STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455835	A. Building B. Wing	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Interlochen Health and Rehabilitation Center	2645 West Randol Mill Rd Arlington, TX 76012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 44405 Based on interview and record review the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status that was, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications, for one of three residents (Resident #1) reviewed for notification of changes. 1. The facility failed to immediately notified the physician of a change in condition or decline when Resident #1 experienced shortness of breath and required as needed breathing treatments and oxygen therapy on [DATE] and [DATE]. There was no documented evidence that the facility attempted to notify the physician on [DATE] on 2P - 10P and 10P - 6A shifts or during any shift (6A - 2P, 2P - 10P, 10P - 6A) on [DATE] there was a need to alter treatment significantly, decide to transfer, or discharge Resident #1 to the hospital. On [DATE], Resident #1 was transferred to the ER. Resident #1 was intubated and passed away at the hospital. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems . These failures could place residents at risk of serious injury, harm, impairment, or death . Findings included: Record review of Resident #1's MDS significant change in status assessment, dated [DATE], reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had active diagnoses which included COPD (a common lung disease that makes it difficult to breathe) and Other Secondary Pulmonary Hypertension (a chronic condition that occurs when pulmonary hypertension is caused by a known risk factor or underlying disease. [symptoms include Shortness of breath, at first while exercising and eventually while at rest; Blue or gray skin color due to low oxygen levels; Chest pressure or pain; Dizziness or fainting spells; Fast pulse or pounding heartbeat; Fatigue]). Resident #1's most recent re-entry to the facility was [DATE] with a diagnosis which included Displaced Commuted Fracture of Shaft of Right Femur. The MDS assessment reflected no known shortness of breath or trouble breathing with exertion, when sitting at rest, or when lying flat. (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	Record review of Resident #1's Order Summary Report reflected: - Physician written Order date - [DATE]: Administer oxygen at 2 LPM via NC continuously every night for SOB (D/C : [DATE]) - Physician written Order date - [DATE]: Tylenol Oral Tablet 325 Mg (Acetaminophen). Give 2 tablets by mouth every 4 hours as needed for pain. (D/C: [DATE]) - Physician written Order date - [DATE]: Oxygen 2 LPM as needed for SOB - Physician written Order date - [DATE]: Ipratropium-Albuterol Solution 0XXX,d+[DATE].5, 3mg/3mL. 3mL inhale orally via nebulizer every 8 hours as needed for SOB or Wheezing. - Verbal Order date - [DATE]: Acetaminophen-Codeine Oral Tablet ,d+[DATE] mg (Acetaminophen with Codeine) Give 1 tablet by mouth every 6 hours as needed for pain (pain level 7 - 10) for 30 days. Do not exceed >4,000 mg/24 hrs - Verbal Order date - [DATE]: Tramadol Oral Tablet 50 mg. Give 1 tablet by mouth every 8 hours for pain for mild to moderate pain (pain level 1 - 5) - Phone Order date - [DATE]: Send patient to the hospital for SOB for further evaluation and treatment as indicated. Record review of Resident #1's [DATE] TAR reflected he was administered Ipratropium-Albuterol Solution 0XXX,d+[DATE].5, 3mg/3mL. 3mL inhale orally via nebulizer for SOB or Wheezing on [DATE] at 9:09 AM (O2 Sat = 94%) by LVN A; [DATE] at 5:13 PM (O2 Sat = 93%) by LVN B. Both breathing treatments were documented as effective. Record review of Resident #1's care plan, last reviewed [DATE], reflected, [Resident #1] has oxygen therapy PRN (Date initiated: [DATE]). Goal: [Resident #1] will have no s/sx of poor oxygen absorption through the review date (Date initiated: [DATE]; Target Date: [DATE]). Interventions included: Monitor for s/sx of respiratory distress and report to MD PRN; Respirations, pulse oximetry, increased heart rate . lethargy, confusion . accessory muscle usage, skin color (Initiated: [DATE]) Record review of Resident #1's vital signs summary reflected the following. There were not a full set of vitals (Temperature, Pulse, Respirations, Blood Pressure, Oxygen Saturation, and Pain) on [DATE] - [DATE] in the Vitals Summary: Temperature values: [DATE] at 2:34 PM (98.0 F via Forehead [non-contact]) - entered by LVN A Pulse value: [DATE] at 9:44 AM (60 bpm) - entered by LVN A; [DATE] at 7:48 PM (64 bpm) - entered by MA E; [DATE] at 10:21 AM (68 