STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	04/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on observation, interview and record review, the facility failed to ensure timely physician notification of a significant change in condition for 1 of 6 residents (CR #1) reviewed for notification of changes. The facility failed to notify the physician when CR #1, who was within a 72-hour neurological monitoring period following a fall with head injury, developed acute hypotension (blood pressure 81/48) and bradycardia (heart rate 55 bpm), which were significantly below his established baseline vital signs. This change in condition required administration of a PRN medication, Midodrine, that had not previously been administered during the resident's stay. Despite these significant clinical changes, the physician was not notified at the time of the event. Approximately 21 hours later, CR #1 developed left-sided facial droop and weakness and was transferred to the hospital, where he was diagnosed with septic shock and required ICU-level care. An Immediate Jeopardy (IJ) was identified on 4/17/2026 at 4:47 PM. The IJ template was provided to the facility on 4/17/2026 at 4:50 PM. The IJ was removed on 4/19/2026. 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 isolated as the facility continued to monitor the implementation and effectiveness of its plan of removal. The facility's failure prevented timely medical evaluation and intervention, placing the resident at risk for serious harm, deterioration, hospitalization, and death.Findings included: Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged to the hospital on [DATE]. His diagnoses included COPD (a progressive lung disease causing restricted airflow and breathing difficulties); insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early); dementia (a progressive syndrome caused by abnormal brain changes resulting in cognitive decline that interferes with daily functioning); depression; anxiety; dysphagia following cerebral infarction (difficulty swallowing caused by stroke-induced neurological damage); cognitive communication deficit (a communication impairment stemming from underlying cognitive issues); lack of coordination; and gastrostomy status (the presence of a surgically created opening between the abdominal wall and the stomach, typically used for feeding and medication administration). Record review of CR #1's admission MDS dated [DATE] revealed a Staff Assessment of Mental Status indicating short- and long-term memory impairment and moderate impairment in decision-making related to activities of daily living. Further review of the MDS revealed behaviors of inattention, disorganized thinking, and altered level of consciousness, which were present but fluctuated. The MDS also noted wandering occurred 4 to 6 days per week, but not daily. Additionally, the MDS indicated CR #1 had a history of falls, including two or more falls with injury since admission. Record review of CR #1's care plan, initiated on 11/14/2025 and last revised on 11/20/2025, revealed a problem identified as an actual fall related to impaired cognition, impaired mobility, and poor impulse control. Interventions included, in part: helmet use (initiated 11/19/2025) and neurological checks per facility protocol (initiated 11/14/2025 and revised 11/20/2025). Further review of CR #1's care plan revealed no identified problems or interventions related to hypotension (low blood pressure, generally less than 90/60mmHg, that occurs (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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	when blood flow to organs is inadequate) or bradycardia (an abnormally slow resting heart rate, typically under 60bpm). Record review of CR #1's history and physical dated 11/14/2025, signed by the nurse practitioner (NP), revealed that prior to admission to the facility, CR #1 was evaluated at the hospital on 9/20/2025 and found to be hypotensive with systolic blood pressure (top number in blood pressure value) in the 60s-70s. He was admitted to the intensive care unit (ICU) for septic shock (a life-threatening condition in which infection leads to severe hypotension, impaired tissue perfusion, and multi-organ dysfunction) secondary to pneumonia and influenza A and was treated with vasopressor support (medications used to rapidly increase blood pressure and improve blood circulation in patients with severe, life-threatening hypotension or shock), broad-spectrum antibiotics, and mechanical ventilation. Further review revealed CR #1 was started on Midodrine (a medication used to treat hypotension by constricting blood vessels and increasing blood pressure) on 9/21/2025. By discharge from the hospital on [DATE], he had been weaned off vasopressors and was noted to be hemodynamically stable (maintaining adequate blood pressure and heart rate to ensure proper oxygen and nutrient delivery to tissues). The history further noted that following discharge from the hospital on [DATE], CR #1 was admitted to another facility and later transferred to this facility on 11/7/2025 due to wandering behaviors. Record review of CR #1's progress note dated 11/19/2025 at 6:00PM revealed, Resident was being pushed to room in wheelchair by CNA to change brief when resident leaned forward and threw self on floor. Head to toe assessment performed. Bleeding laceration to middle of forehead. Laceration cleaned with pressure dressing placed. Resident able to move all extremities without complications. Resident is nonverbal but able to understand staff. Doctor at bedside with new orders to send patient to ER for evaluation and treatment. Resident transferred to ER by EMS. RP Notified of transfer. DON/Administrator notified. 