothing would come out. We could not change it because of difficulty. They are not ever supposed to wait for few days before notifying the hospice or the Doctor. During an interview on [DATE] at 3:22 p.m., the MD stated she was familiar with Resident #1. The MD stated, The patient was on hospice, PO intake was poor, enlarge prostate and the urine will not flow. The catheter is to drain the urine from the bladder. He was always pulling on the catheter, and it was possible for the catheter to not be in the bladder when he pulled it. It can be a problem if there was no output for about 3 days, the staff were supposed to check for output every shift, within 24 hours, if there was no output they should have notified someone. Because he is on hospice, we cannot monitor him like the normal people. Distended bladder could cause discomfort, moaning is an indication of pain. Hard to say not having output would cause infection, it depends on how long he was distended. We have to do culture to know that. Review of facility's policy titled Foley Catheter insertion; Male Resident dated [DATE] reflected: Purpose The purpose of this procedure is to provide guidelines for the aseptic insertion of a urinary catheter. Documentation The following information should be recorded in the resident's medical record: The date and time the procedure was performed. The name and title of the individual(s) who performed the procedure. All assessment data (e.g., character, color, clarity, etc.) obtained during the procedure. The size of the Foley catheter inserted, and the amount of fluid used to inflate the balloon. How the resident tolerated the procedure. If the resident refused the procedure, the reason(s) why and the intervention taken. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The signature and title of the person recording the data. Reporting Notify the supervisor if the resident refuses the procedure. Notify the physician of any abnormalities (i.e. bleeding, obstruction, etc.). Report other information in accordance with facility policy and professional standards of practice. Review of facility's policy titled Hospice Program dated [DATE] reflected: Policy Statement Hospice services are available to residents at the end of life. In generally, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: a. Twenty-four-hour room and board care, b. Administering prescribed therapies, incl a. b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. c. Notifying the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(4) The resident's death. d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. The Administrator and ADON were notified on [DATE] at 2:02 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on [DATE] at 10:25 am. Immediate Jeopardy Plan of Removal for F690 Tag: F690 - Bowel/Bladder Incontinence, Catheter, UTI On [DATE], an abbreviated survey was initiated at the facility. On [DATE]Tw the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to assess and intervene with Resident #1's foley catheter when it was draining all blood for 3 days before he was sent to the ER on [DATE] for further evaluation and treatment where Resident #1 was diagnosed with Sepsis without acute organ dysfunction, Acute urinary retention, Complicated Urinary tract infection associated with indwelling urethral catheter, Dehydration, and Retention of urine. Plan of Removal 1. Immediate Action Taken to Protect Resident #1 and Related Residents: Resident #1 expired in the hospital. The two residents with the indwelling catheters were assessed by the DON/ADON and/or Charge Nurses for signs/symptoms of UTI placement, drainage, and pain management and catheter necessity. This staff was re-trained/in serviced by the DON, who was re-in serviced by the Regional Nurse consultant. Seven Hospice residents were assessed by DON/ADON and/or Charge nurses for any signs or symptoms of pain and suffering. This staff was re-trained/in serviced by the DON, who was re-in serviced by the Regional Nurse consultant. All hospice residents were found to have no new signs/symptoms of infection or pain to report to the hospice entity/physician. 2. Education/Re-Education: (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There were 5 Nurses and 8 CNAs responsible for Resident #1's care were immediately re-trained on catheter care, infection control, and documentation standards. The success of the training was secured with return demonstration and question/answering. All licensed nurses and cnas will receive re-education on: o Catheter care protocol per facility policy o Signs and symptoms of UTI and urinary retention o catheter-associated urinary tract infection and proper hygiene o Signs and symptoms of pain and suffering Completed by: DON and ADON will complete the re-education before the employees' next assigned shift, or they will not be allowed to work. DON/ADON will use a catheter skills list to check off for nurse and cna roles by [DATE]. This will be to ensure return demonstration of knowledge from the in-service and a allow proper documentation of the intake/output record. 