

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  455592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/08/2025
NAME OF PROVIDER OR SUPPLIER  West Side Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1950 S Las Vegas Trail White Settlement, TX 76108	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45054</p> <p>Based on observation, interview, and record review, the facility failed to ensure the residents' right to be free from abuse for one resident (Resident #1) of ten residents reviewed for abuse.</p> <p>-The facility failed to ensure that Resident #1 was free from physical abuse when he alleged he received methadone from a staff member, was found unresponsive, required Narcan, and tested positive for Methadone for which he did not have an order for. Resident #1 was transported to the local hospital on 4/30/25 and diagnosed with hypoxia (low oxygen) likely due to acute-on-chronic systolic heart failure.</p> <p>An Immediate Jeopardy (IJ) was identified on 5/07/25 at 1:56 PM and an IJ Template was provided to the Administrator at 3:00 PM. While the IJ was removed on 5/08/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure could place residents at risk for abuse.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 5/08/25, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute systolic (congestive) heart failure, unspecified sequelae of cerebral infarction (stroke), major depressive disorder (mood disorder), and hx of cocaine and alcohol abuse.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 04/21/25, reflected his BIMS score was 12, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required moderate to maximal assistance with most ADLs and used a motorized wheelchair. The MDS Assessment under Section N-Medications, reflected Resident #1 was prescribed medication under the high-risk drug class that included and opioid.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's care plan, revised 5/05/25, reflected the resident required pain management r/t to generalized pain that included Gabapentin and Norco. Interventions included: administering analgesia (pain reliever) as ordered, anticipating the resident's need for pain relief immediately to any complaint of pain, monitoring/recording/reporting to nurse any s/sx of non-verbal pain, monitoring/recording/reporting to nurse loss of appetite, refusal to eat, and weight loss, monitoring/recording/reporting to nurse complaints of pain or requests for pain treatment, and observing and reporting changes in usual routine. Further review of this document reflected it was revised on 5/05/25 to reflect that Resident #1 had a history of drug abuse prior to admission to facility. Resident #1 had gone out to hospital and noted to have non prescribed narcotic medication in his system. Interventions included: Drug abuse policy was given to resident with education and signature, Narcan (medication to reverse opioid/narcotic overdose) provided PRN, psychiatric medication management NP to see resident, referral to psychiatric services, resident was offered rehabilitation services and declined, and resident was seen by psychologist.</p> <p>Record review of Resident #1's active consolidated physician orders, dated 5/08/25, reflected in part the following:</p> <p>-HYDROcodone-Acetaminophen oral tablet 5-325 MG (for pain relief) - give 1 tablet by mouth every 6 hours as needed for pain. Hold medication if drowsy and notify MD.</p> <p>-Gabapentin oral capsule 300 MG (for pain relief) - give 1 capsule by mouth three times a day for pain. Hold medication if drowsy and notify MD.</p> <p>Further review of this document revealed there was not an order for Methadone.</p> <p>Record review of Resident #1's hospital records, dated 4/30/25, reflected in part the following:</p> <p>HPI:</p> <p>64 [sic] y.o. male with a past medical history of GERD, hyperlipidemia, hypertension, diabetes mellitus stroke, seizure disorder who was brought into ER from nursing home because of respiratory distress. During my encounter [Resident #1] was on BiPAP and poor historian so history is taken from ER notes. As per ER [Resident #1] is on opioid outpatient in likely took more than dysuria of narcotics and later on was found to be short of breath and drowsy for which EMS was called.</p> <p>On arrival to ER [Resident #1] was found to be drowsy and was given Narcan, [Resident #1] responded very well to Narcan however got very anxious for which morphine was administer after my suspicion of an opioid withdrawal. ABGs: PH 7.25 (normal range 7.35-7.45), pC02 58.7 (normal range 32.0-45.0 mmHg), P02 98 (normal range 83.0-108.0 mmHg). [Resident #1] was on non-rebreather mask initially and was later on placed on BiPAP.</p> <p>CTA chest negative for PE or pleural effusions. Troponin 122 (normal range 38.73-80.22 ng/L), BNP 125 (normal range less than 100 pg/mL). [Resident #1] was given Lasix 100 mg IV once and breathing treatment as well.</p> <p>Review of system is limited as [Resident #1] is on BiPAP and lethargic during my encounter.</p> <p>.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Labs:</p> <p>Specimen: Clean Catch; Urine</p> <p>Methadone- Positive</p> <p>Opiate- Positive</p> <p>.</p> <p>Hospital Course/Long LOS Summary:</p> <p>[Resident #1] is a [AGE] year-old male with past medical history of systolic heart failure, diabetes, hypertension, sleep apnea, and chronic pain who presented to the emergency room for altered mental status and shortness of breath. [Resident #1] was admitted for acute hypoxic respiratory failure requiring supplemental O2 and BiPAP to maintain O2 saturation &gt;92%. Likely related to acute on chronic systolic heart failure versus community acquired or aspiration pneumonia. [Resident #1] was started on IV Lasix (water pill) with good urine output. Discharge plan pending clinical improvement.</p> <p>.</p> <p>Record review of Resident #1's progress note, dated 4/30/25 at 9:30 AM by LVN A, reflected the following:</p> <p>[Resident #1] not alert and SOB noted. [Resident #1] responsive only to sternal rub. b/p 142/90 p137 r22 o2 sat 47% on RA. Applied o2 via mask rebreather at 15l. o2 sat 92%. EMS called and [Resident #1] transferred to [name] ED.</p> <p>Record review of a document titled Resident Out on Pass Log, dated 4/20/25-5/07/25, reflected Resident #1 had not signed out to leave the facility.</p> <p>Record review of Resident #1's EHR reflected the resident was seen by a psychologist to address his s/sx of depression on 5/05/25. The recommendations reflected the following:</p> <ul style="list-style-type: none"> <li>-Psychological consultation is recommended to assist staff in developing and implementing behavior plans to reduce [Resident 1's] affective and/or cognitive symptoms.</li> <li>-Individual therapy to reduce [Resident 1's] affective and/or cognitive symptoms.</li> <li>-Referral for medication evaluation.</li> </ul> <p>Record review of an in-service titled Abuse and Neglect, dated 5/01/25, reflected all staff were educated on the facility's policy on recognizing and reporting abuse and neglect.</p> <p>Record review of an in-service titled Resident Drug and Alcohol Abuse, dated 5/05/25, reflected all staff were educated on the facility's policy on drugs and alcohol.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 5/06/25 at 1:54 PM with the DON and Administrator, the DON stated on 04/30/25 she was alerted by LVN A that Resident #1 was in respiratory distress and needed to be sent out to the hospital. This state investigator informed them that Resident #1 admitted he received the Methadone from a staff member that he refused to identify. The DON stated Resident #1 returned to the facility during the weekend on 5/3/25 and the clinicals showed that Methadone was found in his system. The DON stated the MD and pain management team was notified. The DON stated a care plan meeting with Resident #1 was held on 5/05/25 and during an interview with the resident he denied using any drugs and did not report receiving any drug from staff. The DON stated Resident #1 only stated he was depressed about his mother. The DON stated a referral was sent for psychiatric services and Resident #1 was able to talk with a psychologist on 5/05/25. The Administrator stated staff were in-serviced on the facility's drug policy, s/sx of intoxicated residents, and abuse and neglect. He also stated a Resident Council meeting was scheduled to discuss the facility's drug policy and to see if there were any concerns. The Administrator and DON stated this was new information and they would need to consult with regional managers on how to move forward.</p> <p>In a further interview on 5/06/25 at 3:00 PM with the DON and Administrator, the Administrator stated the Regional Managers advised them to submit a self-report to the state agency and start a provider investigation regarding the alleged abuse.</p> <p>In an interview on 5/07/25 at 9:42 AM with the DON and Administrator, the Administrator stated the facility submitted a self-report to the stated agency and started the provider investigation. The Administrator stated Resident #1 was interviewed again and still denied any drug use and getting drugs from a staff member. The Administrator stated the police were called out and Resident #1 also denied everything to them.</p> <p>In a further interview on 5/07/25 at 11:50 AM with the DON and Administrator, The DON stated she received and reviewed Resident #1's hospital records on 5/02/25, prior to the resident discharging from the hospital, when it was found that Methadone was in the resident's system. The DON stated Resident #1 did not have an order to take Methadone at the facility and was not receiving any outpatient treatment where he would receive Methadone. The Administrator stated the incident had just happened and they were still gathering information to determine what happened, which is why a self-report was not submitted prior to the state investigator entering the facility.</p> <p>In an interview on 05/07/25 at 3:45 PM with the Regional Nurse Consultant and Regional Director of Operations, the Regional Nurse Consultant stated she was informed by the DON on 5/02/25 that Resident #1's hospital records indicated there was Methadone found in his system and she advised the DON to start an investigation. The Regional Director of Operations stated the facility began reviewing the resident sign-out logs, in-servicing staff, auditing medications in the facility to check for Methadone/narcotics and medication errors, and conducting safe surveys with staff and residents. The Regional Director of Operations stated the investigation continued over the weekend, with the DON doing pop-up visits to check the facility for drugs. Both Regional managers stated they were not sure why the DON and Administrator did not provide this information prior to the Immediate Jeopardy being called. This state investigator informed that the only evidence that was provided prior to the Immediate Jeopardy being called were the staff in-services, Resident #1's psychology assessment note, Resident #1's care plan conference notes, and a scheduled Resident Council Meeting to discuss the facility's drug policy. There was no evidence of medications audits, safe surveys, interviews, IDT notification, or a report to the state agency provided.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised 08/2020, reflected in part the following:</p> <p>Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.</p> <p>Policy:</p> <p>I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>A. Definitions for the meaning of key terms used in this policy.</p> <p>II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial wellbeing.</p> <p>III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems.</p> <p>IV. This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin, the reporting of suspected rape, and resident-to-resident abuse.</p> <p>Procedure:</p> <p>.</p> <p>IV Prevention</p> <p>A. Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation.</p> <p>B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring.</p> <p>.</p> <p>VII Investigation</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>13. Staff in-service on facility drug policy, identifying intoxicated residents, Narcan administration on 5/7/25, and will be completed on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff who are not in-serviced for any reason will receive it before the start of the shift.</p> <p>14. Abuse and neglect in-service started on 5/7 /25 and will be completed on 5/8/25. All staff in services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive them before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.</p> <p>15. 1:1 in-service conducted for DON and Administrator on Abuse and Neglect Policy. In-service conducted by RDO and RNC on 5/7/25</p> <p>16. Staff and resident questionnaires 5/5/25.</p> <p>17. Safe surveys on 5/2/25</p> <p>18. Offered drug rehab services to resident 5/5/25</p> <p>Implementation of Changes:</p> <p>1. Audit of all residents who have a drug history or potential for drug use and have completed the drug policy acknowledgement form. This started on 5/7/25 and will end on 5/8/25. This will be ongoing to ensure all new admits and changes are made where necessary. This will be conducted by the DON or Designee.</p> <p>2. Appropriate interventions are being put in place as needed.</p> <p>3. All staff were re-educated on identifying intoxicated residents and the resident drug and alcohol abuse policy. This started on 5/7/25 and will end on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive then1 before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.</p> <p>4. Staff (nurses) in-service on facility drug policy, identifying intoxicated residents, Narcan administration, abuse, and neglect started on 5/7/25 and will end on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive them before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.</p> <p>Monitoring:</p> <p>The Administrator/DON/Designee will be responsible for monitoring the implementation and effectiveness of in-service conducted on 5/7 /25 and ongoing.</p> <p>The Administrator/DON will review the effectiveness of this daily X 7 days and weekly X 4 weeks, then X 3 monthly, continued monitoring will be ongoing and report any adverse findings to the QAPI committee. All concerns noted will be addressed at the time of discover1y.</p> <p>Involvement of Medical Director</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  West Side Campus of Care		STREET ADDRESS, CITY, STATE, ZIP CODE  1950 S Las Vegas Trail White Settlement, TX 76108	
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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The Medical Director met with the Interdisciplinary team on 5/6/25 and conducted an Ad HOC QAPI regarding resident drug use. The Medical Director was notified about the immediate Jeopardy on 5/7/25, the Plan of removal was reviewed and accepted by Medical Director.</p> <p>Involvement of QA:</p> <p>An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, to review the plan of removal on 5/7/25.</p> <p>Who is responsible for the implementation of the process?</p> <p>The Director of Nursing and Administrator will be responsible for the implementation of Process.</p> <p>Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 5/7/25.</p> <p>On 5/08/25 the investigator began monitoring (12:30 PM-2:45 PM) to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by:</p> <p>Observation, interview, and record review on 5/08/25, 12:30 PM-1:15 PM, of Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 revealed no concerns for abuse . Record review of residents' EHRs reflected no concerns for changes in physical, mental, or psychosocial status. Observations and interviews with residents and/or RPs revealed no concerns for abuse. The residents denied receiving any nonprescription drugs from staff or other residents. They also denied being physically, mentally, or emotionally abused.</p> <p>Interviews on 5/08/25, 1:20 PM-2:35 PM, conducted with the Administrator, DON, ADON, nurses, CMAs, and CNAs: RN B (1st shift), CNA F (1st shift), LVN L (3rd shift), MDS Nurse/LVN M (1st shift), LVN N (2nd shift), CMA O (2nd shift), CMA P (1st shift), CNA Q (2nd shift), RN R (PRN/all shifts), CNA S (2nd/3rd shift/weekends), RN T (2nd shift), CNA U (3rd shift), and LVN V (2nd shift) indicated they all participated in in-service trainings starting on 5/07/25-5/08/25. All staff were able to state per the facility's policy on drugs and alcohol that the facility was zero tolerance for drugs and alcohol on the premises unless ordered for the residents by the MD. The staff were able to state s/sx of intoxicated residents and who to report it to. The staff were also able to state how to identify and report any suspected or reported abuse. In addition, the nurses were able to state the protocol for identifying and treating residents suspected of an overdose and who to report it to. The Administrator and DON understood that it was their responsibility to implement the interventions and monitor for effectiveness.</p> <p>Record review of an in-service titled Resident Drug and Alcohol Abuse, dated 5/07/25, reflected all staff were re-educated on the facility's policy on drugs and alcohol.</p> <p>Record review of an in-service titled Intoxicated Residents, dated 5/07/25, reflected all staff were re-educated on recognizing s/sx of an intoxicated resident and who to notify.</p> <p>Record review of an in-service titled Abuse and Neglect, dated 5/07/25, reflected all staff were educated on the facility's policy on recognizing and reporting abuse and neglect.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of an in-service titled Naloxone Administration, dated 5/07/25, reflected all nurses were re-educated on the protocol for administering Naloxone to a resident suspected of an overdose.</p> <p>Record review of a document provided by the Administrator titled Drug &amp; Alcohol Abuse Policy Acknowledgement &amp; Consent dated 5/07/25, reflected the DON audited all residents who had a drug history, reviewed the drug and alcohol policy, and signed updated acknowledgement forms.</p> <p>Record review of an in-service titled Abuse and Neglect, dated 5/08/25, reflected the Administrator and DON were educated by the Regional Nurse Consultant and Regional Director of Operations regarding coordinating and implementing the facility's abuse and prevention policy and procedure.</p> <p>On 5/08/25 at 1:57 PM, the Administrator provided documents from an investigation binder that included the following:</p> <ul style="list-style-type: none"> <li>-Safe survey, dated 5/02/25</li> <li>- Resident #1's Care Plan Conference notes, dated 5/05/25</li> <li>- Resident #1's psychology/behavioral note, dated 5/05/25</li> <li>-Resident #1's signed behavioral contract, dated 5/05/25</li> <li>-Trauma screening for Resident #1, dated 5/06/25</li> <li>- Police Report, dated 5/06/25</li> <li>-Resident Drug and Alcohol Abuse Questionnaire, dated 5/06/25</li> <li>-Corrective Action Memo for Activity Staff, dated 5/06/25 (which indicated the Activity Staff was suspended pending an investigation of abuse)</li> <li>-Self-report to state agency, dated 5/06/25</li> </ul> <p>An Immediate Jeopardy (IJ) was identified on 5/07/25 at 1:56 PM and an IJ Template was provided to the Administrator at 3:00 PM. While the IJ was removed on 5/08/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45054</p> <p>Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for one resident (Resident #1) of ten residents reviewed for abuse.</p> <p>-The facility failed to implement the abuse and neglect policy and procedures to ensure that Resident #1 was free from physical abuse when he alleged he received methadone from a staff member, was found unresponsive, required Narcan, and tested positive for Methadone for which he did not have an order for. Resident #1 was transported to the local hospital on 4/30/25 and diagnosed with hypoxia (low oxygen) likely due to acute-on-chronic systolic heart failure.</p> <p>An Immediate Jeopardy (IJ) was identified on 5/07/25 at 1:56 PM and an IJ Template was provided to the Administrator at 3:00 PM. While the IJ was removed on 5/08/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>This failure could place all residents at an increased risk for abuse and neglect.</p> <p>Findings included:</p> <p>Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised 08/2020, reflected in part the following:</p> <p>Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.</p> <p>Policy:</p> <p>I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>A. Definitions for the meaning of key terms used in this policy.</p> <p>II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial wellbeing.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems.</p> <p>IV. This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin, the reporting of suspected rape, and resident-to-resident abuse.</p> <p>Procedure:</p> <p>.</p> <p>IV Prevention</p> <p>A. Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation.</p> <p>B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring.</p> <p>.</p> <p>VII Investigation</p> <p>A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts.</p> <p>.</p> <p>IX. Reporting/Response</p> <p>A. Facility Staff are Mandatory Reporters</p> <p>i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults.</p> <p>.</p> <p>Review of the facility's policy titled Resident Drug and Alcohol Abuse, revised 08/2020, reflected in part the following:</p> <p>Purpose: To provide a safe and drug-free environment for residents while at the Facility.</p> <p>Policy Statement:</p> <p>I. The Facility will admit a resident who has a history of drug and alcohol abuse as long as their primary diagnosis is suitable for skilled care at this Facility.</p> <p>(continued on next page)</p>