155/74, 125, 96.6, 18, 97% RA. Record review of CR #1's progress note dated 11/20/2025 at 12:24AM revealed, Resident returns from ER via stretcher this shift s/p fall with abrasion to forehead. CT results negative for intracranial bleeding or fracture. Resident assisted to bed x 2 EMT, stands up from bed immediately. Resident assisted to wheelchair at this time, neurological assessments continue without adverse results noted. Vital signs 112/66, 68, 18, 97.7, 98% RA. Resident without changes to ADL status, LOC or behaviors. Record review of CR #1's progress note dated 11/20/2025 at 5:37AM revealed, Resident remains in wheelchair at nurses station this shift, unable to leave unattended as Resident attempts to stand with extremely unsteady gait/balance. Resident declines assistance to bed, watches television, flips through magazines and coloring books. Neurological assessments continue. Record review of CR #1's progress note dated 11/20/2025 at 11:14PM revealed, Resident s/p fall day 1/3 with noted injury to forehead. Resident without changes in ADL status or LOC this shift, remains awake in television room, soft helmet in place for protection/prevention. Resident stands spontaneously from chair requiring frequent redirection and frequent staff monitoring. Neurological assessments continue. Record review of CR #1's progress note dated 11/21/2025 at 10:34PM by ADON revealed, Resident s/p fall day 2/3 with noted injury to forehead. Resident without changes in ADL status or LOC this shift, remains awake in television room, soft helmet in place for protection/prevention. Resident stands spontaneously from chair requiring frequent redirection and frequent staff monitoring. Resident stands and pushes dining room table multiple times, unable to be redirected. Neurological assessments continue. Record review of CR #1's progress notes revealed no entries on 11/22/2025 regarding resident status post fall day 3/3. Record review of CR #1's November 2025 Medication Administration Record (MAR), dated 11/8/2025 through 11/22/2025, revealed his blood pressure was ordered to be taken every shift (day shift 6:00 AM-6:00 PM and night shift 6:00 PM-6:00 AM). Blood pressure readings from 11/8/2025 through 11/21/2025 showed systolic values consistently greater than 110 (ranging from 110 to 124) and diastolic values (bottom number in blood pressure value) consistently greater than 60 (ranging from 62 to 78). The MAR further noted that on 11/22/2025, the day shift blood pressure decreased to 97/52 (entered by RN C), indicating a decline from the resident's established baseline, while the night shift blood pressure was 110/56 (entered by LVN B). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of CR #1's vital signs log dated 11/22/2025 through 11/23/2025 revealed blood pressure and heart rate were:11/22/2025 at 9:09 AM - 81/48 mmHg, HR 5511/22/2025 at 12:55 PM - 97/52 mmHg, HR 5611/23/2025 at 5:57 AM - 110/56 mmHg, HR 60 Record review of CR #1's November 2025 MAR revealed a physician's order for Midodrine HCl 5 mg to be administered every 8 hours as needed for systolic blood pressure less than 90, initiated on 11/7/2025. Further review revealed a one-time administration of this medication by LVN A on 11/22/2025 at 9:06 AM, which was documented as effective. Record review of CR #1's progress note dated 11/22/2025 at 9:06 AM by LVN A revealed Midodrine HCl 5 mg was administered due to a blood pressure reading of 81/48 and heart rate of 55. No further documentation regarding an assessment of CR #1 after having blood pressure reading of 81/48 and heart rate of 55. Record review of CR #1's progress notes from 11/22/2025 revealed no further notations in the record after 9:06am to indicate monitoring of resident. Record review of CR #1's progress note dated 11/23/2025 at 5:58 AM by LVN B revealed the PRN administration of Midodrine was documented as effective. No further notation regarding how medication was found to be effective. Record review of CR #1's November 2025 MAR, dated 11/8/2025 through 11/22/2025, revealed his pulse was ordered to be taken every shift. Pulse readings from 11/8/2025 through 11/21/2025 were consistently greater than 60 bpm (ranging from 64 to 78 bpm).The MAR further noted that on 11/22/2025, the day shift pulse decreased to 56 bpm (entered by RN C), while the night shift pulse was 60 bpm (entered by LVN B). Record review of CR #1's Neurological Assessment Checklist, initiated on 11/19/2025 at 6:00 PM, revealed the following:11/19/2025: No entries were completed, as CR #1 was not in the facility.11/20/2025 at 1:45 AM - BP 114/62, Pulse 70, RR 18, Temp 97.8 F. CR #1 was alert, had equal hand grasp, moved all extremities, pupils were reactive to light and brisk, and responded appropriately to pain.11/20/2025 at 5:45 AM - BP 114/63, HR 68, RR 18, Temp 97.6 F. Findings remained within normal limits.11/20/2025 at 9:45 AM - BP 118/76, HR 72, RR 18, Temp 98.3 F. Findings remained within normal limits.11/20/2025 at 1:45 PM - BP 114/68, HR 76, RR 18, Temp 98.2 F. Findings remained within normal limits.11/20/2025 at 9:45 PM - BP 118/75, HR 68, RR 18, Temp 97.6 F. Findings remained within normal limits.11/21/2025 at 5:45 AM - BP 110/62, HR 68, RR 18, Temp 97.8 F. Findings remained within normal limits.11/21/2025 at 9:45 PM - No assessment findings were documented.11/22/2025 at 5:45 AM - BP 127/77, HR 72, RR 18, Temp 97.8 F. Findings remained within normal limits. (Entry signed late by LVN D on 11/24/2025.)11/22/2025 at 1:45 PM - BP 110/64, HR 68, RR 18, Temp 97.6 F. Findings remained within normal limits. (Entry signed late by LVN D on 11/24/2025.)11/22/2025 at 9:45 PM - BP 114/71, HR 72, RR 18, Temp 97.6 F. Findings remained within normal limits; however, it was not documented whether the resident was able to move all extremities. (Entry signed late by LVN D on 11/24/2025.) Record review of CR #1's change in condition note dated 11/23/2025 at 7:08 AM revealed RN C documented that CR #1 exhibited left-sided weakness and left-sided facial drooping, with onset noted on 11/23/2025. Vital signs at the time included blood pressure 102/58, pulse 51, respirations 18, temperature 97.7 F, and oxygen saturation of 98%. Further documentation indicated CR #1 experienced a change in functional status, including decreased mobility and weakness consistent with hemiparesis (a neurological condition causing weakness on one side of