3. Facility-Wide Audit and Monitoring: A 100% audit of all residents with indwelling catheters was completed on [DATE] utilizing a facility developed audit tool by DON/ADON. Each catheterized resident was reviewed for: o Proper physician orders o Documentation of catheter necessity o Evidence of routine catheter care and hygiene o (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Monitoring for UTI symptoms Daily monitoring records were implemented for this catheter care documentation to be captured in the morning clinical meetings. Audit Completion Date: [DATE] 4. Infection Control Measures Enhanced: DON/ADON reviewed and revised the catheter care protocol to align with facility protocol. In-servicing of hand hygiene, PPE usage, and catheter technique conducted for all licensed staff/CNAs. Random observations of catheter care are now being performed daily for 2 weeks, weekly thereafter for 1 month. Completed by: DON and ADON will complete the re-education before the employees next assigned shift or they will not be allowed to work. An audit tool will be developed by ADON to assure return demonstration/competency of the in-service. 5. Medical Oversight and Ongoing Review: Medical Director reviewed all cases of catheter use and collaborated with nursing to eliminate unnecessary catheters. Hospice management entity review with facility on pain and suffering. Beginning [DATE] and ongoing Weekly interdisciplinary team (IDT) meetings include a catheter review component. Pharmacy consultant notified to assist in UTI surveillance and antibiotic stewardship with monthly reviews and electronic chart data. Audit tools will be developed for each of these areas by ADON. 6. Monitoring for Effectiveness: DON or designee will audit those catheterized residents weekly for compliance and document on a facility developed form beginning 06032025 and ongoing. DON/ADON will monitor new UTIs and catheter-associated urinary tract infection, report trends monthly to QAPI. This will be documented on an audit tool starting 06032025 and ongoing. Random staff interviews and skill checks on catheter care will occur weekly for 4 weeks and monthly thereafter beginning [DATE] and ongoing. The Surveyor monitored the POR on [DATE] from 10:26 am to 5:30 pm as follows: (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During interviews on [DATE] from 1:55 PM - 3:03 PM revealed four CNAs, one MA, one LVN, and one RN from different shifts all stated they were in-serviced before their shifts by the DON on catheter care, pain, and notifying the MD. The CNAs stated they were responsible for emptying the catheter bag before the end of their shift, making sure it was clean, and that peri care was provided. The CNAs stated they were responsible for charting the input and output of urine and notifying the nurse if there was anything abnormal such as blood in the urine, cloudiness, or if the resident was in pain. The nurses all stated it was their responsibility to set eyes on residents' catheters every shift to monitor if it was in place, if there was any sediment in the tubing, and that it was draining properly. The nurses stated if there was blood in the bag or if the resident was in uncontrolled pain, they would contact the MD immediately. Review of facility's in-services dated [DATE] and [DATE] reflected the following: Facility had an QAPI for identification of deficient practice 0n [DATE] at 7:20 pm Nurses and CMA checkoff on Foley Catheter Insertion, Hand hygiene, PPE/EBP with posttest. DON completed an audit on all Resident with foley Catheter. MD review all resident with catheter and were on hospice, reviewed their documents and there were no concerns. Review of facility's in-service dated [DATE] reflected the DON was in-serviced by the Regional Nurse on the following topics: change of condition, significant change of conditions, pain and suffering management, pain management assessment, catheter care / management policy. Review of facility's audit tools reflected all residents with indwelling catheter (2 residents) and were on hospice (7 residents) were listed and kept in the 24-hour report binder and there were no issues with their catheter and hospice care. It was reflected Resident were assessed and assessments were documented