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>II. The Facility has a zero-tolerance policy for the use or possession of illegal drugs (including marijuana) or any type of drug apparatus in the Facility or on the grounds of the Facility. All illegal drugs and/or drug paraphernalia will be confiscated from the resident and /or their room.</p> <p>B. The only drugs permissible at the Facility and/or on Facility grounds are those for which there is an Attending Physician order.</p> <p>IV. Any resident found in violation of this policy will be discharged to a more appropriate setting for care (See Policy Transfer and Discharge).</p> <p>Record review of Resident #1's face sheet, dated 5/08/25, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute systolic (congestive) heart failure, unspecified sequelae of cerebral infarction (stroke), major depressive disorder (mood disorder), and hx of cocaine and alcohol abuse.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 04/21/25, reflected his BIMS score was 12, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required moderate to maximal assistance with most ADLs and used a motorized wheelchair. The MDS Assessment under Section N-Medications, reflected Resident #1 was prescribed medication under the high-risk drug class that included and opioid.</p> <p>Record review of Resident #1's care plan, revised 5/05/25, reflected the resident required pain management r/t to generalized pain that included Gabapentin and Norco. Interventions included: administering analgesia (pain reliever) as ordered, anticipating the resident's need for pain relief immediately to any complaint of pain, monitoring/recording/reporting to nurse any s/sx of non-verbal pain, monitoring/recording/reporting to nurse loss of appetite, refusal to eat, and weight loss, monitoring/recording/reporting to nurse complaints of pain or requests for pain treatment, and observing and reporting changes in usual routine. Further review of this document reflected it was revised on 5/05/25 to reflect that Resident #1 had a history of drug abuse prior to admission to facility. Resident #1 had gone out to hospital and noted to have non prescribed narcotic medication in his system. Interventions included: Drug abuse policy was given to resident with education and signature, Narcan (medication to reverse opioid/narcotic overdose) provided PRN, psychiatric medication management NP to see resident, referral to psychiatric services, resident was offered rehabilitation services and declined, and resident was seen by psychologist.</p> <p>Record review of Resident #1's active consolidated physician orders, dated 5/08/25, reflected in part the following:</p> <p>-HYDROcodone-Acetaminophen oral tablet 5-325 MG (for pain relief) - give 1 tablet by mouth every 6 hours as needed for pain. Hold medication if drowsy and notify MD.</p> <p>-Gabapentin oral capsule 300 MG (for pain relief) - give 1 capsule by mouth three times a day for pain. Hold medication if drowsy and notify MD.</p> <p>Further review of this document revealed there was not an order for Methadone.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of Resident #1's hospital records, dated 4/30/25, reflected in part the following:</p> <p>HPI:</p> <p>64 [sic] y.o. male with a past medical history of GERD, hyperlipidemia, hypertension, diabetes mellitus stroke, seizure disorder who was brought into ER from nursing home because of respiratory distress. During my encounter [Resident #1] was on BiPAP and poor historian so history is taken from ER notes. As per ER [Resident #1] is on opioid outpatient in likely took more than dysuria of narcotics and later on was found to be short of breath and drowsy for which EMS was called.</p> <p>On arrival to ER [Resident #1] was found to be drowsy and was given Narcan, [Resident #1] responded very well to Narcan however got very anxious for which morphine was administer after my suspicion of an opioid withdrawal. ABGs: PH 7.25 (normal range 7.35-7.45), pC02 58.7 (normal range 32.0-45.0 mmHg), P02 98 (normal range 83.0-108.0 mmHg). [Resident #1] was on non-rebreather mask initially and was later on placed on BiPAP.</p> <p>CTA chest negative for PE or pleural effusions. Troponin 122 (normal range 38.73-80.22 ng/L), BNP 125 (normal range less than 100 pg/mL). [Resident #1] was given Lasix 100 mg IV once and breathing treatment as well.</p> <p>Review of system is limited as [Resident #1] is on BiPAP and lethargic during my encounter.</p> <p>.</p> <p>Labs:</p> <p>Specimen: Clean Catch; Urine</p> <p>Methadone- Positive</p> <p>Opiate- Positive</p> <p>.</p> <p>Hospital Course/Long LOS Summary:</p> <p>[Resident #1] is a [AGE] year-old male with past medical history of systolic heart failure, diabetes, hypertension, sleep apnea, and chronic pain who presented to the emergency room for altered mental status and shortness of breath. [Resident #1] was admitted for acute hypoxic respiratory failure requiring supplemental O2 and BiPAP to maintain O2 saturation &gt;92%. Likely related to acute on chronic systolic heart failure versus community acquired or aspiration pneumonia. [Resident #1] was started on IV Lasix (water pill) with good urine output. Discharge plan pending clinical improvement.</p> <p>.</p> <p>Record review of Resident #1's progress note, dated 4/30/25 at 9:30 AM by LVN A, reflected the following:</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>[Resident #1] not alert and SOB noted. [Resident #1] responsive only to sternal rub. b/p 142/90 p137 r22 o2 sat 47% on RA. Applied o2 via mask rebreather at 15l. o2 sat 92%. EMS called and [Resident #1] transferred to [name] ED.</p> <p>Record review of a document titled Resident Out on Pass Log, dated 4/20/25-5/07/25, reflected Resident #1 had not signed out to leave the facility.</p> <p>Record review of Resident #1's EHR reflected the resident was seen by a psychologist to address his s/sx of depression on 5/05/25. The recommendations reflected the following:</p> <ul style="list-style-type: none"> <li>-Psychological consultation is recommended to assist staff in developing and implementing behavior plans to reduce [Resident 1's] affective and/or cognitive symptoms.</li> <li>-Individual therapy to reduce [Resident 1's] affective and/or cognitive symptoms.</li> <li>-Referral for medication evaluation.</li> </ul> <p>Record review of an in-service titled Abuse and Neglect, dated 5/01/25, reflected all staff were educated on the facility's policy on recognizing and reporting abuse and neglect.</p> <p>Record review of an in-service titled Resident Drug and Alcohol Abuse, dated 5/05/25, reflected all staff were educated on the facility's policy on drugs and alcohol.</p> <p>Record review of an in-service titled Intoxicated Residents, dated 5/05/25, reflected all staff were educated on recognizing s/sx of an intoxicated resident and who to notify.</p> <p>Record review of an in-service titled Naloxone Administration, dated 5/06/25, reflected all nurses were educated on the protocol for administering Naloxone to a resident suspected of an overdose.</p> <p>In an interview and observation on 5/06/25 at 11:42 AM, Resident #1 was sitting in his wheelchair in his room. He was dressed and well-groomed with no s/sx of distress. Observation of the room revealed it was clean with no evidence of drugs, alcohol, or paraphernalia. Resident #1 immediately asked if I was from social services and if he was in trouble. This state investigator stated No and asked Resident #1 about his recent hospital stay. Resident #1 stated he was transported to the hospital for what he thought was another stroke. Resident #1 stated he could not recall what happened but was told that he was found unresponsive in his room. Resident #1 looked concerned, then proceeded to state that he did not want to be in trouble or get anyone else in trouble; however, he became sick after taking Methadone that he received from a staff member. Resident #1 refused to identify the staff. He stated he must have taken too much, and it caused him to pass out. Resident #1 did not recall exactly when he took the drug or how much he consumed. Resident #1 stated he was sad about his mother, who was sick at a different nursing facility, and he needed something to take his mind off it. Resident #1 refused to provide any additional information.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 5/06/25 at 12:20 PM, LVN A stated she worked at the facility for about 6 months. She stated she worked with Resident #1 on 4/30/25 when he was transported to the ER. LVN A stated she entered Resident #1's room to check his blood sugar at approximately 7:30 AM and found the resident less responsive than usual and exhibited respiratory distress. LVN A stated she immediately called for help while checking Resident #1's vitals. She stated she was unable to get an O2 reading and put the resident on oxygen. LVN A stated EMTs had already been called and arrived at the facility to transfer Resident #1 to the local hospital. LVN A stated initially she was unsure what caused Resident #1's change in condition, but later found it appeared to be from a drug overdose based on clinical records. LVN A stated she was aware Resident #1 had a hx of drug use. She stated she had not ever seen the resident have possession of nonprescription drugs or use them at the facility. LVN A stated she had never seen any staff members or other residents with nonprescription drugs. She stated the staff were in-serviced on the facility's drug policy on 5/05/25.</p> <p>In an interview on 5/06/25 at 1:10 PM, RN B stated she worked at the facility since 2019. She stated she worked with Resident #1 during the incident on 4/30/25. RN B stated the nurses were checking blood sugars on the hall when LVN A called for her help in Resident #1's room. RN B stated LVN A informed that she was unable to obtain an O2 reading from Resident #1, and he was unresponsive. RN B stated when she entered the room, she found that Resident #1 was breathing but was not responding normally. She stated after calling his name loudly a few times, Resident #1 opened his eyes and said Yes then went back to sleep. RN B stated Resident #1 needed constant engagement to stay alert. RN B stated she remained in the room with Resident #1 until EMTs arrived.</p> <p>In an interview on 5/06/25 at 1:54 PM with the DON and Administrator, the DON stated on 04/30/25 she was alerted by LVN A that Resident #1 was in respiratory distress and needed to be sent out to the hospital. This state investigator informed them that Resident #1 admitted he received the Methadone from a staff member that he refused to identify. The DON stated Resident #1 returned to the facility during the weekend on 5/3/25 and the clinicals showed that Methadone was found in his system. The DON stated the MD and pain management team was notified. The DON stated a care plan meeting with Resident #1 was held on 5/05/25 and during an interview with the resident he denied using any drugs and did not report receiving any drug from staff. The DON stated Resident #1 only stated he was depressed about his mother. The DON stated a referral was sent for psychiatric services and Resident #1 was able to talk with a psychologist on 5/05/25. The Administrator stated staff were in-serviced on the facility's drug policy, s/sx of intoxicated residents, and abuse and neglect. He also stated a Resident Council meeting was scheduled to discuss the facility's drug policy and to see if there were any concerns. The Administrator and DON stated this was new information and they would need to consult with regional managers on how to move forward.</p> <p>In a further interview on 5/06/25 at 3:00 PM with the DON and Administrator, the Administrator stated the Regional Managers advised them to submit a self-report to the state agency and start a provider investigation regarding the alleged abuse.</p> <p>In an interview on 5/07/25 at 9:42 AM with the DON and Administrator, the Administrator stated the facility submitted a self-report to the stated agency and started the provider investigation. The Administrator stated Resident #1 was interviewed again and still denied any drug use and getting drugs from a staff member. The Administrator stated the police were called out and Resident #1 also denied everything to them.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In a further interview on 5/07/25 at 11:50 AM with the DON and Administrator, The DON stated she received and reviewed Resident #1's hospital records on 5/02/25, prior to the resident discharging from the hospital, when it was found that Methadone was in the resident's system. The DON stated Resident #1 did not have an order to take Methadone at the facility and was not receiving any outpatient treatment where he would receive Methadone. The Administrator stated the incident had just happened and they were still gathering information to determine what happened, which is why a self-report was not submitted prior to the state investigator entering the facility.