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	09/06/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on interview and record review, the facility failed to immediately consult with the resident's physician 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 complication) for 1 of 7 residents (CR #1) reviewed for physician notification. -The facility failed to consult with the physician when CR#1 had a change in condition and continued losing weight, had a physical decline in performing ADL's, stopped eating and developed a burning in his throat. -The facility failed to notify CR#1's Family member when changes occurred. These failures could place residents at risk of not having their physician informed and residents not receiving adequate medical interventions, not having their care needs met, not being seen by physicians, not receiving adequate and timely interventions, which could cause a decline in physical and psychosocial health and even death. Findings included: Record review of CR #1's face sheet dated [DATE] revealed he was a sixty-six-year-old male admitted to the facility on [DATE]. His admitting diagnoses were chronic obstructive pulmonary disease with acute exacerbation (difficulty breathing), unspecified protein-calorie malnutrition, nicotine dependence, anxiety, hypertension (high blood pressure), acute pancreatitis without necrosis (pancreas inflamed), arthritis, osteoarthritis (degenerative joint disease), muscle wasting and atrophy (loss or thinning of muscle tissue), dysphagia (difficulty swallowing), difficulty in walking, cognitive communication deficit and history of Covid. Record review of CR #1's care plan dated [DATE] revealed the following: -CR#1 was on a regular mechanical soft diet with interventions for Dietary Manager to monitor/discuss food preferences, monitor and document intake, offer snacks within diet, serve diet as ordered and offer substitute if less than 50% is eaten, weigh every month and PRN-report 5% loss/gain to MD and responsible party. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-CR #1 was at risk for weight loss protein calorie malnutrition. On [DATE] CR#1's Actual weight loss was 7. 1% x 30 days and [DATE] was 10% over 6 months. The interventions were to assess resident for food preferences, serve resident food preferences, monitor dietary intake, weigh weekly or monthly as ordered by MD. Offer supplements between meals to enhance caloric intake. Offer substitute if less than 50% of meals is eaten, [DATE] Liquid protein 30 ml daily x 30 days, Ensure Plus 1 carton daily, snacks at 2 am and 2 pm, and house shakes with meals. -CR#1 required pain management for muscle atrophy and wasting, had a swallowing problem, and was at risk for weight loss. CR #1 requested code status of full code (perform all possible measures to save their life in the event of a medical emergency). MDS assessment signed on [DATE] revealed a BIMS summary score of 15 indicating CR#1's cognition was intact. CR#1's functional abilities and goals revealed: Supervision or touching assistance for eating, partial/moderate assistance for upper body dressing and personal hygiene, substantial/maximal assistance for toileting, oral hygiene and lower body dressing and he was dependent on staff for showers and putting on/taking off footwear. CR#1 required partial/moderate assistance for roll left and right, sit to lying, and lying to sitting on side of bed and toilet transfer, and walking 10 feet were not applicable. CR#1's height was 66 inches, weight was 73 lbs., weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, and CR#1 was on a mechanically altered diet. Record review of CR#1's Physician Orders revealed: *Assess Pain every shift for monitoring dated [DATE] *May not exceed APAP 3GM24 hr. dated [DATE] *Monitor SpO2 every shift for monitoring COPD dated [DATE] *O2 at 2L-5Lper NC to maintain SpO2 >90% every 12 hours as needed for SOB Indicate if oxygen was provided this shift by answering yes or no dated [DATE] *Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for SOB dated [DATE] *Mirtazapine Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for depression dated [DATE] *Vitamin D3 Tablet 5000 UNIT (Cholecalciferol) Give 1 tablet by mouth one time a day for Supplement dated [DATE] *Clean/Change oxygen concentrator filters every night shift every Sun for Monitoring dated [DATE] *FULL CODE dated [DATE] *Multi-Vitamin/Minerals Oral Tablet (Multiple Vitamins w/Minerals) Give 1 tablet by mouth one time a day for Supplement dated [DATE] (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Monitor Blood pressure every 12hours dated [DATE] *Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 0.5 tablet by mouth two times a day for Anxiety -Give , d+[DATE] a tab to equal 0.25 mg dated [DATE] *Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 2 tablet by mouth every 8 hours for moderate to severe pain Give 2 tablets total 100mg dated [DATE] *Calcium 500 + D3 Oral Tablet ,d+[DATE] MG-MCG (Calcium Carbonate-Cholecalciferol) Give 1 tablet by mouth in the morning for Supplement Prescriber dated [DATE] *Metformin HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day dated [DATE] *CBC AND BMP dated [DATE] *Give at least 240 ml of water with medications three times a day dated [DATE] *House Shake with meals for Supplement dated [DATE] *Ensure Plus at bedtime for Supplement -Administer 1 carton PO daily dated [DATE] *Provide snacks BID at 10 am and 2 pm two times a day for snack dated [DATE] *Document Vitals with each breathing treatment as needed for Shortness of *Breath Pre breathing treatment. Record lung sounds as C=Clear, W=Wheezing, CR=Crackles Verbal Active dated [DATE] Megestrol Acetate Tablet 20 MG Give 2 tablet by mouth one time a day for Appetite stimulant for 30 Days Administer 2 tabs to equal 40 mg -Start Date- [DATE] and ended [DATE] *STAT: CBC, BMP, UA with C&S dated [DATE] *CXR Phone Active dated [DATE] *ST clarification order for ST to treat 3x weekly for 30 days for cognitive communication methods and oropharyngeal dysphagia in order to address weight loss. Codes: one time only dated [DATE] *ST to eval and treat as indicated. one time only for 30 Days dated [DATE] *Megestrol Acetate Tablet 20 MG Give 2 tablet by mouth two times a day for Appetite for 14 Days dated [DATE] *Pulmonary Consult dated [DATE] *Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally three times a day for shortness of Breath; Cough dated [DATE] (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Regular diet pureed texture, regular consistency dated [DATE] *GI Consult Phone dated [DATE] Record review of CR#1's Clinical Records dated [DATE] to [DATE] did not reveal any notes from CR#1's Physician (Physician A). Record review of CR#1's Clinical Records dated [DATE] to [DATE] did not reveal any notes from CR#1's Physician (Physician A) notifying that there was a change in condition. Record review of CR#1's Clinical Records dated [DATE] to [DATE] did not reveal any progress notes #1's indicating there was a physician notification of the change in condition. Record review of CR#1's Change in Condition Evaluation dated [DATE] and signed [DATE] at 11:16 am revealed: List of the other change: cough started [DATE], vitals blood pressure ,d+[DATE], date [DATE]. Record review of CR#1's Change in Condition Evaluation dated [DATE] and signed [DATE] revealed: Poor appetite, general weakness without fever, change in level of consciousness, or