| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 455862 | A. Building<br>B. Wing | 05/21/2025 |

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| Coral Rehabilitation and Nursing of Austin | 6909 Burnet LN<br>Austin, TX 78757 |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to immediately consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications);- for one (Resident #1) of four residents reviewed for quality of care.<br><br>The facility failed notify Resident #1's NP or RP when he was experiencing a change in condition/decline for an unknown length of time when he stopped getting out of bed, was unable to feed himself, and complained of leg pain during personal care. He was admitted to the hospital on [DATE] and was diagnosed with possible aspiration pneumonia (a lung infection that occurs when food or liquid is inhaled into the lungs, leading to inflammation and infection), a UTI, and a left femur fracture.<br><br>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/19/25 at 4:27 PM. While the IJ was removed on 05/21/25 4:30 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures could place residents at risk of not receiving necessary medical care, pain, injury, infection, hospitalization, and death.<br><br>Findings included:<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including stroke, unspecified dementia, age-related physical debility, nicotine dependence, and chronic pain syndrome.<br><br>Review of Resident #1's admission MDS assessment, dated 03/31/25, reflected a BIMS score of 11, indicating a moderate cognitive impairment.<br><br>Review of Resident #1's admission care plan, reflected there was no focus, goal, or interventions regarding his need for ADL assistance. A focused revision on 05/15/25 reflected Care Plan Meeting with a goal of choosing which activities to attend and that he was an active smoker.<br><br>Review of Resident #1's Safe Smoking Evaluation, dated 03/28/25, reflected he smoked 3-5 cigarettes a day.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #1's incident report, dated 05/07/25 and documented by RN E, reflected she was called by the AD that Resident #1 was on the floor. A head-to-toe assessment was completed, ROM to all extremities, and no apparent injuries were observed.<br><br>Review of Resident #1's ST treatment note, dated 05/14/25, reflected redirection/cues and encouragement were needed to remain engaged in meal. Increased lethargy was noted with decreased awareness of deficits and impact on PO intake.<br><br>Review of Resident #1's Care Plan Conference, dated 05/15/25, reflected there were no concerns/issues/changes from the last care plan.<br><br>Review of Resident #1's progress note, dated 05/15/25 at 2:40 PM and documented by RN A, reflected the following:<br><br>[Resident #1] been in bed today. And notified NP notified of temp 102.4 [degrees] . (pain medication) given. 6:33 PM [Resident #1] arousable and eating dinner will continue to monitor vital signs.<br><br>Review of Resident #1's progress note, dated 05/15/25 at 10:14 PM and documented by LVN B, reflected the following:<br><br>This nurse went to assess [Resident #1] and obtain glucose 235 and administered (insulin). During assessment febrile (showing signs of fever) 102F went to provide (pain medication) but unable to arouse [Resident #1] discarded medication. [Resident #1] was hypertensive 185/105. Noticed resident breathing with accessory muscles. Notified on call received order to transfer to hospital.<br><br>Review of Resident #1's progress notes, from 05/01/25 - 05/19/25, reflected no other documentation regarding following up post-fall (05/07/25), pain to his left leg, his lethargy, him staying in bed, or being unable to feed himself.<br><br>Review of Resident #1's EMS records, dated 05/15/25 at 10:19 PM, reflected the following:<br><br>Dispatched for [Resident #1] at a nursing home who was altered. Staff stated that he may have aspirated (choked) earlier in the day, but he has been altered for two days.<br><br>Review of Resident #1's hospital records, dated 05/15/25, reflected the following:<br><br>[Resident #1] presents with altered mental status started this morning. Also noted to have a fever at the skilled nursing facility. [Resident #1] is currently nonverbal, altered, and unable to provide further history .<br><br>Palliative care assessment and plan:<br><br>Dyspnea (shortness of breath) 2nd to acute hypoxic (low levels of oxygen in your body tissues) respiratory failure, possible aspiration pneumonia . CTA chest with secretions within left main bronchus, left lower lobe bronchi, patchy left lower lobe opacity.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Weakness secondary to above, history of chronic debility. CT revealed subacute fracture of left intertrochanteric femur . Denies pain. Up until recently he was wheelchair-bound and able to transfer, has had multiple falls at facility.<br><br>Acute urinary tract infection present on admission . He was receiving antibiotics and was still admitted at the hospital as of 05/19/25.<br><br>During a telephone interview on 05/19/25 at 9:15 AM, Resident #1's RP stated in his care plan meeting on 05/15/25, there was no mention of any kind of change in condition. She stated after the meeting, she went to his room (around 12:15 PM) and he was in bed and out of it. She stated it was difficult to arouse him and when she did, he would not answer any questions. She stated she was surprised he was in his room because he was always out roaming around the facility in his wheelchair. She stated she had not seen him in 2-3 weeks, but when she last saw him, he was at his baseline - wheeling himself around in his wheelchair and in the dining room eating lunch. She stated staff told her he had not smoked that day and historically he smoked every chance he got. She stated she was most concerned with the fact that he had a femur fracture upon admission to the ER as she had not been notified of any recent falls. She stated she could not believe she was not notified of any of his changes in condition as she would have sought out immediate medical care sooner.<br><br>During an interview on 05/19/25 at 10:27 AM, MA C stated she worked with Resident #1 the week prior (including 05/15/25), and she stated he did not get out of bed when he was usually up in his wheelchair. She stated she could not remember how many days he was like that, but it had been a few. She stated he did take his medications, but appeared more lethargic than normal.<br><br>During an interview on 05/19/25 at 10:36 AM, RN A stated she was PRN but knew Resident #1 well. She stated when she started her shift on 05/15/25, she immediately knew he was not himself. She stated he did not get out of bed, had to be fed when he normally ate everything by himself in the dining room for meals, and he did not smoke at all that day. She stated he normally was always looking to smoke. She was told by the previous nurse (at shift change) that he had not been out of bed the previous day either. She stated Resident #1's RP visited him and requested that he be put in his wheelchair. She stated they attempted to, but he was not looking good, looked sick, and was very drowsy. She stated she contacted the NP and got orders for labs . She stated in the afternoon he had a fever that would not subside, and he was later (after her shift) sent to the ER.<br><br>During a telephone interview on 05/19/25 at 10:55 AM, CNA D stated she worked with Resident #1 on 05/12/25 and 05/13/25. She stated on both of those days he was not himself. She stated he stayed in bed the whole day and she had to feed him. She stated when she changed his brief, he would complain of pain to his left leg. She stated she could not remember who the nurse was, but believed she knew about the pain and that he was not at his baseline. She stated she did not remember specifically notifying her nurse.<br><br>During a telephone interview 05/19/25 at 11:26 AM, CNA I stated he worked with Resident #1 one day before he went to the hospital (on 05/15/25). He stated he was not assigned to him specifically but was helping on the hall. He stated he remembered seeing him asleep in his room at lunch time which was extremely unusual for him. He stated he was normally in his wheelchair in the dining room for meals. He stated he did not remember if he notified his nurse.