</p> <p>In an interview on 05/07/25 at 3:45 PM with the Regional Nurse Consultant and Regional Director of Operations, the Regional Nurse Consultant stated she was informed by the DON on 5/02/25 that Resident #1's hospital records indicated there was Methadone found in his system and she advised the DON to start an investigation. The Regional Director of Operations stated the facility began reviewing the resident sign-out logs, in-servicing staff, auditing medications in the facility to check for Methadone/narcotics and medication errors, and conducting safe surveys with staff and residents. The Regional Director of Operations stated the investigation continued over the weekend, with the DON doing pop-up visits to check the facility for drugs. Both Regional managers stated they were not sure why the DON and Administrator did not provide this information prior to the Immediate Jeopardy being called. This state investigator informed that the only evidence that was provided prior to the Immediate Jeopardy being called were the staff in-services, Resident #1's psychology assessment note, Resident #1's care plan conference notes, and a scheduled Resident Council Meeting to discuss the facility's drug policy. There was no evidence of medications audits, safe surveys, interviews, IDT notification, or a report to the state agency provided.</p> <p>The Administrator and DON were notified of an Immediate Jeopardy (IJ) on 5/07/25 at 2:57 PM, due to the above failures and the IJ Template was provided at 3:00 PM. The facility's Plan of Removal (POR) was accepted on 5/08/25 at 12:30 PM and included:</p> <p>Date: 5/7/25</p> <p>PLAN OF REMOVAL FOR</p> <p>IMMEDIATE JEOPARDY</p> <p>To Whom it may concern,</p> <p>Summary of Details which lead to outcomes.</p> <p>F600 Free from Abuse</p> <p>On 5/6/25, during a complaint survey at [Nursing Facility]. The facility failed to ensure Resident #1 was free from abuse when he suffered respiratory distress after taking methadone that the resident reported was provided by a staff member.</p> <p>The notification of the alleged immediate jeopardy states as follows:</p> <p>Resident #1 is a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses that included: hx</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>of stroke, major depressive disorder, and hx of alcohol and cocaine abuse. On 4/29/25 [sic], Resident# 1 was found to be in respiratory distress and less aroused than usual. He was sent out to the local hospital where he was diagnosed with hypoxia (low oxygen) likely due to acute-on-chronic systolic heart failure with labs that were positive for methadone.</p> <p>Identify residents who could be affected:</p> <p>All Residents have the potential to be affected by this deficiency</p> <p>Identify responsible staff/ what action taken:</p> <ol style="list-style-type: none"> <li>1. Alleged employee suspended pending investigation. Last day employee worked was 4/27/25</li> <li>2. Attending Physicians was notified of the incident involving the resident on 5/2/25</li> <li>3. Trauma screen was completed on 5/6/25.</li> <li>4. Police notified on 5/6/25.</li> <li>5. Resident referred to Deer OAKS for psychological assessment on 5/5/25</li> <li>6. Care plans updated on 5/5/25</li> <li>7. Reviewed out on pass for 5/2/25</li> <li>8. Reviewed advance entry for visitors on 5/2/25</li> <li>9. Reviewed facility medications for use of methadone 5/2/25</li> <li>10. Completed care plan conference with residents on 5/5/25</li> <li>11. Resident seen by psychologist on 5/5/25</li> <li>12. Drug abuse contract and policy discussed with residents and signed 5/5/25</li> <li>13. Staff in-service on facility drug policy, identifying intoxicated residents, Narcan administration on 5/7/25, and will be completed on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff who are not in-serviced for any reason will receive it before the start of the shift.</li> <li>14. Abuse and neglect in-service started on 5/7 /25 and will be completed on 5/8/25. All staff in services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive them before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.</li> <li>15. 1:1 in-service conducted for DON and Administrator on Abuse and Neglect Policy. In-service conducted by RDO and RNC on 5/7/25</li> </ol> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>16. Staff and resident questionnaires 5/5/25.</p> <p>17. Safe surveys on 5/2/25</p> <p>18. Offered drug rehab services to resident 5/5/25</p> <p>Implementation of Changes:</p> <p>1. Audit of all residents who have a drug history or potential for drug use and have completed the drug policy acknowledgement form. This started on 5/7/25 and will end on 5/8/25. This will be ongoing to ensure all new admits and changes are made where necessary. This will be conducted by the DON or Designee.</p> <p>2. Appropriate interventions are being put in place as needed.</p> <p>3. All staff were re-educated on identifying intoxicated residents and the resident drug and alcohol abuse policy. This started on 5/7/25 and will end on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive then1 before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.</p> <p>4. Staff (nurses) in-service on facility drug policy, identifying intoxicated residents, Narcan administration, abuse, and neglect started on 5/7/25 and will end on 5/8/25. All staff in-services will be ongoing to ensure all PRN, new staff, and any staff not in-serviced for any reason receive them before the start of the shift. In-service will be conducted by the Administrator/DON or Designee.</p> <p>Monitoring:</p> <p>The Administrator/DON/Designee will be responsible for monitoring the implementation and effectiveness of in-service conducted on 5/7 /25 and ongoing.</p> <p>The Administrator/DON will review the effectiveness of this daily X 7 days and weekly X 4 weeks, then X 3 monthly, continued monitoring will be ongoing and report any adverse findings to the QAPI committee. All concerns noted will be addressed at the time of discove1y.</p> <p>Involvement of Medical Director</p> <p>The Medical Director met with the Interdisciplinary team on 5/6/25 and conducted an Ad HOC QAPI regarding resident drug use. The Medical Director was notified about the immediate Jeopardy on 5/7/25, the Plan of removal was reviewed and accepted by Medical Director.</p> <p>Involvement of QA:</p> <p>An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, to review the plan of removal on 5/7/25.</p> <p>Who is responsible for the implementation of the process?</p> <p>The Director of Nursing and Administrator will be responsible for the implementation of Process.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Please accept this letter as our plan of removal for the determination of Immediate Jeopardy issued on 5/7/25.</p> <p>On 5/08/25 the investigator began monitoring (12:30 PM-2:45 PM) to determine if the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy by:</p> <p>Observation, interview, and record review on 5/08/25, 12:30 PM-1:15 PM, of Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10 revealed no concerns for abuse. Record review of residents' EHRs reflected no concerns for changes in physical, mental, or psychosocial status. Observations and interviews with residents and/or RPs revealed no concerns for abuse. The residents denied receiving any nonprescription drugs from staff or other residents. They also denied being physically, mentally, or emotionally abused.</p> <p>Interviews on 5/08/25, 1:20 PM-2:35 PM, conducted with the Administrator, DON, ADON, nurses, CMAs, and CNAs: RN B (1st shift), CNA F (1st shift), LVN L (3rd shift), MDS Nurse/LVN M (1st shift), LVN N (2nd shift), CMA O (2nd shift), CMA P (1st shift), CNA Q (2nd shift), RN R (PRN/all shifts), CNA S (2nd/3rd shift/weekends), RN T (2nd shift), CNA U (3rd shift), and LVN V (2nd shift) indicated they all participated in in-service trainings starting on 5/07/25-5/08/25. All staff were able to state per the facility's policy on drugs and alcohol that the facility was zero tolerance for drugs and alcohol on the premises unless ordered for the residents by the MD. The staff were able to state s/sx of intoxicated residents and who to report it to. The staff were also able to state how to identify and report any suspected or reported abuse. In addition, the nurses were able to state the protocol for identifying and treating residents suspected of an overdose and who to report it to. The Administrator and DON also understood that it was their responsibility to implement the interventions and monitor for effectiveness. The Administrator and DON stated they received 1 on 1 education regarding the facility's abuse and neglect policy and were able to state they were responsible for implementing the policy to ensure all allegations of abuse, neglect, and exploitation were reported and investigated.</p> <p>Record review of the facility's policy titled Abuse Prevention and Prohibition Program, revised 08/2020, reflected in part the following:</p> <p>Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.</p> <p>Record review of an in-service titled Resident Drug and Alcohol Abuse, dated 5/07/25, reflected all staff were re-educated on the facility's policy on drugs and alcohol.</p> <p>Record review of an in-service titled Intoxicated Residents, dated 5/07/25, reflected all staff were re-educated on recognizing s/sx of an intoxicated resident and who to notify.</p> <p>Record review of an in-service titled Abuse and Neglect, dated 5/07/25, reflected all staff were educated on the facility's policy on recognizing and reporting abuse and neglect.</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Record review of an in-service titled Naloxone Administration, dated 5/07/25, reflected all nurses were re-educated on the protocol for administering Naloxone to a resident suspected of an overdose.</p> <p>Record review of a document provided by the Administrator titled Drug &amp; Alcohol Abuse Policy Acknowledgement &amp; Consent dated 5/07/25, reflected the DON audited all residents who had a drug history, reviewed the drug and alcohol policy, and signed updated acknowledgement forms.</p> <p>Record review of an in-service titled Abuse and Neglect, dated 5/08/25, reflected the Administrator and DON were educated by the Regional Nurse Consultant and Regional Director of Operations regarding coordinating and implementing the facility's abuse and prevention policy and procedure.</p> <p>On 5/08/25 at 1:57 PM, the Administrator provided documents from an investigation binder that included the following:</p> <ul style="list-style-type: none"> <li>-Safe survey, dated 5/02/25</li> <li>- Resident #1's Care Plan Conference notes, dated 5/05/25</li> <li>- Resident #1's psychology/behavioral note, dated 5/05/25</li> <li>-Resident #1's signed behavioral contract, dated 5/05/25</li> <li>-Trauma screening for Resident #1, dated 5/06/25</li> <li>- Police Report, dated 5/06/25</li> <li>-Resident Drug and Alcohol Abuse Questionnaire, dated 5/06/25</li> <li>-Corrective Action Memo for Activity Staff, dated 5/06/25 (which indicated the Activity Staff was suspended pending an investigation of abuse)</li> <li>-Self-report to state agency, dated 5/06/25</li> </ul> <p>An Immediate Jeopardy (IJ) was identified on 5/07/25 at 1:56 PM and an IJ Template was provided to the Administrator at 3:00 PM. While the IJ was removed on 5/08/25, the facility remained out of compliance at a scope of isolated with the severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45054</p> <p>Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving the reasonable suspicion of a crime, abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the suspicion or allegation was made, to a law enforcement entity or State Agency in accordance with State law through established procedures, for one resident (Resident #1) of ten residents reviewed for abuse.</p> <p>-The facility failed to report to law enforcement and the State Agency when Resident #1 alleged he received methadone from a staff member, was found unresponsive, required Narcan, and tested positive for Methadone for which he did not have an order for.