other acute symptoms. Record review of CR#1's Percentages Eaten revealed: *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% breakfast, ,d+[DATE]% lunch, ,d+[DATE]% for dinner *[DATE] - ,d+[DATE]% breakfast, ,d+[DATE]% lunch, ,d+[DATE]% dinner *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% breakfast, ,d+[DATE]% lunch, ,d+[DATE]% dinner *[DATE] - Resident refused Record review of CR#1's Weight Summary dated [DATE] at 10:31 am revealed: *[DATE] - 85 lbs. *[DATE] - 86 lbs. *[DATE] - 83 lbs. *[DATE] - 84 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*[DATE] - 84 lbs. *[DATE] - 81 lbs. *[DATE] - 80 lbs. *[DATE] - 78 lbs. *[DATE] - 79 lbs. *[DATE] - 77 lbs. *[DATE] - 75 lbs. *[DATE] - 77 lbs. *[DATE] - 77 lbs. *[DATE] - 78 lbs. *[DATE] - 77 lbs. *[DATE] - 78 lbs. *[DATE] - 77lbs. *[DATE] - 75 lbs. *[DATE] - 75 lbs. *[DATE] - 73 lbs. *[DATE] - 74 lbs. *[DATE] - 72 lbs. *[DATE] - 73 lbs. *[DATE] - 74.5 lbs. *[DATE] - 71 lbs. *[DATE] - 69 lbs. *[DATE] - 67 lbs. *[DATE] - 67 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*[DATE] - 67 lbs. *[DATE] - 64 lbs. In an interview on [DATE] at 2:48 p.m., the DON stated they were monitoring CR#1's weight weekly because when he came to the facility, he was tiny weighing 85 lbs. and had a history of malnourishment. She stated CR#1 had an order for ensure with meals for supplement, and it had a bunch of protein calories that they gave every meal, snacks twice a day at 10 am and 2 pm, ensure plus at bedtime, megestrol 40 mg (megestrol) twice a day for appetite stimulant, multi vitamin with minerals daily, and mirtazapine 15 mg at bed time for depression and appetite stimulant. The DON stated last Friday, [DATE] CR#1 had a modified barium swallow study . She stated based on those results, she got with the speech therapist for clarification, and she stated CR#1 needed to down grade to a puree diet because he was on mechanical soft diet. The DON stated the speech therapist said CR#1 could be a candidate for a g-tube, so she scheduled a GI consult on [DATE]. The DON stated she put the following interventions in place for CR#1: Weekly weights started on admission [DATE], House shake started on [DATE] with meals active, Snacks twice a day [DATE] based on his diet, when he started, he was on mechanical soft. He did eat and had his moments where he told her not to remove his sandwich stating it took a while for him to eat it, and that he was a slow eater, Ensure plus ,d+[DATE] once a day continued, Liquid protein (active protein supplement 30 mls 1 time a day for 30 days [DATE], (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Megestrol 40 mg twice a day started [DATE] and ended [DATE] and restarted on [DATE]. The DON stated it was not a medication that continued long term and then they reevaluate to see if they need it again, and Multi Vitamin started on [DATE]. The DON stated as soon as CR#1 admitted to the facility they completed a baseline care plan and he was so little, she had never seen such a little man. She stated CR#1 told her his baseline was in the 70's for his weight. She stated, the RP said he was not a big eater and said she brought him candy. She stated CR#1 was alert and oriented times 4 (alert and oriented to person, place, times and event) and he could tell them everything that was going on. The DON stated on [DATE], she said he continued losing weight, so she spoke with the interdisciplinary team and said they needed a care plan meeting, she spoke with the NP, and she was recommending hospice. The DON stated the NP said, let's get with the family and see what she thinks. The DON stated she called RP and she said she was right around the corner, and she was at the facility within 5 minutes. The DON stated the RP stated CR#1's weight was always a concern and that she was open to hospice, but she wanted CR#1 to be involved with a decision like that. The DON stated she called the RP weeks before and asked them to bring CR#1 some stuff he liked, and the RP brought CR#1 a bunch of snacks and candy because he was a candy eater. The DON stated they spoke with CR#1, and he said he wanted to get better. She stated she asked him why he was not eating, and she asked if he did not like the food and CR#1 said he felt some burning when he swallowed. The DON stated she asked did CR#1 report that to anyone before and he said no, he was reporting it to the DON now. She stated she told CR#1 she would get with the Speech therapist to evaluate him, and she would call the NP as well. She stated when the meeting finished, she spoke with the NP and the NP gave an order for a swallow study and the RP was still there, so she informed them it was approved to do the swallow study. The DON stated they all agreed, and the swallow study was completed on [DATE] from 2 to 4 pm. The DON stated they asked CR#1 again during the meeting about hospice and CR#1 stated hospice was not an option. She stated the RP stated let's focus on the swallow study and CR#1 was informed of the swallow study results and his diet was downgraded to puree. The DON stated she also told CR#1 he was a candidate for G tube/feeding tube, and he said he would be open to that. The DON stated she let the NP know about the results and that he was a candidate for g-tube. The DON stated she did not contact CR#1's physician. The DON stated the NP said to put in the GI consult and Monday she contacted his insurance to get providers that were in network and only 1 responded for [DATE] at 2pm. The DON stated CR#1's [DATE] and [DATE] weight was stabilizing, and the supplements were working. She stated CR#1's weight stabilized, and he was not triggering for weight loss. She stated on [DATE] they got his weight, and he lost 2 lbs. so they called the doctor and got him megestrol to stimulate his appetite for 30 days. The DON stated CR#1 should have gotten a peg tube a long time ago, but the NP is the one who would say. She stated CR#1 was already 85 lbs. when he admitted to the facility, and they do what they could at the facility. The DON stated CR#1's Physician did not have any notes in the computer for CR#1 and she stated the Physician came to the facility in the evening. The DON stated CR#1's Physician came to the facility monthly and that he had his own practice. The DON stated on [DATE] CR#1 had a UTI and they treated it with Rocephin, and antibiotics and he also had a chest x-ray on [DATE] and it was clear of pneumonia. The DON stated CR#1 did a chest x-ray for the burning sensation in his throat to make sure he did not aspirate. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a telephone interview on [DATE] at 4:04 p.m., the NP stated CR#1 was losing weight, and was diagnosed with dysphagia and other comorbidities, declining, refusing to eat, she started him on megestrol, house shakes and supplements, they had a care plan meeting to talk about hospice and other resources. She stated she had been working at the facility for a few years. The NP stated they suggested G-tube placement she did a GI consult for the peg tube placement to be set up. The NP stated the facility was not telling her about CR#1 every month, and that they spoke to her about CR#1 periodically. The NP stated she knew the RP was informed on the care and she did not know if they made a decision for hospice. She stated CR#1 was refusing food and meals when offered. She stated she asked CR#1 about the meals but CR#1 was not really responding to her with the memory loss and everything. The NP stated from the progress notes and him refusing to eat, they just decided to do the consult. She stated she remembered mentioning a peg tube placement with the DON. She stated if someone had spoken with her earlier on, with all the weight loss, she could have suggested earlier on about g-tube placement. The NP stated a G-tube is something they could try to be more aggressive with the weight loss, but sometimes with comorbidities the body will decline even with supplemental feeding. The NP stated it could have been possible for CR#1 to eat food and have the g-tube placement. She stated they had a care plan meeting, and he was eating during the meeting. She stated CR#1 received house shakes, ensure and the staff were providing one on one feeding to assist him with meals. The NP stated any resident that may be refusing to eat was encouraged to eat. The NP stated LVN C was holding the ensure and giving CR#1 sips of ensure. The NP stated she did not know if CR#1's Physician went to see him, she could not speak on the Physician. The NP stated CR#1's Physician was aware of CR#1 (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:00 p.m., CR#1's Physician (Physician A) stated CR#1 came to the facility for rehab and he was under weight. Physician A stated in the beginning CR#1 was sick and had falls. He stated CR#1's weight was a problem, and unfortunately when CR#1 came into the hospital his blood pressure was low and was under respiratory distress. The Physician stated his NP was following CR#1, so they were following CR#1. Physician A was asked by State Surveyor A if he had seen CR#1 and he stated he saw CR#1 through the NP Physician A stated his understanding was that CR#1 went up to 90 lbs. The Physician stated he thought CR#1 went up to 90 lbs. He stated an option would have been getting the peg tube placement. He stated if all these measures were failing, then the next option was getting a peg tube placement. He stated unfortunately when CR#1 was brought into the nursing facility he was underweight and they put him on supplements and all these things, but still he lost weight. He stated a few days ago, when he was consistently losing weight, he stated the NP was on top of this. Physician A stated he was trying to see when he spoke with the NP, and they discussed CR#1. He stated the options were to refer to GI and getting a peg placement. He stated he would have said to get the peg tube when he started losing weight. Physician A stated the NP was following CR#1, and at one point they thought about the peg tube. He stated when CR#1 began weighing in the 70's, they want to get a peg tube placement. He stated CR#1 was underweight when he came in and they tried getting megestrol and supplements and they tried, unfortunately nothing worked for him. Physician A stated he would speak with the NP about CR#1 because they discussed it, and they had a plan. He stated they put a GI consult for a peg placement at the time. He stated they ordered it, but unfortunately it was not placed. He stated sometimes a consult and getting the placement takes a little longer. He stated the NP said the GI consult was in place and they had supplements and megestrol to push his appetite. Physician A stated the megestrol was stopped on [DATE], and was not restarted until [DATE], but what happens is when they look at medication it goes for 30 days. He stated he would speak with the NP to talk to the NH about why he was not getting the megestrol for so long. He stated once they started the megestrol they had to see if CR#1 was eating and if he was not eating, they should call them (NP and Physician A). Physician A stated no one informed him CR#1 was still losing weight. Physician A stated he used megestrol all the time because it helped a lot. He stated after 30 days, then they needed to see if CR#1 would eat by himself and he needed to see what happened in the next 2 weeks. The Physician stated he wanted to look into why the gap was there for the medication. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 3:36 p.m., CR#1's RP stated she had concerns regarding his care and his weight loss. She stated she was not told that he lost weight until 2 weeks before he passed (unknown date). She stated especially the amount of weight that CR#1 lost and at that point they called and asked if she wanted to put him on hospice. She stated she deferred the decision to CR#1, and he said no. She stated CR#1 asked for other plans of care and they said a feeding tube. The RP stated they started the process with a swallow test and that was the Friday before he expired. She stated they were going to feed him, and they did express that he refused to eat on many occasions. She stated the time she was there, she tried to get him to eat something, and he did but he gave her push back. The RP stated he had Vienna sausage during the care plan meeting, and they discussed the feeding tube. She stated she was not sure on the dates and the times. She stated the DON said the only person she could get to come in was at the end of August and she stated he was not going to survive that long. She stated she told the DON, they probably needed to send CR#1 to the hospital and if they saw his condition then the hospital would put the tube in. The RP stated she told the DON this the Friday of the Care plan meeting on [DATE]. She stated she did not know why they did not send him to the hospital on [DATE]. She stated she was disappointed with herself, and she should have said take him to the hospital or she would have done it herself. She stated she was thinking that although he was small, he was still viable, so they went on. She stated on Wednesday, [DATE] she was getting dressed to go to the NH to visit him and she got the call that they were taking CR#1 to the Hospital. She stated when she went to the hospital, she thought she was going to tell them to put the feeding tube in, but when she got there, they were in full emergency mode. The RP stated the DON told her on Wednesday, [DATE] that she had not been able to find anyone for the peg tube and the DON said when she went into the room CR#1 was confused so she called EMS. She stated the DON told her when EMS came CR#1 refused to go to the hospital and she talked him into going. She stated the DON said the EMS said CR#1 told them noonce and they refused to take CR#1 to the hospital. She said that they refused to take him, so she was calling their private transport service and have them to take him to the hospital. She stated CR#1's baseline weight was 86 lbs. and that he lost 16 lbs while at the facility. She stated he stayed around 100 lbs., and it was a battle for him to stay around 100 lbs. She stated he was always small and as he aged, he did not eat as much. She stated the Doctor put him on high proteins, to get his weight up. In an interview on [DATE] at 4:30 pm the Administrator stated she was aware of CR#1's condition. She stated she saw CR#1 in the beginning when he was admitted to the facility, and he was really small. She stated other than that she did not see the residents every day because she was not clinical. She stated she was told that CR#1 came to them malnourished, and the RP said CR#1 ate very little. The Administrator stated CR#1 was seen by NP, the dietician saw him, and they had interventions in place. She stated he was seen by the physical therapist and if there was a big change they go back to the physician if the interventions did not work. She stated it was reported to her CR #1 was 70 lbs. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 10:35 a.m., Charge Nurse B stated CR#1 was on continuous oxygen and he had anxiety for breathing and took Ativan twice a day. She stated CR#1 did not like to eat, but he liked lemonheads, potted meat, Vienna sausages and drank sweet stuff like punch. She stated ever since she met him, he never had a big appetite. Charge Nurse B stated when CR#1 first admitted to the facility he was eating more off the food tray, but he said he did not like their food and to just give him some Vienna sausage or some potted meat. She stated she did not have a definite date that he started not eating as much. She stated the Nurses did not get the weights. She stated the restorative person got the weights and gave them to the DON. Charge Nurse B stated sometimes the weights came up on their MAR. She stated they did not get the percent of weight loss, and that it went to the DON. She stated the DON talked to the dietician and they decide what supplements and they tell the Nurses about the orders. She stated they got the orders for ensure. She stated the nursing staff did not get the triggers for weight loss. She stated the CNA's put the info for how much food the residents eat and some of them come to tell them how much food they ate. She stated she went to ask the residents why they did not eat lunch, then if the person is alert, then she will ask if they wanted something else to eat. Charge Nurse B stated she encouraged CR#1 to drink the ensure and asked him to at least taste the food and not just eat the Vienna sausages and stuff. She stated she did not know if the CNAs were hand feeding CR#1 because he could feed himself. She stated even at the end he could hold a cup and drink. She stated she did not work the last 2 days before he went out of the facility. She stated she communicated with the NP and rarely or never communicated with Physician A. The DON stated she did not call Physician A regarding CR#1, and that she called the NP. She stated if they could not get in touch with the NP then they contacted the MD. She stated the NP was always available and they were the ones who did rounds the most. She stated she had not seen Physician A here at the facility and she had worked here for 2 years. She stated they had a care plan meeting with everybody with the NP, DON, CR#1 and the RP and after the DON gets the weights, she tracked the residents for the first week and if there was weight loss, she got the order and brought it to the Nurses station. She stated that she saw CR#1 lost weight. She stated CR#1 said he did not want to be on hospice, and he wanted to live, and he wanted to stay full code. She stated they offered him a g-tube and that was what they were going to be working on. She stated she was sure it would have been beneficial for CR#1 to have the g-tube earlier. She stated she did not think CR#1's weight loss was significant at that point, but she did not do the weights. In an interview on [DATE] at 12:07 p.m., the Executive Director stated the NP is the extender of the MD. She stated that she relied heavily on clinical staff, her nurses, Physicians, and NP's. In an interview on [DATE] at 12:08 p.m., the DON stated she had worked in many facilities, and she had always contacted the NP because they were trained to take care of residents and give orders and they report to the MD. She stated they never reached out to the MD. She stated if that was the case that the MD played the primary role, then the NP role would be completely eliminated. She stated what's the point of them being an NP. She stated the residents knew the NP, but they did not know the Physicians. She stated she would get the Physicians a lot more involved. In an interview on [DATE] at 11:43 a.m., LVN D stated she worked the 6pm to 6 am shift. She stated she works the night shift so most of the physicians come in the day shift. She stated she had not seen Physician A in the facility. She stated she texted the NP. She stated she had never met with Physician A and that the NP was more active with the residents. She stated Physician A was more active for medication refills. She stated she had never involved Physician A with CR#1. She stated most of the time she got report from the day shift. She stated she had worked at the facility for 2 years. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on [DATE] at 12:15 p.m., CNA G stated she had never seen Physician A in the facility. In an interview on [DATE] at 12:22 p.m., CNA H stated she had worked at the facility for about 2 years and sometimes she worked the double shift. She stated she had never seen Physician A come into the facility. In an interview on [DATE] at 1:03 p.m., Charge Nurse C stated she had never seen Physician A in the facility until the State came into the building. She stated she had called Physician A if she could not get the NP. Record review of Facility Policy, Weight Surveillance Program revised on ,d+[DATE] revealed, The purpose of this is policy is to establish facility guidelines on how and when the facility obtains and documents residents weights. This policy is also to ensure that the resident maintains the highest quality of life and wellness in the facility. Procedure: Resident Weights: Based on a resident's comprehensive assessment the facility must ensure that a resident: 1. Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless critical condition demonstrates that this is not possible, and 2. Receives a therapeutic diet when there is a nutritional problem Any resident who experiences a significant weight loss or gain must be placed on the Weight Surveillance Program. The Weight Surveillance program consists of the following: Physician, resident and family notification of the weight loss/gain, Observation of the residents eating habits, Initiation of a colored identifying object placed on the resident's meal tray will identify the resident as someone who may need extra assistance, encouragement, substitute meal, or supplements or has current weight loss identified .Dietician recommendations should be implemented or if needed, sent to the physician immediately upon receipt. If the physician has not responded within 72 hours, call the physician's office. Record review of Facility policy, Change in Condition effective [DATE] revealed, It will be the policy that once the nurse has notified the physician for a change in condition the resident/patient will be monitored for 1 hour until the physician has responded. The monitoring will include vital signs, pulse ox .If you are unable to reach the physician within 2 hours, repeat call. If you are still unable to reach the physician, you may call the Medical Director. If the resident/patient condition appears emergent transfer to local ER may occur without physician order. On [DATE] at 5:02 p.m., the DON was notified of the Immediate Jeopardy due to the above failures. The IJ template was provided to the DON and a plan of removal was requested at that time. In an interview on [DATE] at 11:39 a.m., the DON stated the facility had an IJ on F 580 for failure to notify the MD as it states in the policy. The DON stated she could not answer if Physician A came to the facility or not. She stated the NP was at the facility twice a week religiously. In an interview on [DATE] at 12:36 p.m., the Executive Director stated they had an IJ on consulting a physician due to