STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34957 Based on interviews and record review, the facility failed to ensure licensed nurses had the specific competencies and skill sets necessary to care for residents' needs, as described in the plan of care for 2 of 3 staff (LVN B and LVN F) reviewed for nursing competencies, in that: The facility failed to ensure LVN B and LVN F followed physician's fentanyl order which resulted in Resident #1 becoming unresponsive and suffering respiratory failure. This failure could place residents at risk for not having medications accurately dispensed, not receiving the intended therapeutic effects of their medications and could contribute to possible adverse reactions. The findings included: Record review of LVN B's Nursing Competency Skills Checklist dated 7/22/24 and signed off by the DON revealed LVN B was marked as competent to perform Transdermal Patches to include fentanyl. Record review of LVN H's Nursing Competency Skills Checklist dated 7/22/23 and signed off by the DON revealed LVN B was marked as competent to perform Transdermal Patches to include fentanyl. Record review of Resident #1 face sheet dated 7/24/24, Resident# 1 was a [AGE] year-old male admitted on [DATE] with diagnoses that included: COPD (chronic obstructive pulmonary disease), DM (diabetes), HTN (hypertension) , Bipolar disorder, quadriplegia non ambulatory. He discharged to hospital on 7/16/24. Record review of Resident #1's physician orders dated July 2024 revealed: Fentanyl patch 50 mcg change every 72 hours. Narcan PRN for opioid overdose [no order to monitor for opioid overdose] Record review of Resident #1's MAR July 2024 revealed: 7/13/24-removed from the abdomen's left upper quadrant (9:38 AM) and applied fentanyl path (09:38) by RN A to the abdomen's right lower quadrant. 7/16/24- removed from the abdomen's lower upper quadrant (9:58 AM) and applied to the lower upper quadrant (09:58) [by LVN B witnessed by LVN F]. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's hospital record MD C note dated 7/17/24 at 5:58 AM read: HPI (History of Present Illness .Chief Complaint: unresponsive .74 yo (year old) M (male) with hx (history) of quadriplegia, chronic pain, recently dx (diagnosed) HCC (lover cancer) with mets (metabolic equivalents) to the lumbar spine, DM (diabetes), HTN (hypertension), COPD, mood disordered .concern for narcotic overdose .Per report [patient] was brought in from SNF (skilled nursing facility) with concern for decreased responsiveness. Patient was found to have multiple fentanyl patches on him in the ER (emergency room) .He was noted to be hypoxic (lack of oxygen) in the ER and was placed on bi-pap (breathing mask) with improvement in [respiratory] status . Record review of Resident #1's hospital record MD H note dated 7/17/24 at 5:58 AM read: .At ER patient received a dose of Narcan and his fentanyl patch (unknown dose and quantity) was removed, then he rather quickly woke up and was conversant. After few hours patient once again became lethargic and required repeat dosing of Narcan, thus was started on Narcan drip .Diagnosis, Assessment & Plan .Impression .1. Fentanyl Overdose . Record review of EMS Run Sheet dated 7/16/24 revealed the following timeline: 7/16/24 at 11:44 PM EMS dispatched to NF. 7/16/24 at 11:59 arrived at patient. 7/17/24 at 00:29 AM arrived at ER. Also, The EMS narrative read: Medic 3 (Paramedic E) dispatched to nursing home for a 74 yo male that is unresponsive and difficulty breathing patient lethargic and with swallow breathing .Patient pupils presented pin point bilaterally . the patient was placed on a 12 lead ECG that revealed the patient in atrial flutter and RVR (rapid ventricular rhythm) .Upon further examination it was found that the patient presented with 2 Fentanyl patches that had not been reported to EMS crew by Nursing Home staff . During a telephone interview with the facility RN A on 7/24/24 at 3:45 PM she stated she remembered Resident #1 having Fentanyl patch ordered for pain. She stated she removed one and placed a new one the weekend before[7/13/24] before he [Resident #1] was sent to the hospital.[7/17/24] She further stated she knew that only one patch should be placed on a resident at one time because an overdose could occur. During a telephone interview on 7/25/24 at 10:00 AM, LVN B stated: he removed and applied a fentanyl patch [Resident #1'] on 7/16/24 witnessed by LVN F. LVN B stated that he only lifted the resident's T-shirt chest high but did not strip the resident or search for other patches. LVN B stated he documented the removal and application of the fentanyl patch on the MAR July 2024. LVN B stated he could not recall the location of the patch removed and applied. LVN B stated he was familiar with fentanyl protocols. During an interview on 7/25/24 at 10:15 AM, LVN F stated she was present when LVN B removed and applied a fentanyl patch to Resident (#1's) abdomen. LVN F stated she could not recall where the location where the old patch removed and the location of the new patch. LVN F stated that the resident was not stripped or T-Shirt removed to check on the existence of any other fentanyl patch. LVN F stated that the removed patch was discarded in the sharps-container. LVN F stated he was familiar with fentanyl protocols. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/25/24 at 1:19 PM, the DON stated: The DON stated that when a resident was on an order for fentanyl patches the patch was removed and applied every 72 hours. The DON stated a fentanyl patch could be place on the abdomen, back , shoulder and any fatty place; and should be dated. The DON stated that best practice when removing an applying a fentanyl patch should be to do a full body search. The DON stated it was an unfortunate incident and LVN B and LVN F were competent and knowledgeable about the facility's fentanyl protocol. The DON could not give an explanation as to why there was a confusion in the March 16, 2024, MAR as to the placement of the fentanyl patch on Resident #1. The DON acknowledged the documented [DATE] read: 7/13/24 placement of fentanyl patch was on RUQ (right upper quadrant) while on 7/16/24 LVN B witnessed by LVN F read parch removed and applied to the LUQ (lower upper quadrant). Record review of facility's Mediation Administration: Transdermal (Patch) Application policy dated revised 10/101/19 read: .Identify the location on the body for patch placement .Remove old path from body .Label path with date and nurse's initials .Document placement site on MAR .Fentanyl Patches require the path to be folded after removal, destroyed per policy and state regulations, dropped in the Sharps container and a witness be present to sign . Request for facility's Nursing Staff Competency policy was requested by surveyor from DON on 7/25/24 and none given by exit on 7/26/24 at 4:50 PM. .

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 34957 Based on observation, interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #1) reviewed for pharmacy services in that: The facility failed to follow physician orders for the fentanyl patch resulting in Resident #1 becoming unresponsive and suffering respiratory failure. An Immediate Jeopardy was identified on 7/25/24 at 3:15 PM. While the Immediate Jeopardy was removed on 7/26/24 at 4:15 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor and evaluate the effectiveness of the plan of removal and corrective actions. This failure could affect residents and place them at risk for not receiving a therapeutic effect, could result in a decline in health, and overdose or death. The findings included: Record review of Resident #1 face sheet dated 7/24/24, Resident# 1 was a [AGE] year-old male admitted on [DATE] with diagnoses that included: COPD (chronic obstructive pulmonary disease), DM (diabetes), HTN (hypertension) , Bipolar disorder, quadriplegia non ambulatory. He discharged to hospital on 7/16/24. Record review of Resident #1's physician orders dated July 2024 revealed: Fentanyl patch 50 mcg change every 72 hours. Narcan PRN for opioid overdose [no order to monitor for opioid overdose] Record review of Resident #1's MAR July 2024 revealed: 7/13/24-removed from the abdomen's left upper quadrant (9:38 AM) and applied fentanyl path (09:38) by RN A to the abdomen's right lower quadrant. 7/16/24- removed from the abdomen's lower upper quadrant (9:58 AM) and applied to the lower upper quadrant (09:58) [by LVN B witnessed by LVN F]. Record review of EMS run sheet, dated 7/16/24 revealed: On 7/16/24 at 11:44 PM, EMS was dispatched to NF because Resident #1 was unresponsive and suffering respiratory failure. Resident #1, in the ambulance, was found with 2 fentanyl patches on body not reported by the facility. At the ER, resident was administered Narcan twice for a fentanyl overdose. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of EMS Run Sheet dated 7/16/24 revealed the following timeline: 7/16/24 at 11:44 PM EMS dispatched to NF. 7/16/24 at 11:59 arrived at patient. 7/17/24 at 00:29 AM arrived at ER. Also, The EMS narrative read: Medic 3 (Paramedic E) dispatched to nursing home for a 74 yo (year old) male that is unresponsive and difficulty breathing patient lethargic and with swallow breathing .Patient pupils presented pin point bilaterally .the patient was placed on a 12 lead ECG that revealed the patient in atrial flutter and RVR (rapid ventricular rhythm) .Upon further examination it was found that the patient presented with 2 Fentanyl patches that had not been reported to EMS crew by Nursing Home staff . Record review of Resident #1's hospital record MD C note dated 7/17/24 at 5:58 AM read: HPI (History of Present Illness .Chief Complaint: unresponsive .74 yo (year old) M (male) with hx (history) of