</p> <p>This failure could place residents at risk for continued abuse due to unreported allegations of abuse.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 5/08/25, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute systolic (congestive) heart failure, unspecified sequelae of cerebral infarction (stroke), major depressive disorder (mood disorder), and hx of cocaine and alcohol abuse.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 04/21/25, reflected his BIMS score was 12, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required moderate to maximal assistance with most ADLs and used a motorized wheelchair. The MDS Assessment under Section N-Medications, reflected Resident #1 was prescribed medication under the high-risk drug class that included and opioid.</p> <p>Record review of Resident #1's care plan, revised 5/05/25, reflected the resident required pain management r/t to generalized pain that included Gabapentin and Norco. Interventions included: administering analgesia (pain reliever) as ordered, anticipating the resident's need for pain relief immediately to any complaint of pain, monitoring/recording/reporting to nurse any s/sx of non-verbal pain, monitoring/recording/reporting to nurse loss of appetite, refusal to eat, and weight loss, monitoring/recording/reporting to nurse complaints of pain or requests for pain treatment, and observing and reporting changes in usual routine. Further review of this document reflected it was revised on 5/05/25 to reflect that Resident #1 had a history of drug abuse prior to admission to facility. Resident #1 had gone out to hospital and noted to have non prescribed narcotic medication in his system. Interventions included: Drug abuse policy was given to resident with education and signature, Narcan (medication to reverse opioid/narcotic overdose) provided PRN, psychiatric medication management NP to see resident, referral to psychiatric services, resident was offered rehabilitation services and declined, and resident was seen by psychologist.</p> <p>Record review of Resident #1's active consolidated physician orders, dated 5/08/25, reflected in part the following:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-HYDRocodone-Acetaminophen oral tablet 5-325 MG (for pain relief) - give 1 tablet by mouth every 6 hours as needed for pain. Hold medication if drowsy and notify MD.</p> <p>-Gabapentin oral capsule 300 MG (for pain relief) - give 1 capsule by mouth three times a day for pain. Hold medication if drowsy and notify MD.</p> <p>Further review of this document revealed there was not an order for Methadone.</p> <p>Record review of Resident #1's hospital records, dated 4/30/25, reflected in part the following:</p> <p>HPI:</p> <p>64 [sic] y.o. male with a past medical history of GERD, hyperlipidemia, hypertension, diabetes mellitus stroke, seizure disorder who was brought into ER from nursing home because of respiratory distress. During my encounter [Resident #1] was on BiPAP and poor historian so history is taken from ER notes. As per ER [Resident #1] is on opioid outpatient in likely took more than dysuria of narcotics and later on was found to be short of breath and drowsy for which EMS was called.</p> <p>On arrival to ER [Resident #1] was found to be drowsy and was given Narcan, [Resident #1] responded very well to Narcan however got very anxious for which morphine was administer after my suspicion of an opioid withdrawal. ABGs: PH 7.25 (normal range 7.35-7.45), pC02 58.7 (normal range 32.0-45.0 mmHg), P02 98 (normal range 83.0-108.0 mmHg). [Resident #1] was on non-rebreather mask initially and was later on placed on BiPAP.</p> <p>CTA chest negative for PE or pleural effusions. Troponin 122 (normal range 38.73-80.22 ng/L), BNP 125 (normal range less than 100 pg/mL). [Resident #1] was given Lasix 100 mg IV once and breathing treatment as well.</p> <p>Review of system is limited as [Resident #1] is on BiPAP and lethargic during my encounter.</p> <p>.</p> <p>Labs:</p> <p>Specimen: Clean Catch; Urine</p> <p>Methadone- Positive</p> <p>Opiate- Positive</p> <p>.</p> <p>Hospital Course/Long LOS Summary:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>[Resident #1] is a [AGE] year-old male with past medical history of systolic heart failure, diabetes, hypertension, sleep apnea, and chronic pain who presented to the emergency room for altered mental status and shortness of breath. [Resident #1] was admitted for acute hypoxic respiratory failure requiring supplemental O2 and BiPAP to maintain O2 saturation &gt;92%. Likely related to acute on chronic systolic heart failure versus community acquired or aspiration pneumonia. [Resident #1] was started on IV Lasix (water pill) with good urine output. Discharge plan pending clinical improvement.</p> <p>.</p> <p>Record review of Resident #1's progress note, dated 4/30/25 at 9:30 AM by LVN A, reflected the following:</p> <p>[Resident #1] not alert and SOB noted. [Resident #1] responsive only to sternal rub. b/p 142/90 p137 r22 o2 sat 47% on RA. Applied o2 via mask rebreather at 15l. o2 sat 92%. EMS called and [Resident #1] transferred to [name] ED.</p> <p>Record review of a document titled Resident Out on Pass Log, dated 4/20/25-5/07/25, reflected Resident #1 had not signed out to leave the facility.</p> <p>Record review of Resident #1's EHR reflected the resident was seen by a psychologist to address his s/sx of depression on 5/05/25. The recommendations reflected the following:</p> <ul style="list-style-type: none"> <li>-Psychological consultation is recommended to assist staff in developing and implementing behavior plans to reduce [Resident 1's] affective and/or cognitive symptoms.</li> <li>-Individual therapy to reduce [Resident 1's] affective and/or cognitive symptoms.</li> <li>-Referral for medication evaluation.</li> </ul> <p>Record review of an in-service titled Abuse and Neglect, dated 5/01/25, reflected all staff were educated on the facility's policy on recognizing and reporting abuse and neglect.</p> <p>Record review of an in-service titled Resident Drug and Alcohol Abuse, dated 5/05/25, reflected all staff were educated on the facility's policy on drugs and alcohol.</p> <p>Record review of an in-service titled Intoxicated Residents, dated 5/05/25, reflected all staff were educated on recognizing s/sx of an intoxicated resident and who to notify.</p> <p>Record review of an in-service titled Naloxone Administration, dated 5/06/25, reflected all nurses were educated on the protocol for administering Naloxone to a resident suspected of an overdose.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview and observation on 5/06/25 at 11:42 AM, Resident #1 was sitting in his wheelchair in his room. He was dressed and well-groomed with no s/sx of distress. Observation of the room revealed it was clean with no evidence of drugs, alcohol, or paraphernalia. Resident #1 immediately asked if I was from social services and if he was in trouble. This state investigator stated No and asked Resident #1 about his recent hospital stay. Resident #1 stated he was transported to the hospital for what he thought was another stroke. Resident #1 stated he could not recall what happened but was told that he was found unresponsive in his room. Resident #1 looked concerned, then proceeded to state that he did not want to be in trouble or get anyone else in trouble; however, he became sick after taking Methadone that he received from a staff member. Resident #1 refused to identify the staff. He stated he must have taken too much, and it caused him to pass out. Resident #1 did not recall exactly when he took the drug or how much he consumed. Resident #1 stated he was sad about his mother, who was sick at a different nursing facility, and he needed something to take his mind off it. Resident #1 refused to provide any additional information.</p> <p>In an interview on 5/06/25 at 12:20 PM, LVN A stated she worked at the facility for about 6 months. She stated she worked with Resident #1 on 4/30/25 when he was transported to the ER. LVN A stated she entered Resident #1's room to check his blood sugar at approximately 7:30 AM and found the resident less responsive than usual and exhibited respiratory distress. LVN A stated she immediately called for help while checking Resident #1's vitals. She stated she was unable to get an O2 reading and put the resident on oxygen. LVN A stated EMTs had already been called and arrived at the facility to transfer Resident #1 to the local hospital. LVN A stated initially she was unsure what caused Resident #1's change in condition, but later found it appeared to be from a drug overdose based on clinical records. LVN A stated she was aware Resident #1 had a hx of drug use. She stated she had not ever seen the resident have possession of nonprescription drugs or use them at the facility. LVN A stated she had never seen any staff members or other residents with nonprescription drugs. She stated the staff were in-serviced on the facility's drug policy on 5/05/25.</p> <p>In an interview on 5/06/25 at 1:10 PM, RN B stated she worked at the facility since 2019. She stated she worked with Resident #1 during the incident on 4/30/25. RN B stated the nurses were checking blood sugars on the hall when LVN A called for her help in Resident #1's room. RN B stated LVN A informed that she was unable to obtain an O2 reading from Resident #1, and he was unresponsive. RN B stated when she entered the room, she found that Resident #1 was breathing but was not responding normally. She stated after calling his name loudly a few times, Resident #1 opened his eyes and said Yes then went back to sleep. RN B stated Resident #1 needed constant engagement to stay alert. RN B stated she remained in the room with Resident #1 until EMTs arrived.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 5/06/25 at 1:54 PM with the DON and Administrator, the DON stated on 04/30/25 she was alerted by LVN A that Resident #1 was in respiratory distress and needed to be sent out to the hospital. This state investigator informed them that Resident #1 admitted he received the Methadone from a staff member that he refused to identify. The DON stated Resident #1 returned to the facility during the weekend on 5/3/25 and the clinicals showed that Methadone was found in his system. The DON stated the MD and pain management team was notified. The DON stated a care plan meeting with Resident #1 was held on 5/05/25 and during an interview with the resident he denied using any drugs and did not report receiving any drug from staff. The DON stated Resident #1 only stated he was depressed about his mother. The DON stated a referral was sent for psychiatric services and Resident #1 was able to talk with a psychologist on 5/05/25. The Administrator stated staff were in-serviced on the facility's drug policy, s/sx of intoxicated residents, and abuse and neglect. He also stated a Resident Council meeting was scheduled to discuss the facility's drug policy and to see if there were any concerns. The Administrator and DON stated this was new information and they would need to consult with regional managers on how to move forward.</p> <p>In a further interview on 5/06/25 at 3:00 PM with the DON and Administrator, the Administrator stated the Regional Managers advised them to submit a self-report to the state agency and start a provider investigation regarding the alleged abuse.</p> <p>In an interview on 5/07/25 at 9:42 AM with the DON and Administrator, the Administrator stated the facility submitted a self-report to the stated agency and started the provider investigation. The Administrator stated Resident #1 was interviewed again and still denied any drug use and getting drugs from a staff member. The Administrator stated the police were called out and Resident #1 also denied everything to them.