communication directly to the physician. She stated they have dived deep into the situation and there was a communication breakdown. The following Plan of Removal (POR) was submitted by the facility and accepted on [DATE] at 9:02 a.m. and indicated the following: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediate Jeopardy Plan of Removal F580: Immediate Actions On [DATE] resident CR#1 was sent to the ER for further evaluation. On [DATE] the Director of Nursing or designee reported all residents with significant weight losses to physicians. On [DATE] the Director of Nursing or designee reported all residents with significant weight losses to the registered dietitian. On [DATE] Director of nursing or designee started education with all licensed nurses to report all weight losses to the Medical Doctor that are triggering such as: o 5% in 30 days or less o 7.5% in 90 days o 10% in 180 days The results of the weekly audits conducted during standards of care meeting will be brought to the floor staff for monitoring of efficacy of the interventions This education will be completed by [DATE]. On [DATE] Director of nursing or designee started education with all licensed nurses to report all changes of condition to the medical doctor. This will be completed by [DATE]. On [DATE] Director of Nursing or designee started education with all CNAs that if a resident consumes less than 50% of a meal, it must be reported to the assigned nurse immediately, who will then notify the medical doctor. This education will be completed by [DATE]. On [DATE] the regional director of clinical operations conducted training education with the director of nurses on notifying physicians of resident significant weight losses and the facility weight loss program. RDCO reviewed facility nutrition management policy. This education will be completed by [DATE]. *The below policies were reviewed on [DATE] and there were no changes made to current pol [TRUNCATED]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32677 Based on interview and record review the facility failed to ensure a resident who is unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene for 1 (CR#1) of 7 residents reviewed for neglect. -The facility failed to provide ADL care for CR#1 when he was transferred to the local hospital on [DATE] and CR#1 was found covered in fresh and dried feces and urine. These failures could place residents at risk of neglect and not having their care needs met, not being seen by physicians, not receiving adequate and timely interventions, which could cause a decline in physical and psychosocial health and even death. Findings included: Record review of CR #1's face sheet dated [DATE] revealed he was a sixty-six-year-old male admitted to the facility on [DATE]. His admitting diagnoses were chronic obstructive pulmonary disease with acute exacerbation (difficulty breathing), unspecified protein-calorie malnutrition, nicotine dependence, anxiety, hypertension (high blood pressure), acute pancreatitis without necrosis (pancreas inflamed), arthritis, osteoarthritis (degenerative joint disease), muscle wasting and atrophy (loss or thinning of muscle tissue), dysphagia (difficulty swallowing), difficulty in walking, cognitive communication deficit and history of Covid. Record review of CR #1's care plan dated [DATE] revealed the following care areas: *CR#1 was on a regular mechanical soft diet with interventions for Dietary Manager to monitor/discuss food preferences, monitor and document intake, offer snacks within diet, serve diet as ordered and offer substitute if less than 50% is eaten, weigh every month and PRN-report 5% loss/gain to MD and responsible party. * CR#1 was at risk for weight loss protein calorie malnutrition. On [DATE] CR#1's Actual weight loss was 7. 1% x 30 days and on [DATE] weight loss was 10% over 6 months. The interventions were to assess resident for food preferences, serve resident food preferences, monitor dietary intake, weigh weekly or monthly as ordered by MD. Offer supplements between meals to enhance caloric intake. Offer substitute if less than 50% of meals is eaten, [DATE] Liquid protein 30 ml daily x 30 days, Ensure Plus 1 carton daily, snacks at 2 am and 2 pm, and house shakes with meals. *CR#1 required pain management for muscle atrophy and wasting, had a swallowing problem, and was at risk for weight loss. CR#1 requested code status of full code (perform all possible measures to save their life in the event of a medical emergency). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's Quarterly MDS assessment signed on [DATE] revealed a BIMS summary score of 15 indicating CR#1's cognition was intact. CR#1's functional abilities and goals revealed: Supervision or touching assistance for eating, partial/moderate assistance for upper body dressing and personal hygiene, substantial/maximal assistance for toileting, oral hygiene and lower body dressing and he was dependent on staff for showers and putting on/taking off footwear. CR#1 required partial/moderate assistance for roll left and right, sit to lying, and lying to sitting on side of bed and toilet transfer, and walking 10 feet were not applicable. CR#1's height was 66 inches, weight was 73 lbs., weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, and CR#1 was on a mechanically altered diet. Record review of CR#1's Nutrition note dated [DATE] at 6:30 pm by Dietician revealed, Current weight 80 lbs. , BMI 12.9, Significant weight loss of 5.8% in 30 days. Inadequate oral intake of both calories and fluids. Currently receiving abt for UTI. Weight loss despite good intake of meals reported by resident and already offered house shake BID as well. Diet order: Regular diet, mechanical soft texture, regular consistency. Supplements: Ensure Plus, House shake BID, snacks BID, mvi, vitamin D Plan: Continue previously ordered nutrition supplements and also Give Active protein 30 ml daily x 30 days. Give at least 240 ml water with medications TID. Encourage fluid intake with meals/meds. Record review of CR#1's Nutrition Note dated [DATE] by the Dietician revealed, May monthly weight was 78 lbs., significant weight loss of 9.3% in 90 days. Current weight 75 lbs. ([DATE]), BMI 12.1, usual weight 85 lbs. (At admission [DATE]). Diet order: Regular diet, Mechanical Soft texture, Regular consistency Supplements: house shake TID, snack BID, Ensure Plus q HS, Ca+vitD, mvi. Weight loss has slowed in the last 30 days. However, resident is still underweighting by BMI. His meal intake varies greatly day to day and will not consistently consume house shake or Ensure supplements. Plan: Continue to offer nutrition supplements as tolerated. Encourage adequate fluid intake. Record review of CR#1's Physician Orders dated [DATE] revealed the following: *Assess Pain every shift for monitoring dated [DATE] *May not exceed APAP 3GM24 hr. dated [DATE] *Monitor SpO2 every shift for monitoring COPD dated [DATE] *O2 at 2L-5Lper NC to maintain SpO2 >90% every 12 hours as needed for SOB Indicate if oxygen was provided this shift by answering yes or no dated [DATE] *Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally every 4 hours as needed for SOB dated [DATE] *Mirtazapine Oral Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth at bedtime for depression dated [DATE] *Vitamin D3 Tablet 5000 UNIT (Cholecalciferol) Give 1 tablet by mouth one time a day for Supplement dated [DATE] *Clean/Change oxygen concentrator filters every