STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on record review and interview the facility failed to consult with the physician when there was a significant change in residents' physical status that was life threatening for 2 of 7 residents (Resident #1 and Resident #2) reviewed for change in condition. The facility failed notify Resident #1's physician on 2/5/25 when his PICC continued to be dislodged and he was unable to receive his IV antibiotics. Resident #1 did not receive his IV antibiotic medication from 2/6/25 through 2/7/25 (a total of 6 doses). The facility failed to notify Resident #1's physician of his x-ray results that were ordered on 2/7/25 with results that indicated they were sent back to the facility on [DATE]. Res #1's MD was notified on 2/10/25 that Res #1's x-ray indicated he had pneumonia, and he was transferred to the hospital. Resident #1 was admitted to the hospital on 2/10/25 with diagnoses of right lobe pneumonia due to ESBL(extended spectrum beta lactamase). The facility failed to notify Res #2's physician that his surgical wound had worsened. Resident #2 was admitted to the hospital on 2/9/25 with left lower leg pain and fever. He had a diagnosis of sepsis (a life threatening complication of an infection) left below the knee amputation infection. The facility failed to follow their policy on notification of changes with significant health issues. An Immediate Jeopardy (IJ) situation was identified 2/13/25 at 5:00 p.m. While the IJ was removed on 2/14/25 at 7:35 p.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate threat with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures caused life threatening consequences for these two residents and put other residents at risk for not receiving timely medical interventions. Findings included: (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's face sheet dated 2/11/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He was readmitted on [DATE] with diagnoses of Diffused traumatic brain injury, osteomyelitis, pneumonia, covid 19, quadriplegia, contracture of the right and left hand, and presence of left artificial elbow joint. Record review of Resident #1's admission MDS dated [DATE] indicated he was moderately impaired in decision making. He was unable to complete the BIMS. The resident had impaired range of motion on both sides of his upper extremity (shoulder, elbow, wrist, and Hand) and his lower extremity (hip, knee, ankle, and foot.) He required a wheelchair for mobility. He was dependent on staff for all activities of daily living. The MDS indicated the resident had an indwelling catheter and ostomy. Record review of Resident #1's care plan dated 1/28/25 indicated a problem of altered respiratory status/difficulty breathing related to recent hospitalization stay for Covid and pneumonia. The resident will be on IV antibiotics for pneumonia with an initiation date of 1/27/25 and a revision date of 2/7/25. Some of the interventions were to monitor and document changes in orientation. Monitor for signs and symptoms of respiratory distress and report to the physician increased respirations, decreased pulse oximetry, increased heart rate, restlessness, lethargy, confusion, and cough. A care plan problem of IV medications related to pneumonia. The care plan interventions were related to complications related to IV therapy such as infiltrated IV, drainage, or inflammation. Record review of Resident #1's prior to facility admission hospital records dated 1/31/25 indicated a diagnosis of pneumonia due to covid dated 1/23/25, ESBL Extended spectrum beta lactamase: producing bacterial infection dated 9/17/24 still present, Acute osteomyelitis of the right elbow dated 12/24/24 still present. His discharge medication included meropenem 1 GM. Record review of Resident #1's nursing notes dated 1/31/25 at 6:17 p.m. indicated the resident was returning to the facility from the hospital. Signed by RN H. Record review of Resident #1's physician order indicated Meropenem Intravenous Solution Reconstituted use 1 gram intravenously every 8 hours for pneumonia due to covid for 7 days dated 2/1/25. Record review of Resident #1's MAR indicated Meropenem Intravenous Solution Reconstituted 1 GM use 1 gram intravenously every 8 hours for pneumonia due to covid for 7 days. With a start date of 2/1/25. The MAR indicated the medication was to be administered at 7:00 a.m., 3:00 p.m., and 11:00 p.m. The MAR indicated the mediation was given 3 times daily with the last dose 2/5/25 at 11:00 p.m. Record review of Resident #1's nursing notes indicated: On 2/6/25 at 1:27 p.m. meropenem intravenous Solution reconstituted 1GM was not given due to loss of PICC access. The PICC company was notified for replacement. The NP was made aware. Signed by LVN C. On 2/6/25 at 10:13 p.m. indicated the resident refused midline, would not let staff unbend arm to pace midline. Signed by LVN F. On 2/7/25 at 1:40 p.m. the company that replaced PICC lines was called to replace Resident #1's PICC line. Signed by LVN E (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 2/7/25 at 2:58 p.m. no PICC line in place for administration of medication. Signed by LVN E On 2/7/25 at 10:12 p.m. no PICC line access. Signed by LVN F On 2/8/25 at 12:17 a.m. resident remained without IV access signed by LVN F. On 2/10/25 at 11:38 a.m. Resident #1's PICC line was dislodged on 2/5/25 and the NP was informed. An outside service provider attempted to replace and insert new PICC line in the facility. The technician was unsuccessful due to contraction of upper extremities of patient. The patient did not complete antibiotic therapy and missed several doses. The nurse contacted NP regarding situation and current symptoms to include cough, abnormal lung sounds, abnormal chest x ray. The nurse received an order to send Resident #1 to the ER. His blood pressure was 116/64, oxygen status on room air was 91 percent, his temperature was 98.8 and his pulse was 80. Signed by LVN E. Record review of a change in condition note dated 2/10/25 at 6:57 p.m. indicated Resident #1 had increased cough, a positive chest x ray, incomplete antibiotic therapy, these things made the condition worse. Signed by LVN E. Record review of Resident #1's x ray report dated 2/7/25 and signed electronically on 2/7/25 at 11:07 a.m. indicated Resident #1 had patch bilateral lung opacities (area of increased density or darkness in the lungs.) This was consistent with bilateral pneumonia. The findings are worse compared with prior. There was no indication the physician was notified. Record review of Resident #1's hospital records dated 2/10/25 indicated Resident #1 was receiving IV antibiotics for pneumonia. He lost his PICC line assess, and the facility attempted to have it replaced but was unsuccessful. The resident had an x ray showing he still had pneumonia and was sent to the hospital for PICC line replacement. He has a history of pneumonia. He is nonverbal and quadriplegic, unable to move upper or lower extremities, with severe contractions noted. The hospital records indicated they spoke with the RN at the facility and was informed the PICC line had been out since 2/5/25. He had a diagnosis of pneumonia of the right lower lobe due to infectious organism ESBL (extended spectrum beta -lactamase) producing bacterial infection. Record review of a nursing note dated 2/10/25 at 9:56 p.m. indicated the nurse called to check on Resident #1's status. He was admitted to the hospital with a diagnosis of right lower lobe pneumonia, acute osteomyelitis, ESBL. Signed by LVN E During an interview and record review on 2/12/25 at 3:21 p.m. LVN C said Resident #1 did not have PICC line access when she came in on 2/6/25. She said she had gotten the ADON/RN D to come in and help her assess the resident. She said the NP was in the building doing rounds. She said the NP told them to contact a company that replaced PICC lines. She said she had contacted that company on 2/6/25 for them to come out and replace Resident #1's PICC line. A review of the nursing notes with LVN C indicted Resident #1 had refused the reinsertion on 2/6/25. LVN C said she was not aware the company had been contacted again on 2/7/25 by LVN E and she did not know what had happened with Resident #1's PICC line. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 2/12/25 at 3:44 p.m. ADON/RN D said she was not sure if Resident #1's PICC line had been noted as displaced by the prior shift on 2/5/25. She said Resident #1's right arm was contracted, and he held it tightly to his biceps. The ADON/RN said she did not know how the PICC line came out. She said LVN C had asked her to come in and assess Resident #1 on the morning of 2/6/25. She said the NP was in the building and the NP and told them to contact a company that replaced PICC lines. She said she knew LVN C had called the company. She did not know Resident #1 had refused or how many times the company had been called or why the PICC line was not replaced. During a telephone interview on 2/12/25 at 4:30 p.m. the NP, he said he had gotten a text earlier on the morning of 2/6/25 that Resident #1's PICC line had come out. He said he told them to call the PICC line replacement company and have them to come out to replace the PICC line. He said the facility did not inform him they were unable to replace the PICC line. He said he was not informed Resident #1 was not taking the antibiotic. The NP said if they had informed him Resident #1 was not able to finish his antibiotic, he would have told them to send him to the hospital. During a telephone interview on 2/12/25 at 4:31 p.m. the DON said on 2/7/25 LVN E told her that the PICC line company said they would not come back to the facility to try and reinsert Resident #1's PICC line. They said they were unable to do so due to his contractures. She said she told LVN E to call the physician and let him know. The DON said on the morning of Monday, 2/10/25 after the x rays were reviewed, she told LVN E to call the physician and send Resident #1 to the hospital. During a telephone interview on 2/12/25 at 4:32 p.m. LVN E said she had talked to the PICC line company, and their nurse said they were not coming out. She said the nurse said Resident #1 was too contracted and they were not able to place the PICC line. LVN E said she was leaving for the day and told the DON what the company had said. The DON told her to make the physician aware. She told the oncoming nurse LVN F about the situation during report. She said she did not know what happened after then. She said she had not notified the physician. During a telephone interview on 2/12/25 at 4:55 p.m. LVN F said that on Friday 2/7/25 LVN E told her the PICC line company had refused to come out. She said it was mentioned in the conversation about notifying the physician, but she thought LVN E had notified the physician. LVN F said she had not notified the physician because she thought it was already done. During an interview on 2/13/25 at 7:21 a.m. LVN C said she did not know anything about Resident #1's x rays results until Monday, 2/10/25. She said she worked PRN and was under the impression x rays results would be sent by fax. She said that on Monday, 2/10/25 Resident #1 had a cough that was deeper than on 2/7/25 and she was told he had x ray results that indicated pneumonia and to send him out to the hospital. During an interview on 2/13/25 at 10:30 a.m. the Regional Nurse Consultant said ADON/RN D and Administrator did not find any nurse that admitted to seeing the x ray results for Resident #1 on the weekend. He said it appeared the first time the x rays were noted was on 2/10/25. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 2/13/25 at 10:34 a.m. the Administrator said they did not find any nurse that discovered the x ray results for Resident #1 over the weekend. She said she was aware of what the NP always said he would send a resident to the hospital if they had a change in condition. The Administrator said she had reached out to the nurses on the weekend they thought the order was complete for Resident #1's antibiotics because the completion date was 2/7/25 and it fell off the system orders. She said they did not see any issues and they did not review the records to see if there was a problem because they thought the antibiotic was completed. Resident #2 Record review of Resident #2's face sheet dated 2/11/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He was last admitted [DATE] with diagnoses of surgical amputation, absence of left leg below the knee, and absence of right leg below the knee. Record review of an admission MDS dated [DATE] indicated a BIMS score of 11 which indicated moderate cognitive impairment. The resident required substantial to maximum assistance with the helper doing more than half the effort for sit to lying, sit to stand, and transfers. Record review of Resident #2's care plan dated 12/26/24 and revised on 1/3/25 indicated a problem of the resident was at risk for skin integrity related to reduced mobility due to bilateral amputation, poor nutrition and immune comprised. Some of the interventions were to monitor and document size and location and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection or maceration to the physician. Record review of Resident #2's prior to facility admission hospital records dated 1/27/25 indicated to cleanse left BKA site daily with antibacterial soap and water or wound cleanser, apply no stick dressing and secure with ace wrap compression. Start taking Amoxicillin potassium-clavulanate (Augmentin) 875-125 mg oral one tablet two times a day for 10 days. Record review of Resident #2's MAR for February 2025 indicated Amoxicillin potassium-clavulanate (Augmentin) 875-125 mg give one tablet by mouth q 12 hours for cellulitis for 10 days with a start dated on 1/27/25. The medication was noted to be last given on 2/6/25 at 8:00 a.m. Record review of Resident #2's TAR for February 2025 indicated cleanse left BKA site with antibacterial soap and water or wound cleanser, apply nonstick dressing, secure with ace wrap compression one time a day every Tuesday, Thursday, and Saturday for wound care with start date of 1/30/25. The TAR indicated the last time wound care was provided was Tuesday 2/4/25. On Thursday 2/6/25 the TAR indicated to see the nurses' notes on Saturday 2/8/25 indicated the drug refused. Record review of Resident #2's nursing notes dated 2/6/25 indicated Resident #2 refused wound care. Signed by treatment nurse. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #2's wound evaluation dated 2/7/25 at 6:22 a.m. indicated a surgical wound with 38 staples on the left below the knee amputation site. The area of the wound was 44.65 cm, and the length was 8.14 cm and 7.58 cm. the wound was one to 3 months old. It had 50 percent granulation and 50 percent slough. There was evidence of infection such as increased drainage, increased pain, redness/inflammation, warmth, and bleeding. There was moderate sanguineous bloody drainage. The was pitting edema that extended 4 cm around the wound and was warm, the pain was at a level 4 with continuous frequency. The wound evaluation indicated the wound was deteriorating and the physician diagnosed the infection. The wound evaluation was signed by the treatment nurse. Record review of Resident #2's nursing note dated 2/7/25 at 11:09 a.m. indicated surgery for BKA revision rescheduled for 2/12/25 arrival at 9:30 a.m. for 11:30 a.m. procedure. Record review of Resident #2's nursing note dated 2/8/25 at 6:15 p.m. indicated cleanse left BKA site with antibacterial soap or wound cleanser and apply dressing. Record review of Resident #2's change in condition notes dated 2/9/25 at 1:00 p.m. indicated Resident #2 had a change in condition that consisted of lethargy, confusion, loss of appetite, elevated heart rate at rest started 2/9/25 and had stayed the same. His primary diagnosis was orthopedic aftercare following surgery. his blood pressure was 106/68, pulse 115 (irregular), respiration 16, temp 98.9, oxygen status 96. Signed by LVN A Record review of nursing notes dated 2/9/25 at 2:40 p.m. indicated Resident #2 was sent to the hospital. Record review of Resident #2's hospital records dated 2/9/25 indicated the resident was admitted at 12:53 p. m. He was admitted with complaints of left lower extremity wound pain and fever. He had a recent BKA performed at another hospital his blood pressure was 173/95, pulse 114, respirations 16, temp 100.4 and oxygen status 99 percent. The x rays were concerning for gas within the wound that could be either an abscess or gaseous gangrene. He was started on antibiotics and wanted to be transferred to another hospital. The disposition summary on 2/9/25 at 4:51 p.m. indicate a diagnosis of sepsis unspecified organism/left BKA infection. During an interview on 2/11/25 at 3:45 p.m. LVN B said Resident #2 was on antibiotics and had finished them a few days prior to going to the hospital. She said he was sent to the hospital to have surgery on an amputation that needed a revision. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview and observation on 2/12/25 at 2:00 p.m. with the treatment nurse and the RN C, the treatment nurse said Resident #2 came to the facility after he had an amputation. She said the wound care physician would not see him because his wound was surgical. She said the last time she completed an assessment on Resident #1 was Friday, 2/7/25. She said Resident #2's surgical wound had deteriorated by her assessment. She said she did not call NP or the physician because she thought Resident #2 was going to surgery center that day. She said she wanted to see the wound herself and document what was going on with the wound before he left for his surgery. She said on Friday, 2/7/25 she noted a change to the wound. She said it did not look like that the week before. She said she had taken a picture that was observed by the surveyor. She described the wound with drainage and yellow slough (a layer of dead tissue formed when cells and other debris are trapped in the wound, and do not get properly removed. It can impede wound healing) around the circumference of the wound. The treatment nurse said Resident #2's leg was cut below the knee, it black above the staples on the wound. The treatment nurse said LVN B had assisted her with wound care on 2/7/25. During a telephone interview on 2/12/25 at 2:20 p.m. LVN B said Resident #2 had an appointment on 2/7/25 for a surgical revision to his BKA. She said it was right on the computer, but it was placed on the transport log with the wrong date. LVN B said when they realized the resident was not at his appointment they had called the clinic and were initially told to bring the resident to the appointment late. She said in about an hour the clinic called back and said the physician said to reschedule. She said the appointment was rescheduled to 2/12/25. She had written the note about the rescheduled appointment, but had not notified anyone he missed the appointment. She said she had assisted the Treatment Nurse on 2/7/25 when she provided wound care to Resident #2. LVN B said Resident #2's surgical wound had drainage, no odor, and the darkness above the wound had grown larger. During a telephone interview on 2/12/25 at 4:30 p.m. the NP, he said he was informed Resident # 2 had a change in condition when they were sending him to the hospital. He said he was not informed Resident #2's wound had deteriorated. Review of the facility policy on Notification of Changes dated 10/24/22 indicated the purpose of the policy was to ensure the facility promptly informed the resident, consulted with the resident physician. The facility must inform the resident, consult with the resident's physician when there is a change requiring such notification such as a significant change. Such as life threatening conditions or clinical complications. Circumstances that require a need to alter treatment such as adverse consequences, acute condition or exacerbation of symptoms. Due to the above findings, it was determined the facility was in an Immediate Jeopardy (IJ) situation on 2/13/25 at 5:00 p.m. The Administrator, Regional Nurse Consultant, and ADON/RN G were informed on 2/13/25 at 5:00 p.m. an email was sent to the Administrator. The facility's Plan of Removal was accepted on 2/14/25 at 10:51 a.m. Plan of Removal for F580: [To Identify Any Other Residents to Have the Potential: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Beginning 2/13/25, the Licensed Nurse will evaluate all other residents in the center for any change in condition. Should any changes be evaluated, the physician will be notified. The evaluation will be documented in the resident's clinical record. All residents, evaluated, validated and documented on 2/13/25 with no additional cases identified. Education/ System Change: On 2/12/25, the Director of Nursing /Designee initiated reeducation with Licensed Nurses on the following topics: o Documentation in Medical Record o Medication Administration o Notification of Changes Policy to include changes in medication administration, wound care and abnormal radiology results o When a licensed nurse identifies a change in condition, they will evaluate the resident and document their evaluation in the clinical record. The Licensed Nurse will notify the Medical Provider of the change in condition and document that notification in the clinical record. o Licensed Nurses will give shift report from the PCC generated 24 hour report. (PCC generated from clinical documentation). o Licensed Nurses will review the Results Module in PCC (Lab and Radiology) at the shift change to notify the Medical Provider of results. Re-education will continue until 100% of nursing staff are reeducated. Those that are PRN, agency and/ or out on FMLA/ LOA will have the education completed prior to accepting assignment for their next scheduled shift. DON/Designee will provide training. Monitoring: Beginning 2/13/25, and going forward, the Director of Nursing / designee will review the 24- hour report, the PCC Skin and Wound Module and the PCC Results Module in the morning clinical meeting to ensure that changes of condition documented in the clinical record are identified and communicated with the physician and the resident representative. Beginning 2/13/25, and on-going, the Director of Nursing or designee will monitor compliance each weekly morning. Results of findings will be discussed in the monthly QAPI meeting for three months and the plan will be continues as needed. Beginning 2/13/25, and on-going, the Administrator will attend the morning clinical meeting to ensure the Director of Nursing or designee is reviewing the 24-hour report in the morning clinical meeting to identify changes in condition. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The Weekend Supervisor will review the 24-hour report in PCC as well as the Results Module (Lab and Radiology to ensure that Medical Providers are notified of results. An Ad Hoc QAPI {quality assurance and performance improvement} Meeting was conducted on February 13, 2025, by the Administrator, with the Medical Director, and the Regional Clinical Specialist to discuss the immediate jeopardy concerning F580 Notification of Changes and plan to correct.] On 02/14/25 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of in-services dated 2/13/25 and 2/14/25 indicated staff were trained on provider notification, shift hand off/reporting, 24-hour report, accessing/reviewing lab/radiology, medication administration, documentation in the medical record and abuse/neglect. Record review of 24-hour reports dated 2/13/25 and 2/14/25, the PCC Skin and Wound Module, and the PCC Results Module revealed no concerns. Record review of the facilty's QAPI meeting attendance sheet indicated they met on 2/13/25. Interviews on 2/14/25 with the ADON, Regional Clinical Specialist and Administrator indicated in-services were completed with staff on provider notification, shift hand off/reporting, 24-hour report, accessing/reviewing lab/radiology, medication administration, documentation in the medical record and abuse/neglect. They said staff had knowledge and were able to explain procedures on notification of changes, changes in medication administration, wound care, radiology/lab results, and documentation in the medical record. They said staff were knowledgable on giving report during shift change from the 24 hour report that was generated from the clinical documentation. They said staff were able to explain procedures on changes of condition and notifying the provider of the change, and documentating in the clincial record. They said they went over the 24 hour reports during their morning meeting. Interviews and record reviews were conducted on 02/14/25 from 4:00 p.m. through 8:00 p.m. and included 3 RNs, 4 LVNs, ADON, Regional Clinical Specialist and Administrator. Staff were able to explain documentation in medical record and medication administration. Staff had knowledge on notification of changes policy and to include changes in medication administration, wound care, and abnormal radiology results. The staff successfully provided an explanation when a licensed nurse identifies a change in condition, they will evaluate the resident and document their evaluation in the clinical record. The Licensed Nurse will notify the Medical Provider of the change in condition and document that notification in the clinical record. The staff was well-informed about licensed nurses will give shift report from the PCC generated 24-hour report. (PCC {point click care- facility medical records system} generated from clinical documentation). Also, Staff was able to explain licensed nurses will review the Results Module in PCC (Lab and Radiology) at the shift change to notify the Medical Provider of results. All residents in the facility were evaluated for any change in condition, validated and documented on 2/13/25 with no additional cases identified. This was verified by interview with the ADON (DON Designee), the Administrator and record review of 24-hour summary listing resident name, room number and progress notes dated 2/13/25. (continued on next page)

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	455684	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an observation on 2/14/25 at 6:35 p.m. of a shift change and reporting between LVN E and LVN I, there were no issues noted. The Administrator and ADON/RN G were informed on 2/14/25 at 7:35 p.m. the IJ was removed. The facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate threat with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on record review and interview the facility failed to provide care and treatment in accordance with professional standards of practice based on the comprehensive assessment for 2 of 7 residents (Resident #1 and Resident #2) reviewed for quality of care. The facility failed to ensure Resident #1 received IV antibiotics when his PICC line was dislodged on 2/5/25. Resident #1 did not receive his IV antibiotic medication from 2/6/25 through 2/7/25 (a total of 6 doses). The facility failed to address Resident #1's chest x-ray that was ordered and sent back to the facility on [DATE] until 2/10/25. The facility notified Resident #1's MD on 02/10/25 that Resident #1's x-ray indicated he had pneumonia, and he was transferred to the hospital. Resident #1 was admitted to the hospital on 2/10/25 with diagnoses of right lobe pneumonia due to ESBL(extended spectrum beta lactamase). The facility failed to ensure Resident #2's surgical wound did not worsen. Resident #2 was admitted to the hospital on 2/9/25 with left lower leg pain and fever. He had a diagnosis of sepsis (a life threatening complication of an infection) left below the knee amputation infection. An Immediate Jeopardy (IJ) situation was identified 2/13/25 at 5:00 p.m. While the IJ was removed on 2/14/25 at 7:35 p.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures caused life threatening consequences for these two residents and put other residents at risk for not receiving timely medical interventions. Findings included: Record review of Resident #1's face sheet dated 2/11/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He was readmitted on [DATE] with diagnoses of Diffused traumatic brain injury, osteomyelitis, pneumonia, covid 19, quadriplegia, contracture of the right and left hand, and presence of left artificial elbow joint. Record review of Resident #1's admission MDS dated [DATE] indicated he was moderately impaired in decision making. He was unable to complete the BIMS. The resident had impaired range of motion on both sides of his upper extremity (shoulder, elbow, wrist, and Hand) and his lower extremity (hip, knee, ankle, and foot.) He required a wheelchair for mobility. He was dependent on staff for all activities of daily living. The MDS indicated the resident had an indwelling catheter and ostomy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #1's care plan dated 1/28/25 indicated a problem of altered respiratory status/difficulty breathing related to recent hospitalization stay for Covid and pneumonia. The resident will be on IV antibiotics for pneumonia with an initiation date of 1/27/25 and a revision date of 2/7/25. Some of the interventions were to monitor and document changes in orientation. Monitor for signs and symptoms of respiratory distress and report to the physician increased respirations, decreased pulse oximetry, increased heart rate, restlessness, lethargy, confusion, and