in the resident's EMR progress notes, assessments were done using either verbal or visual assess. Staff were in-serviced on s/s of UTIS, urinary retention, infection control, catheter care. Review of progress notes of Residents with indwelling catheter reflected it was reviewed by the MD on [DATE]. Review of facility's audit tools initiated [DATE] reflected 2 Residents in the facility with catheter. Audit tools tracs urine output, color clarity, odor, completion of catheter care, s/s of UTI, s/s of pain, signs of blood in urine. Observation on [DATE] of hospice residents and residents with indwelling catheter reflected no concerns or non-compliance. On [DATE] at 05:03 p.m., the Administrator was informed the immediacy was removed. While the IJ was removed on [DATE] at 05:03 p.m., the facility remained out of compliance at a severity of no actual harm and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and records review, the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (Resident #1) of 3 residents review for pain management. The facility failed to provide effective pain interventions for Resident #1 from [DATE] through [DATE]. The facility failed to assess and intervene when Resident #1's foley catheter (a medical device, a thin flexible, sterile tube that is inserted through the urethra into the bladder to drain urine) when Resident #1's foley catheter was draining all blood from [DATE] until 3 days later on [DATE]; Resident #1 was sent to the local ER for further evaluation and treatment and was diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) without acute organ dysfunction dated [DATE], Acute urinary retention (a sudden and often painful inability to empty the bladder, which can develop rapidly and may require immediate medical attention. Symptoms may include suprapubic pain, bloating, urgency, and distress), Complicated Urinary tract infection (is a UTI with a higher risk of treatment failure) associated with indwelling urethral catheter, Dehydration (occurs when your body loses more fluids than it takes in, leading to insufficient water for normal bodily functions). Resident #1 later died in the hospital on [DATE]. This failure resulted in an identification of an Immediate Jeopardy (IJ) on [DATE] at 2:02 pm and an IJ template was given. While the IJ was removed on [DATE] at 05:03 pm, the facility remained out of compliance at a severity of no actual harm with a potential for more than minimal harm, that was not immediate jeopardy at a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems. This deficient practice could place residents at risk for discomfort, hospitalization, and death. Findings included: Review of Resident # 1's face sheet dated [DATE] reflected an [AGE] year-old male admitted on [DATE] with diagnoses that included: Parkinson's disease (is a movement disorder that affects the nervous system and cause tremor, stiffness, slowing of movement and other problems), Acute Kidney failure (also known as acute renal failure is a condition where your kidneys stop working suddenly), obstructive and reflux uropathy (occurs when urine flow is blocked, either partially or completely through the ureter, bladder, or urethra.), BPH(Benign prostatic Hyperplasia occurs when the cells of the prostate gland begin to multiply. These additional cells cause your prostate gland to swell, which squeezes the urethra and limit urine flow) with lower urinary tract symptoms, history of Urinary Tract Infections (UTI -occurs when bacteria get in the urinary system, often through the urethra, and begin to multiply in the bladder). Review of Resident #1's significant change MDS dated [DATE] indicated the Staff assessment of Mental Status reflected Resident #1 has short-term and long-term memory problems. Section H- Bladder and Bowel reflected Resident #1 had an indwelling catheter. Section J-Pain Assessment Interview reflected Resident #1 experience pain almost constantly of 7 on the scale 0-10. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of McGregor	414 Johnson Dr MC Gregor, TX 76657

