STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675127	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44241 Based on interviews and record review, the facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices for 1 resident of 17 residents (CR #1) reviewed for quality of care. The facilities failure to assess CR#1 after she complained of pain during peri care at 5:00am on 06/06/24 but was not sent to the hospital until 06/07/24 at 12:06am which was over 18hours later. After being admitted into the hospital CR#1 was diagnosed with intertrochanteric fracture of the right femoral neck of indeterminate age. On 06/10/2024 at 3:46 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 06/14/2024, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm that was not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures placed residents who experience falls with injuries at risk of further injury, pain and delayed medical treatment. Findings include: Record review of CR#1 face sheet on 06/07/23 at 8:30pm revealed that she was an [AGE] year-old female that was originally admitted into the facility on [DATE]. She had diagnoses of cognitive communication deficit, contracture of muscle left ankle and foot, aneurysm of carotid artery (a bulge in the wall of one of these arteries), constipation, hemiplegia (one-sided muscle paralysis or weakness), hemiparesis (weakness or the inability to move on one side of the body), and insomnia. Record review of CR#1's Quarterly MDS, dated [DATE] revealed CR #1's BIMS score was determined to be 14 due to limited cognitive impairment. The MDS completed by the staff, which indicated CR#1 did not exhibit behavioral symptoms of wandering and required supervision. CR#1 was bed bound and must be encouraged to participate in activities as well as bathing. CR#1 was one-person physical assist for ADLs, but two- person assist when transferring. Record review of CR #1's care plan dated 05/30/24revealed that CR#1 had impaired visual functioning and was at risk for a decrease in ADLs and Injuries. CR#1's contractures did not affect the possibility of being able to perform her ADL's according to her cognitive and physical abilities. CR#1 had a splint in the past that she refused to wear and low motivation to participate with ADL care. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Focus: I have an ADL self-care performance deficit r/t Left sided paralysis along with contracture of left arm. Goal: number 1. I will maintain current level of function in eating through the review date. Interventions: 1. Resident requires limited assist of 1 staff for locomotion and eating at times. 2. Resident requires extensive assist with one staff for bed mobility, dressing, incontinent care, and personal hygiene. Interview with CNA-A on 06/08/24 at 12:54pm she stated that on 06/06/24 at around 5:00am she was performing peri care on CR#1 when CR#1 said it's hurting me. CNA-A said that she continued to perform peri care on CR#1 even though she was complaining of pain. CNA-A said that she told the Nurse that CR#1 was complaining of pain. Interview with LVN C on 06/08/2024 at 3:22pm she stated that on 06/06/24 at 5:15am she heard CR#1 telling CNA-A it's hurting me, while CNA-A was administering peri care. LVN-C stated that she offered CR#1 PRN (pro re nata or as needed) pain medication, but she refused. LVN-C said that she did not conduct an assessment on CR#1 because she refused her PRN pain medication and because she was not exhibiting any signs of pain. Interview with LVN A on 06/07/24 at 4:53pm she stated that she read CR#1 Xray report on 06/06/24 and she interpreted it as saying that CR# 1 had no dislocation, no radiographic evidence of avascular necrosis of the femoral head. No acute abnormality of the visualized pelvis was identified. LVN A stated that at 5:33pm on 06/06/24 she sent CR#1's Xray report to the NP via text message. Interview with the facilities' NP on 06/07/24 at 5:01pm, he stated that he did not receive an Xray report stating that CR#1's hip was fractured. He stated that he learned of the fracture the morning of 06/07/24 between the hour of 7:00am and 8:00am when he was checking his voicemail and he had a message from CR#1's guardian informing him that CR#1 was in the hospital. He stated that if he had been notified of the injury to CR#1's hip that he would have given an order to have CR#1 be transported to the hospital immediately for further evaluation. Interview with the facilities DON on 06/07/24 at 3:20pm, the DON stated that she was notified on 06/06/24 at 11:30am by the ADON that CR#1 was complaining of pain to her right hip. The DON at 11:45am directed the ADON to call the facility Doctor so that an Xray could be performed on CR#1. The DON said that she was checking her emails on the night of 06/06/24 at 11:00pm and she reviewed CR#1's Xray report and saw that CR#1 had a fracture to her right hip. The DON stated that she immediately contacted LVN B and had LVN B call the on-call Doctor to get an order and have CR#1 sent out to the hospital immediately . She said that the pain assessment should have been completed by LVN C immediately, unless the resident refused, and documentation should be completed if a resident refused. She said that the facility did not have a policy for completing pain assessment timely. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LVN B on 06/08/24 at 6:15am she stated that the DON sent me an Xray report for CR#1 on 06/06/24 at 11:19pm, and the DON directed me to call the facility Doctor to get an order to send CR#1 to the hospital immediately because she had a right hip fracture. LVN B stated that she called and received the Doctor's order and CR#1 was sent to the Hospital at 12:02am on 06/07/24 via Emergency medical services (EMS) Interview with CR#1 on 06/08/24 at 10:35am she stated that at night a few days ago a Black female was changing my diaper. When I told her that you're hurting me, but she kept on pushing me from side to side. Record review of CR#1's physician orders dated 03/28/23 revealed that she was prescribed the blood thinner Clopidogrel Bisulfate tablet 75mg once per day by mouth for blood clot prevention. Record review on 06/07/24 of the facility sign in log dated 06/06/24 at 4:30pm revealed that an Xray technician signed in at the facility 12:20pm. Record review on 06/07/24 of CR#1's Xray report dated 06/06/24 revealed that CR#1 Xray was read by the Radiologist at 2:25pm revealed an intertrochanteric fracture of the right femoral neck of indeterminate age on 06/06/2024. Record review of facility policy titled Incident and Accident with effective date 03/01/2017 reflected in part, .3. Licensed nurse will complete a fall investigation report after every fall to include vital signs, pain assessment, and environment assessment It was determined to be an Immediate Jeopardy (IJ) on 06/10/2024 at 3:46 p.m. The Administrator and the DON were both notified. The Administrator was provided with the IJ template on 06/10/2024 at 3:46 p.m. The following Plan of Removal submitted by the facility was accepted on 06/12/2024 at 10:08 a.m. Facility Plan to ensure compliance: Plan to remove immediate jeopardy. 1. Immediate Action: Resident returned to the facility status post-surgery on 6/10/24 with orders for Occupational Therapy (OT) services. Resident was assessed by the nurse. Pain assessment was completed. The residents care plan was reviewed by the Interdisciplinary Team (IDT) and updated. The facility scheduled a follow up appointment with an orthopedic surgeon. The Resident was being provided with care in the facility and receiving OT services and pain management. On 6/7/24 the Director of Nursing or designee started education with all licensed nurses on ensuring diagnostic results were reported to the Attending Physician/Nurse practitioner as soon as possible via phone and fax. This will guide the clinical team on ensuring that each resident received emergency care immediately. This education will be completed by 6/11/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/7/24 the Director of Nursing or designee started education with licensed nurses on properly assessing residents for change of condition. This education will be completed by 6/11/24. On 6/7/24 the Assistant Director of Nursing or designee started education with all staff on the facility abuse and neglect policy and procedures. This education will be completed by 6/11/24. On 6/7/24 the Assistant Director of Nursing or designee started education with all staff on repositioning and proper communication during care. This education will be completed by 6/11/24. On 6/7/24 the director of nursing educated the licensed nurse on notification of diagnostic results to physician/nurse practitioner in a timely manner and accurately. On 6/7/24 the CNA-A was suspended pending investigation. On 6/8/24 the Director of Nursing or designee started education with ALL nursing staff on Pain Management and assessing for pain. This education will be completed by 6/11/24. On 6/10/24 the Assistant Director of Nursing started education on resident rights to include patients right to refuse. This education will be completed by 6/11/24. On 6/10/24 the Director of Nursing in-serviced all licensed nurses to report all diagnostic results to the DON upon receipt of results. This education will be completed by 6/11/24. On 6/10/24 the CNA-A received 1:1 education on Abuse and Neglect, repositioning of residents to include residents with contractures, and reporting pain immediately to the charge nurse. On 6/10/24 the Director of Nursing started education with C.N. A's on reporting pain and changes of condition to the nurse immediately. This education will be completed by 6/11/24. On 6/11/24 the Director of Nursing or designee started education with nursing staff on using the Kardex (electronic nursing worksheet that includes a summary of patient information, such as prescribed medications, clinical follow-ups, and daily care schedules) on identifying resident care needs and identifying residents with contractures. This education will be completed by 6/11/24. *The below policies were reviewed on 6/7/24 and there were no changes to the current policy. - Incident and Accident Policy - Pain Assessment and Management Policy On 6/10/24 the Director of Nursing or designee completed an audit for any residents who had a diagnostic conducted in the last 30 days. We identified 8 residents who had a diagnostic conducted and all have been reported to the physician/nurse practitioner. The Director of Nursing or designee completed an audit on 6/11/24 on residents with contractures. On 6/11/24 the Director of Nursing or designee conducted a change of condition audit. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 6/10/24 the facility Administrator notified the Medical Director regarding the immediate jeopardy the facility received related to failure to provide treatment and care in accordance with professional standards and reviewed to sustain compliance. *Staff will not be allowed to provide direct care until in-service training has been completed. Monitoring: Record review of 'In-service Training Report dated 06/07/2024 and titled The Director of Nursing or designee started education with all licensed nurses on ensuring diagnostic results were reported to the Attending Physician/Nurse practitioner as soon as possible via phone and fax. This In-service training was completed on 06/11/24 with all facility Nurses. Record review of in-service training that was conducted on 06/13/24 and revealed that on 6/7/24 the Director of Nursing or designee started education with licensed nurses on properly assessing of residents for change of condition. This education was to be completed by 6/11/24. The in-service was completed by the DON on 06/07/24 with all Nursing staff in attendance. Record review was conducted on 06/12/24 of an in-service dated 6/7/24 and revealed that the Assistant Director of Nursing or designee started education with all staff on the facility abuse and neglect policy and procedures. Record review revealed that this education was to be completed by 6/11/24. Record review was conducted on 06/13/24 of an in-service document dated 6/7/24 and revealed that the Assistant Director of Nursing or designee started education with all staff on repositioning and proper communication during care. This education was to be completed by 6/11/24. Record review was conducted on 06/13/24 of an in-service document dated 6/7/24 and revealed that the Director of Nursing educated the licensed nurse on notification of diagnostic results to physician/nurse practitioner in a timely manner and accurately. Record review of CNA-A disciplinary form was conducted on 06/11/24, and it was dated 06/07/24 , and it read that C.N.A.-A was suspended pending their investigation. Record review was conducted on 06/12/24 and revealed that on 6/8/24 the Director of Nursing or designee started education with ALL nursing staff on Pain Management and assessing for pain. This education was completed by 6/11/24. Record review was conducted on 06/12/24 and revealed that on 6/10/24 the Assistant Director of Nursing started education on resident rights to include the patient's right to refuse. This education was completed by 6/11/24. Record review was conducted on 06/12/24 and revealed that this in-service was conducted and completed on 6/10/24, the Director of Nursing in-serviced all licensed nurses to report all diagnostic results to the DON upon receipt of results. This education will be completed by 6/11/24. Record review was conducted of the in-service and revealed that on 6/10/24 CNA-A did receive 1:1 education on Abuse and Neglect, repositioning of residents to include residents with contractures, and reporting pain immediately to the charge nurse. The in-service was conducted by the facilities DON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review was conducted on 6/10/24 and revealed that the Director of Nursing started education with C. N. A's on reporting pain and changes of condition to the nurse immediately. This education will be completed by 6/11/24. Record review was conducted on 06/13/24 of in-service document dated 6/11/24 and revealed that the Director of nursing or designee started education with nursing staff on using the Kardex on identifying resident care needs and identifying residents with contractures. This education was be completed by 6/11/24. Record review was conducted on 06/14/23 of audit documentation forms dated 6/10/24 and revealed that the Director of Nursing or designee completed an audit for any residents who had a diagnostic conducted in the last 30 days. We identified 8 residents who had a diagnostic conducted and all have been reported to the physician/nurse practitioner. The Director of Nursing or designee completed an audit on 6/11/24 on residents with contractures. On 6/11/24 the Director of Nursing or designee conducted a change of condition audit. Interviews were conducted on 06/12/2024 from 10:50 a.m. until 3:00 p.m. with staff on both shifts (6:00 a.m. - 6:00 p.m. and phone interviews with staff from 6:00 p.m. - 6:00 a.m.) The interviews were geared toward what the staff had been in-serviced on. The staff interviewed were Nurses LVN's A, B, C, D, E, F, and G. Interviews were also conducted with CNA's A, B, C, D, E, and F. The staff were able to answer the questions without any concerns. The Administrator and the DON were informed the Immediate Jeopardy was removed on 06/14/2024 at 12:50 p.