bpm) - entered by LVN A; [DATE] at 8:19 PM (69 bpm) - entered by MA D; [DATE] at 10:25 AM (90 bpm) - entered by LVN C. Respiration values: [DATE] at 2:34 PM (18 breaths/min) - entered by LVN A (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the 24 Hour Report for [DATE] reflected dated reports [DATE] - [DATE]. The next 24-hour report was undated and reflected remarks related to [Resident #1] Day shift - monitor for SOB; Evening shift - SOB at 9:30 PM, 92%, pain management. There were no remarks for the Night shift. The next 24-hour report was dated [DATE] and reflected remarks related to Resident #1. Day shift - continue to monitor for SOB, O2 94%. There was no remark for the Evening shift. Night shift - monitor SOB. The 24-hour report dated [DATE] reflected Resident #1 was sent out to [hospital] for SOB, elevated temperature, and elevated heart rate. The Night shift entered Monitor SOB. Resident #1 did not return to the facility. Resident #1 passed away at the hospital. Record review of an Occupational Therapy Treatment Encounter Note, dated [DATE], entered by COTA D, reflected, [Resident #1] participated in task presented, but demonstrated increased fatigue and weakness. [Resident #1] continues to demonstrate decline in health and fear of falling while seated in wheelchair. [Resident #1] also demonstrated labored breathing when he is given his utensils to participate in feeding A record review of Resident #1's hospital medical records, dated [DATE], reflected [Resident #1] arrived at the ED on [DATE] at 2:51 PM. The reason for visit reflected Fever and high heart rate for 3 days. The visit diagnoses included Acute hypoxic respiratory failure. The ED provider notes reflected EMS states [facility] staff reported [Resident #1] with worsened confusion from baseline for the past 2 days. EMS states [Resident #1] was noted to be SOB and in mild respiratory distress on arrival and was given an albuterol/Atrovent treatment, 125 mg solumedrol, and 1 Liter bolus fluids enroute. Facility denied any falls or trauma, however history otherwise limited. Initial assessment reflected a temperature of 105 degrees Fahrenheit, heart rate of 170 bpm, lung sounds crackle bilaterally, and was started on BiPAP (a device that helps you breathe) on arrival due to respiratory distress. Resident #1 was intubated [[DATE]] at 5:20 PM. The lowest O2 saturation during intubation was 92%. CPR was initiated on [DATE] at 5:31 PM. Resident #1 ultimately expired. Time of death was called at 6:27 PM. The final diagnosis was Acute hypoxic respiratory failure that led to Cardiac arrest. During an interview on [DATE] at 2:21 PM, the ADON stated she was informed about Resident #1's episodes of shortness of breath on [DATE]. The ADON said interventions were implemented as ordered - supplemental oxygen and breathing treatments as needed. The ADON said no significant concerns were reported to her. The ADON said she expected for nurses to initiate nursing interventions, notify the MD/NP, and notify the RP; as well as notify the ADON and DON . The ADON said vital signs should be monitored daily as ordered and as needed. The ADON said any changes in vital signs, behavior, level of functioning from a resident baseline should be documented and reported. The ADON stated therapy staff would monitor a resident oxygen level of concerned and always communicated with nursing staff. During an interview on [DATE] at 1:56 PM, CNA F stated she worked Friday, [DATE] and Saturday, [DATE], 6A - 2P shifts. CNA F said she notified LVN A on Friday morning that Resident #1 appeared to have difficulty breathing, even with oxygen. CNA F demonstrated shallow breathing and other than normal rise and fall of the chest. CNA F said Resident #1 felt warm to touch. CNA F said LVN A assessed Resident #1 and told [CNA F] he did not have an elevated temperature. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 2:44 PM, LVN B stated she worked Thursday, [DATE] and Friday, [DATE], 2P - 10P shifts. LVN B stated she received verbal handoff shift report from LVN A on Thursday, [DATE] at 2:00 PM. LVN B said [LVN A] reported Resident #1 had shortness of breath when he returned from therapy, received a breathing treatment, and was on oxygen therapy. [LVN A] said to monitor for shortness of breath. LVN B said she did not notify the MD/NP because she figured LVN A called during the day shift (6A - 2P). LVN B said she checked Resident # 1's vital signs and O2 Sat after occupational therapy and applied oxygen, but there were no other concerns. LVN B said Resident #1's RP visited on [DATE] and requested Resident #1 get up out of bed. LVN B said she tried to explain to the RP that