</p> <p>In a further interview on 5/07/25 at 11:50 AM with the DON and Administrator, The DON stated she received and reviewed Resident #1's hospital records on 5/02/25, prior to the resident discharging from the hospital, when it was found that Methadone was in the resident's system. The DON stated Resident #1 did not have an order to take Methadone at the facility and was not receiving any outpatient treatment where he would receive Methadone. The Administrator stated the incident had just happened and they were still gathering information to determine what happened, which is why a self-report was not submitted prior to the state investigator entering the facility.</p> <p>In an interview on 05/07/25 at 3:45 PM with the Regional Nurse Consultant and Regional Director of Operations, the Regional Nurse Consultant stated she was informed by the DON on 5/02/25 that Resident #1's hospital records indicated there was Methadone found in his system and she advised the DON to start an investigation. The Regional Director of Operations stated the facility began reviewing the resident sign-out logs, in-servicing staff, auditing medications in the facility to check for Methadone/narcotics and medication errors, and conducting safe surveys with staff and residents. The Regional Director of Operations stated the investigation continued over the weekend, with the DON doing pop-up visits to check the facility for drugs. Both Regional managers stated they were not sure why the DON and Administrator did not provide this information prior to the Immediate Jeopardy being called. This state investigator informed that the only evidence that was provided prior to the Immediate Jeopardy being called were the staff in-services, Resident #1's psychology assessment note, Resident #1's care plan conference notes, and a scheduled Resident Council Meeting to discuss the facility's drug policy. There was no evidence of medications audits, safe surveys, interviews, IDT notification, or a report to the state agency provided.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised 08/2020, reflected in part the following:</p> <p>Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.</p> <p>Policy:</p> <p>I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>A. Definitions for the meaning of key terms used in this policy.</p> <p>II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial wellbeing.</p> <p>III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems.</p> <p>IV. This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin, the reporting of suspected rape, and resident-to-resident abuse.</p> <p>Procedure:</p> <p>.</p> <p>IV Prevention</p> <p>A. Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation.</p> <p>B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring.</p> <p>.</p> <p>VII Investigation</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts.</p> <p>.</p> <p>IX. Reporting/Response</p> <p>A. Facility Staff are Mandatory Reporters</p> <p>i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults.</p> <p>.</p> <p>Review of the facility's policy titled Resident Drug and Alcohol Abuse, revised 08/2020, reflected in part the following:</p> <p>Purpose: To provide a safe and drug-free environment for residents while at the Facility.</p> <p>Policy Statement:</p> <p>I. The Facility will admit a resident who has a history of drug and alcohol abuse as long as their primary diagnosis is suitable for skilled care at this Facility.</p> <p>II. The Facility has a zero-tolerance policy for the use or possession of illegal drugs (including marijuana) or any type of drug apparatus in the Facility or on the grounds of the Facility. All illegal drugs and/or drug paraphernalia will be confiscated from the resident and /or their room.</p> <p>B. The only drugs permissible at the Facility and/or on Facility grounds are those for which there is an Attending Physician order.</p> <p>IV. Any resident found in violation of this policy will be discharged to a more appropriate setting for care (See Policy Transfer and Discharge).</p> <p>.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45054</p> <p>Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress for one resident (Resident #1) of ten residents reviewed for abuse.</p> <p>-The facility failed to implement their abuse, neglect, and exploitation policy and investigate suspected or alleged abuse when Resident #1 alleged he received methadone from a staff member, was found unresponsive, required Narcan, and tested positive for Methadone for which he did not have an order for.</p> <p>This failure could place all residents at an increased risk for abuse and neglect.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet, dated 5/08/25, reflected a [AGE] year-old male who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute systolic (congestive) heart failure, unspecified sequelae of cerebral infarction (stroke), major depressive disorder (mood disorder), and hx of cocaine and alcohol abuse.</p> <p>Record review of Resident #1's quarterly MDS assessment, dated 04/21/25, reflected his BIMS score was 12, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required moderate to maximal assistance with most ADLs and used a motorized wheelchair. The MDS Assessment under Section N-Medications, reflected Resident #1 was prescribed medication under the high-risk drug class that included and opioid.</p> <p>Record review of Resident #1's care plan, revised 5/05/25, reflected the resident required pain management r/t to generalized pain that included Gabapentin and Norco. Interventions included: administering analgesia (pain reliever) as ordered, anticipating the resident's need for pain relief immediately to any complaint of pain, monitoring/recording/reporting to nurse any s/sx of non-verbal pain, monitoring/recording/reporting to nurse loss of appetite, refusal to eat, and weight loss, monitoring/recording/reporting to nurse complaints of pain or requests for pain treatment, and observing and reporting changes in usual routine. Further review of this document reflected it was revised on 5/05/25 to reflect that Resident #1 had a history of drug abuse prior to admission to facility. Resident #1 had gone out to hospital and noted to have non prescribed narcotic medication in his system. Interventions included: Drug abuse policy was given to resident with education and signature, Narcan (medication to reverse opioid/narcotic overdose) provided PRN, psychiatric medication management NP to see resident, referral to psychiatric services, resident was offered rehabilitation services and declined, and resident was seen by psychologist.</p> <p>Record review of Resident #1's active consolidated physician orders, dated 5/08/25, reflected in part the following:</p> <p>-HYDROcodone-Acetaminophen oral tablet 5-325 MG (for pain relief) - give 1 tablet by mouth every 6 hours as needed for pain. Hold medication if drowsy and notify MD.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>-Gabapentin oral capsule 300 MG (for pain relief) - give 1 capsule by mouth three times a day for pain. Hold medication if drowsy and notify MD.</p> <p>Further review of this document revealed there was not an order for Methadone.</p> <p>Record review of Resident #1's hospital records, dated 4/30/25, reflected in part the following:</p> <p>HPI:</p> <p>64 y.o. male with a past medical history of GERD, hyperlipidemia, hypertension, diabetes mellitus stroke, seizure disorder who was brought into ER from nursing home because of respiratory distress. During my encounter [Resident #1] was on BiPAP and poor historian so history is taken from ER notes. As per ER [Resident #1] is on opioid outpatient in likely took more than dysuria of narcotics and later on was found to be short of breath and drowsy for which EMS was called.</p> <p>On arrival to ER [Resident #1] was found to be drowsy and was given Narcan, [Resident #1] responded very well to Narcan however got very anxious for which morphine was administer after my suspicion of an opioid withdrawal. ABGs: PH 7.25 (normal range 7.35-7.45), pC02 58.7 (normal range 32.0-45.0 mmHg), P02 98 (normal range 83.0-108.0 mmHg). [Resident #1] was on non-rebreather mask initially and was later on placed on BiPAP.</p> <p>CTA chest negative for PE or pleural effusions. Troponin 122 (normal range 38.73-80.22 ng/L), BNP 125 (normal range less than 100 pg/mL). [Resident #1] was given Lasix 100 mg IV once and breathing treatment as well.</p> <p>Review of system is limited as [Resident #1] is on BiPAP and lethargic during my encounter.</p> <p>.</p> <p>Labs:</p> <p>Specimen: Clean Catch; Urine</p> <p>Methadone- Positive</p> <p>Opiate- Positive</p> <p>.</p> <p>Hospital Course/Long LOS Summary:</p> <p>[Resident #1] is a [AGE] year-old male with past medical history of systolic heart failure, diabetes, hypertension, sleep apnea, and chronic pain who presented to the emergency room for altered mental status and shortness of breath. [Resident #1] was admitted for acute hypoxic respiratory failure requiring supplemental O2 and BiPAP to maintain O2 saturation &gt;92%. Likely related to acute on chronic systolic heart failure versus community acquired or aspiration pneumonia. [Resident #1] was started on IV Lasix (water pill) with good urine output. Discharge plan pending clinical improvement.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In an interview on 5/06/25 at 12:20 PM, LVN A stated she worked at the facility for about 6 months. She stated she worked with Resident #1 on 4/30/25 when he was transported to the ER. LVN A stated she entered Resident #1's room to check his blood sugar at approximately 7:30 AM and found the resident less responsive than usual and exhibited respiratory distress. LVN A stated she immediately called for help while checking Resident #1's vitals. She stated she was unable to get an O2 reading and put the resident on oxygen. LVN A stated EMTs had already been called and arrived at the facility to transfer Resident #1 to the local hospital. LVN A stated initially she was unsure what caused Resident #1's change in condition, but later found it appeared to be from a drug overdose based on clinical records. LVN A stated she was aware Resident #1 had a hx of drug use. She stated she had not ever seen the resident have possession of nonprescription drugs or use them at the facility. LVN A stated she had never seen any staff members or other residents with nonprescription drugs. She stated the staff were in-serviced on the facility's drug policy on 5/05/25.</p> <p>In an interview on 5/06/25 at 1:10 PM, RN B stated she worked at the facility since 2019. She stated she worked with Resident #1 during the incident on 4/30/25. RN B stated the nurses were checking blood sugars on the hall when LVN A called for her help in Resident #1's room. RN B stated LVN A informed that she was unable to obtain an O2 reading from Resident #1, and he was unresponsive. RN B stated when she entered the room, she found that Resident #1 was breathing but was not responding normally. She stated after calling his name loudly a few times, Resident #1 opened his eyes and said Yes then went back to sleep. RN B stated Resident #1 needed constant engagement to stay alert. RN B stated she remained in the room with Resident #1 until EMTs arrived.