the body). Additional documentation stated: CNA called the nurse to the resident's room. The CNA reported that after assisting the resident with a shower, she noticed a change in condition upon returning to the room. The resident was observed sitting in a wheelchair with noticeable left-sided weakness and facial drooping. The resident is nonverbal at baseline but is typically able to mouth words; however, during assessment, the resident was unable to mouth words. Emergency Medical Services (EMS) were notified for possible stroke due to stroke-like symptoms. EMS arrived and transported the resident via stretcher to the hospital. The Director of Nursing (DON) and responsible party (RP) were notified of the change in condition. Further review revealed the nurse practitioner (NP) was notified at 7:00 AM on 11/23/2025. Record review of CR #1's Emergency Medical Services (EMS) report dated 11/23/2025 revealed EMS arrived to assess CR #1 at 7:26 AM. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Staff reported the estimated onset of CR #1's condition was approximately 6:30 AM on 11/23/2025. The chief complaint was left-sided facial drooping, with a secondary complaint of hand tremors. Review of vital signs obtained by EMS at 7:26 AM revealed that a blood pressure reading was not obtained due to CR #1 removing the cuff and exhibiting continuous movement. The pulse was recorded at 45 bpm. Further EMS assessment noted bilateral lower extremity swelling. The EMS narrative also documented that vital signs obtained prior to EMS arrival included a heart rate of 50 bpm and blood pressure of 102/58. CR #1 was transported to the hospital via EMS and was noted to be agitated and uncooperative during transport. Record review of CR #1's progress note dated 11/23/2025 at 2:07PM revealed RN A noted she spoke with an RN at the hospital who said CR #1 was admitted to the ICU for diagnosis of altered mental status. Record review of CR #1's hospital record dated 12/1/2025 revealed he was admitted on [DATE] with a chief complaint of altered mental status. Documentation indicated that at approximately 6:30 AM on 11/23/2025, while at the nursing facility, the resident developed left-sided facial drooping, was no longer able to ambulate independently, and was not following commands. CR #1 was noted to arrive at the emergency department wearing a foam helmet, and EMS reported the resident had experienced 3 to 4 falls within the week prior to admission. Further review of the History of Present Illness revealed that upon evaluation in the emergency department on 11/23/2025, CR #1 was found to be hypotensive and diagnosed with bilateral pneumonia, septic shock and acute metabolic encephalopathy (a sudden alteration in brain function caused by an underlying systemic condition). Hospital records further revealed CR #1 remained hospitalized for approximately 2 months before he was discharged to another nursing facility. Interview on 4/16/2026 at 10:00 AM, the Director of Nursing (DON) stated that LVN A (the nurse who administered Midodrine to CR #1) was a PRN nurse and had not been at the facility recently. The DON further stated that RN C (the day shift nurse who worked on 11/22/2025 and 11/23/2025 with CR #1) and LVN D (the nurse who completed the neurological assessments for CR #1 on 11/22/2025) were no longer employed at the facility. Phone interviews were attempted with LVN A on 4/16/2026 at 10:56 AM and 4/17/2026 at 10:57 AM; however, there was no answer, and voicemail messages were left. A phone interview was attempted with LVN D on 4/17/2026 at 12:10 PM; however, there was no answer, and the voicemail box was not set up. A follow-up text message was sent requesting a return call. Interview on 4/16/2026 at 12:04 PM, the DON confirmed that vital signs are a component of neurological assessments and should be monitored for changes. She stated that the nurse assigned to the resident is responsible for completing the neurological assessment checklist, although other nurses may assist if needed. The DON stated that nurses are expected to notify the physician of changes identified during neurological assessments. However, she stated she would not consider CR #1's decrease in blood pressure and heart rate below baseline, along with the need for PRN medication, to be a change in condition requiring physician notification, as the PRN medication was documented as effective. Interview on 4/17/2026 at 1:00 PM, the Director of Nursing (DON) stated she had not thoroughly reviewed CR #1's chart and was unsure whether the physician had been notified of CR #1's episode of hypotension and bradycardia. The DON stated that if a resident has a PRN order for hypotension and the medication is effective, she would not expect nursing staff to notify the physician and would not consider this a change in condition. She explained that physician notification would only be expected if the PRN medication was ineffective, such as in cases where blood pressure remained low after administration or if the resident required repeated use of the PRN medication over multiple days. The DON further stated that if the resident's vital signs returned to an acceptable range after PRN administration, she would expect nursing staff to continue monitoring the resident by rechecking vital signs. She indicated that, in CR #1's case, the resident's blood pressure improved following administration and was no longer concerning. The DON stated that although CR #1 had not previously required use of PRN Midodrine while at the facility, this would not be considered a change in condition because the medication order was already in place, indicating a prior history of hypotension. She acknowledged she could not confirm whether CR #1 had (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	experienced prior hypotensive episodes at the facility but stated that, since the medication had not been previously administered, it indicated the resident's systolic blood pressure had not dropped below 90 prior to this event. Interview on 4/17/2026 at 11:02 AM, the nurse