Resident #1 was in bed to be monitored for shortness of breath. LVN B said Resident #1 was assisted up to his wheelchair and went to occupational therapy. LVN B said she had to administer a breathing treatment when Resident #1 returned from therapy after dinner. LVN B denied inspection for abnormal findings such as blue or pale discoloration, labored breathing, or listening to lung sounds. LVN B said unexpected respiratory findings should be reported to the MD/NP immediately included a decreased oxygen saturation of less than 92%, restlessness, and increased difficulty breathing. During an interview on [DATE] at 4:13 PM, LVN C stated she worked Saturday, [DATE], 6A - 10P shift. LVN C stated she received verbal handoff shift report from the overnight nurse to monitor Resident #1 for shortness of breath. LVN C said she inquired if Resident #1 had pneumonia and the nurse stated to monitor for shortness of breath. LVN C said she observed Resident #1 in his room during change of shift walking rounds and he received oxygen via NC. LVN C said she worked weekend doubles and Resident #1 did not receive oxygen continuously the previous weekends. LVN C said she asked the CNA to come get her when ADLs were provided to Resident #1 so she could monitor breathing when repositioned. LVN C said when she assisted with Resident #1's ADLs, she noticed Resident #1 had difficulty breathing. LVN C said she raised the head of the bed when they finished to help Resident #1 breathe a little easier. LVN C said when she checked Resident #1's vital signs after breakfast, and he was breathing fast and had an elevated temperature. LVN C said she administered a breathing treatment, administered Tylenol for the fever, and when Resident #1 did not appear to improve, notified the NP ([DATE] at 1:30 PM), called 911, and transferred Resident #1 to the hospital An attempt to interview the PCP on [DATE] at 1:34 PM was routed to an automated voicemail. A message identified caller, explained purpose of call, and a callback number was left on the voicemail. No callback was received. Interview on [DATE] at 2:23 PM, LVN A stated she worked Thursday, [DATE] and Friday, [DATE], 6A - 2P shifts. LVN A said therapy staff reported on [DATE] Resident #1 had shortness of breath. LVN A said she checked Resident #1's O2 Sats. LVN A said [Resident #1] oxygen level was low (less than 90%) and administered a breathing treatment and applied oxygen via nasal cannula. LVN A said the breathing treatment was effective. LVN A said she left a message for the NP and did not receive a callback before her end of shift at 2 PM. LVN A said she reported to the oncoming nurse (LVN B) to monitor Resident #1 for shortness of breath. LVN A said to monitor meant to watch for signs of shortness of breath, like a low oxygen level. LVN A said the next nurse would be responsible to call the MD/NP if they had concerns to report. LVN A said she checked Resident #1's vital signs and he did not have a temperature. LVN A said she listened to Resident #1's lungs but could not describe what she heard. LVN A said Resident #1's lungs were clear. LVN A said a breathing treatment was administered on [DATE] and it was effective. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 1:27 PM, the NP indicated it was not unusual not to call back if she received a page from the facility nurse. The NP stated if the nurse did not hear back [from the NP] within 15 minutes, she should have tried to call again. The NP stated Resident #1 had a diagnosis of cardiomegaly (an enlarged heart), COPD (a group of diseases that cause airflow blockage and breathing-related problems), and a medical history of pneumonia that she would have suggested a PRN diuretic and a chest x-ray had she received a call about the change in condition before Saturday, [DATE]. The NP said the suggested treatments would have been ineffective by Saturday ([DATE]) and sending Resident #1 to the hospital for a higher level of care was the best treatment option at the time. The NP stated she may have requested a COVID test if demonstrated temperature and/or cough. A record review of the facility's policy titled, Significant Change in Condition, Response, revised [DATE], reflected 1. If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware 4. The nurse will communicate the change to other departments as appropriate and updated communications will be available during morning report Record review of the facility's Notifying the Physician of Change in Status policy, revised [DATE], reflected: The nurse should not hesitate to contact the physician at any time when an assessment and their professional judgment deem it necessary for