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's care plan dated [DATE] reflected Resident #1 needed staff participation with ADLs due to weakness, Resident #1 required the use of indwelling catheter related to urinary retention with intervention to observe for signs and symptoms for UTI and notify charge nurse and physician for further assessment, medication as ordered, irrigate catheter per physician orders. It was noted that Resident #1 was at risk for pain related to disease process End Stage Parkinson with intervention to Administer analgesia as per orders. Give 1/2 hour before treatments or care. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/document for probable cause of each pain episode. Remove/limit causes where possible. Review of Resident #1's progress notes reflected no documentation of change of condition on 5/16, 5/17 and [DATE]. Review of Resident #1's interact form dated [DATE] reflected Resident #1 went to the ER for foley catheter re-insertion. Review of Resident #1's hospital records dated [DATE] reflected: Current Symptoms Seen on rounds. Not verbalizing other than moaning. Writhing in bed. RN at bedside providing pain medication. Symptom Management: 1.) Pain - Significant nonverbal signs of pain (PAINAD score 9) - Change to fentanyl 12.5-25 mcg IV q2h prn 2.) Anxiety/agitation - Change to Ativan 0.5 mg IV q4h prn PAINAD Breathing: Brief labored or hyperventilation periods Vocalization: Loud moans/groans. Repeated troubled calling out. Crying Expression: Grimacing Body Language: Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out. Consolability: Unable to console, distract, or reassure. PAINAD SCORE: 9 (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's Physician order reflected: Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 50 mg by mouth every 12 hours as needed for Pain and Discomfort Give One 50mg Tab Every 12 hours as needed for pain dated [DATE] Morphine Sulfate Oral Solution 10 MG/5ML (Morphine Sulfate) Give 0.5 ml by mouth every 2 hours as needed for PAIN/SOB Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth two times a day for pain dated [DATE] Review of Resident #1's EMR reflected Resident #1 did not have any pain from [DATE] through [DATE] Review of Resident #1's MAR /TAR reflected Resident #1 was not given any breakthrough pain medication during the day shift. Review of Resident #1's Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 50 mg narcotic count sheet for the last week before Resident #1 was sent to the ER reflected the following: [DATE] at 8:30 pm- 0.5 ml administrator by LVN C [DATE] at 10:30 pm- 0.5 ml administrator by LVN C [DATE] at 10:45 pm- 0.5 ml administrator by LVN C [DATE] at 4:30 am- 0.5 ml administrator by LVN C [DATE] at 8:00 pm- 0.5 ml administrator by LVN C [DATE] at 11:0 pm- 0.5 ml administrator by LVN C Review of Resident #1's Morphine Sulfate Oral Solution 10 MG/5ML (Morphine Sulfate) narcotic count sheet for the last week before Resident #1 was sent to the ER reflected the following: [DATE] at 8:00 pm- 1 tab administrator by LVN C . Review of Resident #1's hospital records dated [DATE] reflected he was diagnosed with Sepsis (a serious condition in which the body responds improperly to an infection, causing organ damage and sometimes death) without acute organ dysfunction, Acute urinary retention (a sudden and often painful inability to empty the bladder, which can develop rapidly and may require immediate medical attention. Symptoms may include suprapubic pain, bloating, urgency, and distress), Complicated Urinary tract infection (a UTI with a higher risk of treatment failure) associated with indwelling urethral catheter, Dehydration (occurs when your body loses more fluids than it takes in, leading to insufficient water for normal bodily functions). Review of Resident #1's hospital records dated [DATE] reflected, Resident [#1] was admitted to inpatient Hospice services, symptoms were managed with IV medication. He expired peacefully on [DATE] while in the hospital. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's hospital records dated [DATE] reflected, Resident [#1] was admitted to inpatient Hospice services, symptoms were managed with IV medication. He expired peacefully on [DATE] while in the hospital. During an interview on [DATE] at about 12:35 p.m., Resident #1's Hospice nurse stated she assessed Resident #1 on [DATE] at about 10:00 am, and his abdomen was distended, she attempted to re-insert the foley catheter but was unsuccessful, so she transferred Resident #1 to the ER. The Hospice nurse stated distended bladder can cause pain, discomfort and infection. She stated Resident #1 might have pull his catheter out, he had history of pulling his catheter out. During an interview on [DATE] at about 1:30 p.m., after the DON reviewed Resident #1's urine output which indicated the resident had no urine output on 5/17 and 25 cc on 5/18. The DON stated not having urine output with distended stomach can cause infection, if bad it can cause sepsis which can lead to death. During an interview on [DATE] at 11:33 a.m., Resident #1's Hospice nurse stated she was not made aware the Resident #1 had blood in his catheter since [DATE], she would have sent Resident #1 to the hospital sooner to replace his catheter. Resident #1's hospice nurse stated when she saw Resident #1 on [DATE] he was uncomfortable. During interviews on [DATE] at about 12:00 p.m., CNA F stated she worked with Resident #1 during the night shift on 5/16/, 5/17 5/18 and [DATE]. CNA F stated Resident #1 had blood in his foley catheter and LVN C was aware. CNA F stated Resident #1 had at least 100 cc in his foley bag, maybe she forgot to document Resident #1's output for the entire weekend. CNA F stated Resident #1 had pain all over but mainly his stomach area and LVN C was aware of that. During an interview on [DATE] at about 12:13 p.m., CNA E, stated she worked with Resident #1 during the day shift on 5/16/, 5/17 5/18 and [DATE].CNA E stated Resident #1 started to have blood in his foley catheter bag from [DATE]. CNA E stated Resident #1's urine output was never over 50 cc and was all blood. CNA E stated it was brought to the attention of LVN A and B and they both stated they knew. CNA E also stated Resident #1 was pulling on the catheter like there was discomfort and he did not want the catheter in, he was fidgeting. During an interview on [DATE] at about 12:39 p.m., LVN C stated he worked with Resident #1 on the weekend of 5/16 through [DATE] overnight. LVN C stated he got in report on [DATE] that Resident #1 had blood in his foley catheter. LVN C also stated Resident #1 was making the AHHH sound while moaning and he gave Resident #1 pain medication on 5/17 and [DATE]. LVN C stated he did not document Resident #1's change in condition because Resident #1 was on hospice, and everyone was aware that there was blood in Resident #1's catheter and that Resident #1 was noted for pulling his catheter out. LVN C also stated they just pass it on in report from shift to shift each day the entire weekend. During an interview on [DATE] at 3:22 p.m., the MD stated she was familiar with Resident #1. The MD stated, The patient was on hospice, PO intake was poor, enlarge prostate and the urine will not flow. The catheter is to drain the urine from the bladder. He was always pulling on the catheter, and it was possible for the catheter to not be in the bladder when he pulled it. Because he is on hospice, we cannot monitor him like the normal people. Distended bladder could cause discomfort, moaning is an indication of pain. Hard to say not having output would cause infection, it depends on how long he was distended. We have to do culture to know that. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility's policy titled Pain Management Assessment Policy undated [DATE] reflected: Purpose To establish a comprehensive and Standardized approach to assessing and managing pain in nursing home residents, ensuring that pain is effectively identified, documented and managed in a timely and compassionate manner. Scope-This policy applies to all healthcare providers working in the nursing home, including nurses, physicians, certified nursing assistant (CNAs), and other staff involved in patient care. Definitions o Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain can be acute or chronic, and may involve physical, emotional, or psychological distress. o Verbal Cues: Spoken or written expressions of pain, discomfort, or distress. o Non-Verbal Cues: Body language, facial expressions, or behavioral changes that indicate the presence of pain or discomfort. o Uncontrolled Pain: Pain that remains at an unmanageable level despite administration of pain-relief interventions, requiring reassessment or escalation of treatment. 1.2 Non-Verbal Pain Cues For residents who are unable to communicate verbally (e.g., those with advanced dementia, nonverbal residents, or residents who are cognitively impaired), the following non-verbal cues should be closely observed: o Facial Expressions: o Grimacing, frowning, or clenching of the jaw. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Eyes wide open or squinting, especially when touched or moved. Body Movements: o Restlessness, agitation, or sudden jerking motions. o Posturing, guarding, or bracing certain body parts. o Decreased activity level or withdrawal. o Repetitive movements such as rocking or pacing. Behavioral Cues: o Increased irritability, crying, or sudden outbursts. o Changes in sleeping patterns (frequent waking or inability to sleep). o Refusing to participate in activities or to be touched. Assessment Tools for Non-Verbal Residents: o PAINAD Scale (Pain Assessment in Advanced Dementia): A validated tool that scores facial expression, body movements, vocalizations, and changes in behavior to assess pain levels in residents with advanced dementia or those who are non-verbal. ABC Charting: Observe and document behaviors or