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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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 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44241 Based on interview, and record review the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fell outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 of 10 residents (CR#1) reviewed for radiology services: The facilities failure to assess CR#1 after she complained of pain during peri care at 5:00am on 06/06/24 but was not sent to the hospital until 06/07/24 at 12:06am which was over 18hours later. After being admitted into the hospital CR#1 was diagnosed with intertrochanteric fracture of the right femoral neck of indeterminate age. On 06/10/2024 at 3:46 p.m. an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 06/14/2024, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm that was not immediate jeopardy, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk for delayed treatment and hospitalization s. Findings include: Record review of CR#1 face sheet on 06/07/23 at 8:30pm revealed that she was an [AGE] year-old female that was originally admitted into the facility on [DATE]. She had diagnoses of cognitive communication deficit, contracture of muscle left ankle and foot, aneurysm of carotid artery (a bulge in the wall of one of these arteries), constipation, hemiplegia (one-sided muscle paralysis or weakness), hemiparesis (weakness or the inability to move on one side of the body), and insomnia. Record review of CR#1's Quarterly MDS, dated [DATE] revealed CR #1's BIMS score was determined to be 14 due to limited cognitive impairment. The MDS completed by the staff, which indicated CR#1 did not exhibit behavioral symptoms of wandering and required supervision. CR#1 was bed bound and must be encouraged to participate in activities as well as bathing. CR#1 was one-person physical assist for ADLs, but two- person assist when transferring. Record review of CR #1's care plan dated 05/30/24revealed that CR#1 had impaired visual functioning and was at risk for a decrease in ADLs and Injuries. CR#1's contractures did not affect the possibility of being able to perform her ADL's according to her cognitive and physical abilities. CR#1 had a splint in the past that she refused to wear and low motivation to participate with ADL care. Focus: I have an ADL self-care performance deficit r/t Left sided paralysis along with contracture of left arm. Goal: number 1. I will maintain current level of function in eating through the review date. Interventions: (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Resident requires limited assist of 1 staff for locomotion and eating at times. 2. Resident requires extensive assist with one staff for bed mobility, dressing, incontinent care, and personal hygiene. Interview with ADON on 06/07/24 at 4:00pm she stated that a COTA reported to her at 11:00am that CR#1 was complaining of pain to her right leg. ADON said that she performed a brief assessment by touching CR#1 leg and asked her if it hurt and CR#1 reported a little. The ADON said that she reported the matter to the DON and the DON told her to call for an Xray. The ADON said that at 11:30 called the medical team and provided information regarding CR#1 and she was given an order for an Xray to be performed on CR#1. Interview with the facilities DON on 06/07/24 at 3:20pm. The DON stated that she was notified on 06/06/24 by the ADON that CR#1 was complaining of pain to her right hip. The DON ordered Xray to be done. The DON stated that she was checking her emails on the night of 06/06/24 at 11:00pm and she reviewed CR#1 Xray report and saw that CR#1 had a fracture to her right hip. She stated that she immediately contacted LVN B and had LVN B to call the on-call Doctor to get an order and have CR#1 sent out to the Hospital immediately. CR#1 was sent to the Hospital at 12:02am on 06/07/24 via Emergency Medical Service (EMS). Interview with LVN A on 06/07/24 at 4:53pm she stated that she read CR#1 Xray report on 06/06/24 and she interpreted it as saying that CR# 1 had no dislocation, no radiographic evidence of avascular necrosis of the femoral head. No acute abnormality if the visualized pelvis is identified. LVN A stated that at 5:33pm on 06/06/24 she sent CR#1 Xray report to the NP via text message. Interview with the facilities' NP on 06/07/24 at 5:01pm, he stated that he did not receive an Xray report stating that CR#1's hip was fractured. He stated that he learned of the fracture the morning of 06/07/24 between the hour of 7:00am and 8:00am when he was checking his voicemail and he had a message from CR#1's guardian informing him that CR#1 was in the hospital. He stated that if he had been notified of the injury to CR#1's hip that he would have given an order to have CR#1 be transported to the hospital immediately for further evaluation . Interview with LVN B on 06/08/24 at 6:15am she stated that the DON sent her the Xray report for CR#1 on 06/06/24 at 11:19pm, and the DON direction was to call the facility Doctor to get an order to send CR#1 to the Hospital immediately because she had a right hip fracture. LVN B stated that she called and received the Doctor's order and CR#1 was sent to the Hospital at 12:02am on 06/07/24 via EMS. Record review of the facility sign in log dated 06/06/24 revealed that an Xray tech signed in at the facility at 12:20pm on 06/06/24. Record review on 06/07/24 of CR#1's Xray report dated 06/06/24 revealed that CR#1 Xray was read by the Radiologist at 2:25pm revealed an intertrochanteric fracture of the right femoral neck of indeterminate age on 06/06/2024. This was determined to be an Immediate Jeopardy (IJ) on 06/10/2024 at 3:46 p.m. The Administrator and the DON were both notified. The Administrator was provided with the IJ template on 06/10/2024 at 3:46 p.