immediate medical attention. This facility utilizes the INTERACT tool, Change in Condition - When to Notify the MD/NP/PA to review resident conditions and guide the nurse when to notify the physician. This tool informs the nurse if the resident condition requires immediate notification of the physician or non-immediate/Report on Next Work day notification of the physician. This was determined to be an Immediate Jeopardy (IF) on [DATE] at 5:50 PM. The NFA was notified and was provided with the IJ template on [DATE] at 5:50 PM . The following Plan of Removal submitted by the facility was accepted on [DATE] at 3:17 PM: All residents have the potential to be affected by this deficient practice. Interventions: All residents in the facility were assessed for any change of condition by the DON, ADON and Charge Nurses as of [DATE]. No additional issues were found. DON, ADON will audit all resident nursing notes for a change of condition to ensure notification of changes to the attending physician/nurse partitioner. Completed [DATE]. Going forward the DON/ADON/designee will monitor progress notes for a change in condition and notification to the attending physician/nurse practitioner daily during the morning clinical meeting. All residents with orders for oxygen continuous and as needed had oxygen saturation levels obtained as of [DATE] by the DON/ADON. No additional issues were found. LVN A and LVN B were immediately suspended pending investigation on [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on observation, interview and record review the facility failed to ensure that residents who needed respiratory care, including tracheostomy care and tracheal suctioning, provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 of 3 residents (Resident #1) reviewed for respiratory care . On [DATE] - [DATE], the facility failed to conduct a respiratory assessment for a potential change in condition or decline when Resident #1 experienced shortness of breath and required as needed breathing treatments and oxygen therapy. On [DATE], Resident #1 was transferred to the ER. Resident #1 was intubated and passed away at the hospital. An Immediate Jeopardy (IJ) situation was identified on [DATE]. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems . This failure could place residents at risk of not receiving timely medical interventions as needed, which could result in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. Findings included: Record review of Resident #1's MDS significant change in status assessment, dated [DATE], reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 had active diagnoses which included COPD (a common lung disease that makes it difficult to breathe) and Other Secondary Pulmonary Hypertension (a chronic condition that occurs when pulmonary hypertension is caused by a known risk factor or underlying disease. [symptoms include Shortness of breath, at first while exercising and eventually while at rest; Blue or gray skin color due to low oxygen levels; Chest pressure or pain; Dizziness or fainting spells; Fast pulse or pounding heartbeat; Fatigue]). Resident #1's most recent re-entry to the facility was [DATE] with a diagnosis which included Displaced Commuted Fracture of Shaft of Right Femur. The MDS assessment reflected no known shortness of breath or trouble breathing with exertion, when sitting at rest, or when lying flat. Record review of Resident #1's Order Summary Report reflected: - Physician written Order date - [DATE]: Administer oxygen at 2 LPM via NC continuously every night for SOB (D/C: [DATE]) - Physician written Order date - [DATE]: Tylenol Oral Tablet 325 Mg (Acetaminophen). Give 2 tablets by mouth every 4 hours as needed for pain. (D/C: [DATE]) - Physician written Order date - [DATE]: Oxygen 2 LPM as needed for SOB - Physician written Order date - [DATE]: Ipratropium-Albuterol Solution 0XXX,d+[DATE].5, 3mg/3mL. 3mL inhale orally via nebulizer every 8 hours as needed for SOB or Wheezing. (continued on next page)

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	455835	A. Building B. Wing	09/03/2024