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a telephone interview on 05/19/25 at 11:36 AM, RN E stated she had worked with Resident #1 on 05/14/25. She stated he was in bed and asked CNA D to get him up, but she told him he refused. She stated she went into his room and his breakfast tray was sitting there. She stated she had to help him eat breakfast. She stated that was not normal for him as he normally fed himself while in his wheelchair. She stated she asked him if he wanted to get out of bed and he yelled, No! No! Leave me alone! I do not want to get up! She stated it was not normal for him but thought maybe he was tired . She stated she had been off for a few days prior to 05/14/25 so she was not sure how long it had been going on. She stated if she had known it had been more than that day, she would have notified the NP immediately because that was a big change in condition for him. She stated CNA D never notified her that he had complained of pain.<br><br>During a telephone interview on 05/19/25 at 11:06 AM, CNA F stated he last worked with Resident #1 on 05/13/25. He stated for several days prior to 05/13/25 (up to two weeks), he had been declining. He stated he was hardly talking, was not active, was staying in bed, was not going outside to smoke, and would complain of leg pain when he changed his brief. He stated he believed the nurses were aware, but could not remember if he specifically told his nurse.<br><br>During a telephone interview on 05/19/25 at 11:49 AM, NP G stated she was covering for NP H while he was on vacation and was not Resident #1's regular NP. She stated she had not been notified of any change in condition for Resident #1 until the day he went to the hospital on [DATE]. She stated she would have expected to have been notified sooner if there had been a change in condition.<br><br>During an interview on 05/19/25 at 2:02 PM, the ADM stated Resident #1 was sent out on 05/15/25 due to a change in condition such as a fever and lethargy. She stated his baseline was he was always in his wheelchair and was very interactive with people. She stated he was not completely cognitive but could express how he was or what he needed. She stated she was not informed of any changes before that day. She stated he was a smoker but rarely smoked. She stated if there had been a change in condition such as not being able to feed himself, she would expect for the nurses to notify the DON and NP and seek recommendations such as labs, a UA, and to find out what was occurring. She stated she remembered seeing him up and about in his wheelchair until 05/15/25. She stated she was not aware he had acquired a fracture but did not believe it was due to the fall on 05/07/25. She stated, per the nursing staff, he did not sustain any injuries from the fall.<br><br>During a telephone interview on 05/20/25 at 9:03 AM, NP H stated he had been on vacation and NP G had been covering for him. He stated he did remember being notified of a fall for Resident #1 on 05/07/25 and was informed there were no injuries. He stated he had not been notified of any changes after the fall incident. He stated if Resident #1 had been in bed for days, not feeding himself, and was in pain, that would be extremely concerning because that would be a huge change in condition for him. He stated NP G should have been notified immediately because she could have ordered labs and a UA, been assessed, or could have been sent to the ER sooner.<br><br>Review of the facility's Change in a Resident's Condition or Status Policy, Revised December of 2010, reflected the following:<br><br>Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and or/status.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition.<br><br>2. A significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff by implementing standard disease-related clinical interventions.<br><br>The ADM was notified on 05/19/25 at 4:27 PM that an IJ had been identified and an IJ template was provided.<br><br>The following POR was approved on 05/21/25 at 7:38 AM:<br><br>Immediate action: 05/19/2025<br><br>Resident #1 was affected by this deficiency (F580) and was sent out to the hospital on [DATE] and admitted to the hospital for treatment. The Director of nursing and/or nursing supervisor initiated a comprehensive assessment- Daily Skill Note of all residents on 5/19/2025 and is ongoing to be completed on 05/21/2025, to identify any unreported changes of condition.<br><br>An investigation was initiated on 05/19/2025 by the Administrator on the course of change of condition for the resident #1, investigation is ongoing.<br><br>Training of staff on change in resident's condition or status was initiated by the Administrator on 05/19/2025, training is estimated to be completed by 05/22/2025. An audit of the 24- hour report on residents was initiated by the Administrator and DON on 05/19/2025 for identification of any change of condition, task was completed on 05/20/2025.<br><br>The CEO educated the Administrator and DON on the facility promptly notify the resident, his or her physician and representative of changes in the resident's medical/ mental condition and/ or status and comprehension verified at the same time, this was completed on 05/19/2025, prior to In servicing staff.<br><br>The facility is verifying comprehension on staff training by following up after education based on a random selection. A testing form will be provided electronically to test knowledge. The Administrator will verify results from testing. Verbal contact with personnel began on 05/19/2025 on in-servicing of change in a resident's condition by department heads. Staff will not be allowed to work their shifts until this Inservice, and training has been completed, this includes PRN and new staff. The Administrator will be responsible for the direct Inservice of her staff, completed on 05/20/2025.<br><br>Identification of others:<br><br>All residents who have a change of condition have the potential to be impacted by this deficient practice. The Administrator reviewed all residents with changes of condition (completed 05/19/25) to identify changes/needs. All changes of conditions were reported to physician/ NP, if any by the charge nurse. As of 5/19/2025 there were no new findings.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Action: Review of residents on the 24-hour report to identify any change of conditions. After review of report findings of the change of conditions, we identified five residents with a change of condition or behavior ensured that documentation of notification to physician/NP was completed.<br><br>Start Date: 5/19/25<br><br>Completion Date: 5/20/25<br><br>Responsible: DON, ADON<br><br>Action: Creation of spreadsheet of an audit for identifying change of condition of the current residents in the facility. Any other residents identified with a change of condition; physician/NP will be notified. Any treatments/ care received will be provided to the residents.<br><br>Start Date: 5/19/25<br><br>Completion Date: 5/20/25<br><br>Responsible: DON, Administrator<br><br>A review is of the change in a resident's condition or status policy was reviewed on 05/19/2025 to ensure communication on the protocol, defining a change of condition, and notification/ documentation of changes in condition or status was done by the Ad-Hoc QAPI team and revisions will be submitted to the facility for approval. No revisions were noted to be made as of 5/19/2025.<br><br>The Administrator has created an audit tool to monitor compliance the facility's communication procedure for contacting Physicians and confirming changes of condition have been documented for three times a week for two weeks, weekly for two weeks and monthly for two months. Audits will be conducted by the DON daily for two weeks, weekly for 2 weeks and monthly for two months, a spreadsheet was created for the audit to be conducted and documented. Any negative findings will be reported to the administrator for immediate correction.<br><br>The Medical Director was notified of the deficiency (F580) on 05/19/2025 and an Ad-Hoc QAPI meeting was held on 05/19/2025 to discuss the findings.<br><br>In-service: An Inservice was conducted by the Administrator with the department heads on changes of condition. Following an Inservice was initiated by department heads with all staff (this includes PRN and new staff) on changes of condition with staff on ensuring education on notification to charge nurse, documentation of change of condition in electronic health record, and physician/ NP notification done by the nurse supervisor/ charge nurse. Verbal notification of all staff was initiated on 05/19/2025 and will obtain signatures upon arrival to the facility, this includes PRN and new staff. The Administrator will oversee the in-service.