practitioner (NP) stated he was unable to access the historical vital signs for CR #1 but was able to review progress notes. The NP stated he could not determine whether he would have expected to be notified of CR #1's blood pressure of 81/48 and heart rate of 55 bpm on 11/22/2025, as he was not present and did not have the full clinical picture at the time. The NP confirmed he was not notified of the hypotension and bradycardia on 11/22/2025. He stated he was notified the following morning, on 11/23/2025, of a change in condition involving facial droop, at which time CR #1 was sent to the emergency room. The NP added he would expect nursing staff to administer PRN Midodrine for low blood pressure; however, he was unable to state whether he would have expected to be notified following its administration. Interview on 4/17/2026 at 1:14 PM, the MD (Medical Director) stated he did not recall being notified of CR #1's hypotension and bradycardia on 11/22/2025. The MD stated that if a PRN medication for hypotension was in place, it would indicate a prior history of hypotension. He stated he would expect nursing staff to administer the PRN medication if indicated and would expect physician notification if the medication was ineffective, but not necessarily if the medication was effective. The MD further stated that if CR #1 was undergoing neurological assessments at the time of the hypotension and bradycardia, he would expect nursing staff to use clinical judgment to determine whether physician notification was warranted. Record review of the facility Notification of Changes policy with implement date of 10/24/2022 revealed in part, The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. Record review of e-mail sent by Administrator on 04/17/2026 at 1:58 PM revealed the facility does not have a policy for Neurological Assessments. An IJ was identified on 4/17/2026 at 4:47pm. The IJ template was provided to the Administrator on 4/17/2026 at 4:50pm and a Plan of Removal was requested. The following Plan of Removal submitted by the facility was accepted on 4/18/2026 at 10:50AM. PLAN OF CREDIBLE ALLEGATIONFOR REMOVAL OF IMMEDIATE JEOPARDY F580 - NotificationThe facility staff failed to immediately consult with the resident's physician when there was a change in condition, including sudden hypotension and bradycardia requiring administration of PRN medication to assist with increasing CR #1's blood pressure. Actions for Resident InvolvedOn 11/23/2025 CR #1 discharged from the facility. Identify residents who could be affected:The Director of Nursing and/ or designee reassessed all facility residents for any changes in condition to include obtaining vital signs. Should any changes and significant alterations in vital signs are identified, the Attending Physician/ Nurse Practitioner will be notified. The assessment and vital signs will be documented in the medical record. Findings revealed no changes in condition or significant changes in vital signs.The Director of Nursing and/or designee reviewed vital signs on residents with neurological assessments initiated in the last seven days for episode of hypotension and/ or bradycardia. Identified changes in condition will be reported to the Attending Physician/ Nurse Practitioner. Findings revealed no changes in condition or significant changes in vital signs.The Director of Nursing and/ or designee assessed for change in condition and reviewed blood pressure and heart for the last seven days for the one current resident with orders for Midodrine to identify any significant alterations and will report to Physician/Nurse Practitioner if there are significant alterations and there were none identified. Action Taken/ System Change: Beginning 4/17/2026, 100% of Licensed Nurses will be reeducated by the Director of Nursing and/or designee on: The process for changes in resident condition and physician notification. Licensed Nurse to inform the Medical Provider where there is a change in resident condition requiring notification to include significant (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	identified. Record review of facility monitoring tools dated 4/17/2026 and 4/18/2026 revealed the DON conducted audits of:24-hour reports to ensure appropriate action was taken for identified changes in conditionNeurological assessments to ensure timely completion and appropriate response to changesResident charts to identify alterations in vital signsNo negative findings were identified during these audits. Record review of Quality Assurance and Performance Improvement (QAPI) meeting minutes dated 4/17/2026 at 4:50 PM revealed a meeting was held with the Administrator, DON, Medical Director, Regional Clinical Specialist, and Regional [NAME] President of Operations to address the Immediate Jeopardy related to physician notification and quality of care. Interviews conducted on 4/17/2026 from 12:12pm -12:50pm and 4/18/2026 from 1:00pm - 3:45pm with licensed nursing staff and CNAs from both day and night shifts (CNA A, CNA B, CNA C, RN D, RN G, LVN B, LVN E, and LVN F) revealed staff were able to verbalize understanding of the in-service education and related expectations. Interview and observation on 4/18/2026 starting at 12:10pm - 12:35pm with five residents (Resident #1, #2, #3, #4, and #5) identified as having recent changes in condition revealed appropriate interventions were in place, with no evidence of harm or potential for harm observed. Record review of Resident #2, #3, #4, #5, and #6 clinical records dated 4/17/2026 through 4/18/2026 revealed they had appropriate documentation of assessment, physician notification, and follow-up monitoring. Interview on 4/19/2026 at 12:43 PM, the DON demonstrated understanding of expectations for staff regarding assessment, physician notification, and monitoring of changes in condition. The DON also described ongoing monitoring processes, including re-education if deficiencies are identified. Interview on 4/19/2026 at 4:16 PM, the Administrator demonstrated understanding of expectations for staff to recognize and respond to changes in condition. The Administrator stated that if the DON is unavailable, staff are expected to notify him to ensure appropriate actions are taken. The Administrator acknowledged that failure to assess, notify, and monitor changes in condition could result in deterioration of resident status. The Administrator reported plans to monitor compliance through daily meetings, review of audit tools, and weekly staff huddles. The Administrator was informed the Immediate Jeopardy was removed on 4/19/2026 at 4:28 PM. 