night shift every Sun for Monitoring dated [DATE] (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*FULL CODE dated [DATE] *Multi-Vitamin/Minerals Oral Tablet (Multiple Vitamins w/Minerals) Give 1 tablet by mouth one time a day for Supplement dated [DATE] *Monitor Blood pressure every 12hours dated [DATE] *Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 0.5 tablet by mouth two times a day for Anxiety -Give , d+[DATE] a tab to equal 0.25 mg dated [DATE] *Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) Give 2 tablet by mouth every 8 hours for moderate to severe pain Give 2 tablets total 100mg dated [DATE] *Calcium 500 + D3 Oral Tablet ,d+[DATE] MG-MCG (Calcium Carbonate-Cholecalciferol) Give 1 tablet by mouth in the morning for Supplement Prescriber dated [DATE] *Metformin HCl Oral Tablet 500 MG (Metformin HCl) Give 1 tablet by mouth two times a day dated [DATE] *CBC AND BMP dated [DATE] *Give at least 240 ml of water with medications three times a day dated [DATE] *House Shake with meals for Supplement dated [DATE] *Ensure Plus at bedtime for Supplement -Administer 1 carton PO daily dated [DATE] *Provide snacks BID at 10 am and 2 pm two times a day for snack dated [DATE] *Document Vitals with each breathing treatment as needed for Shortness of *Breath Pre breathing treatment. Record lung sounds as C=Clear, W=Wheezing, CR=Crackles Verbal Active dated [DATE] *Megestrol Acetate Tablet 20 MG Give 2 tablet by mouth one time a day for Appetite stimulant for 30 Days Administer 2 tabs to equal 40 mg -Start Date- [DATE] and ended [DATE] *STAT: CBC, BMP, UA with C&S dated [DATE] *CXR Phone Active dated [DATE] *ST clarification order for ST to treat 3x weekly for 30 days for cognitive communication methods and oropharyngeal dysphagia in order to address weight loss.one time only dated [DATE] *ST to eval and treat as indicated. One time only for 30 Days dated [DATE] *Megestrol Acetate Tablet 20 MG Give 2 tablet by mouth two times a day for Appetite for 14 Days dated [DATE] (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Pulmonary Consult dated [DATE] *Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally three times a day for shortness of Breath; Cough dated [DATE] *Regular diet pureed texture, regular consistency dated [DATE] *GI Consult Phone dated [DATE] Record review of CR#1's Nutritional Risk assessment dated [DATE] revealed CR#1's height was 66 inches, weight was 69 lbs. on [DATE], the BMI was <18.5 Underweight, ideal body weight was 142 lbs., usual body weight was 85 lbs. (At admission [DATE]) and CR#1 did not have any amputations. CR#1's nutrition related medications were megestrol twice a day, buspirone, metformin and mirtazapine and diet order was regular diet, mechanical soft texture, regular consistency and supplement orders were house shake 3 times a day, snack twice a day, ensure plus every night, Calcium with Vitamin D, multivitamin, ice cream twice a day, extra fluids: 240 ml of water with medications 3 times a day. CR#1's food texture was mechanical soft ground, and regular liquid consistency. CR#1's required limited assistance with eating: self-performance with one-person physical assist and the average percentage of the meals eaten was ,d+[DATE]%. CR#1 dined in room and was bed bound and calories were 989 x 1.2 x 1.0 + 500 = 1186 kcal. Protein was 38.64 kg x 1.0 g/kg= <50 with Minimum 50 g protein is recommended for elderly daily. CR#1's fluid was minimum 1500 ml fluids is recommended for elderly daily. Nutrition assessment revealed CR#1 was seen quarterly assessment. Further review reflected the Resident was eating very little, having more difficulty breathing route of COPD. Multiple extra food items (snacks, ice cream) and nutrition supplement drinks (Ensure, shake) are offered several times a day to support adequate calorie intake. Acceptance was poor. He was eating about 50% of meals and accepting snacks, but now consumes <25% of meals. Megestrol has been ordered for appetite stimulant. Nutrition diagnosis: 1. Underweight r/t COPD, history of PCM and inadequate oral intake AEB BMI < 18.5, Nutrition concerns: altered nutrition related labs r/t history of vitamin deficiency, PCM. Goals: no signs and symptoms of dehydration or fluid overload, no significant weight loss of 5% or more in 30 days, no signs and symptoms with difficulty chewing/swallowing on modified texture diet. Nutrition plan/prescription: Encourage fluid intake during hours awake/alert. Continue supplement drinks and extra foods as tolerated. Support comfort care by honoring food preferences as much as possible. Monitor intake, weight, labs, and skin. Record review of CR#1's Care Conference Summary: Description-Change in Condition dated [DATE] and signed [DATE] at 12:05 pm revealed: CR#1's RP notified of resident's weight loss and poor appetite. RP aware of NP recommendation for hospice. RP stated that she would be open for hospice, but she would want resident to take part in that decision. Progress/Goals: Resident stated that he would like to remain a full code and receive full course treatment if needed. MBSS swallow study was ordered due to resident stating that he felt a burning sensation while swallowing. New order for megestrol for appetite stimulant SLT to evaluate and treat MBSS test continue weekly weights. Family agrees with plan of care, family agrees with MBSS test and to determine plan of care based on MBSS test. Record review of CR#1's Change in Condition Evaluation dated [DATE] and signed [DATE] at 11:16 am revealed: List of the other change: cough started [DATE], vitals blood pressure ,d+[DATE], date [DATE]. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's Change in Condition Evaluation dated [DATE] and signed [DATE] revealed: Poor appetite, general weakness without fever, change in level of consciousness, or other acute symptoms. Record review of CR#1's Percentages Eaten revealed: *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% breakfast, ,d+[DATE]% lunch, ,d+[DATE]% for dinner *[DATE] - ,d+[DATE]% breakfast, ,d+[DATE]% lunch, ,d+[DATE]% dinner *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% for all three meals *[DATE] - ,d+[DATE]% breakfast, ,d+[DATE]% lunch, ,d+[DATE]% dinner *[DATE] - Resident refused Record review of CR#1's Weight Summary dated [DATE] at 10:31 am revealed: *[DATE] - 85 lbs. *[DATE] - 86 lbs. *[DATE] - 83 lbs. *[DATE] - 84 lbs. *[DATE] - 84 lbs. *[DATE] - 81 lbs. *[DATE] - 80 lbs. *[DATE] - 78 lbs. *[DATE] - 79 lbs. *[DATE] - 77 lbs. *[DATE] - 75 lbs. *[DATE] - 77 lbs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's Local EMS Transportation record dated [DATE] revealed: Time phone rang was [DATE] at 6:13 pm, emergent one way, sick person, priority 2 (Emergent), reason for transport was for ER call [CR#1] was in need of emergency care not available at origin, reason for stretcher: monitoring requirement-oxygen administration, [CR#1] was on 10 lpm O2 and had severe muscular dystrophy and could not ambulate. Condition of patient on scene: Emergent , time activated [DATE] at 6:21 pm, time assigned [DATE] at 6:22 pm, time enroute [DATE] at 7:04 pm, minutes spent enroute 30, time on scene [DATE] 7:34 pm, time of patient contact [DATE] 7:35 pm, time transport began [DATE] at 7:49 pm, time at destination [DATE] at 8 pm, Acute symptoms: Digestive: weight loss- abnormal, general: abuse/neglect- suspected. [CR#1] was found at 7:35 pm in emergent condition. [CR#1] was a [AGE] year-old adult male. EMS