</p> <p>In an interview on 5/06/25 at 1:54 PM with the DON and Administrator, the DON stated on 04/30/25 she was alerted by LVN A that Resident #1 was in respiratory distress and needed to be sent out to the hospital. This state investigator informed them that Resident #1 admitted he received the Methadone from a staff member that he refused to identify. The DON stated Resident #1 returned to the facility during the weekend on 5/3/25 and the clinicals showed that Methadone was found in his system. The DON stated the MD and pain management team was notified. The DON stated a care plan meeting with Resident #1 was held on 5/05/25 and during an interview with the resident he denied using any drugs and did not report receiving any drug from staff. The DON stated Resident #1 only stated he was depressed about his mother. The DON stated a referral was sent for psychiatric services and Resident #1 was able to talk with a psychologist on 5/05/25. The Administrator stated staff were in-serviced on the facility's drug policy, s/sx of intoxicated residents, and abuse and neglect. He also stated a Resident Council meeting was scheduled to discuss the facility's drug policy and to see if there were any concerns. The Administrator and DON stated this was new information and they would need to consult with regional managers on how to move forward.</p> <p>In a further interview on 5/06/25 at 3:00 PM with the DON and Administrator, the Administrator stated the Regional Managers advised them to submit a self-report to the state agency and start a provider investigation regarding the alleged abuse.</p> <p>In an interview on 5/07/25 at 9:42 AM with the DON and Administrator, the Administrator stated the facility submitted a self-report to the stated agency and started the provider investigation. The Administrator stated Resident #1 was interviewed again and still denied any drug use and getting drugs from a staff member. The Administrator stated the police were called out and Resident #1 also denied everything to them.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>In a further interview on 5/07/25 at 11:50 AM with the DON and Administrator, The DON stated she received and reviewed Resident #1's hospital records on 5/02/25, prior to the resident discharging from the hospital, when it was found that Methadone was in the resident's system. The DON stated Resident #1 did not have an order to take Methadone at the facility and was not receiving any outpatient treatment where he would receive Methadone. The Administrator stated the incident had just happened and they were still gathering information to determine what happened, which is why a self-report was not submitted prior to the state investigator entering the facility.</p> <p>In an interview on 05/07/25 at 3:45 PM with the Regional Nurse Consultant and Regional Director of Operations, the Regional Nurse Consultant stated she was informed by the DON on 5/02/25 that Resident #1's hospital records indicated there was Methadone found in his system and she advised the DON to start an investigation. The Regional Director of Operations stated the facility began reviewing the resident sign-out logs, in-servicing staff, auditing medications in the facility to check for Methadone/narcotics and medication errors, and conducting safe surveys with staff and residents. The Regional Director of Operations stated the investigation continued over the weekend, with the DON doing pop-up visits to check the facility for drugs. Both Regional managers stated they were not sure why the DON and Administrator did not provide this information prior to the Immediate Jeopardy being called. This state investigator informed that the only evidence that was provided prior to the Immediate Jeopardy being called were the staff in-services, Resident #1's psychology assessment note, Resident #1's care plan conference notes, and a scheduled Resident Council Meeting to discuss the facility's drug policy. There was no evidence of medications audits, safe surveys, interviews, IDT notification, or a report to the state agency provided.</p> <p>Review of the facility's policy titled Abuse Prevention and Prohibition Program, revised 08/2020, reflected in part the following:</p> <p>Purpose: To ensure the Facility establishes, operationalizes, and maintains an Abuse Prevention and Prohibition Program designed to screen and train employees, protect residents, and to ensure a standardized methodology for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, misappropriation of property, and crime in accordance with federal and state requirements.</p> <p>Policy:</p> <p>I. Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. The Facility has zero-tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property.</p> <p>A. Definitions for the meaning of key terms used in this policy.</p> <p>II. The Facility is committed to protecting residents from abuse by anyone, including but not limited to Facility Staff, other residents, consultants, volunteers, staff from other agencies serving residents, family members, legal guardians, surrogates, sponsors, friends, and visitors. This policy statement also includes deprivation by any individual, including a caretaker, of goods, services or rights that are necessary for a resident to attain or maintain physical, mental, and psychosocial wellbeing.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>III. The Administrator is responsible for coordinating and implementing the Facility's abuse prevention policies, procedures, training programs, and systems.</p> <p>IV. This policy also identifies Special Considerations regarding the investigation of injuries of unknown origin, the reporting of suspected rape, and resident-to-resident abuse.</p> <p>Procedure:</p> <p>.</p> <p>IV Prevention</p> <p>A. Staff, residents and families will be able to report concerns, incidents and grievances without fear of retribution or retaliation.</p> <p>B. Supervisors shall immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring.</p> <p>.</p> <p>VII Investigation</p> <p>A. The Facility promptly and thoroughly investigates reports of resident abuse, mistreatment, neglect, injuries of an unknown source, or criminal acts.</p> <p>.</p> <p>IX. Reporting/Response</p> <p>A. Facility Staff are Mandatory Reporters</p> <p>i. Facility owners, operators, employees, managers, agents, and contractors are obligated by the Elder Justice Act and any state specific regulations to report known or suspected instances of abuse of elder or dependent adults.</p> <p>.</p> <p>Review of the facility's policy titled Resident Drug and Alcohol Abuse, revised 08/2020, reflected in part the following:</p> <p>Purpose: To provide a safe and drug-free environment for residents while at the Facility.</p> <p>Policy Statement:</p> <p>I. The Facility will admit a resident who has a history of drug and alcohol abuse as long as their primary diagnosis is suitable for skilled care at this Facility.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>II. The Facility has a zero-tolerance policy for the use or possession of illegal drugs (including marijuana) or any type of drug apparatus in the Facility or on the grounds of the Facility. All illegal drugs and/or drug paraphernalia will be confiscated from the resident and /or their room.</p> <p>B. The only drugs permissible at the Facility and/or on Facility grounds are those for which there is an Attending Physician order.</p> <p>IV. Any resident found in violation of this policy will be discharged to a more appropriate setting for care (See Policy Transfer and Discharge).</p>

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45054</p> <p>Based on observation, interview, and record review the facility failed to ensure that a resident who needs respiratory care was provided such care, consistent with professional standards of practice for one resident (Residents #2) of six residents reviewed for respiratory care in that:</p> <p>-The facility failed to ensure that Residents #2, who required continuous oxygen therapy, continued to receive adequate oxygen when her portable oxygen tank ran out of oxygen while the resident was in the community at an appointment on 4/28/2025. Resident #2 was sent to the local hospital by the clinic after running out of oxygen and complaining of SOB and chest pain.</p> <p>The non-compliance was identified as past non-compliance (PNC). The Administrator and DON were notified of the PNC on 05/07/25 at 2:57 PM. The Immediate Jeopardy began on 04/28/25 and ended on 04/28/25. The facility had corrected the non-compliance before the state's investigation began.</p> <p>This failure could affect all residents who receive oxygen therapy by placing them at risk of receiving inadequate oxygen support, which could result in serious harm or death.</p> <p>Findings included:</p> <p>Record review of Resident #2's face sheet, dated 5/08/25, reflected a [AGE] year-old female who was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Chronic Obstructive Pulmonary Disease (lung disease), emphysema (lung disease), chronic respiratory failure, and chronic bronchitis (inflammation of lungs).</p> <p>Record review of Resident 2's quarterly MDS assessment, dated 04/20/25, reflected her BIMS score was 10, which indicated moderate cognitive impairment. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #2 required setup to supervision assistance with most ADLs and used a manual wheelchair. The MDS Assessment under Section I-Active Diagnoses reflected Resident #2 had a primary medical condition of cardiorespiratory with other comorbidities that included chronic lung disease and respiratory failure. Further review of this document, under Section O-Special Treatments, Procedures, and Programs, reflected Resident #2 received oxygen therapy.</p> <p>Record review of Resident 2's care plan, revised 4/29/25, reflected the resident was on oxygen therapy r/t ineffective gas exchange and respiratory illness. Interventions included: changing respiratory equipment every 7 days, checking O2 sat every shift and PRN, providing extension tubing and portable oxygen apparatus, giving medications as ordered, requiring additional oxygen tank while away from the facility, monitoring for s/sx of respiratory distress and reporting to MD, O2 at 2 lpm, positioning to facilitate ventilation matching, re-directing if nasal canula was off, and suctioning as needed.</p> <p>Record review of Resident #2's consolidated physician orders, dated 05/06/25, reflected in part the following:</p> <p>-O2 at 2 liters per minute via nasal canula-start date: 2/25/25; discontinue date: 5/01/25</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's progress notes, dated 04/28/25 at 2:44 PM by LVN C, reflected the following: [Resident #2 went to appt [Surgical Clinic] sent to ER because she ran out of oxygen. Went to appt with a full tank of oxygen. [Resident #2] able to make needs known. Call light in reach. WCTM.</p> <p>Record review of Resident #2's hospital records, dated 04/28/25, reflected in part the following:</p> <p>[AGE] year-old woman history significant COPD on 2 L home oxygen who presents to ED with complaints of dyspnea (shortness of breath), pleuritic chest pain (sharp pain in chest when breathing) after running out of oxygen during an outpatient appointment. [Resident #2] reports she has been feeling unwell for about a day, she endorses increased cough. [Resident #2] is not sure of the home medications.