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 isolated due to the need to evaluate the effectiveness of corrective actions implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	04/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that, based on the comprehensive assessment of a resident, the resident received treatment and care in accordance with professional standards of practice and the comprehensive, person-centered care plan for 1 of 6 residents (CR #1) reviewed for quality of care. The facility failed to assess CR #1 after a blood pressure reading of 81/48 and heart rate 55 bpm. The facility failed to monitor and asses CR #1's condition after PRN Midodrine HCl 5 mg was administered due to abnormal blood pressure reading of 81/48 and heart rate 55 bpm. According to documentation, approximately 21 hours after CR #1 had abnormal blood pressure reading of 81/48 and heart rate 55 bpm, he developed left-sided facial droop and weakness, was transferred to the hospital, where he was diagnosed with septic shock and required intensive care. An Immediate Jeopardy (IJ) was identified on 4/17/2026 at 4:47 PM. The IJ was removed on 4/19/2026. 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 isolated as the facility continued to monitor the implementation and effectiveness of its plan of removal. The failures placed residents at risk for deterioration in health, hospitalization, and death.Findings included: Record review of CR #1's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE] and discharged to the hospital on [DATE]. His diagnoses included COPD (a progressive lung disease causing restricted airflow and breathing difficulties); insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking too early); dementia (a progressive syndrome caused by abnormal brain changes resulting in cognitive decline that interferes with daily functioning); depression; anxiety; dysphagia following cerebral infarction (difficulty swallowing caused by stroke-induced neurological damage); cognitive communication deficit (a communication impairment stemming from underlying cognitive issues); lack of coordination; and gastrostomy status (the presence of a surgically created opening between the abdominal wall and the stomach, typically used for feeding and medication administration). Record review of CR #1's admission MDS dated [DATE] revealed a Staff Assessment of Mental Status indicating short- and long-term memory impairment and moderate impairment in decision-making related to activities of daily living. Further review of the MDS revealed behaviors of inattention, disorganized thinking, and altered level of consciousness, which were present but fluctuated. The MDS also noted wandering occurred 4 to 6 days per week, but not daily. Additionally, the MDS indicated CR #1 had a history of falls, including two or more falls with injury since admission. Record review of CR #1's care plan, initiated on 11/14/2025 and last revised on 11/20/2025, revealed a problem identified as an actual fall related to impaired cognition, impaired mobility, and poor impulse control. Interventions included, in part: helmet use (initiated 11/19/2025) and neurological checks per facility protocol (initiated 11/14/2025 and revised 11/20/2025). Further review of CR #1's care plan revealed no identified problems or interventions related to hypotension (low blood pressure, generally less than 90/60mmHg, that occurs when blood flow to organs is inadequate) or bradycardia (an abnormally slow resting heart rate, typically under 60bpm). Record review of CR #1's history and physical dated 11/14/2025, signed by the nurse practitioner (NP), revealed that prior to admission to the facility, CR #1 was evaluated at the hospital on 9/20/2025 and found to be hypotensive with systolic blood pressure (top number in blood pressure value) in the 60s-70s. He was admitted to the intensive care unit (ICU) for septic shock (a life-threatening condition in which infection leads to severe hypotension, impaired tissue perfusion, and multi-organ dysfunction) secondary to pneumonia and influenza A and was treated with vasopressor support (medications used to rapidly increase blood pressure and improve blood circulation in patients with severe, life-threatening hypotension or shock), broad-spectrum antibiotics, and mechanical ventilation. Further review revealed CR #1 was started on Midodrine (a medication used to treat hypotension by constricting blood vessels and increasing blood pressure) on 9/21/2025. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	By discharge from the hospital on [DATE], he had been weaned off vasopressors and was noted to be hemodynamically stable (maintaining adequate blood pressure and heart rate to ensure proper oxygen and nutrient delivery to tissues). The history further noted that following discharge from the hospital on [DATE], CR #1 was admitted to another facility and later transferred to this facility on 11/7/2025 due to wandering behaviors. Record review of CR #1 progress note dated 11/19/2025 at 6:00PM revealed, Resident was being pushed to room in wheelchair by CNA to change brief when resident leaned forward and threw self on floor. Head to toe assessment performed. Bleeding laceration to middle of forehead. Laceration cleaned with pressure dressing placed. Resident able to move all extremities without complications. Resident is nonverbal but able to understand staff. Doctor at bedside with new orders to send patient to ER for evaluation and treatment. Resident transferred to ER by EMS. RP Notified of transfer. DON/Administrator notified. 