cough. A care plan problem of IV medications related to pneumonia. The care plan interventions were related to complications related to IV therapy such as infiltrated IV, drainage, or inflammation. Record review of Resident #1's prior to facility admission hospital records dated 1/31/25 indicated a diagnosis of pneumonia due to covid dated 1/23/25, ESBL Extended spectrum beta lactamase: producing bacterial infection dated 9/17/24 still present, Acute osteomyelitis of the right elbow dated 12/24/24 still present. His discharge medication included meropenem 1 GM. Record review of Resident #1's nursing notes dated 1/31/25 at 6:17 p.m. indicated the resident was returning to the facility from the hospital. Signed by RN H. Record review of Resident #1's physician order indicated Meropenem Intravenous Solution Reconstituted use 1 gram intravenously every 8 hours for pneumonia due to covid for 7 days dated 2/1/25. Record review of Resident #1's MAR indicated Meropenem Intravenous Solution Reconstituted 1 GM use 1 gram intravenously every 8 hours for pneumonia due to covid for 7 days. With a start date of 2/1/25. The MAR indicated the medication was to be administered at 7:00 a.m., 3:00 p.m., and 11:00 p.m. The MAR indicated the mediation was given 3 times daily with the last dose 2/5/25 at 11:00 p.m. Record review of Resident #1's nursing notes indicated: On 2/6/25 at 1:27 p.m. meropenem intravenous Solution reconstituted 1GM was not given due to loss of PICC access. The PICC company was notified for replacement. The NP was made aware. Signed by LVN C. On 2/6/25 at 10:13 p.m. indicated the resident refused midline, would not let staff unbend arm to pace midline. Signed by LVN F. On 2/7/25 at 1:40 p.m. the company that replaced PICC lines was called to replace Resident #1's PICC line. Signed by LVN E On 2/7/25 at 2:58 p.m. no PICC line in place for administration of medication. Signed by LVN E On 2/7/25 at 10:12 p.m. no PICC line access. Signed by LVN F On 2/8/25 at 12:17 a.m. resident remained without IV access signed by LVN F. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	On 2/10/25 at 11:38 a.m. Resident #1's PICC line was dislodged on 2/5/25 and the NP was informed. An outside service provider attempted to replace and insert new PICC line in the facility. The technician was unsuccessful due to contraction of upper extremities of patient. The patient did not complete antibiotic therapy and missed several doses. The nurse contacted NP regarding situation and current symptoms to include cough, abnormal lung sounds, abnormal chest x ray. The nurse received an order to send Resident #1 to the ER. His blood pressure was 116/64, oxygen status on room air was 91 percent, his temperature was 98.8 and his pulse was 80. Signed by LVN E. Record review of a change in condition note dated 2/10/25 at 6:57 p.m. indicated Resident #1 had increased cough, a positive chest x ray, incomplete antibiotic therapy, these things made the condition worse. Signed by LVN E. Record review of Resident #1's x ray report dated 2/7/25 and signed electronically on 2/7/25 at 11:07 a.m. indicated Resident #1 had patch bilateral lung opacities (area of increased density or darkness in the lungs.) This was consistent with bilateral pneumonia. The findings are worse compared with prior. Record review of Resident #1's hospital records dated 2/10/25 indicated Resident #1 was receiving IV antibiotics for pneumonia. He lost his PICC line assess, and the facility attempted to have it replaced but was unsuccessful. The resident had an x ray showing he still had pneumonia and was sent to the hospital for PICC line replacement. He has a history of pneumonia. He is nonverbal and quadriplegic, unable to move upper or lower extremities, with severe contractions noted. The hospital records indicated they spoke with the RN at the facility and was informed the PICC line had been out since 2/5/25. He had a diagnosis of pneumonia of the right lower lobe due to infectious organism ESBL (extended spectrum beta -lactamase) producing bacterial infection. Record review of a nursing note dated 2/10/25 at 9:56 p.m. indicated the nurse called to check on Resident #1's status. He was admitted to the hospital with a diagnosis of right lower lobe pneumonia, acute osteomyelitis, ESBL. Signed by LVN E During an interview and record review on 2/12/25 at 3:21 p.m. LVN C said Resident #1 did not have PICC line access when she came in on 2/6/25. She said she had gotten the ADON/RN D to come in and help her assess the resident. She said the NP was in the building doing rounds. She said the NP told them to contact a company that replaced PICC lines. She said she had contacted that company on 2/6/25 for them to come out and replace Resident #1's PICC line. A review of the nursing notes with LVN C indicted Resident #1 had refused the reinsertion on 2/6/25. LVN C said she was not aware the company had been contacted again on 2/7/25 by LVN E and she did not know what had happened with Resident #1's PICC line. During an interview on 2/12/25 at 3:44 p.m. ADON/RN D said she was not sure if Resident #1's PICC line had been noted as displaced by the prior shift on 2/5/25. She said Resident #1's right arm was contracted, and he held it tightly to his biceps. The ADON/RN said she did not know how the PICC line came out. She said LVN C had asked her to come in and assess Resident #1 on the morning of 2/6/25. She said the NP was in the building and the NP and told them to contact a company that replaced PICC lines. She said she knew LVN C had called the company. She did not know Resident #1 had refused or how many times the company had been called or why the PICC line was not replaced. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During a telephone interview on 2/12/25 at 4:30 p.m. the NP, he said he had gotten a text earlier on the morning of 2/6/25 that Resident #1's PICC line had come out. He said he told them to call the PICC line replacement company and have them to come out to replace the PICC line. He said the facility did not inform him they were unable to replace the PICC line. He said he was not informed Resident #1 was not taking the antibiotic. The NP said if they had informed him Resident #1 was not able to finish his antibiotic, he would have told them to send him to the hospital. During a telephone interview on 2/12/25 at 4:31 p.m. the DON said on 2/7/25 LVN E told her that the PICC line company said they would not come back to the facility to try and reinsert Resident #1's PICC line. They said they were unable to do so due to his contractures. She said she told LVN E to call the physician and let him know. The DON said on the morning of Monday, 2/10/25 after the x rays were reviewed, she told LVN E to call the physician and send Resident #1 to the hospital. During a telephone interview on 2/12/25 at 4:32 p.m. LVN E said she had talked to the PICC line company, and their nurse said they were not coming out. She said the nurse said Resident #1 was too contracted and they were not able to place the PICC line. LVN E said she was leaving for the day and told the DON what the company had said. The DON told her to make the physician aware. She told the oncoming nurse LVN F about the situation during report. She said she did not know what happened after then. During a telephone interview on 2/12/25 at 4:55 p.m. LVN F said that on Friday 2/7/25 