<br><br>Expected compliance date is 05/19/2025.<br><br>The Surveyor monitored the POR on 05/21/25 as followed:<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During interviews on 05/21/25 from 11:38 AM - 4:02 PM, one HSK, the MS, one MA, three CNAs, three LVNS, and two RNs from all shifts stated they were in-serviced on reporting changes of condition before starting their shifts. They all stated they would notify their charge nurse and the DON should the notice a change of condition in a resident. The nurses stated they would immediately notify the NP and document the changes in the resident's HER. They all gave examples of changes in condition, such as lethargy, staying in bed more often, or eating less than normal.<br><br>During an interview on 05/21/25 at 2:56 PM, the DON stated she initiated the comprehensive assessments on all residents from 05/19/25 through 05/21/25. She identified 5 residents on 05/19/25, 2 residents on 05/20/25, and 2 residents on 05/21/25 as having change in condition. She notified the physician and family, transferred residents to hospital as indicated, and conducted additional orders as indicated. She and the ADM initiated and audit of the 24-hour reports on all residents to identify any change in condition and had the same results as found during the comprehensive assessments on all residents. She was in-serviced by the CEO on 05/19/25 on change in condition policy and procedure. She learned types of changes in condition, notifying change in condition to MD, RP, physician, and family as indicated, and document in change in condition, UDA, or progress notes. She prepared an audit spreadsheet that was to be reviewed and documented on for 2 weeks, weekly for 2 weeks, and monthly for 2 months on 05/19/25. There were some change in conditions (negative findings) identified, ADM was notified, and the notifications to the NP/Physician and family/RP were sent out on 05/19/25. She attended QAPI on 05/19/25. ADM notified the MD on 05/19/25. She also attended the department heads in-service on 05/19/25 and learned the same material as what was presented by the CEO. ADM was in-serviced by staff by phone, electronic, and in-person before they started their shifts.<br><br>During an interview on 05/21/25 at 3:11 PM, the ADM stated she investigated Resident #1's change in condition. She in-serviced staff on change in condition. She found it was inconclusive if there was a change in condition based on interviews with staff informing her that Resident #1 was able to respond, feed himself, and wanted to stay in bed. Her and the DON were educated by CEO on 05/19/25 on change in condition policy, what to do when there was a change in condition, who notified physician and family, and ensuring there was documentation. She learned the types of change in condition, reporting change in condition to charge nurse, immediately notifying the physician and NP, and documenting in residents' EHR, SBAR, progress note, and residents' assessment. Her and the DON were also given comprehension tests verifying they were educated on change in condition on 05/19/25. She in-serviced the department heads on 05/19/25. Department heads in-serviced the staff in their departments started on 05/19/25. Staff who were in-serviced in person were able to sign acknowledging receiving the in-service. Staff not available in person were in-serviced by phone by the department heads on 05/19/25. She also had presented random selection comprehension tests to staff in-serviced on change in condition on 05/20/25. Her and the DON audited the 24-hour reports to identify any other residents with change in condition on 05/19/25 and completed on 05/20/25. There were no residents identified on 05/19/25. There were residents identified on 05/20/25 as having a change in condition. The residents' charts were reviewed and the DON ensured the NP/Physician was notified of the change in condition by reviewing the EHR and contacting NP. She performed a review of all residents with change in condition on 05/19/25. There were no residents noted with a change in condition on 05/19/25 during her review of the 24 hours reports. She prepared an audit tool to monitor compliance for communicating/contacting physician for three times a week for two weeks, weekly for two weeks, and monthly for two months on 05/19/25. She started to monitor the audit on 05/20/25 after the 5 residents were identified as having a change in condition. Ad-Hoc QAPI reviewed the change in condition policy on 05/19/25 and there were no revisions to the policy that needed to be completed. QAPI also met on 05/19/25 to discuss the PORs and action to remove the IJs. She notified the MD by phone on 05/19/25.<br><br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the facility's Ad-Hoc QAPI meeting agenda, dated 05/19/25, reflected the ADM, the DON, the SW, the DOR, the BOM, the SC, the HSKS, and the MD were in attendance.<br><br>Review of the ADM's and DON's in-service comprehension verification by the CEO, dated 05/19/25, reflected they were tested on the reporting change in condition training.<br><br>Review of the Facility's Change in a Resident's Condition or Status Policy, revised December 2010, reflected the facility reviewed the policy and procedure on 05/19/25, ensured significant change was defined and physician notification and documentation procedures were present. There were no updates needed at the time of the review.<br><br>Review of the ADM's and DON's Audit Tool, on 05/21/25, reflected a spreadsheet in which they would monitor compliance for communicating and contacting the physician three time a week for two weeks, weekly for two weeks, and monthly for two months. The ADM and DON would review and document the date, resident, change in condition (if any), and documentation of contact.<br><br>Review of the ADM's and DON's Audit Spreadsheet, on 05/21/25, reflected they would identify any residents with a change in condition by reviewing and documenting the date, resident, change in condition, date the PCP/NP was notified, and any treatment or care given to the resident.<br><br>Review of the ADM's and DON's audit of all residents 24-hour reports, from 05/18/25 through 05/20/25, reflected there were five residents identified with a change in condition or behavior. NP/Physician and RP/Family were notified of the changes in condition.<br><br>Review of the Department Heads In-Service, dated 05/19/25, reflected they were educated on reporting resident's change in condition.<br><br>Review of the Staff's In-Service, dated 05/19/25, reflected they were educated on reporting resident's change in condition by the DON.<br><br>Review of the Staff In-Service Verbal Notification, from 05/19/25 - 05/20/25, reflected staff who were not present for the in-person in-service were verbally notified and in-serviced.<br><br>Review of the ADM's audit template, undated, reflected a spreadsheet that will be used to monitor resident's 24-hour reports to identify any changes in condition.<br><br>The ADM was notified on 05/21/25 at 4:30 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. |