155/74, 125, 96.6, 18, 97% RA. Record review of CR #1 progress note dated 11/20/2025 at 12:24 AM revealed, Resident returns from ER via stretcher this shift s/p fall with abrasion to forehead. CT results negative for intracranial bleeding or fracture. Resident assisted to bed x 2 EMT, stands up from bed immediately. Resident assisted to wheelchair at this time, neurological assessments continue without adverse results noted. Vital signs 112/66, 68, 18, 97.7, 98% RA. Resident without changes to ADL status, LOC or behaviors. Record review of CR #1 progress note dated 11/20/2025 at 5:37AM revealed, Resident remains in wheelchair at nurses station this shift, unable to leave unattended as Resident attempts to stand with extremely unsteady gait/balance. Resident declines assistance to bed, watches television, flips through magazines and coloring books. Neurological assessments continue. Record review of CR #1 progress note dated 11/20/2025 at 11:14PM revealed, Resident s/p fall day 1/3 with noted injury to forehead. Resident without changes in ADL status or LOC this shift, remains awake in television room, soft helmet in place for protection/prevention. Resident stands spontaneously from chair requiring frequent redirection and frequent staff monitoring. Neurological assessments continue. Record review of CR #1 progress note dated 11/21/2025 at 10:34PM by ADON revealed, Resident s/p fall day 2/3 with noted injury to forehead. Resident without changes in ADL status or LOC this shift, remains awake in television room, soft helmet in place for protection/prevention. Resident stands spontaneously from chair requiring frequent redirection and frequent staff monitoring. Resident stands and pushes dining room table multiple times, unable to be redirected. Neurological assessments continue. Record review of CR #1's progress notes revealed no entries on 11/22/2025 regarding resident status post fall day 3/3. Record review of CR #1's November 2025 Medication Administration Record (MAR), dated 11/8/2025 through 11/22/2025, revealed his blood pressure was ordered to be taken every shift (day shift 6:00 AM-6:00 PM and night shift 6:00 PM-6:00 AM). Blood pressure readings from 11/8/2025 through 11/21/2025 reflected systolic values consistently greater than 110 (ranging from 110 to 124) and diastolic values consistently greater than 60 (ranging from 62 to 78). The MAR further reflected that on 11/22/2025, the day shift blood pressure decreased to 97/52 (entered by RN C) while the night shift blood pressure was 110/56 (entered by LVN B). Record review of CR #1's vital signs log dated 11/22/2025 through 11/23/2025 revealed the following blood pressures and heart rate, including:11/22/2025 at 9:09 AM - 81/48 mmHg, HR 5511/22/2025 at 12:55 PM - 97/52 mmHg, HR 5611/23/2025 at 5:57 AM - 110/56 mmHg, HR 60 Record review of CR #1's November 2025 MAR revealed a physician's order for Midodrine HCl 5 mg to be administered every 8 hours as needed for systolic blood pressure less than 90, initiated on 11/7/2025. Further review revealed a one-time administration of this medication by LVN A on 11/22/2025 at 9:06 AM, which was documented as effective. Record review of CR #1's progress note dated 11/22/2025 at 9:06 AM by LVN A revealed Midodrine HCl 5 mg was administered due to a blood pressure reading of 81/48 and heart rate of 55. No further documentation regarding an assessment of CR #1 after having blood pressure reading of 81/48 and heart rate of 55. Record review of CR #1's progress notes from 11/22/2025 revealed no further notations in the record after 9:06am to indicate monitoring of resident. Record review of CR #1's progress note dated 11/23/2025 at 5:58 AM by LVN B revealed the PRN (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	administration of Midodrine was documented as effective. No further notation regarding how medication was found to be effective. Record review of CR #1's November 2025 MAR, dated 11/8/2025 through 11/22/2025, revealed his pulse was ordered to be taken every shift. Pulse readings from 11/8/2025 through 11/21/2025 were consistently greater than 60 bpm (ranging from 64 to 78 bpm).The MAR further noted that on 11/22/2025, the day shift pulse decreased to 56 bpm (entered by RN C), while the night shift pulse was 60 bpm (entered by LVN B). Record review of CR #1's Neurological Assessment Checklist, initiated on 11/19/2025 at 6:00 PM, revealed the following:11/19/2025: No entries were completed, as CR #1 was not in the facility.11/20/2025 at 1:45 AM - BP 114/62, Pulse 70, RR 18, Temp 97.8 F. CR #1 was alert, had equal hand grasp, moved all extremities, pupils were reactive to light and brisk, and responded appropriately to pain.11/20/2025 at 5:45 AM - BP 114/63, HR 68, RR 18, Temp 97.6 F. Findings remained within normal limits.11/20/2025 at 9:45 AM - BP 118/76, HR 72, RR 18, Temp 98.3 F. Findings remained within normal limits.11/20/2025 at 1:45 PM - BP 114/68, HR 76, RR 18, Temp 98.2 F. Findings remained within normal limits.11/20/2025 at 9:45 PM - BP 118/75, HR 68, RR 18, Temp 97.6 F. Findings remained within normal limits.11/21/2025 at 5:45 AM - BP 110/62, HR 68, RR 18, Temp 97.8 F. Findings remained within normal limits.11/21/2025 at 9:45 PM - No assessment findings were documented.11/22/2025 at 5:45 AM - BP 127/77, HR 72, RR 18, Temp 97.8 F. Findings remained within normal limits. (Entry signed late by LVN D on 11/24/2025.)11/22/2025 at 1:45 PM - BP 110/64, HR 68, RR 18, Temp 97.6 F. Findings remained within normal limits. (Entry signed late by LVN D on 11/24/2025.)11/22/2025 at 9:45 PM - BP 114/71, HR 72, RR 18, Temp 97.6 F. Findings remained within normal limits; however, it was not documented whether the resident was able to move all extremities. (Entry signed late by LVN D on 11/24/2025.) Record review of the facility staffing schedule for 11/22/2025 revealed LVN D was scheduled to work from 8:00 AM to 5:00 PM in the role of Assistant Director of Nursing (ADON). Record review of LVN D's time sheet dated 11/22/2025 revealed she