LVN E told her the PICC line company had refused to come out. She said it was mentioned in the conversation about notifying the physician, but she thought LVN E had notified the physician. LVN F said she had not notified the physician because she thought it was already done. During an interview on 2/13/25 at 7:21 a.m. LVN C said she did not know anything about Resident #1's x rays results until Monday, 2/10/25. She said she worked PRN and was under the impression x rays results would be sent by fax. She said that on Monday, 2/10/25 Resident #1 had a cough that was deeper than on 2/7/25 and she was told he had x ray results that indicated pneumonia and to send him out to the hospital. During an interview on 2/13/25 at 10:30 a.m. the Regional Nurse Consultant said ADON/RN D and Administrator did not find any nurse that admitted to seeing the x ray results for Resident #1 on the weekend. He said it appeared the first time the x rays were noted was on 2/10/25. He said they did not have a policy on change in condition. During an interview on 2/13/25 at 10:34 a.m. the Administrator said they did not find any nurse that discovered the x ray results for Resident #1 over the weekend. She said she was aware of what the NP always said he would send a resident to the hospital if they had a change in condition. The Administrator said she had reached out to the nurses on the weekend they thought the order was complete for Resident #1's antibiotics because the completion date was 2/7/25 and it fell off the system orders. She said they did not see any issues and they did not review the records to see if there was a problem because they thought the antibiotic was completed. Resident #2 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #2's face sheet dated 2/11/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He was last admitted [DATE] with diagnoses of surgical amputation, absence of left leg below the knee, and absence of right leg below the knee. Record review of an admission MDS dated [DATE] indicated a BIMS score of 11 which indicated moderate cognitive impairment. The resident required substantial to maximum assistance with the helper doing more than half the effort for sit to lying, sit to stand, and transfers. Record review of Resident #2's care plan dated 12/26/24 and revised on 1/3/25 indicated a problem of the resident was at risk for skin integrity related to reduced mobility due to bilateral amputation, poor nutrition and immune comprised. Some of the interventions were to monitor and document size and location and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection or maceration to the physician. Record review of Resident #2's prior to facility admission hospital records dated 1/27/25 indicated to cleanse left BKA site daily with antibacterial soap and water or wound cleanser, apply no stick dressing and secure with ace wrap compression. Start taking amoxicillin potassium-clavulanate (Augmentin) 875-125 mg oral one tablet two times a day for 10 days. Record review of Resident #2's MAR for February 2025 indicated Amoxicillin potassium-clavulanate (Augmentin) 875-125 mg give one tablet by mouth q 12 hours for cellulitis for 10 days with a start dated on 1/27/25. The medication was noted to be last given on 2/6/25 at 8:00 a.m. Record review of Resident #2's TAR for February 2025 indicated cleanse left BKA site with antibacterial soap and water or wound cleanser, apply nonstick dressing, secure with ace wrap compression one time a day every Tuesday, Thursday, and Saturday for wound care with start date of 1/30/25. The TAR indicated the last time wound care was provided was Tuesday 2/4/25. On Thursday 2/6/25 the TAR indicated to see the nurses' notes on Saturday 2/8/25 indicated the drug refused. Record review of Resident #2's nursing notes dated 2/6/25 indicated Resident #2 refused wound care. Signed by treatment nurse. Record review of Resident #2's wound evaluation dated 2/7/25 at 6:22 a.m. indicated a surgical wound with 38 staples on the left below the knee amputation site. The area of the wound was 44.65 cm, and the length was 8.14 cm and 7.58 cm. the wound was one to 3 months old. It had 50 percent granulation and 50 percent slough. There was evidence of infection such as increased drainage, increased pain, redness/inflammation, warmth, and bleeding. There was moderate sanguineous bloody drainage. The was pitting edema that extended 4 cm around the wound and was warm, the pain was at a level 4 with continuous frequency. The wound evaluation indicated the wound was deteriorating and the physician diagnosed the infection. The wound evaluation was signed by the treatment nurse. Record review of Resident #2's nursing note dated 2/7/25 at 11:09 a.m. indicated surgery for BKA revision rescheduled for 2/12/25 arrival at 9:30 a.m. for 11:30 a.m. procedure. Record review of Resident #2's nursing note dated 2/8/25 at 6:15 p.m. indicated cleanse left BKA site with antibacterial soap or wound cleanser and apply dressing. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review of Resident #2's change in condition notes dated 2/9/25 at 1:00 p.m. indicated Resident #2 had a change in condition that consisted of lethargy, confusion, loss of appetite, elevated heart rate at rest started 2/9/25 and had stayed the same. His primary diagnosis was orthopedic aftercare following surgery. his blood pressure was 106/68, pulse 115 (irregular), respiration 16, temp 98.9, oxygen status 96. Signed by LVN A Record review of nursing notes dated 2/9/25 at 2:40 p.m. indicated Resident #2 was sent to the hospital. Record review of Resident #2's hospital records dated 2/9/25 indicated the resident was admitted at 12:53 p. m. He was admitted with complaints of left lower extremity wound pain and fever. He had a recent BKA performed at another hospital his blood pressure was 173/95, pulse 114, respirations 16, temp 100.4 and oxygen status 99 percent. The x rays were concerning for gas within the wound that could be either an abscess or gaseous gangrene. He was started on antibiotics and wanted to be transferred to another hospital. The disposition summary on 2/9/25 at 4:51 p.m. indicate a diagnosis of sepsis unspecified organism/left BKA infection. During an interview on 2/11/25 at 3:45 p.m. LVN B said Resident #2 was on antibiotics and had finished them a few days prior to going to the hospital. She said he was sent to the hospital to have surgery on an amputation that needed a revision. During an interview and observation on 2/12/25 at 2:00 p.m. with the treatment nurse and the RN C, the treatment nurse said Resident #2 came to the facility after he had an amputation. She said the wound care physician would not see him because his wound was surgical. She said the last time she completed an assessment on Resident #1 was Friday, 2/7/25. She said Resident #2's surgical wound had deteriorated by her assessment. She said she did not call NP or the physician because she thought Resident #2 was going to surgery center that day. She said she wanted to see the wound herself and document what was going on with the wound before he left for his surgery. She said on Friday, 2/7/25 she noted a change to the wound. She said it did not look like that the week before. She said she had taken a picture that was observed by the surveyor. She described the wound with drainage and yellow slough (a layer of dead tissue