quadriplegia, chronic pain, recently dx (diagnosed) HCC (liver cancer) with mets (metabolic equivalents) to the lumbar spine, DM (diabetes), HTN (hypertension), COPD, mood disordered .concern for narcotic overdose .Per report [patient] was brought in from SNF (skilled nursing facility) with concern for decreased responsiveness. Patient was found to have multiple fentanyl patches on him in the ER (emergency room) .He was noted to be hypoxic (lack of oxygen) in the ER and was placed on bi-pap (breathing mask) with improvement in [respiratory] status . Record review of Resident #1's hospital record MD H note dated 7/17/24 at 5:58 AM read: .At ER patient received a dose of Narcan and his fentanyl patch (unknown dose and quantity) was removed, then he rather quickly woke up and was conversant. After few hours patient once again became lethargic and required repeat dosing of Narcan, thus was started on Narcan drip .Diagnosis, Assessment & Plan .Impression .1. Fentanyl Overdose . Observation and interview on7/24/24 at 9:00 AM, Resident #1 was in bed on a ventilator in the ICU in a local hospital. Resident #1 had difficulties communicating because of the ventilator apparatus in his month. [Surveyor employed an thumbs up (meaning yes) and thumbs down (meaning no) interview technique. Resident #1 responded with thumbs up to the direct question whether he felt he received too much fentanyl and was overdose. [Resident #1 was too exhausted to continue the interview] During an interview on 7/23/24 at 12:45 PM, the DON stated: her internal investigation revealed there was no overdose of Resident #1. The DON stated that the facility could account for all the fentanyl patches given to the resident (Resident #1) for the past month (July 2024). The DON stated the resident was sent to the ER because of respiratory failure. The DON stated the facility had Narcan in the e-kit; and there were two other residents on fentanyl patches [Resident #2 and #3] During an interview on 7/24/24 at 9:05 AM, RN (ICU) stated: the resident was slightly sedated and was scheduled for a trach. The RN (ICU) stated that the hospital progress notes revealed that numerous fentanyl patches had been found on the resident in the ER. The RN (ICU) stated, the ER staff administered Narcan twice to counteract a drug overdose. During an interview on 7/24/24 at 10:50 AM, EMS Administrator, stated: EMS responded on 7/17/24 to an unresponsive resident at the nursing home. The EMS Administrator stated that the EMS staff was not told by nursing home staff that the resident had fentanyl patches. The EMS Administrator stated that in the ambulance the resident was found by the paramedics with two fentanyl patches. The EMS Administrator stated the treatment given to the resident in the ambulance was breathing treatment, heart medication and monitoring. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview with Resident #1's primary physician on 7/24/2024 at 3:36 PM , she stated Fentanyl patch for pain should be removed every 72 hours and then a new one placed. If one were left on it would exceed the dose ordered by the physician, and respiratory and other overdose symptoms such as unresponsiveness could occur if overdosed was present. During a telephone interview with the facility RN A on 7/24/24 at 3:45 PM she stated she remembered Resident #1 having the Fentanyl patch ordered for pain. She stated she removed one and placed a new one the weekend before [7/13/24] before Resident #1 was sent to the hospital 7/17/24. She further stated she knew that only one patch should be placed on a resident at one time because an overdose could occur. During a telephone interview on 7/25/24 at 9:00 AM, witnessed by the Chief of EMS, Paramedic D [driver in the ambulance] stated that Paramedic E found two fentanyl patches on the resident's body in the ambulance. Paramedic D stated one patch was at the LLQ abdomen and the second patch was at the right upper shoulder. Paramedic D stated the LLQ patch was new and dated but the date was not recorded by EMS and the second patch on the upper right shoulder appeared to have reached the 7 day mark (date was not recorded by EMS); mcg were unknown on both patches. Paramedic D was present at the ER when the ER staff removed both patches and the physician stated they were fentanyl. Paramedic D stated once the 2 patches were removed the resident became responsive. During a telephone interview on 7/25/24 at 10:00 AM, LVN B stated: he removed and applied a fentanyl patch [on Resident #1] on 7/16/24 witnessed by LVN F. LVN B stated that he only lifted the resident's T-shirt chest high but did not strip the resident or search for other patches. LVN B stated he documented the removal and application of the fentanyl patch on the MAR July 2024. LVN B stated he could not recall the location of the patch removed and applied. LVN B stated he was familiar with