worked a total of 3.30 hours; however, specific clock-in and clock-out times were not documented. Record review of CR #1's change in condition note dated 11/23/2025 at 7:08 AM revealed RN C documented that CR #1 exhibited left-sided weakness and left-sided facial drooping, with onset noted on 11/23/2025. Vital signs at the time included blood pressure 102/58, pulse 51, respirations 18, temperature 97.7 F, and oxygen saturation of 98%. Further documentation indicated CR #1 experienced a change in functional status, including decreased mobility and weakness consistent with hemiparesis (a neurological condition causing weakness on one side of the body). Additional documentation reflected: CNA called the nurse to the resident's room. The CNA reported that after assisting the resident with a shower, she noticed a change in condition upon returning to the room. The resident was observed sitting in a wheelchair with noticeable left-sided weakness and facial drooping. The resident is nonverbal at baseline but is typically able to mouth words; however, during assessment, the resident was unable to mouth words. Emergency Medical Services (EMS) were notified for possible stroke due to stroke-like symptoms. EMS arrived and transported the resident via stretcher to the hospital. The Director of Nursing (DON) and responsible party (RP) were notified of the change in condition. Further review revealed the nurse practitioner (NP) was notified at 7:00 AM on 11/23/2025. Record review of CR #1's Emergency Medical Services (EMS) report dated 11/23/2025 revealed EMS arrived to assess CR #1 at 7:26 AM. Staff reported the estimated onset of CR #1's condition was approximately 6:30 AM on 11/23/2025. The chief complaint was left-sided facial drooping, with a secondary complaint of hand tremors. Review of vital signs obtained by EMS at 7:26 AM revealed that a blood pressure reading was not obtained due to CR #1 removing the cuff and exhibiting continuous movement. The pulse was recorded at 45 bpm. Further EMS assessment noted bilateral lower extremity swelling. The EMS narrative also documented that vital signs obtained prior to EMS arrival included a heart rate of 50 bpm and blood pressure of 102/58. CR #1 was transported to the hospital via EMS and was noted to be agitated and uncooperative during transport. Record review of CR #1's progress note dated 11/23/2025 at 2:07PM revealed RN A noted she spoke with an (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	RN at the hospital who said CR #1 was admitted to the ICU for diagnosis of altered mental status. Record review of CR #1's hospital record dated 12/1/2025 revealed he was admitted on [DATE] with a chief complaint of altered mental status. Documentation indicated that at approximately 6:30 AM on 11/23/2025, while at the nursing facility, the resident developed left-sided facial drooping, was no longer able to ambulate independently, and was not following commands. CR #1 was noted to arrive at the emergency department wearing a foam helmet, and EMS reported the resident had experienced 3 to 4 falls within the week prior to admission. Further review of the History of Present Illness revealed that upon evaluation in the emergency department on 11/23/2025, CR #1 was found to be hypotensive and diagnosed with bilateral pneumonia, septic shock and acute metabolic encephalopathy (a sudden alteration in brain function caused by an underlying systemic condition). Hospital records further revealed CR #1 remained hospitalized for approximately 2 months before he was discharged to another nursing facility. Interview on 4/16/2026 at 10:00 AM, the DON stated that LVN A (the nurse who administered Midodrine to CR #1) was a PRN nurse and had not been at the facility recently. The DON further stated that RN C (the day shift nurse who worked on 11/22/2025 and 11/23/2025 with CR #1) and LVN D (the nurse who completed the neurological assessments for CR #1 on 11/22/2025) were no longer employed at the facility. Phone interviews were attempted with LVN A on 4/16/2026 at 10:56 AM and 4/17/2026 at 10:57 AM; however, there was no answer, and voicemail messages were left. Phone interview was attempted with LVN D on 4/17/2026 at 12:10 PM; however, there was no answer, and the voicemail box was not set up. A follow-up text message was sent requesting a return call. Interview on 4/16/2026 at 12:04 PM, the DON stated that neurological assessments were completed when a resident had an unwitnessed fall or may have hit their head. The DON explained the purpose of these assessments was to monitor for changes in condition and identify any negative developments early. The DON stated neurological assessments should be conducted for 72 hours and completed each shift. She further stated there were specific time frames for completing the assessments; however, she was unable to recall them at the time of the interview. The DON indicated there was a form within the facility's electronic medical record system used to guide staff in completing and documenting neurological assessments. The DON confirmed that vital signs were a component of neurological assessments and should be monitored for changes. She stated that the nurse assigned to the resident as responsible for completing the neurological assessment checklist, although other nurses may assist if needed. The DON stated LVN D was functioning as the ADON at the time CR #1's neurological assessments were completed on 11/22/2025. She indicated it was possible LVN D could have completed the assessments outside of her scheduled hours and not clocked in. The DON further stated assessments were expected to be completed at the time designated by the form; however, she was unable to explain why LVN D documented entries for 11/22/2025 two days later, noting that late entries were permitted. The DON stated that nurses were expected to notify the physician of changes identified during neurological assessments. However, she stated she would not consider CR #1's decrease in blood pressure and heart rate below baseline, along with the need for PRN