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The following Plan of Removal submitted by the facility was accepted on 06/12/2024 at 10:08 a.m. Facility Plan to ensure compliance: Plan to remove immediate jeopardy. 1. Immediate Action: Resident returned to the facility status post-surgery on 6/10/24 with orders for Occupational Therapy (OT) services. Resident was assessed by the nurse. Pain assessment was completed. The residents care plan was reviewed by the Interdisciplinary Team (IDT) and updated. Facility scheduled follow up appointment with ortho. Resident being provided with care in facility and receiving OT services and pain management. On 6/7/24 the Director of Nursing or designee started education with all licensed nurses on ensuring diagnostic results are reported to the physician/Nurse practitioner as soon as possible. This will guide the clinical team on ensuring that each resident receives emergency care immediately. This education will be completed by 6/11/24. On 6/7/24 the director of nursing educated the licensed nurse on notification of diagnostic results to MD/NP in a timely manner and accurately. On 6/10/24 the Director of nursing in-serviced all licensed nurses to report all diagnostic results to the DON upon receipt of results. This education will be completed by 6/11/24. On 6/10/24 reviewed the policy and procedure with the diagnostic vendor to ensure reporting was distributed to the facility fax, facility email, and verbal notifications to be done for any abnormalities. This education will be completed by 6/11/24. *The below policies were reviewed on 6/7/24 and there were no changes to the current policy. - Incident and Accident Policy - Pain Assessment and Management Policy - Diagnostic Policy On 6/10/24 the Director of Nursing or designee completed an audit for any residents who had a diagnostic conducted in the last 30 days. We identified 8 residents who had a diagnostic conducted and all have been reported to the NP/MD. On 6/11/24 the director of nursing or designee conducted a change of condition audit. *Staff will not be allowed to provide direct care until in-service training has been completed Monitoring: (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review was conducted on 06/12/24 of Nurses notes and the following was confirmed via record review. Resident returned to the facility status post-surgery on 6/10/24 with orders for OT services. Resident was assessed by the nurse. Pain assessment was completed. The residents care plan was reviewed by IDT and updated. Facility scheduled follow up appointment with ortho. Resident being provided with care in facility and receiving OT services and pain management. Record review was conducted on 06/12/24 of the in-service dated on 6/7/24, the Director of Nursing or designee started education with all licensed nurses on ensuring diagnostic results are reported to the physician/Nurse practitioner as soon as possible. This will guide the clinical team on ensuring that each resident receives emergency care immediately. This education was completed by 6/11/24. Record review was conducted 06/12/24 of the in-service dated on 6/7/24, the Director of Nursing educated the licensed nurse on notification of diagnostic results to MD/NP in a timely manner and accurately. Record review was conducted on 06/12/24 and it was revealed that the Director of Nursing in-serviced all licensed nurses to report all diagnostic results to the DON upon receipt of results. This education was completed by 6/11/24. Record review was conducted on 06/12/24 and it was revealed that the policy and procedure with the diagnostic vendor to ensure reporting was distributed to the facility fax, facility email, and verbal notifications to be done for any abnormalities. This education was completed by 6/11/24. Record review was conducted on 06/12/24 and it was revealed that, the Director of nursing or designee completed an audit for any residents who had a diagnostic conducted in the last 30 days. We identified 8 residents who had a diagnostic conducted and all have been reported to the NP/MD. On 6/11/24 the Director of Nursing or designee conducted a change of condition audit. Interviews were conducted on 06/12/2024 from 10:50 a.m. until 3:00 p.m. with staff on both shifts (6:00 a.m. - 6:00 p.m. and phone interviews with staff from 6:00 p.m. - 6:00 a.m.) The interviews were geared toward what the staff had been in-serviced on. The staff interviewed were Nurses LVN's A, B, C, D, E, , F, and G. Interviews were also conducted with CNA's A, B, C, D, E, and F. The staff were able to answer the questions without any concerns. The Administrator and DON were informed the Immediate Jeopardy was removed on 06/14/2024 at 12:50 p. m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.