determined that transportation was justified for ER call [CR#1] was in need of emergency care not available at origin. EMS found [CR#1] to be extremely malnourished and in pain. [CR#1] had been on 3lpm via nasal cannula and was changed to 10lpm via non-rebreather from the crew. [CR#1] had labored breathing and thready pulse rate. [CR#1] required stretcher transportation due to monitoring requirement - oxygen administration ([CR#1] was on 10lpm O2 and had severe muscular dystrophy and could not ambulate.). [CR#1] was moved to the stretcher by two-man assisted lift, then to the ambulance and secured for transport. Transportation started at 7:49 pm, proceeding emergent at emergency traffic speed, and completed after 10 minutes. [CR#1] was verbally responsive (but not alert). Vitals were taken at 7:50 pm, severe hypoxia (SPO2 75), labored breathing with mild tachypnea (RR ,d+[DATE]), mild bradycardia (HR 41), a blood glucose of 128, and decreased responsiveness (verbal) were observed. Vitals were taken again 5 minutes later: since vital signs were last checked, the labored breathing with mild tachypnea (RR , d+[DATE]) persisted, the thready pulse with mild bradycardia (HR 45) persisted, the decreased responsiveness (verbal) persisted, the severe hypoxia had become moderate hypoxia (SPO2 81). [CR#1] pulse rate was believed to be faulty upon palpating of [CR#1] pulse, pulse rate was found to be significantly faster and around 90 bpm. [CR#1] O2 was raised additionally to 15 lpm during transport at 7:55 pm. There were two acute symptoms recorded during the examination of the patient: Digestive: Weight loss -abnormal (R63.4), and General: Abuse/Neglect - suspected, arrived at [local hospital] at 8:00. Record review of CR#1's Local Hospital Record Imaging dated [DATE] revealed: Hematology [NAME] Blood Count- 13.8 High (normal range is 5XXX,d+[DATE].0). Imaging recent impressions revealed Radiology x-ray chest [DATE] at 8:41 pm revealed: Large right-sided pneumothorax (a collapsed lung, occurs when air builds up in the pleural space between the chest wall and lung) greater than 80%, with compressive atelectasis of the right lung. Record review of CR#1's Local Hospital Record dated [DATE] revealed CR#1's procedures dated [DATE]: Insertion of infusion Dev into, Respiratory ventilation, Insertion of endotracheal airway, and drainage of right pleural cavity with. The primary code set revealed Septicemia or severe sepsis without MV>96 hours with M other code set. General Information revealed discharge diagnosis: multiorgan failure and septic shock. ICU team was consulted for septic shock and multi organ failure. [CR#1] desalted and required intubation. He also became hypotensive and required pressors. Despite our best efforts, resuscitation was futile because [CR#1] was in multiorgan failure. It was discussed with family that persistent measures would be futile and would end up doing more damage than good. Family decided to make [CR#1] DNR/DNI. Withdrawal of care measures were made including the administration of morphine and Ativan. Ventilator and pressor support were withdrawn. [CR#1] expired at 2:39 am. (continued on next page)

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Focused Care at Humble	93 Isaacks Rd Humble, TX 77338

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's Free Text HPI Notes from Local Hospital records dated [DATE] at 9:50 pm revealed [AGE] year-old male no known past medical history presents today via EMS from nursing home. EMS reports that he has not been eating for a week and the nursing home called due to respiratory distress. [CR#1] presenting is severely cachectic (a wasting syndrome that causes a person to lose weight and muscle mass) and with increased work of breathing. [CR#1] quickly moved to a room and started on albuterol and Bipap. Central line access needed due to lack of peripheral IVs. General: Severely cachectic, increased work of breathing, can tell me his name. HEENT: EOMI, mucous membranes are severely dry. Neck: Atraumatic, supple. Cardiac: Tachycardia, no murmurs or rubs. Respiratory: Decreased air movement in bilateral lungs, diffuse wheezing, severe increased work of. Abdomen: Non-distended, able to see bones of the pelvis and rib. Record review of CR#1's Patient Discharge and Departure: Critical Care at Local Hospital dated [DATE] at 11:14 pm revealed: Critical Care, time spent (minutes): 120, Services performed patient management by me, time spent at bedside, reviewing test results, reviewing imaging, Discussing patient care, documentation in record, time with family surrogate. [CR#1] was critically ill due to acute respiratory failure, hyperkalemia, pneumothorax, septic shock. My treatment and management were fluids, pressor, chest tube, intubation, insulin, dextrose, albuterol. CC Note 1: Total critical care time (120) minutes .CC Note 2: The high probability of sudden, clinically significant deterioration in the patient's condition required the highest level of my preparedness to intervene urgently. The services I provided to this patient were to treat and/or prevent clinically significant deterioration that could result in severe disability or death. Record review of CR#1's Local Hospital's Triage Reassessment dated [DATE] at 5:56 am revealed, [CR#1's] description of reason for visit: [CR#1] presents to ER complaining of failure to thrive. EMS states they arrived at [Nursing facility] and nurse said [CR#1] had not eaten for a week. EMS stated [CR#1] looked anorexic. States he was short of breath, placed on nonrebreather. Disposition: Expired, Chief complaint: Respiratory. Date body pronounced: [DATE], Time body pronounced: 2:39 am Record review of CR#1's Clinical Records from [DATE] to [DATE] did not reveal any notes from CR#1's Physician (Physician A). Record review of CR#1's Nurse Practitioner notes dated [DATE] at 2:10 pm revealed Treatment Goals: Diagnosis: LACK OF COORDINATION, MUSCLE WEAKNESS GENERALIZED, ARTHRITIS MULTIPLE SITES J44.1 COPD WITH ACUTE EXACERBATION. Assessment: PT- Focus on range of motion, strengthening of lower extremities, balance training, transfer training, safety awareness, and energy conservation techniques. Gait training with assistive devices when ready. Care Plan: skin care, reduce friction, prevent/reduce pressure, optimize nutrition, encourage nursing staff to increase oob activity during the day as much as possible and as patient tolerates, monitor bowel and bladder, pain management as appropriate to improve ability to participate in therapy activities; Monitoring and management of pain with Rx per IM/Physiatry collaboration as appropriate, Monitor frequently for change in mental status, neurological status, pulmonary status, cardiovascular status, and UTIs and address as appropriate, F/U Therapy visit ,d+[DATE]x week as appropriate and continue ongoing medical management by PCP/IM. Record review of CR#1's Nurse Practitioner notes dated [DATE] at 4:28 pm revealed Current Medications: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient has no known medications. Vitals: Height: 66 in. Respiration: 18O2 Sat Additional Comments: [FIELD} {NODATA]Pulse: 67 BP 1: 142 / 89. MEDICATIONS: Acetaminophen Extra Strength Oral Tablet 500 MG Ipratropium-Albuterol Inhalation Solution 0XXX,d+[DATE].5 (3) MG/3ML Vitamin D3 Tablet 5000 UNIT Buspirone HCl Oral Tablet 10 MG Albuterol Sulfate HFA Inhalation Aerosol Solution 108 Mirtazapine Oral Tablet 15 MG Prednisone Oral Tablet 