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| Coral Rehabilitation and Nursing of Austin | 6909 Burnet LN<br>Austin, TX 78757 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 7 (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, Resident #7, Resident #8) of 7 residents reviewed for a clean and homelike environment.<br><br>1. The facility failed to maintain temperatures between 71 degrees and 81 degrees Fahrenheit on the 100 and 200 halls on 05/20/2025.<br><br>This failure could place residents at risk of living in an uncomfortable and unsafe environment, diminished quality of life and experience symptoms related to heat exacerbation.<br><br>Findings include:<br><br>Review of Resident #2's face sheet reflected at [AGE] year-old woman admitted on [DATE] with diagnoses of primary osteoarthritis right shoulder (condition where connection arm bone and should brake joint break down over time), malignant neoplasm of brain (cancerous brain tumor), central pain syndrome (neurological condition caused by long-term pain) and generalized anxiety disorder (mental health condition characterized by persistent and excessive worry about everyday events).<br><br>Review of Resident #2's care plan dated 03/13/20222 reflected Resident #2 had osteoarthritis of right should with interventions to encourage adequate hydration and nutrition.<br><br>Review of Resident #2's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicate no cognitive impairment.<br><br>During an interview and observation on 05/20/2025 at 1:31 PM, Resident #2 was observed in her room with an air conditioner window unit on and functioning and a box fan beside her dresser. Observation revealed there was no temperature displayed on the air conditioner window unit. Resident #2 stated that the facility air conditioner had not been working for at least two weeks. Resident #2 stated that she received a window air conditioner on Monday (05/19/2025). Resident #2 stated that it was really hot in her room and stated that staff did not ask if she wanted to go to another room. Resident #2 stated the air conditioner in the facility had been out for a while but was unsure how long. Resident #2 stated everybody knew her room was too hot. She stated that the aides that went into her room and said its too hot in here.<br><br>Review of Resident #3's face sheet reflected an [AGE] year-old woman admitted on [DATE] with diagnoses of chronic diastolic heart failure (condition where part of the heart doesn't relax properly between heart beats), hypertensive heart disease with heart failure (condition where high blood pressure leads to heart failure), chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe), dementia (brain disorder that causes a decline in thinking, memory, and reasoning abilities) and type 2 diabetes mellitus (a chronic condition characterized by the body's inability to maintain blood sugar).<br><br>Observation on 05/21/2025 at 1:09 revealed thermostat probe in room read 75 degrees Fahrenheit.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of Resident #3's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment.<br><br>Review of Resident #3's care plan dated 08/01/2024 reflected Resident #3 had diabetes mellitus with interventions to avoid exposure to extreme heat or cold. Further review reflected Resident #3 had COPD with intervention to encourage good fluid intake.<br><br>During observation and interview on 05/20/2025 at 1:33 PM, Resident #3 was observed with a box fan placed on her dresser and on. Resident #3 stated that the air conditioner was out for at least two weeks. Resident #3 stated she had a fan but it was so hot she felt like she was going to pass out. Resident #3 stated that it was still warm.<br><br>?<br><br>Observation on 05/21/2025 at 1:09 revealed thermostat probe in room read 75 degrees Fahrenheit.<br><br>Review of Resident #4's face sheet reflected a [AGE] year-old man admitted on [DATE] with diagnoses of progressive spinal muscle atrophy (ongoing neuromuscular disorder characterized by breakdown of lower motor neurons leading to loss of muscle function), spinal stenosis (condition where spinal canal narrows and puts pressure on spinal cord and nerve roots), and cognitive communication deficit (condition where communication is impaired due to problems with attention, memory and reasoning).<br><br>Review of Resident #4's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment.<br><br>Review of Resident #4's care plan reflected Resident #4 had alteration in musculoskeletal status with intervention to anticipate and meet his needs.<br><br>During an observation an interview on 05/20/2025 at 1:40 PM, it was revealed Resident #4 had an air conditioner unit and box fan in his room. The box fan was leaning against the wall and the air conditioner was functioning and blowing cool air. There was no temperature displayed on the air conditioner. Resident #4 stated that he received the air conditioner in his room on Monday (05/19/2025). He stated that on Friday (05/16/2025) the box fan broke and it was hot over the weekend.<br><br>Observation on 05/21/2025 at 2:15 PM revealed thermostat probe in Resident #4's room read 76 degrees Fahrenheit.<br><br>Review of Resident #5's face sheet revealed a [AGE] year-old male admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (long-term lung disease that makes it hard to breathe), type 2 diabetes mellitus (a chronic condition characterized by the body's inability to maintain blood sugar), and vascular dementia (type of dementia caused by reduced blood floor to the brain).<br><br>Review of Resident #5's quarterly MDS dated [DATE] reflected at BIMS score of 15 which indicate no cognitive impairment.<br><br>Review of Resident #5's care plan reflected he had COPD with intervention to avoid extremes of hot or cold.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During observation and interview on 05/20/2025 at 1:47 PM, revealed Resident #5 had a box fan in his room angled behind him, blowing air, as he sat in his wheelchair. Resident #5 stated he had a fan in his room for a month or so. He stated that it did get warm in his room, but he had not let anyone know. He stated that he thought the air conditioner was out but he was unsure. Observation revealed no window air conditioner in Resident #5's room.<br><br>During an observation on 05/20/2025 at 2:14 PM, Resident #5 was observed ambulating in the hall in his wheelchair and was heard saying It feels cool over here. +It is burning on my side of the hall.<br><br>Review of Resident #6's face sheet revealed a [AGE] year-old man admitted on [DATE] with diagnoses of type 2 diabetes mellitus (a chronic condition characterized by the body's inability to maintain blood sugar), vascular dementia (type of dementia caused by reduced blood floor to the brain), essential hypertension (high blood pressure without clear cause), and blindness in right eye.<br><br>Review of Resident #6's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicated no cognitive impairment.<br><br>Review of Resident #6's care plan dated 10/28/2024 reflected resident had vascular dementia related to heart disease and intervention included to assure an adequate fluid intake to prevent dehydration. Further review reflected Resident #6 has diabetes and interventions reflected to avoid exposure to extreme hot or cold.<br><br>During an observation an interview on 05/20/2025 at 2:01 PM, Resident #6 stated that he noticed about a week ago his room was getting warmer. Resident #6 stated he started to sweat in his room and he had to go into the hallway to cool down. Observation revealed Resident #6 did not have an air conditioner unit in his window or a fan in his room.<br><br>Observation on 05/21/2025 at 2:13 PM reflected thermostat probe in Resident #6's room read 75 degrees Fahrenheit.<br><br>Review of Resident #7's face sheet reflected a [AGE] year-old woman admitted on [DATE] with diagnosis of essential hypertension (high blood pressure without clear cause), paroxysmal atrial fibrillation (irregular rapid heartbeat), cerebral infarction (stroke caused by blood flow blockage to brain) and bipolar disorder (mental health condition characterized by extreme mood swings).<br><br>Review of Resident #7's quarterly MDS dated [DATE] reflected a BIMS score of 14 which indicate no cognitive impairment.<br><br>Review of Resident #7's care plan dated 02/13/2025 reflected Resident #6 has a communication problem related to cerebral infarction with intervention to anticipate needs.<br><br>During an interview and observation on 05/20/2025 at 2:33 PM, Resident #7 stated that her room got hot during the day and she started sweating. She stated it was uncomfortable. Resident #7 stated she told staff but they did not offer her a fan. She was not sure who she told. Resident #7 stated she did not think the AC vent reached her side of the room. Observation revealed no fan in Resident #7's room.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 05/21/2025 at 1:14 revealed thermostat probe in Resident #7's room read 77 degrees Fahrenheit.<br><br>Review of Resident #8's face sheet reflected a [AGE] year-old man admitted on [DATE] with diagnoses of acute respiratory failure with hypoxia (life-threatening condition where the lungs cannot deliver enough oxygen to the blood), end stage renal disease (severe condition where kidney can no longer effectively filter waste and excess fluid from the blood), type 2 diabetes mellitus (a chronic condition characterized by the body's inability to maintain blood sugar), tracheostomy status (surgically created windpipe for breathing) and essential hypertension (high blood pressure without clear cause).<br><br>Review of Resident #8's quarterly MDS dated [DATE] reflected a BIMS score of 15 which indicated no cognitive impairment.