changes in appearance, such as agitation, that may suggest pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Timely Administration: o Ensure that pain medication is administered in accordance with the prescribed schedule to maintain consistent pain relief. o PRN (as needed) medications should be given in a timely manner when pain is reported or observed. If a resident has chronic pain, use a scheduled dosing regimen (e.g., around-the-clock opioids for cancer pain) in addition to PRN medications for breakthrough pain. Review of facility's policy titled Hospice Program dated [DATE] reflected: Policy Statement Hospice services are available to residents at the end of life. In generally, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: a. Twenty-four-hour room and board care, b. Administering prescribed therapies, incl a. b. Administering prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care. c. Notifying the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day; The Administrator and ADON were notified on [DATE] at 2:02 pm that an IJ had been identified and an IJ template was provided. The following POR was approved on [DATE] at 10:25 am. Plan of Removal - F697: Pain Management Regulatory Tag: F697 On [DATE], an abbreviated survey was initiated at the facility. On 06/03 2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The notification of Immediate Jeopardy states as follows: The facility failed to assess and intervene with Resident #1's foley catheter for 3 days when his foley catheter was draining all blood for 3 days before he was sent to the ER on [DATE] for further evaluation and treatment where Resident #1 was diagnosed with Sepsis without acute organ dysfunction, Acute urinary retention, Complicated Urinary tract infection associated with indwelling urethral catheter, Dehydration, Retention of urine, unspecified 1. Immediate Corrective Actions: Resident-Centered Interventions for Resident #1 and Related Residents: o Resident #1 expired in the hospital. o There are two other residents with indwelling catheters. They were reviewed for appropriate pain management which included PRN and scheduled pain medications were reviewed. No changes to their med needs were identified. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o To document this review a care plan meeting will be held with the physician and responsible party by [DATE] to understand the goals of the pain management program for these two residents. o Pain assessments re a part of our policy for nurses to complete per shift and quarterly by the MDS Coordinator. This will be completed on an on-going basis as part of our policy. This action addressed the residents with the two indwelling catheters. Physician and responsible party contacted as well. Staff Education/Re-Education: o All licensed nurses and medication aides will be in serviced immediately by the DON/ADON before their next assigned shift starting on [DATE] or they will not be allowed to work: Pain assessment procedures (verbal and non-verbal cues) Timely medication administration and documentation Notification protocols for uncontrolled pain o An audit of these competencies for the nurse and nurse aide will be conducted and signed off by the Director of Nursing/or Designee prior to staff beginning their next assigned shift. Their understanding will be reestablished by the return demonstration/question-answer of this in-service. The DON had her re-education completed by the Regional Nurse. These competencies must be completed, or they will not be allowed to work. This will be done by [DATE]. o Monitoring and Oversight: o DON or designee will begin on [DATE] conducting daily pain management audits for all residents with indwelling catheter for 2 weeks and monthly thereafter to ensure: Pain is assessed using a standardized tool (e.g., numeric or PAINAD) Timely and appropriate interventions are provided. Documentation reflects assessment, intervention, and outcome. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Audits will be performed and documented during morning clinical reviews. 