formed when cells and other debris are trapped in the wound, and do not get properly removed. It can impede wound healing) around the circumference of the wound. The treatment nurse said Resident #2's leg was cut below the knee, it black above the staples on the wound. The treatment nurse said LVN B had assisted her with wound care on 2/7/25. During a telephone interview on 2/12/25 at 2:20 p.m. LVN B said Resident #2 had an appointment on 2/7/25 for a surgical revision to his BKA. She said it was right on the computer, but it was placed on the transport log with the wrong date. LVN B said when they realized the resident was not at his appointment they had called the clinic and were initially told to bring the resident to the appointment late. She said in about an hour the clinic called back and said the physician said to reschedule. She said the appointment was rescheduled to 2/12/25. She had written the note about the rescheduled appointment, but had not notified anyone he missed the appointment. She said she had assisted the Treatment Nurse on 2/7/25 when she provided wound care to Resident #2. LVN B said Resident #2's surgical wound had drainage, no odor, and the darkness above the wound had grown larger. During a telephone interview on 2/12/25 at 4:30 p.m. the NP, he said he was informed Resident # 2 had a change in condition when they were sending him to the hospital. He said he was not informed Resident #2's wound had deteriorated. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Record review on the policy on Laboratory Services and Reporting dated 4/8/23 indicated. The facility must provide or obtain laboratory services when ordered. The facility responsible for the timeliness of services. The facility will promptly notify the ordering physician, or nurse practitioner of the laboratory results that fall outside the clinical reference range. Due to the above findings, it was determined the facility was in an Immediate Jeopardy (IJ) situation on 2/13/25 at 5:00 p.m. The Administrator, Regional Nurse Consultant, and ADON/RN G were informed on 2/13/25 at 5:00 p.m. an email was sent to the Administrator. The facility's Plan of Removal was accepted on 2/14/25 at 10:51 a.m. Plan of Removal for F684: [To Identify Any Other Residents to Have the Potential: Beginning 2/13/25, the Licensed Nurse will evaluate all other residents in the center for any change in condition. Should any changes be evaluated, the physician will be notified. The evaluation will be documented in the resident's clinical record. All residents, evaluated, validated and documented on 2/13/25 with no additional cases identified. Education/ System Change: On 2/12/25, the Director of Nursing /Designee initiated reeducation with Licensed Nurses on the following topics: o Documentation in Medical Record o Medication Administration o Notification of Changes Policy to include changes in medication administration, wound care and abnormal radiology results o When a licensed nurse identifies a change in condition, they will evaluate the resident and document their evaluation in the clinical record. The Licensed Nurse will notify the Medical Provider of the change in condition and document that notification in the clinical record. o Licensed Nurses will give shift report from the PCC generated 24 hour report. (PCC generated from clinical documentation). o Licensed Nurses will review the Results Module in PCC (Lab and Radiology) at the shift change to notify the Medical Provider of results. Re-education will continue until 100% of nursing staff are reeducated. Those that are PRN, agency and/ or out on FMLA/ LOA will have the education completed prior to accepting assignment for their next scheduled shift. DON/Designee will provide training. Monitoring: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Beginning 2/13/25, and going forward, the Director of Nursing / designee will review the 24- hour report, the PCC Skin and Wound Module and the PCC Results Module in the morning clinical meeting to ensure that changes of condition documented in the clinical record are identified and communicated with the physician and the resident representative. Beginning 2/13/25, and on-going, the Director of Nursing or designee will monitor compliance each weekly morning. Results of findings will be discussed in the monthly QAPI meeting for three months and the plan will be continues as needed. Beginning 2/13/25, and on-going, the Administrator will attend the morning clinical meeting to ensure the Director of Nursing or designee is reviewing the 24-hour report in the morning clinical meeting to identify changes in condition. The Weekend Supervisor will review the 24-hour report in PCC as well as the Results Module (Lab and Radiology to ensure that Medical Providers are notified of results. An Ad Hoc QAPI {quality assurance and performance improvement} Meeting was conducted on February 13, 2025, by the Administrator, with the Medical Director, and the Regional Clinical Specialist to discuss the immediate jeopardy concerning [Quality of Care] and plan to correct.] On 02/14/25 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of in-services dated 2/13/25 and 2/14/25 indicated staff were trained on provider notification, shift hand off/reporting, 24-hour report, accessing/reviewing lab/radiology, medication administration, documentation in the medical record and abuse/neglect. Record review of 24-hour reports dated 2/13/25 and 2/14/25, the PCC Skin and Wound Module, and the PCC Results Module revealed no concerns. Record review of the facilty's QAPI meeting attendance sheet indicated they met on 2/13/25. Interviews on 2/14/25 with the ADON, Regional Clinical Specialist and Administrator indicated in-services were completed with staff on provider notification, shift hand off/reporting, 24-hour report, accessing/reviewing lab/radiology, medication administration, documentation in the medical record and abuse/neglect. They said staff had knowledge and were able to explain procedures on notification of changes, changes in medication administration, wound care, radiology/lab results, and documentation in the medical record. They said staff were knowledgable on giving report during shift change from the 24 hour report that was generated from the clinical documentation. They said staff were able to explain procedures on changes of condition and notifying the provider of the change, and documentating in the clincial record. They said they went over the 24 hour reports during their morning meeting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Interviews and record reviews were conducted on 02/14/25 from 4:00 p.m. through 8:00 p.m. and included 3 RNs, 4 LVNs, ADON, Regional Clinical Specialist and Administrator. Staff were able to explain documentation in medical record and medication administration. Staff had knowledge on notification of changes policy and to include changes in medication administration, wound care, and abnormal radiology results. The staff successfully provided an explanation when a licensed nurse identifies a change in condition, they will evaluate the resident and document their evaluation in the clinical record. The Licensed Nurse will notify the Medical Provider of the change in condition and document that notification in the clinical record. The staff was well-informed about licensed nurses will give shift report from the PCC generated 24-hour report. (PCC {point click care- facility medical records system} generated from clinical documentation). Also, Staff was able to explain licensed nurses will review the Results Module in PCC (Lab and Radiology) at the shift change to notify the Medical Provider of results. During an observation on 2/14/25 at 6:35 p.m. of a shift change and reporting between LVN E and LVN I, there were no issues noted. All residents in the facility were evaluated for any change in condition, validated and documented on 2/13/25 with no additional cases identified. This was verified by interview with the ADON (DON Designee), the Administrator and record review of 24-hour summary listing resident name, room number and progress notes dated 2/13/25. The Administrator and ADON/RN G were informed on 2/14/25 at 7:35 p.m. the IJ was removed. The facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as a pattern due to the facility's need to evaluate the effectiveness of the corrective systems.