<br><br>During an observation and interview on 05/20/2025 at 6:14 PM revealed Resident #8 fanning himself with his hand and stated it was hot. Resident #8 stated that it had been hot because the air conditioner had not been working for three months. Resident #8 stated he had a fan and air conditioner window unit but it did not cool Observation revealed Resident #8's window air conditioner was cooling but did not display temperature.<br><br>Observation on 05/20/2025 at 1:49 PM, revealed 200 hall thermostat was set to 70 degrees Fahrenheit and read it was 81 degrees Fahrenheit inside.<br><br>Observation on 05/20/2025 at 1:59 PM, revealed 100 hall thermostat was set to 68 degrees Fahrenheit and read it was 81 degrees Fahrenheit inside.<br><br>Review of temperature on 05/20/2025 at 5:00 PM revealed outside temperature was a high of 95 degrees.<br><br>Observation on 05/20/2025 at 2:10 PM, revealed the 100 hall thermostat was set to 68 degrees and read it was 81 degrees Fahrenheit inside.<br><br>Observation on 05/20/2025 at 3:32 PM, revealed the 100 hall thermostat was set to 71 degrees Fahrenheit and read it was 82 degrees Fahrenheit inside.<br><br>Observation on 05/20/2025 at 3:33 PM, revealed the 200 hall thermostat was set to 70 degrees Fahrenheit and read it was 82 degrees Fahrenheit inside.<br><br>Observation on 05/20/2025 at 4:00 PM, revealed the 100 hall thermostat read it was 82 degrees and MA was observed looking at it.<br><br>Observation on 05/20/2025 at 4:01 PM, revealed the 200 hall thermostat was set to 70 degrees Fahrenheit and read it was 83 degrees Fahrenheit inside.<br><br>Observation on 05/20/2025 at 6:05 PM, revealed the 100 hall thermostat read it was set to 69 degrees and read it was 82 degrees inside.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Observation on 05/20/2025 at 6:06 PM, revealed the 200 hall thermostat read it was set to 70 degrees and read it was 83 degrees inside.<br><br>Observations on 05/20/2025 between 1:49 PM and 6:06 PM revealed thermostats were locked behind plastic box.<br><br>During an interview on 05/20/2025 at 2:39 PM with Spanish translator via telephone, MAN stated that there were two air conditioners broken for at least three months. He stated he monitored the temperature via the thermostat on the walls and only had a water thermometer available and did not have one to monitor the temperature in the residents rooms. MAN stated that he did write down the temperatures in a logbook. He stated that Resident #2, Resident #3 and Resident #8's rooms were provided with window units on 5/16/2025 and 5/19/2025. He stated there were two residents who complained it was too hot. He stated he checked the temperatures in the residents' rooms and it was 80 degrees but it was not written down anywhere. MAN stated there was currently two air conditioners not working. MAN stated that there was a technician at the facility today (05/20/2025) but he needed a part and was going to provide estimates.<br><br>During an interview on 05/20/2025 at 3:49 PM, the MS stated that he traveled between two facilities, and he was at this facility two or three times a week. The MS stated he had not been to the facility in a few weeks. The MS stated that the facility air conditioners were serviced last week. He stated there was one repair done on the kitchen air conditioner. The MS stated that air conditioners were also maintained in-house such as cleaning the coils. The MS stated the kitchen air conditioner went down and was repaired. The MS stated he believed there was an air conditioner on the 200 hall that also just went down and believed the technician was at the facility today. The MS stated it had not been three months that units were not working. The MS stated that MAN should have checked temperatures in the hallways and in resident rooms. The MS stated MAN was good about the checks. The MS stated that the facility tried to keep the temperature between 74 or 75 degrees Fahrenheit and tried to work with the residents and make everyone comfortable. The MS stated window units were from a while back when air conditioner unit went out and the facility went out and bought units. The MS stated that was a good while ago before he was at the facility. The MS stated he meant to tell the MAN to take the units out of the windows. The MS stated MAN should have been documenting temperatures especially when the facility had a unit that was not working and each room temperature should have been documented. The MS stated that if the repair could not occur that same day then the facility would have needed to move a resident to a cooler area for the time being. The MS stated that a red beam thermometer was used to take temperatures and it was directed at the vent to get the temperature. He stated that MAN should have had the thermometer as the MS provided him one and if he did not then the MS would have told MAN to go pick up another one. The MS stated when he is at the facility he reviewed the temperature logs. MS stated that if there was a problem the facility should have checked temperatures or if a resident complained. The MS stated that if a thermostat read 82 degrees Fahrenheit the facility needed to log that. The MS stated that it was concern if a unit was reading at 82 degrees Fahrenheit and stated that was considered a high priority. The MS stated he hoped they moved the windows units to an area to keep the residents nice and cool. The MS stated if it was too hot then they would need to move residents around for their comfort. The MS stated the temperature was not supposed to be over 81 degrees.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 05/20/2025 at 4:03 PM, the ADM stated that the facility was recently informed of potential issues with the air conditioners. The ADM stated that initially a company had worked on the kitchen air conditioner and she stated she heard through others there may have been other issues. The ADM stated the company returned today (05/20/2025) and assessed all the other air conditioner units. The ADM stated the kitchen air conditioner was out a few weeks ago and that was why the company was called to come and fix it. The ADM stated that the company asked to inspect the rest of the units. The ADM stated that it was not reported to her directly and was considered hearsay because she heard indirectly there may have been some other concerns. The ADM stated any complaints from residents regarding temperature would have been put in the maintenance log and then addressed by maintenance.<br><br>During an interview on 05/20/2025 at 4:52 PM, LVN A stated he had not received complaints from residents regarding the temperature of the building or their rooms. He stated Resident #4 complained when he first moved to his current room but the air conditioner was restored. LVN A stated Resident #4 was given a fan and then the air conditioner was installed. LVN A stated Resident #4 has been in that room for about three weeks.<br><br>During an interview on 05/21/2025 at 8:34 PM, the air conditioner representative stated that he signed the facility up for their energy efficient program about three weeks ago. He stated the company cleaned all air conditioner units and found one unit (the kitchen) was not working. The representative stated that it was fixed and while the technicians were cleaning there were other units found not working. The representative stated he believed there were two more units not working. The representative stated he spoke with ADM that additional units were found not working and the ADM requested a quote. The representative stated that it only took a day to fix the kitchen and that was only because they waited for a part otherwise it could have been fixed the day of the cleaning. The representative stated that had the ADM requested the other units to be fix, it could have already been fixed with the only delay to order a part if it was not in the warehouse. The representative stated they could have received any parts in a day or so. The representative stated that the requested quote delayed the air conditioner being fixed.<br><br>Review of facility maintenance logs dated 04/21/2205 reflected a resident would like an ac unit. Further review reflected an additional entry with date of 05/09/2025 a resident needs window air conditioner. Entry dated 05/14/2025 reflected an additional resident needs a fan or ac. Entry dated 04/01/2025 reflected room was hot.