fentanyl protocols. During an interview on 7/25/24 at 10:15 AM, LVN F stated she was present when LVN B removed and applied a fentanyl patch to Resident (#1's) abdomen. LVN F stated she could not recall where the location where the old patch removed and the location of the new patch. LVN F stated that the resident was not stripped or T-Shirt removed to check on the existence of any other fentanyl patch. LVN F stated that the removed patch was discarded in the sharps-container. LVN F stated he was familiar with fentanyl protocols. During a telephone interview on 7/25/24 at 10:30 AM, RN A stated, that she removed and applied a fentanyl patch to the RLQ (right left quadrant) . RN A stated that on 7/13/24 she did not strip down the resident or search for other fentanyl patches. RN A stated she gave the resident a bed bath on 7/14/24 and the resident only had one fentanyl patch present. During telephone interview on 7/25/24 at 11:55 AM, CNA G stated that: she gave Resident #1 a bed bath on 7/16/24 between 9:00 AM and 11:00 AM and noticed two patches on the resident's knees one on each knee and a patch on the floor. CNA G stated that there were no patches on the resident's abdomen and she did not see any other patches on the resident's body. CNA G stated she threw the patch on the floor in the trash can and did not know whether it was a fentanyl patch. CNA G stated that she informed LVN B that she threw the patch on the floor in the trash can. During a telephone interview on 7/25/24 at noon, LVN B stated that he was never told by CNA G that she found an unknown patch on the floor in Resident #1's room and threw it in the trash can. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/25/24 at 1:19 PM, the DON stated: she could not explain why the resident's hospital report stated, multiple fentanyl patches. The DON stated the resident sweated a lot and starting in July 2024 the location of the fentanyl patch was moved to the abdomen. The DON stated that when a resident was on an order for fentanyl patches the patch is removed and applied every 72 hours. The DON stated a fentanyl patch could be placed on the abdomen, back , shoulder and any fatty place; and should be dated. The DON stated if a medical patch was found on the floor, regardless as to whether it was fentanyl, the nurse should be informed and not thrown in a trash can; and disposed as medical waste. The DON stated the resident was sent to theER on [DATE] because the resident had respiratory distress at 12:47 AM and altered mental status. The DON stated that Resident #1 was a quadriplegic, required total dependency for transfer and mobility. The DON stated the resident had usage of his arms and could remove a patch. The DON stated that best practice when removing a applying a fentanyl patch should be to do a full body search. The DON stated it was an unfortunate incident and LVN B and LVN F were competent and knowledgeable about the facility's fentanyl protocol. Record review of facility's investigation file, undated, revealed the following written statements: 7/23/24 LVN B: he only removed and applied one fentanyl patch. LVN B stated he did not see other patches Because he wears a T-shirt. 7/22/24; CNA H stated that she only saw one patch on the resident [present on 7/14/24 when bed bath was given by RN A] Record review of LVN B's Medication Pass Competency assessment dated [DATE] revealed LVN B was competent in Transdermal Patches which included: .old patch removed .Two nurses witnessed and signed for controlled substance wasting (fentanyl patch removal) .patch is dated and timed .Patches rotated to site as stated on MAR and placement documented. Record review of LVN F's Medication Pass Competency assessment dated [DATE] revealed LVN B was competent in Transdermal Patches which included: .old patch removed .Two nurses witnessed and signed for controlled substance wasting (fentanyl patch removal) .patch is dated and timed .Patches rotated to site as stated on MAR and placement documented. Record review of facility's Mediation Administration: Transdermal (Patch) Application dated revised 10/101/19 read: .Identify the location on the body for patch placement .Remove old path from body .Label path with date and nurse's initials .Document placement site on MAR .Fentanyl Patches require the path to be folded after removal, destroyed per policy and state regulations, dropped in the Sharps container and a witness be present to sign . The Administrator and the DON were notified of the Immediate Jeopardy on 7/25/24 at 3:15 PM and were provided with the Immediate Jeopardy Template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Plan of Removal was accepted on 7/26/24 at 10:53 AM and reflected the following: Nursing and Rehabilitation LETTER OF CREDIBLE ALLEGATION FOR (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	REMOVAL OF IMMEDIATE JEOPARDY Attention Sir or Madam: On 7/25/2024, the facility was notified by the surveyor that an immediate jeopardy had been called and the facility needed to submit a letter of credible allegation. The Facility respectfully submits this Letter for Plan of Removal pursuant to Federal and State regulatory requirements. Submission of the Letter of Credible Allegation does not constitute an admission or agreement of the facts alleged or the conclusions set forth in the verbal and written notice of immediate jeopardy and/or any subsequent Statement of Deficiencies. The alleged immediate jeopardy allegations are as follows: Issue: F755 Pharmacy Services/Procedures/Pharmacist/Records For Residents Involved: Resident #1: Resident #1 is currently in the hospital. To Identify Any Other Residents to Have the Potential: The Director of Nursing and/ or designee has reviewed all current residents with fentanyl patch orders as of 7/22/24. The Director of Nursing and/ or designee has observed current residents for appropriate patch placement and documentation 7/22/24. The Director of Nursing and/ or designee will review new admissions to ensure that any new orders for fentanyl patch are complete and patch is placed appropriately. Education/ System Change: The Director of Nursing or designee began re-education on the following: Licensed nursing staff received re-education on appropriate order, placement and documentation of fentanyl patch, including identifying S/S of possible overdose. Licensed Nursing Staff re-educated on appropriate disposal of Fentanyl Patches Licensed Nursing Staff re-educated on validation of patch placement. Direct care staff re-educated on communication to supervisor of any displaced or dislodged patch, to ensure M.D. orders are followed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 7/26/24 at 1:22 PM, the DON stated: she reviewed all current residents with fentanyl patch orders as of 7/22/24 and there were only two residents present in the facility; Resident #2 and Resident #3. The DON stated: there were no new admissions on 7/25-7/26/24. The DON stated for new admissions, she would ensure that any new orders for fentanyl patch were complete and patch is placed appropriately. The DON added: there were no new admissions on 7/25-7/26/24. The DON stated for new admissions she would ensure that any new orders for fentanyl patch are complete and patch is placed appropriately. In interviews on 07/26/24 from 1:45 PM to 3:15 PM with 4 day shift (6 a.m. to 6 p.m.) nursing staff (2 LVNs and 2 CNAs), 5 evening shift (2 p.m. to 10 p.m.) nursing staff (2 LVNs, 3 CNAs) and 3 night shift (10 p.m. to 6:00 a.m.) (2 RNs, 1 CNA) revealed they had been in-serviced on the S/S (signs and symptoms) of overdose, disposal of fentanyl patches, validation of placement, communications, and on the 5 rights in medication administration especially involving fentanyl patches. During an interview on 7/26/24 at 2:00 PM, the Administrator stated that the issue of new admissions and any concerns with the 2 residents on fentanyl patches was discussed at the 7/25 and 7/26/24 morning meetings. During an interview on 7/26/24 at 2:06 PM, the Regional Nurse stated that ad-hoc QAPI meeting on 7/25/24 discussed the fentanyl protocol and the need for nursing staff to adhere to the protocol. The Regional Nurse stated that the physician present at the meeting by telephone was requested to state in the physician's order the location of the fentanyl patch. Key Record Review Record review of the Resident Roster dated 7/26/24 revealed Resident #1 no longer resided in the facility. Record review of current residents with fentanyl patch orders as of 7/22/24 revealed only two residents on fentanyl patches; Resident #2 and Resident #3. Record review of facility's Fentanyl Audit F755 (form) dated July 26-27, 2024, revealed only 2 residents on fentanyl patches; Resident #2 and Resident #3. The audits were contained in the facility's POR binder. Record review of facility's Admissions/Discharge list dated 7/26/24 revealed non new admissions. Record review of the in-service from 7/25/24 to 7/26/24 revealed 100% completion of 49 nursing staff trained on fentanyl protocol, placement, proper disposal, location, dating, and signatures (see attached sheet). Form also present for non-license nursing staff on communications and patches found. Record review of facility's morning report dated 7/15/24-7/26/24 revealed the report was reviewed and signed by the DON and the Administrator. Record review of ad-hoc QAPI meeting held on 7/25/24 with the Medical Director present by telephone. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/26/24 at 4:50 PM the Administrator was informed the POR was validated and Immediacy was removed. However, the facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated due to the facility's need to monitor the implementation and effectiveness of its Plan of Removal.