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on observation, interview, and record review the facility failed to provide pharmaceutical services including procedures that assure the accurate dispensing and administering of all drugs to meet the needs of residents for 5 of 6 residents reviewed for medication administration. (Resident #3, Resident #4, Resident #5, Resident#6, and Resident #7.) Resident #3 had insulin that was past the 28-day labeled precautionary instructions. LVN E was going to administer the mediations. After she noted the insulin was past the 28- days, she had difficulty finding the correct medications. Residents # 4 # 5, and #7 had insulin in the medication cart that was past the 28-day labeled precautionary instructions. Resident #6's insulin had a space on the box for an opened date but there was not a date listed. These failures could place residents to receive medications that were not effective to control diabetic symptoms. Findings included: 1. Record review of Resident #3's face sheet dated 2/13/25 indicated he was a [AGE] year-old male admitted to the facility on [DATE]. He had a diagnosis of Diabetes mellitus. Record review of Resident #3's a physician order dated 12/5/24 indicated to administer Novolog insulin injection, inject 23 units subcutaneously before meals for diabetes mellitus(a disorder related to high blood sugars). During an observation on 2/13/25 at 7:30 a.m. Resident #3 was observed in his bed. LVN E checked his blood sugar, and it was 335. LVN E said Resident # 3 received 23 units of insulin three times a day before meals. Observation of Resident # 3's multi-use vial of Novolog indicated it was opened 1/12/25 (31 days prior). The package indicated to discard after 28 days. The LVN pulled up the Novolog and was about to enter Resident #3's room. She was asked if she was going to give him the insulin and she said yes. It was pointed out to her the medication had been opened more than 28 days ago. LVN E then put the insulin back. She checked and Resident #3 did not have any Novolog in the refrigerator in the medication room. She got the Refrigerated Emergency-Kit that was zip tied and had a list of medications on the front from the Emergency-kit box from the medication room for her hall. It had Novolog listed but it was not in the box. LVN E went to another hall to get Novolog from their refrigerated Emergency-Kit. At 7:51 a.m. Resident #3 was observed to get 23 units of Novolog via insulin pen. He said he did not like the pen, and he was almost finished eating. 2. Record review of Resident #4's face sheet dated 2/13/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of type 2 diabetes mellitus. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #4's physician order dated 6/24/24 indicated to give Humalog injection 100 unit /ml inject subcutaneously four times a day for diabetes mellitus. During an observation on 2/13/25 at 8:02 a.m. of the Medication cart for the 200 hall showed Resident #4's Humalog100 units was opened on 1/11/25(32 days prior.) Observation revealed the refrigerated Emergency-kit did have a pen for her Humalog. During an observation and interview on 2/13/15 at 8:07 a.m. Resident #4 said she was supposed to get her insulin before breakfast, and she had just finished eating. LVN E said Resident #4's blood sugar was 242. The nurse said she was to receive 4 units of Humalog at 8:10 a.m. Resident #4 received her Humalog injection in the right arm. 3.Record review of Resident #5's face sheet dated 2/13/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of Diabetes mellitus due to underlying condition. Review of Resident #5's physician order dated 1/2/25 indicated to administer Novolog Solution 100 unit/ml (Insulin Aspart). Inject 5 unit subcutaneously with meals due to diabetes mellitus. Observation of the 200-hall medication cart on 2/13/25 at 8:12 a.m. revealed Resident #5's bottle of Insulin Aspart opened on 1/2/25 (41 days prior) box says expires 28 days after opened. Resident #5 opened Lantus dated 1/3/25 (40 days) box says expires 28 days after opened. 4. Record review of Resident #6's face sheet dated 2/13/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of diabetes mellitus. Record review of Resident #6's physician orders dated 6/7/24 indicated an order for insulin Glargine (Lantus) 10 units . During an observation on 2/13/25 at 8:12 a.m. Resident #6's opened multi-use vial of Lantus had no opened date but there was a place for the opened date to be written. 5. Record review of Resident #7's face sheet dated 2/13/25 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. She had a diagnosis of diabetes Mellitus. Record review of Resident #7's physician order dated 8/5/24 indicated to administer Novolog per sliding scale for diabetes mellitus. During an observation and interview of the 200-hall medication cart on 2/13/25 at 8:14 a.m. revealed Resident#7's Novolog opened dated 1/11/25 (32 days prior.) The LVN said she worked PRN as was not responsible for the cart every day. She was not aware the medications were past the date of use. LVN E said she was aware the insulin was to be discarded after the recommend 28 days. Record review of instruction for use of Lantus (last revised June 2023) indicated Lants vials should be refrigerated but could be stored at room temperature for up to 28 days. The Lantus vial should be thrown away after 28 days or it the expiration date has passed even if it still had insulin left. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Food and Drug Administration indicated insulin storage and effectiveness dated 9/19/17. It is recommended insulin be stored in a refrigerator at approximately 35 to 46 degrees Fahrenheit. Insulin may be stored between 59- and 86-degrees Fahrenheit for up to 28 days and continue to work. However, insulin loses some effectiveness when exposed to higher temperatures or lower temperatures. Record review of the facility Medication Administration policy dated 10/1/19 indicated the policy was to administer medication via subcutaneous, intradermal, and intramuscular routes in a safe, accurate and effective manner. Prepare medications and check refrigerator temp, assure the label is attached, check expiration date. write the dated it was opened and expiration date on the container if new vile used. Refer to table of shortened expiration dates for expiration dates to use.