<br><br>Review of facility policy titled Quality of Life- Homelike Environment reflected the facility staff and management shall maximize, to the extend possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: Comfortable temperatures<br><br>Review of undated and untitled facility emergency preparedness plan section titled loss of power, heat, & water reflected if loss is due to equipment failure in isolated area of facility, residents will be relocated to another area.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of section titled Heat Alert Procedure reflected maintain patients free from hyperthermic symptoms when the facility and/or Patient room temperatures are greater than 80 degrees and reflected that equipment included, room thermometers, temperature recording sheet, portable fans, ice chest and ice, pitchers of water or access to water fountains and oral or rectal thermometers. Room temperature to be measured five feet from the floor and record every four hours during the Heat Alert. Portable fans will be placed at strategic locations for ventilation. Cool water and /or other fluids will be available and offered to the Patients every two hours. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of four residents reviewed for quality of care.<br><br>The facility failed to ensure staff did not address (and/or document) a change in condition for an unknown length of time when Resident #1 stopped getting out of bed, was unable to feed himself, and complained of leg pain during personal care. He was admitted to the hospital on [DATE] and was diagnosed with possible aspiration pneumonia (a lung infection that occurs when food or liquid is inhaled into the lungs, leading to inflammation and infection), a UTI, and a left femur fracture.<br><br>This failure resulted in an identification of an Immediate Jeopardy (IJ) on 05/19/25 at 4:27 PM. While the IJ was removed on 05/21/25 4:30 PM, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.<br><br>These failures could place residents at risk of not receiving necessary medical care, pain, injury, infection, hospitalization, and death.<br><br>Findings included:<br><br>Review of Resident #1's undated face sheet reflected a [AGE] year-old male who was admitted to the facility on [DATE] with diagnoses including stroke, unspecified dementia, age-related physical debility, nicotine dependence, and chronic pain syndrome.<br><br>Review of Resident #1's admission MDS assessment, dated 03/31/25, reflected a BIMS score of 11, indicating a moderate cognitive impairment.<br><br>Review of Resident #1's admission care plan, reflected there was no focus, goal, or interventions regarding his need for ADL assistance. A focused revision on 05/15/25 reflected Care Plan Meeting with a goal of choosing which activities to attend and that he was an active smoker.<br><br>Review of Resident #1's Safe Smoking Evaluation, dated 03/28/25, reflected he smoked 3-5 cigarettes a day.<br><br>Review of Resident #1's incident report, dated 05/07/25 and documented by RN E, reflected she was called by the AD that Resident #1 was on the floor. A head-to-toe assessment was completed, ROM to all extremities, and no apparent injuries were observed.<br><br>Review of Resident #1's ST treatment note, dated 05/14/25, reflected redirection/cues and encouragement were needed to remain engaged in meal. Increased lethargy was noted with decreased awareness of deficits and impact on PO intake.<br><br>Review of Resident #1's Care Plan Conference, dated 05/15/25, reflected there were no concerns/issues/changes from the last care plan.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #1's progress note, dated 05/15/25 at 2:40 PM and documented by RN A, reflected the following:<br><br>[Resident #1] been in bed today. And notified NP notified of temp 102.4 [degrees] . (pain medication) given. 6:33 PM [Resident #1] arousable and eating dinner will continue to monitor vital signs.<br><br>Review of Resident #1's progress note, dated 05/15/25 at 10:14 PM and documented by LVN B, reflected the following:<br><br>This nurse went to assess [Resident #1] and obtain glucose 235 and administered (insulin). During assessment febrile (showing signs of fever) 102F went to provide (pain medication) but unable to arouse [Resident #1] discarded medication. [Resident #1] was hypertensive 185/105. Noticed resident breathing with accessory muscles. Notified on call received order to transfer to hospital.<br><br>Review of Resident #1's progress notes, from 05/01/25 - 05/19/25, reflected no other documentation regarding following up post-fall (05/07/25), pain to his left leg, his lethargy, him staying in bed, or being unable to feed himself.<br><br>Review of Resident #1's EMS records, dated 05/15/25 at 10:19 PM, reflected the following:<br><br>Dispatched for [Resident #1] at a nursing home who was altered. Staff stated that he may have aspirated (choked) earlier in the day, but he has been altered for two days.<br><br>Review of Resident #1's hospital records, dated 05/15/25, reflected the following:<br><br>[Resident #1] presents with altered mental status started this morning. Also noted to have a fever at the skilled nursing facility. [Resident #1] is currently nonverbal, altered, and unable to provide further history .<br><br>Palliative care assessment and plan:<br><br>Dyspnea (shortness of breath) 2nd to acute hypoxic (low levels of oxygen in your body tissues) respiratory failure, possible aspiration pneumonia . CTA chest with secretions within left main bronchus, left lower lobe bronchi, patchy left lower lobe opacity.<br><br>Weakness secondary to above, history of chronic debility. CT revealed subacute fracture of left intertrochanteric femur . Denies pain. Up until recently he was wheelchair-bound and able to transfer, has had multiple falls at facility.<br><br>Acute urinary tract infection present on admission. He was receiving antibiotics and was still admitted at the hospital as of 05/19/25.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a telephone interview on 05/19/25 at 9:15 AM, Resident #1's RP stated in his care plan meeting on 05/15/25, there was no mention of any kind of change in condition. She stated after the meeting, she went to his room (around 12:15 PM) and he was in bed and out of it. She stated it was difficult to arouse him and when she did, he would not answer any questions. She stated she was surprised he was in his room because he was always out roaming around the facility in his wheelchair. She stated she had not seen him in 2-3 weeks, but when she last saw him, he was at his baseline - wheeling himself around in his wheelchair and in the dining room eating lunch. She stated staff told her he had not smoked that day and historically he smoked every chance he got. She stated she was most concerned with the fact that he had a femur fracture upon admission to the ER as she had not been notified of any recent falls.<br><br>During an interview on 05/19/25 at 10:27 AM, MA C stated she worked with Resident #1 the week prior (including 05/15/25), and she stated he did not get out of bed when he was usually up in his wheelchair. She stated she could not remember how many days he was like that, but it had been a few. She stated he did take his medications, but appeared more lethargic than normal.<br><br>During an interview on 05/19/25 at 10:36 AM, RN A stated she was PRN but knew Resident #1 well. She stated when she started her shift on 05/15/25, she immediately knew he was not himself. She stated he did not get out of bed, had to be fed when he normally ate everything by himself in the dining room for meals, and he did not smoke at all that day. She stated he normally was always looking to smoke. She was told by the previous nurse (at shift change) that he had not been out of bed the previous day either. She stated Resident #1's RP visited him and requested that he be put in his wheelchair. She stated they attempted to, but he was not looking good, looked sick, and was very drowsy. She stated she contacted the NP and got orders for labs . She stated in the afternoon he had a fever that would not subside, and he was later (after her shift) sent to the ER.<br><br>During a telephone interview on 05/19/25 at 10:55 AM, CNA D stated she worked with Resident #1 on 05/12/25 and 05/13/25. She stated on both of those days he was not himself. She stated he stayed in bed the whole day and she had to feed him. She stated when she changed his brief, he would complain of pain to his left leg. She stated she could not remember who the nurse was, but believed she knew about the pain and that he was not at his baseline. She stated she did not remember specifically notifying her nurse.<br><br>During a telephone interview 05/19/25 at 11:26 AM, CNA I stated he worked with Resident #1 one day before he went to the hospital (on 05/15/25). He stated he was not assigned to him specifically but was helping on the hall. He stated he remembered seeing him asleep in his room at lunch time which was extremely unusual for him. He stated he was normally in his wheelchair in the dining room for meals. He stated he did not remember if he notified his nurse.<br><br>(continued on next page) |