5 MG Multi-Vitamin/Minerals Oral Table Surgical History: colostomy bag .RESPIRATORY: Clear to all bases. diminished No rales, rhonchi, or wheezes. Thorax symmetric with good excursion. No use of accessory muscles. Therapy Evaluation Occupational Therapy Evaluation: Eating = Setup or clean-up assistance Hygiene Oral hygiene = Setup or clean-up assistance Toileting hygiene = Setup or clean-up assistance Transfers Toilet transfer = Setup or clean-up assistance Bathing Shower/bathe self = Supervision or touching assistance Ambulation Walk 10 feet = Supervision or touching assistance Walk 50 feet with Two Turns = Supervision or touching assistance Walk 150 feet = Supervision or touching assistance Walking 10 feet on uneven surfaces = Supervision or touching assistance Assistive Device = Two-wheeled Walker Speech Therapy Evaluation: Executive Function = Within Functional Limits Memory = Within Functional Limits Regular diet, Mechanical Soft texture, Regular consistency (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of CR#1's Nurse Practitioner Notes dated [DATE] revealed Assessment Care Plan: optimize nutrition, monitor bowel and bladder, pain management as appropriate to improve ability to participate in therapy activities, Monitoring and management of pain with Rx per, Safety Precautions/ Fall Prevention: Activity as tolerated with assistance. Interdisciplinary falls prevention strategies per facility and individualized to reduce risk of falls and injuries. Monitor frequently for change in mental status, neurological status, pulmonary status, cardiovascular status, and UTIs and address as appropriate. Continue ongoing medical management by PCP/IM abt treatment Record review of CR#1's Nurse Practitioner Notes dated [DATE] revealed Vitals: Height: 66 in. Weight: 77 lbs. BMI: 12.4O2 Sat Additional Comments: [FIELD} {NODATA] BP 1: 128 / 76. Chief Complaint: Chief Complaint: evaluation of weakness, impaired mobility and gait, s/p fall. HPI Update Patient seen in room laying in bed, no acute distress. Patient exhibits decline in strength, balance, gait impairment and endurance. Swallowing Difficulties (-) [meaning none]; Chest Pain (-) Respiratory Dyspnea (-); Wheezing (-); Cough (-); Gastrointestinal Abdominal Pain (-); Constipation (-); Diarrhea (-); Nausea (-); Genitourinary dysuria (-) pain(-), dark coke colored urine Musculoskeletal Muscle Weakness (+) muscle atrophy. GENERAL: GENERAL: frail adult in no apparent distress. Alert, calm, and cooperative. RESPIRATORY: Clear to all bases. diminished No rales, rhonchi, or wheezes. Thorax symmetric with good excursion. No use of accessory muscles. OT- Focus on bed mobility, transfers, fine and gross motor coordination, upper and lower body ADLs, self care, grooming/hygiene, and toileting copd- Ipratropium-Albuterol Solution 0XXX,d+[DATE].5, Albuterol Sulfate HFA Inhalation Aerosol Solution 108, O2 at 2L-5Lper NC to maintain SpO2 >90% monitor during therapy sessions SPO2, pain management as appropriate to improve ability to participate in therapy activities, Monitoring and management of pain with Rx per IM/Physiatry collaboration as appropriate, UTIs and address as appropriate, weakness, impaired mobility, and gait impairment following his recent fall. The goal is to improve his functional status, mobility, and quality of life within the long-term care setting. Record review of CR#1's Nurse Practitioner notes dated [DATE] at 1:26 pm revealed Vitals: Height: 66 in. Previous Weight: 77 lbs. Occupational Therapy Evaluation: Eating = Supervision or touching assistance; Personal hygiene Partial/moderate assistance; Toileting hygiene = Substantial/maximal assistance; Regular diet, Mechanical Soft texture, Regular consistency. Care Plan: copd- Ipratropium-Albuterol Solution 0XXX, d+[DATE].5, Albuterol Sulfate HFA Inhalation Aerosol Solution 108, O2 at 2L-5Lper NC to maintain SpO2 >90% monitor during therapy sessions SPO2 Monitor frequently for change in mental status, neurological status, pulmonary status, cardiovascular status, and UTIs and address as appropriate. Record review of CR#1's Nurse Practitioner notes revealed she saw CR#1 in February 2024, [DATE], [DATE] and did not see CR#1 until [DATE]. Record review did not reveal any notes indicating the Nurse Practitioner was informed that CR#1's weight continued to decline to 67 lbs. Record review of CR#1's Nurse Practitioner notes dated [DATE] at 7:30 am revealed Note Text: Chief Complaint: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note. History of Present Illness: The patient is a [AGE] year-old African American male under the care of Physician A with a diagnosis of COPD. He has a history of severe COPD, anxiety, and hypertension, who comes in with shortness of breath, coughing, and wheezing. He only has albuterol inhaler at home. His chest x-ray was normal. Patient is alert and conversant, he has no complaints or concerns at the moment. No difficulty in breathing noted. Reviewed medical plans, he will continue on current management. He remains afebrile. BP/HR/Pulse continue to monitor for hypertension. Recent UTI resolved with ABT. Physical Examination: BP: ,d+[DATE] Pulse: 77 RR: 18 Temp: 97.3 F Sat: 97. Nose: Mucosa normal, no obstruction, no discharge, nares patent. Throat: Clear, no exudates, no lesions, no erythema. LUNGS: Clear to auscultation bilaterally. No rales, rhonchi, or wheezes. No use of accessory muscles of respiration. Alert and oriented x3; Assessment & Plan: Shortness of breath, Chronic obstructive pulmonary disease, Diet- Regular diet, Mechanical soft texture, regular consistency. COPD - Titrate oxygen ,d+[DATE] via NC to room air if O2 sats is greater than 90. Monitor O2 saturation, respiration, and cough related to COPD. Record review of CR#1's Nurse Practitioner Notes dated [DATE] at 8:10 am revealed LATE ENTRY, Chief Complaint: progress note. History of Present Illness: The patient is a [AGE] year-old African American male under the care of Physician A with a diagnosis of COPD. He has a history of severe COPD, anxiety, and hypertension, who comes in with shortness of breath, coughing, and wheezing. He only has albuterol inhaler at home. His chest x-ray was normal at this moment. He will be participating in ST sessions for improvement on cognitive communication abilities and oropharyngeal dysphagia management. Patient and staff education on aspiration precaution during meals and when drinking medications. IDT meeting with RP to be held to discuss patient's weight loss due to refusal to eat and hospice consult and care. Patient educated on importance of healthy meals and diet. He refuses to eat meals at times, house shakes offered, ensure provided, megestrol ordered to help with weight gain. He has no concerns at the moment. No pain or discomfort noted. We will continue to monitor. Throat: Denies swelling or pain. RESPIRATORY: Denies SOB or cough. Physical Examination: BP: ,d+[DATE] Pulse: 67 RR: 18 Temp: 98.4 F Sat: 97 LUNGS: Clear to auscultation bilaterally. No rales, rhonchi, or wheezes. No use of accessory muscles of respiration. EXTREMITIES: No deformities, no tenderness, no swelling, no erythema. Good tissue perfusion. 2+ PP bilaterally. Diet- Regular diet, Mechanical soft texture, regular consistency. COPD - Titrate oxygen ,d+[DATE] via NC to room air if O2 sats is greater than 90. Monitor O2 saturation, respiration, and cough related to COPD. (continued on next page)

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