2. How the Facility Will Manage This Event Going Forward: Ongoing Training: o All current and new staff will receive mandatory pain management training upon hire and quarterly thereafter. The DON/ADON will be responsible for overseeing this process, after the re-education by the Regional Nurse. Interdisciplinary Review: o Pain management for indwelling catheters will be a standing item in weekly IDT meetings to discuss residents with pain concerns, review trends, and modify care plans. This will be started by [DATE] and be ongoing. Policy Review and Enforcement: o Pain Management Policy was reviewed by DON/ADON with Regional Nurse on [DATE] to reinforce expectations on identified residents for: Assessment Medication administration Documentation Physician notification o Policy implementation began on [DATE] and will be monitored by DON and IDT weekly for 30 days then monthly for QAPI. o Their understanding will be reestablished by the return demonstration/question-answer of this in-service. Quality Assurance Monitoring: o (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Pain documentation and effectiveness audits will be performed by the DON or designee weekly for 4 weeks, then monthly. This will start [DATE] and be on going. o Results reported to the Quality Assurance & Performance Improvement (QAPI) Committee monthly for continued evaluation and interventions. The Surveyor monitored the POR on [DATE] from 10:26 am to 5:30 pm as follows: During interviews on [DATE] from 1:55 PM - 3:03 PM revealed four CNAs, one MA, one LVN, and one RN from different shifts all stated they were in-serviced before their shifts by the DON on catheter care, pain, and notifying the MD. The CNAs stated they were responsible for emptying the catheter bag before the end of their shift, making sure it was clean, and that peri care was provided. The CNAs stated they were responsible for charting the input and output of urine and notifying the nurse if there was anything abnormal such as blood in the urine, cloudiness, or if the resident was in pain. The nurses all stated it was their responsibility to set eyes on residents' catheters every shift to monitor if it was in place, if there was any sediment in the tubing, and that it was draining properly. The nurses stated if there was blood in the bag or if the resident was in uncontrolled pain, they would contact the MD immediately. Review of facility's in-services dated 06/03 and [DATE]/2025 reflected the following: Facility had an QAPI for identification of deficient practice 0n [DATE] at 7:20 pm DON completed an audit on Residents with PRN pain medications. DON completed an audit on all Resident with foley Catheter. MD review all resident with catheter and were on hospice, reviewed their documents and there were no concerns. Review of facility's in-serviced dated 06/04 through [DATE] titled Pain management was conducted by the ADON and DON for all nursing staff. Nurses stated they were in-serviced on making sure to chart any changes and notify the family and/or the MD. Review of facility's Change of condition and notification policy reflected it was updated on [DATE] and was approved by DON, and the , Regional Nurse Consultant. It reflected the purpose was to provide a standardized process for identifying assessing, and responding to changes in the physical, cognitive or emotional condition of nursing home residents, ensuring timely and appropriate notification to the physician, responsible party and hospice care team (if applicable.) Review of facility's in-service dated [DATE] reflected the DON was in-serviced by the Regional Nurse on the following topics: change of condition, significant change of conditions, pain and suffering management, pain management assessment, catheter care / management policy. Review of facility's in-services reflected LVN B and D were in-serviced on notification on [DATE]. LVN B confirmed verbally that she was in-serviced on pain management. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's matrix dated [DATE] reflected there were 2 other residents with indwelling catheter in the facility. Both Residents progress notes dated [DATE] reflected care plan meeting was held with residents and their RPs regarding indwelling catheter and pain management. Review of Residents with indwelling catheter care plans reflected their care plans were updated on [DATE] by the MDS nurse. Review of Residents with indwelling catheter pain assessment and pain medication reviews were completed on [DATE] and there were no concerns. Progress notes also revealed Physician and family were notified. Review of facility's audit tools reflected all residents with pain management were listed and kept in the 24-hour report binder and there were no issues relating to pain management. Audit revealed PRN pain medications were effective., Scheduled pain medications are assessed at the of administration and documented on the MAR with the use of the pain scale. On [DATE] at 05:03 p.m., the Administrator was informed the immediacy was removed. While the IJ was removed on [DATE] at 05:03 p.m., the facility remained out of compliance at a severity of no actual harm and a scope of isolated, due to the facility's need to evaluate the effectiveness of the corrective systems.