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| | 455862 | A. Building<br>B. Wing | 05/21/2025 |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During a telephone interview on 05/19/25 at 11:36 AM, RN E stated she had worked with Resident #1 on 05/14/25. She stated he was in bed and asked CNA D to get him up, but she told him he refused. She stated she went into his room and his breakfast tray was sitting there. She stated she had to help him eat breakfast. She stated that was not normal for him as he normally fed himself while in his wheelchair. She stated she asked him if he wanted to get out of bed and he yelled, No! No! Leave me alone! I do not want to get up! She stated it was not normal for him but thought maybe he was tired. She stated she had been off for a few days prior to 05/14/25 so she was not sure how long it had been going on. She stated if she had known it had been more than that day, she would have notified the NP immediately because that was a big change in condition for him. She stated CNA D never notified her that he had complained of pain.<br><br>During a telephone interview on 05/19/25 at 11:06 AM, CNA F stated he last worked with Resident #1 on 05/13/25. He stated for several days prior to 05/13/25 (up to two weeks), he had been declining. He stated he was hardly talking, was not active, was staying in bed, was not going outside to smoke, and would complain of leg pain when he changed his brief. He stated he believed the nurses were aware, but could not remember if he specifically told his nurse.<br><br>During a telephone interview on 05/19/25 at 11:49 AM, NP G stated she was covering for NP H while he was on vacation and was not Resident #1's regular NP. She stated she had not been notified of any change in condition for Resident #1 until the day he went to the hospital on [DATE]. She stated she would have expected to have been notified sooner if there had been a change in condition.<br><br>During an interview on 05/19/25 at 2:02 PM, the ADM stated Resident #1 was sent out on 05/15/25 due to a change in condition such as a fever and lethargy. She stated his baseline was he was always in his wheelchair and was very interactive with people. She stated he was not completely cognitive but could express how he was or what he needed. She stated she was not informed of any changes before that day. She stated he was a smoker but rarely smoked. She stated if there had been a change in condition such as not being able to feed himself, she would expect for the nurses to notify the DON and NP and seek recommendations such as labs, a UA, and to find out what was occurring. She stated she remembered seeing him up and about in his wheelchair until 05/15/25. She stated she was not aware he had acquired a fracture but did not believe it was due to the fall on 05/07/25. She stated, per the nursing staff, he did not sustain any injuries from the fall.<br><br>During a telephone interview on 05/20/25 at 9:03 AM, NP H stated he had been on vacation and NP G had been covering for him. He stated he did remember being notified of a fall for Resident #1 on 05/07/25 and was informed there were no injuries. He stated he had not been notified of any changes after the fall incident. He stated if Resident #1 had been in bed for days, not feeding himself, and was in pain, that would be extremely concerning because that would be a huge change in condition for him. He stated NP G should have been notified immediately because she could have ordered labs and a UA, been assessed, or could have been sent to the ER sooner.<br><br>Review of the facility's Change in a Resident's Condition or Status Policy, Revised December of 2010, reflected the following:<br><br>Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and or/status.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition.<br><br>2. A significant change of condition is a decline or improvement in the resident's status that will not normally resolve itself without intervention by staff by implementing standard disease-related clinical interventions.<br><br>The ADM was notified on 05/19/25 at 4:27 PM that an IJ had been identified and an IJ template was provided.<br><br>The following POR was approved on 05/21/25 at 7:38 AM:<br><br>Immediate action: 05/19/2025<br><br>Resident #1 was affected by this deficiency (F684) and was sent out to the hospital on [DATE] and admitted to the hospital for treatment. The Director of nursing and/or nursing supervisor initiated a comprehensive assessment- Daily Skill Note, of all residents on 5/19/2025 and is ongoing to be completed on 05/21/2025 to identify any unreported changes of condition.<br><br>An investigation was initiated on 05/19/2025 by the Administrator on the course of change of condition for the Resident #1, investigation is ongoing.<br><br>Training of staff on change in resident's condition or status was initiated by the Administrator on 5/19/2025, training is estimated to be completed by 05/22/2025. An audit of the 24- hour report on residents was initiated by the Administrator and DON on 05/19/2025 for identification of any change of condition, task was completed on 05/20/2025.<br><br>The CEO educated the Administrator and DON on the facility promptly notifying the resident, his or her physician and representative of changes in the resident's medical/ mental condition and/ or status and comprehension verified at the same time, this was completed on 05/19/2025, prior to in-servicing staff.<br><br>The facility is verifying comprehension on staff training by following up after education based on a random selection. A testing form will be provided electronically to test knowledge. The Administrator will verify results from testing. Verbal contact with personnel began on 05/19/2025 on in-servicing of change in a resident's condition by department heads. Staff will not be allowed to work their shifts until this in-service, and training has been completed, this includes PRN and new staff. The Administrator will be responsible for the direct Inservice of her staff, completed on 05/20/2025.<br><br>Identification of others:<br><br>All residents who have a change of condition have the potential to be impacted by this deficient practice. The Administrator reviewed all residents with changes of condition (completed 05/19/25) to identify changes/needs. All changes of conditions were reported to the physician/ NP, if any by the charge nurse. As of 5/19/2025 there were no new findings.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Action: Review of residents on the 24-hour report to identify any change of conditions. After review of report findings of the change of conditions, we identified five residents with a change of condition or behavior ensured that documentation of notification to physician/NP was completed.<br><br>Start Date: 5/19/25<br><br>Completion Date: 5/20/25<br><br>Responsible: DON, ADON<br><br>Action: Creation of spreadsheet of an audit identifying change of condition of the current residents in the facility. Any other residents identified with a change of condition; physician/NP will be notified. Any treatments/ care received will be provided to the residents.<br><br>Start Date: 5/19/25<br><br>Completion Date: 5/20/25<br><br>Responsible: DON, Administrator<br><br>A review is of the change in a resident's condition or status policy was reviewed and completed on 5/19/2025 to ensure communication on the protocol, defining a change of condition, and notification/ documentation of changes in condition or status was done by the Ad-Hoc QAPI team and revisions will be submitted to the facility for approval. No revisions were noted to be made as of 5/19/2025.