</p> <p>In the ED chest x-ray showed left-sided opacity concerning for pneumonia. [Resident #2] was oxygen saturated 99% on 2 L</p> <p>In an interview and observation on 05/06/25 at 11:30 AM, Resident #2 was sitting on the side of her bed wearing a nasal cannula that was connected to an oxygen concentrator that was set on 2 lpm. Observation of the portable tank on the back of Resident #2's wheelchair revealed it was an e-tank that held 680 liters of oxygen and was full. Resident #2 stated she was not feeling well due having pneumonia. She stated the nurse was giving her abx. Resident #2 stated she went to the hospital about a week ago after she ran out of oxygen while at an appointment. She stated the staff woke her up at about 5:30 that morning to get ready for her appointment and she was so tired that she was fell asleep in her wheelchair while waiting for the Van Driver to come, so she did not see if the nurse checked her portable oxygen tank to make sure it was full like she normally did. Resident #2 stated because of this she felt like it was also her fault for running out of oxygen. Resident #2 stated she knew how to change the setting on her portable oxygen tank, but she did not change it that day. She stated it remained at whatever setting it was last set to, which was usually 2 lpm. Resident #2 stated she had already been feeling bad and while at her appointment her oxygen was running low, and she started feeling worst. Resident #2 stated her chest was hurting and she was short of breath so the 911 was called and after what seemed like an hour, she was transported to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on 05/06/25 at 1:54 PM with the DON and Administrator, the DON stated Resident #2's had a consultation for eye surgery at 8:45 AM and she left the facility at approximately 7:30 AM. The DON stated they were only expecting the appointment to last about 45 minutes, but it lasted over 2 hours. She stated they later found that was normal for those type of consultations due to all the testing required. The DON stated at approximately 10:30 AM, CNA D called and informed that Resident #2's oxygen was low, and the surgical center was giving the facility 15 minutes to bring more oxygen, or they were going to call 911. The DON stated the Van Driver was on her way; however, the nursing facility was about 20-25 minutes away and by the time she arrived Resident #2 had already been transported to the hospital. The DON stated Resident #2 was admitted to the hospital after being diagnosed with pneumonia. The DON stated a full oxygen tank at 2 lpm should have lasted 3-4 hours and LVN C stated she checked, and it was full before Resident #2 left. The DON stated the only explanation she could think of was that Resident #2 waited at the nurse's station for a while, using oxygen from her portable tank, before being transported to the appointment. The DON was asked if an oxygen tank with approximately 680 liters of oxygen, running at 2 lpm could last at least 5 hours and she stated it probably could if the settings were not adjusted. The Administrator stated in-servicing immediately began with all staff on 4/28/25 regarding residents on continuous oxygen therapy. He stated the staff were educated on checking the oxygen levels in portable tanks to ensure they were full before a resident left the facility and the updated protocol to send extra oxygen tanks with residents on appointments that would last longer than 2 hours.</p> <p>In an interview on 05/06/25 at 2:26 PM, LVN C stated she worked with Resident #2 on 04/28/25 when she went to the hospital after running low on oxygen while at an appointment. LVN C stated she assisted Resident #2 that morning before she was transported to her appointment, and she remembered checking the portable oxygen tank and it was completely full and set at 2 lpm. LVN C stated Resident #2 had a lot of respiratory issues, so she always made sure to check her oxygen tanks before she left the facility. LVN C stated Resident #2 was dressed and waiting for her appointment at about 7:15 AM and was using her portable oxygen tank because she required continuous oxygen therapy.</p> <p>In an interview on 05/07/25 at 11:00 AM, CNA D stated she worked on 4/28/25 and rode to the appointment with Resident #2. She stated the nurses checked the portable oxygen tanks before residents were transported to appointments, so she did not check it on that day. CNA D stated she did not make it to work until about 7:45 AM and Resident #2 and the Van Driver were already on the van waiting, she got on the van, and they headed to the appointment. CNA D stated when they arrived, they waited in the lobby for about 30 minutes before Resident #2 was called to the back. She stated while waiting, Resident #2 did not complain of shortness of breath or chest pains while being transported and was acting like her normal self. CNA D also stated she did not see Resident #2 change the setting on her portable oxygen tank. CNA D stated after about an hour, the staff from the surgical center came out and told her that Resident #2's oxygen tank was low, and they were giving them 15 minutes to get her another oxygen tank, or they would have to call 911. CNA D stated she called the facility to inform them and while she was still on the phone, the staff called 911 after they overheard her saying the driver was more than 15 minutes away. CNA D stated she saw Resident #2 being taken to the ambulance and she did not appear to be in distress. She stated Resident #2 was talking and trying to drink water but was asked to not drink anything. CNA D stated when she returned to the nursing facility, she was in-serviced on making sure residents had enough oxygen when going on appointments. CNA D stated she now knew that the aides were also responsible for checking the oxygen tanks and not just the nurses; however, only the nurses could hook the oxygen tanks up.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Oxygen Administration, revised 06/2020, revealed in part the following:</p> <p>Purpose: To prevent or reverse hypoxemia and provide oxygen to the tissues.</p> <p>.</p> <p>A facility's policy on respiratory care regarding portable oxygen tanks was requested from the Administrator on 5/8/25 at 11:46 AM, and he informed that the facility did not have that specific policy.</p> <p>The non-compliance was identified as past non-compliance (PNC). The Administrator and DON were notified of the PNC on 05/07/25 at 2:57 PM. The Immediate Jeopardy began on 04/28/25 and ended on 04/28/25. The facility had corrected the non-compliance before the state's investigation began.</p> <p>The facility took the following actions to correct the non-compliance prior to the survey:</p> <p>Record review of Residents #2, #6, #7, #8, #9, and #10 EHRs revealed their care plans included interventions to address respiratory needs.</p> <p>Observations on 05/06/25 from 11:30 AM-2:55 PM, revealed Residents #2, #6, #7, #8, #9, and #10 had no s/sx of respiratory distress and they all had oxygen concentrators and full portable oxygen tanks available.</p> <p>Interviews with residents and RPs on 5/06/25 from 11:30 AM-2:55 PM revealed no concerns for respiratory care of any residents running out of oxygen while in the community.</p> <p>Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected all staff were educated by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to notify the nurse or clinical staff if portable oxygen tanks were low.</p> <p>Record review on 5/6/25 of in-service titled Oxygen Supply for Appointments, dated 4/28/25, reflected all nurses were in-serviced by the DON regarding appointments for residents who required continuous oxygen therapy to ensure the residents had adequate oxygen while in the community. The nurses were educated on determining the approximate length of time of each appointment, documenting and communicating the information to all staff interacting with the residents and ensuring an extra portable oxygen tank was sent on appointments that would be longer than 2 hours.</p> <p>Record review on 5/6/25 of in-service titled Oxygen Supply for Appointments, dated 4/28/25, reflected all nurses were in-serviced by the DON regarding appointments orders for residents who required continuous oxygen therapy. The nurses were educated on putting orders for appointments by transportation in the EHR 3 days prior to the appointment date, and including information about the approximate length of time for the appointments to ensure the residents are transported with adequate oxygen.</p> <p>Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected LVN C had 1 on 1 education by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to switch out low portable oxygen tanks with full ones.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review on 5/6/25 of in-service titled Portable Oxygen-Appointments, dated 4/28/25, reflected LVN C had 1 on 1 education by the DON on ensuring that residents on continuous oxygen therapy had a full portable oxygen tank before leaving the facility for an appointment and that an extra portable oxygen tank was sent with the residents for all appointments that would be longer than 2 hours.</p> <p>Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected CNA D had 1 on 1 education by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to notify the nurse if portable oxygen tanks were low.</p> <p>Record review on 5/6/25 of in-service titled Portable Oxygen-Appointments, dated 4/28/25, reflected CNA D had 1 on 1 education by the DON on ensuring that residents on continuous oxygen therapy had a full portable oxygen tank before leaving the facility for an appointment and that an extra portable oxygen tank was sent with the residents for all appointments that would be longer than 2 hours.</p> <p>Record review on 5/6/25 of in-service titled Portable Oxygen Tanks, dated 4/28/25, reflected the Van Driver had 1 on 1 education by the DON on ensuring that residents on oxygen therapy always had adequate oxygen available and to notify the nurse or clinical staff if portable oxygen tanks were low.</p> <p>Record review on 5/6/25 of in-service titled Portable Oxygen-Appointments, dated 4/28/25, reflected the Van Driver had 1 on 1 education by the DON on ensuring that residents on continuous oxygen therapy had full portable oxygen tanks before being transported to appointments with and extra portable oxygen tank if the appointments would be longer than 2 hours.</p> <p>Interviews from 5/6/25 (12:00 PM-3:30 PM)-5/8/25 (9:30 AM-10:00 AM), conducted with the Administrator, DON, nurses and CNAs: RN B (1st shift), LVN C (1st shift), CNA D (1st shift), CMA E (1st shift), CNA F (1st shift), RN G (2nd shift, weekends), LVN H (2nd/3rd shift weekends), RN I (3rd shift, PRN), LVN J (2nd shift), RN K (2nd shift) indicated they all participated in in-service trainings on 4/28/25. The nurses were able to state they were ultimately responsible for ensuring that residents who required oxygen therapy always had adequate oxygen available, and residents who required continuous oxygen therapy had full portable tanks when leaving the facility. The nurses were also able to state when confirming an appointment for residents on continuous oxygen therapy, they were responsible for determining the approximate length of time of the appointments, documenting it, and ensuring that the residents had 2 full portable oxygen tanks if the appointments were longer than 2 hours. The CNAs were able to state that while providing care to residents with portable oxygen tanks, they were also responsible for checking the tanks to ensure there was adequate oxygen and to immediately notify the nurse if there was not. The Administrator and DON stated the in-services would be ongoing to include new staff, PRN staff, and any other staff who did not receive the in-service prior to the start of their shifts.</p> <p>A document provided by the DON titled Midnight Census Report-Oxygen List, dated 4/28/25, reflected all residents on oxygen therapy were identified and any of those residents with schedule appointments had all information, including length of time, noted.</p> <p>A document provided by the DON titled AD Hoc Quality Assurance and Performance Improvement Plan, dated 4/28/25, reflected a QAPI meeting was held to discuss failure and interventions put in place to prevent failure from occurring again.</p>		