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Verbal Order date - [DATE]: Acetaminophen-Codeine Oral Tablet ,d+[DATE] mg (Acetaminophen w/Codeine) Give 1 tablet by mouth every 6 hours as needed for pain (pain level 7 - 10) for 30 days. Do not exceed >4,000 mg/24 hrs - Verbal Order date - [DATE]: Tramadol Oral Tablet 50 mg. Give 1 tablet by mouth every 8 hours for pain for mild to moderate pain (pain level 1 - 5) - Phone Order date - [DATE]: Send patient to the hospital for SOB for further evaluation and treatment as indicated. Record review of Resident #1's [DATE] TAR reflected he was administered Ipratropium-Albuterol Solution 0XXX,d+[DATE].5, 3mg/3mL. 3mL inhale orally via nebulizer for SOB or Wheezing on [DATE] at 9:09 AM (O2 Sat = 94%) by LVN A; [DATE] at 5:13 PM (O2 Sat = 93%) by LVN B. Both breathing treatments were documented as effective. Record review of Resident #1's care plan, last reviewed [DATE], reflected, [Resident #1] has oxygen therapy PRN (Date initiated: [DATE]). Goal: [Resident #1] will have no s/sx of poor oxygen absorption through the review date (Date initiated: [DATE]; Target Date: [DATE]). Interventions included: Monitor for s/sx of respiratory distress and report to MD PRN; Respirations, pulse oximetry, increased heart rate . lethargy, confusion . accessory muscle usage, skin color (Initiated: [DATE]) Record review of Resident #1's vital signs summary reflected the following. There were not a full set of vitals (Temperature, Pulse, Respirations, Blood Pressure, Oxygen Saturation, and Pain) on [DATE] - [DATE] in the Vitals Summary: Temperature values: [DATE] at 2:34 PM (98.0 F via Forehead [non-contact]) - entered by LVN A Pulse value: [DATE] at 9:44 AM (60 bpm) - entered by LVN A; [DATE] at 7:48 PM (64 bpm) - entered by MA E; [DATE] at 10:21 AM (68 bpm) - entered by LVN A; [DATE] at 8:19 PM (69 bpm) - entered by MA D; [DATE] at 10:25 AM (90 bpm) - entered by LVN C. Respiration values: [DATE] at 2:34 PM (18 breaths/min) - entered by LVN A O2 Sats values [Range 96% - 97% on RA]: [DATE] at 9:09 AM (94%; with Oxygen via NC) - entered by LVN A; [DATE] at 5:13 PM (93%; with Oxygen via NC) - entered by LVN B. The amount of oxygen received was not documented. Record review of Resident #1's progress notes indicated: - Nursing Progress Note Effective Date: [DATE] at 2:55 PM, LVN A entered, Resident noted with SOB after coming from therapy, O2 Sat checked 88%, oxygen 2L via nasal canula and breathing treatment administered. O2 Sat rechecked later and was 90 - 91%. NP called and left a message, [RP] also notified. Remain on oxygen therapy and coming nurse notified to continue to monitor. Nursing Progress Note Effective Date: [DATE] at 10:25 PM, LVN B did not reflect respiratory assessments, vital signs, or an attempt to contact the MD/NP about Resident #1's O2 Sat at 91% -92% while he received oxygen 3 LPM via NC or when O2 Sat was 90% - 92% during bedtime and that [Resident #1] would not leave the oxygen in place . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- Nursing Progress Note Effective Date: [DATE] at 3:10 PM, LVN A did not reflect a respiratory assessments, vital signs, or an attempt to contact the MD/NP that [Resident #1] Continued to monitor resident for SOB, O2 Sat 94 - 96%. Breathing treatment administered and tolerated well. - Nursing Progress Note Effective Date: [DATE] at 9:17 PM, LVN B did not reflect respiratory assessments, vital signs, or an attempt to contact the MD/NP that [Resident #1] was administered pain meds and breathing treatment. Well tolerated. After therapy and oxygen remains 92% - 93% - Nursing Progress Note Effective Date: [DATE] at 1:30 PM, LVN C entered, [Resident #1] with increased SOB even though he is on 2LPM via NC, BP - ,d+[DATE], P-120, R-22, T-103.1 F. Breathing treatment was administered. Tylenol 500 mg 1 tablet was given for fever at this time. NP was notified via phone and gave order for patient to be sent to [hospital] for further evaluation and treatment as indicated. 911 call was initiated at this time. At 2PM the ambulance left . At 2:05 PM the RP was notified about the change of condition of patient . The ADON was called and updated via voicemail. The 10P - 6A nurse(s) did not enter progress notes that reflected respiratory assessments, vital signs, or an attempt to contact the MD/NP on [DATE] or [DATE]. Review of Resident #1's [DATE] MAR/TARs did not reflect administration of pain medications at any time on [DATE] - [DATE]. The MAR/TARs did not reflect a breathing treatment administered on [DATE] or [DATE]. Record review of a SBAR note dated [DATE], written by LVN C, revealed the primary provider was contacted at 1:50 PM about [Resident #1] with a Respiratory Change-Suspected Infection. BP - ,d+[DATE]; P - 120; R - 22; T - 103.1 F; O2 Sat - 90%; received oxygen at 2lpm via NC. Suspected respiratory infection r/t fever > 102 F, abnormal lung sounds (bilateral lower lobes [sound heard not listed]), and shortness of breath. This started on and/or symptoms first appeared: [DATE] [breathing treatment(s)] attempted to help resolve This condition, symptom, or sign has occurred before with antibiotics. Record review of Resident #1's chart did not reflect other SBARs were documented between [DATE] - [DATE] or indicated MD/NP notification. A review of the 24 Hour Report for [DATE] revealed dated reports [DATE] - [DATE]. The next 24-hour report was undated and revealed remarks related to [Resident #1] Day shift - monitor for SOB; Evening shift - SOB at 9:30 PM, 92%, pain management. There were no remarks for the Night shift. The next 24-hour report was dated [DATE] and revealed remarks related to Resident #1. Day shift - continue to monitor for SOB, O2 94%. There was no remark for the Evening shift. Night shift - monitor SOB. The 24-hour report dated [DATE] indicated Resident #1 was sent out to [hospital] for SOB, elevated temperature, and elevated heart rate. The Night shift entered Monitor SOB. Resident #1 did not return to the facility. Resident #1 passed away at the hospital. Record review of an Occupational Therapy Treatment Encounter Note, dated [DATE], entered by COTA D, reflected, [Resident #1] participated in task presented, but demonstrated increased fatigue and weakness. [Resident #1] continues to demonstrate decline in health and fear of falling while seated in wheelchair. [Resident #1] also demonstrated labored breathing when he is given his utensils to participate in feeding . (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of Resident #1's hospital medical records, dated [DATE], reflected [Resident #1] arrived at the ED on [DATE] at 2:51 PM. The reason for visit reflected Fever and high heart rate for 3 days. The visit diagnoses included Acute hypoxic respiratory failure. The ED provider notes reflected EMS states [facility] staff reported [Resident #1] with worsened confusion from baseline for the past 2 days. EMS states [Resident #1] was noted to be SOB and in mild respiratory distress on arrival and was given an albuterol/Atrovent treatment, 125 mg solumedrol, and 1 Liter bolus fluids enroute. Facility denied any falls or trauma, however history otherwise limited. Initial assessment reflected a temperature of 105 degrees Fahrenheit, heart rate of 170 bpm, lung sounds crackle bilaterally, and was started on BiPAP (a device that helps you breathe) on arrival due to respiratory distress. Resident #1 was intubated [[DATE]] at 5:20 PM. The lowest O2 saturation during intubation was 92%. CPR was initiated on [DATE] at 5:31 PM. Resident #1 ultimately expired. Time of death was called at 6:27 PM. The final diagnosis was Acute hypoxic respiratory failure that led to Cardiac arrest. During an interview on [DATE] at 2:21 PM, the ADON stated that she was informed about Resident #1's episodes of shortness of breath on [DATE]. The ADON said that interventions were implemented as ordered - supplemental oxygen and breathing treatments as needed. The ADON said that no significant concerns were reported to her. The ADON said that she expected for nurses to initiate nursing interventions, notify the MD/NP, and notify the RP; as well as notify the ADON and DON. The ADON said that vital signs should be monitored daily as ordered and as needed. The ADON said that any changes in vital signs, behavior, level of functioning from a resident baseline should be documented and reported. The ADON stated that therapy staff would monitor a resident oxygen level of concerned and always communicated with nursing staff. During an interview on [DATE] at 1:56 PM, CNA F stated she worked Friday, [DATE] and Saturday, [DATE], 6A - 2P shifts. CNA F said that she notified LVN A on Friday morning that Resident #1 appeared to have difficulty breathing, even with oxygen. CNA F demonstrated shallow breathing and other than normal rise and fall of the chest. CNA F said that Resident #1 felt warm to touch. CNA F said that LVN A assessed Resident #1 and told [CNA F] that he did not have an elevated temperature. During an interview on [DATE] at 2:44 PM, LVN B stated she worked Thursday, [DATE] and Friday, [DATE], 2P - 10P shifts. LVN B stated that she received verbal handoff shift report from LVN A on Thursday, [DATE] at 2:00 PM. LVN B said that [LVN A] reported that Resident #1 had shortness of breath when he returned from therapy, received a breathing treatment, and was on oxygen therapy. [LVN A] said to monitor for shortness of breath. LVN B said that she did not notify the MD/NP because she figured LVN A called during the day shift (6A - 2P). LVN B said that she checked Resident # 1's vital signs and O2 Sat after occupational therapy and applied oxygen, but there were no other concerns. LVN B said that Resident #1's RP visited on [DATE] and requested Resident #1 get up out of bed. LVN B said that she tried to explain to the RP that Resident #1 was in bed to be monitored for shortness of breath. LVN B said that Resident #1 was assisted up to his wheelchair and went to occupational therapy. LVN B said that she had to administer a breathing treatment when Resident #1 returned from therapy after dinner. LVN B denied inspection for abnormal findings such as blue or pale discoloration, labored breathing, or listening to lung sounds. LVN B said that unexpected respiratory findings that should be reported to the MD/NP immediately included a decreased oxygen saturation of less than 92%, restlessness, and increased difficulty breathing. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on [DATE] at 4:13 PM, LVN C stated she worked Saturday, [DATE], 6A - 10P shift. LVN C stated she received verbal handoff shift report from the overnight nurse to monitor Resident #1 for shortness of breath. LVN C said she inquired if Resident #1 had pneumonia and the nurse stated to monitor for shortness of breath. LVN C said she observed Resident #1 in his room during change of shift walking rounds and he received oxygen via NC. LVN C said she worked weekend doubles and Resident #1 did not receive oxygen continuously the previous weekends. LVN C said she asked the CNA to come get her when ADLs were provided to Resident #1 so she could monitor breathing when repositioned. LVN C said when she assisted with Resident #1's ADLs, she noticed Resident #1 had difficulty breathing. LVN C said she raised the head of the bed when they finished to help Resident #1 breathe a little easier. LVN C said when she checked Resident #1's vital signs after breakfast, and he was breathing fast and had an elevated temperature. LVN C said she administered a breathing treatment, administered Tylenol for the fever, and when Resident #1 did not appear to improve, notified the NP ([DATE] at 1:30 PM), called 911, and transferred Resident #1 to the hospital An attempt to interview the PCP on [DATE] at 1:34 PM was routed to an automated voicemail. A message identified caller, explained purpose of call, and a callback number was left on the voicemail. No callback was received. On [DATE] at 2:23 PM, a return phone call was accepted by LVN A. During a phone interview, LVN A stated she worked Thursday, [DATE] and Friday, [DATE], 6A - 2P shifts. LVN A said that therapy staff reported on [DATE] that Resident #1 had shortness of breath. LVN A said that she checked Resident #1's O2 Sats. LVN A said that [Resident #1] oxygen level was low (less than 90%) and administered a breathing treatment and applied oxygen via nasal cannula. LVN A said that the breathing treatment was effective. LVN A said that she left a message for the NP and did not receive a callback before her end of shift at 2 PM. LVN A said that she reported to the oncoming nurse (LVN B) to monitor Resident #1 for shortness of breath. LVN A said to monitor means to watch for signs of shortness of breath, like a low oxygen level. LVN A said that the next nurse would be responsible to call the MD/NP if they had concerns to report. LVN A said that she checked Resident #1's vital signs and he did not have a temperature. LVN A said that she listened to Resident #1's lungs but could not describe what she heard. LVN A said that Resident #1's lungs were clear. LVN A said that a breathing treatment was administered on [DATE] and it was effective. During an interview on [DATE] at 1:27 PM, the NP indicated it was not unusual not to call back if she received a page from the facility nurse. The NP stated if the nurse did not hear back [from the NP] within 15 minutes, she should have tried to call again. The NP stated Resident #1 had a diagnosis of cardiomegaly (an enlarged heart), COPD (a group of diseases that cause airflow blockage and breathing-related problems), and a medical history of pneumonia that she would have suggested a PRN diuretic and a chest x-ray had she received a call about the change in condition before Saturday, [DATE]. The NP said the suggested treatments would have been ineffective by Saturday ([DATE]) and sending Resident #1 to the hospital for a higher level of care was the best treatment option at the time. The NP stated she may have requested a COVID test if demonstrated temperature and/or cough. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A record review of the facility's policy titled, Significant Change in Condition, Response, revised [DATE], reflected Policy: It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. Procedure: 1. If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to) . new complaints of pain or worsening of pain . 2. The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of exiting orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. 3 . Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions. An attempt to identify the cause for decline, when it occurs . 4. The nurse will communicate the change to other departments as appropriate and updated communications will be available during morning report . 6. Each department notified will perform their own evaluation and assessment to determine if the change requires further intervention and implement actions accordingly This was determined to be an Immediate Jeopardy (IF) on [DATE] at 5:50 PM. The NFA was notified and provided with the IJ template on [DATE] at 5:50 PM . The following Plan of Removal submitted by the facility was accepted on [DATE] at 3:17 PM: All residents have the potential to be affected by this deficient practice. Interventions: All residents in the facility were assessed for any change of condition by the DON, ADON and Charge Nurses as of [DATE]. No additional issues were found. DON, ADON will audit all resident nursing notes for a change of condition to ensure notification of changes to the attending physician/nurse partitioner. Completed [DATE]. Going forward the DON/ADON/designee will monitor progress notes for a change in condition and notification to the attending physician/nurse practitioner daily during the morning clinical meeting. All residents with orders for oxygen continuous and as needed had oxygen saturation levels obtained as of[DATE] by the DON/ADON. No additional issues were found. LVN A and LVN B were immediately suspended pending investigation on [DATE]. LVN A and LVN B will not be permitted to return to work or provide care to residents until the following 1:1 in-services have been completed by the DON or Compliance Nurse. Completed [DATE]. Abuse and Neglect-failure to perform and assessment and notify a NP/MD for a resident change in condition could be considered neglect. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Performing an assessment and providing care to residents who are experiencing a change in condition or respiratory distress including not limited to: 02 saturation on room air or with oxygen and how much oxygen if applicable, skin color, any use of accessory muscle, lung sounds, any purses lip breathing, is the head of the bed flat or elevated. What interventions have you provided to the resident nonpharmacological or pharmacological. Notification of the MD and RP. Notifications of changes of conditions test, to include components of a focused respiratory assessment. Notification of change of condition to the physician immediately. If any staff members notice a resident in respiratory distress, they will notify a charge nurse or DON immediately. All charge nurses will notify the NP or the Attending MD after an assessment is performed. If the NP cannot be reached, the Attending or Medical Director will be notified. The medical director was notified by the administrator of this plan on [DATE]. An Ad Hoc QAPI meeting to include the Director and IDT team was held [DATE]. In-services: All charge nurses will be in-serviced by [DATE] by the DON/ ADON regarding the following and all nurses not in-serviced by [DATE] will not be allowed to work their assigned position until completion of these in-services. All PRN staff, new hires, and agency staff will be in-serviced prior to start of their shift. The Administrator, DON and ADON were in-serviced 1: 1 by Compliance Nurse. Abuse and Neglect- failure to perform and assessment and notify a NP/MD for a resident change in condition could be considered neglect. Performing an assessment and providing care to residents who are experiencing a change in condition or respiratory distress including not limited to: 02 saturation on room air or with oxygen and how much oxygen if applicable, skin color, any use of accessory muscle, lung sounds, any purses lip breathing, is the head of the bed flat or elevated. What interventions have you provided to the resident nonpharmacological or pharmacological. Notification of the MD and RP. Notifications of changes of conditions test, to include components of a focused respiratory assessment. Notification of change of condition to the physician immediately. If any staff members notice a resident in respiratory distress, they will notify a charge nurse or DON immediately. All charge nurses will notify the NP or the Attending MD after an assessment is performed. If the NP cannot be reached, the Attending or Medical Director will be notified. The medical director was notified by the administrator of this plan on [DATE]. An Ad Hoc QAPI meeting to include the Director and IDT team was held [DATE]. Monitoring: (continued on next page)

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