<br><br>The Administrator has created an audit tool to monitor compliance the facility's communication procedure for contacting Physicians and confirming changes of condition have been documented for three times a week for two weeks, weekly for two weeks and monthly for two months. Audits will be conducted by the DON daily for two weeks, weekly for 2 weeks and monthly for two months, a spreadsheet was created for the audit to be conducted and documented. Any negative findings will be reported to the administrator for immediate correction.<br><br>The Medical Director was notified of the deficiency (F684) on 05/19/2025 and an Ad-Hoc QAPI meeting was held on 05/19/2025 to discuss the findings.<br><br>In-service: An Inservice was conducted by the Administrator with the department heads on changes of condition. Following an Inservice was initiated by department heads with all staff (this includes PRN and new staff) on changes of condition with staff on ensuring education on notification to charge nurse, documentation of change of condition in electronic health record, and physician/ NP notification done by the nurse supervisor/ charge nurse. Verbal notification of all staff was initiated on 05/19/2025 and will obtain signature upon their arrival to the facility, this includes PRN and new staff. The Administrator will oversee the in-service.<br><br>Expected compliance date is 05/19/2025.<br><br>The Surveyor monitored the POR on 05/21/25 as followed:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the ADM's and DON's in-service comprehension verification by the CEO, dated 05/19/25, reflected they were tested on the reporting change in condition training.<br><br>Review of the Department Heads In-Service, dated 05/19/25, reflected they were educated on reporting resident's change in condition.<br><br>Review of the Staff's In-Service, dated 05/19/25, reflected all staff were educated on reporting resident's change in condition by the DON.<br><br>Review of the Staff In-Service Verbal Notification, from 05/19/25 - 05/20/25, reflected staff who were not present for the in-person in-service were verbally notified and in-serviced.<br><br>During interviews on 05/21/25 from 11:38 AM - 4:02 PM, one HSK, the MS, one MA, three CNAs, three LVNS, and two RNs from all shifts stated they were in-serviced on reporting changes of condition before starting their shifts. They all stated they would notify their charge nurse and the DON should they notice a change of condition in a resident. The nurses stated they would immediately notify the NP and document the changes in the resident's EHR. They all gave examples of changes in condition, such as lethargy, staying in bed more often, or eating less than normal.<br><br>During an interview on 05/21/25 at 2:56 PM, the DON stated she initiated the comprehensive assessments on all residents from 05/19/25 through 05/21/25. She identified 5 residents on 05/19/25, 2 residents on 05/20/25, and 2 residents on 05/21/25 as having change in condition. She notified the physician and families, transferred the residents to hospital as indicated, and conducted additional orders as indicated. She and the ADM initiated an audit of the 24-hour reports on all residents to identify any change in condition and had the same results as found during the comprehensive assessments on all residents. She was in-serviced by the CEO on 05/19/25 on the change in condition policy and procedure. She learned the types of changes in condition, notifying change in condition to the MD, RP, physician, and family as indicated, and documenting the change in condition, UDA, or progress notes. She prepared an audit spreadsheet that was to be reviewed and documented on for 2 weeks, weekly for 2 weeks, and monthly for 2 months on 05/19/25. There were some changes in conditions (negative findings) identified, the ADM was notified, and the notifications to the NP/Physician and family/RP were sent out on 05/19/25. She attended the QAPI on 05/19/25. The ADM notified the MD on 05/19/25. She also attended the department heads in-service on 05/19/25 and learned the same material as what was presented by the CEO. The ADM was in-serviced by staff by phone, electronic, and in-person before they started their shifts.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 05/21/25 at 3:11 PM, the ADM stated she investigated Resident #1's change in condition. She in-serviced staff on change in condition. She found it was inconclusive if there was a change in condition based on interviews with staff informing her that Resident #1 was able to respond, feed himself, and wanted to stay in bed. She and the DON were educated by the CEO on 05/19/25 on change in condition policy, what to do when there was a change in condition, who notified physician and family, and ensuring there was documentation. She learned the types of change in condition, reporting change in condition to the charge nurse, immediately notifying the physician and NP, and documenting in the residents' EHRs, SBAR, progress notes, and residents' assessments. She and the DON were also given comprehension tests verifying they were educated on change in condition on 05/19/25. She in-serviced the department heads on 05/19/25. The department heads in-serviced the staff in their departments starting on 05/19/25. Staff who were in-serviced in person were able to sign acknowledging receiving the in-service. Staff not available in person were in-serviced by phone by the department heads on 05/19/25. She also had presented a random selection comprehension tests to staff in-serviced on change in condition on 05/20/25. She and the DON audited the 24-hour reports to identify any other residents with change in condition on 05/19/25 and completed on 05/20/25. There were no residents identified on 05/19/25. There were residents identified on 05/20/25 as having a change in condition. The residents' charts were reviewed and the DON ensured the NP/Physician was notified of the change in condition by reviewing the EHR and contacting the NP. She performed a review of all residents with change in condition on 05/19/25. There were no residents noted with a change in condition on 05/19/25 during her review of the 24 hours reports. She prepared an audit tool to monitor compliance for communicating/contacting physician for three times a week for two weeks, weekly for two weeks, and monthly for two months on 05/19/25. She started to monitor the audit on 05/20/25 after the 5 residents were identified as having a change in condition. The Ad-Hoc QAPI reviewed the change in condition policy on 05/19/25 and there were no revisions to the policy that needed to be completed. The QAPI also met on 05/19/25 to discuss the PORs and action to remove the IJs. She notified the MD by phone on 05/19/25.<br><br>Review of the facility's Ad-Hoc QAPI meeting agenda, dated 05/19/25, reflected the ADM, the DON, the SW, the DOR, the BOM, the SC, the HSKS, and the MD were in attendance.<br><br>Review of the facility's Change in a Resident's Condition or Status Policy, revised December 2010, reflected the facility reviewed the policy and procedure on 05/19/25, ensured significant change was defined and physician notification and documentation procedures were present. There were no updates needed at the time of the review.<br><br>Review of the ADM's and DON's Audit Tool, on 05/21/25, reflected a spreadsheet in which they would monitor compliance for communicating and contacting the physician three time a week for two weeks, weekly for two weeks, and monthly for two months. The ADM and DON would review and document the date, resident, change in condition (if any), and documentation of contact.<br><br>Review of the ADM's and DON's Audit Spreadsheet, on 05/21/25, reflected they would identify any residents with a change in condition by reviewing and documenting the date, resident, change in condition, date the PCP/NP was notified, and any treatment or care given to the resident.<br><br>Review of the ADM's and DON's audit of all residents 24-hour reports, from 05/18/25 through 05/20/25, reflected there were five residents identified with a change in condition or behavior. The NP/Physician and RP/Family were notified of the changes in condition.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the ADM's audit template, undated, reflected a spreadsheet that will be used to monitor resident's 24-hour reports to identify any changes in condition.<br><br>The ADM was notified on 05/21/25 at 4:30 PM that the IJ had been removed. While the IJ was removed, the facility remained at a level of no actual harm at a scope of pattern that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. |