medication, to be a change in condition requiring physician notification, as the PRN medication was documented as effective. Interview on 4/17/2026 at 1:00 PM, the DON stated she had not thoroughly reviewed CR #1's chart and was unsure whether the physician had been notified of CR #1's episode of hypotension and bradycardia on 11/22/2025. The DON stated that if a resident had a PRN order for hypotension and the medication was effective, she would not expect nursing staff to notify the physician and would not consider that a change in condition. She explained that physician notification would only be expected if the PRN medication was ineffective, such as in cases where blood pressure remained low after administration or if the resident required repeated use of the PRN medication over multiple days. The DON further stated that if the resident's vital signs returned to an acceptable range after PRN administration, she would expect nursing staff to continue monitoring the resident by rechecking vital signs. She indicated that, in CR #1's case, the resident's blood pressure improved following administration and was no longer concerning. The DON stated that (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	although CR #1 had not previously required use of PRN Midodrine while at the facility, this would not be considered a change in condition because the medication order was already in place, indicating a prior history of hypotension. She acknowledged she could not confirm whether CR #1 had experienced prior hypotensive episodes at the facility but stated that, since the medication had not been previously administered, it indicated the resident's systolic blood pressure had not dropped below 90 prior to this event. Interview on 4/17/2026 at 11:02 AM, the NP stated he was unable to access the historical vital signs for CR #1 but was able to review progress notes. The NP stated he could not determine whether he would have expected to be notified of CR #1's blood pressure of 81/48 and heart rate of 55 bpm on 11/22/2025, as he was not present and did not have the full clinical picture at the time. The NP confirmed he was not notified of the hypotension and bradycardia on 11/22/2025. He stated he was notified the following morning, on 11/23/2025, of a change in condition involving facial droop, at which time CR #1 was sent to the emergency room. The NP added he would expect nursing staff to administer PRN Midodrine for low blood pressure; however, he was unable to state whether he would have expected to be notified following its administration. Interview on 4/17/2026 at 1:14 PM, the MD stated he did not recall being notified of CR #1's hypotension and bradycardia on 11/22/2025. The MD stated that if a PRN medication for hypotension was in place, it would indicate a prior history of hypotension. He stated he would expect nursing staff to administer the PRN medication if indicated and would expect physician notification if the medication was ineffective, but not necessarily if the medication was effective. The MD further stated that if CR #1 was undergoing neurological assessments at the time of the hypotension and bradycardia, he would expect nursing staff to use clinical judgment to determine whether physician notification was warranted. Record review of the facility Notification of Changes policy with implement date of 10/24/2022 revealed in part, The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications. 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. Record review of e-mail sent by the Administrator on 04/17/2026 at 1:58 PM revealed the facility did not have a policy for Neurological Assessments. Record review of emails sent to the Administrator by surveyors on 4/17/2026 at 9:51 AM and 4/19/2026 at 3:08 PM revealed a request was made for the facility's policy regarding changes in condition. In response to both requests, the facility provided the Notification of Changes policy; however, the policy addressed only physician and responsible party notification requirements and did not include guidance for assessment, identification, or monitoring of a change in condition. An IJ was identified on 4/17/2026 at 4:47pm. The IJ template was provided to the Administrator on 4/17/2026 at 4:50pm and a Plan of Removal was requested. The following Plan of Removal submitted by the facility was accepted on 4/18/2026 at 10:50AM. PLAN OF CREDIBLE ALLEGATIONFOR REMOVAL OF IMMEDIATE JEOPARDY F684 - Quality of CareThe facility staff failed to ensure residents received treatment and care in accordance with professional standards of practice, and the comprehensive care plan for CR #1 who experienced a change in condition of hypotension, bradycardia, and required use of a never used before PRN medication midodrine. Facility failed to complete an assessment of CR #1 at the time he experienced a change in condition of hypotension and bradycardia. Facility failed to identify and monitor hypotension and bradycardia as a change CR #1 experienced while completing neurological assessments from a recent fall. Actions for Resident InvolvedOn 11/23/2025 CR #1 discharged from the facility. Identify residents who could be affected:The Director of Nursing and/ or designee reassessed all facility residents for any changes in condition to include obtaining vital signs. Should any changes and significant alterations in vital signs are identified, the Attending Physician/ Nurse Practitioner will be notified. The assessment and vital signs will be documented in the medical record. Findings revealed no changes in condition or (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	significant changes in vital signs.The Director of Nursing and/or designee reviewed vital signs on residents with neurological assessments initiated in the last seven days for episode of hypotension and/ or bradycardia. Identified changes in condition will be reported to the Attending Physician/ Nurse Practitioner. Findings revealed no changes in condition or significant changes in vital signs.The Director of Nursing and/ or designee assessed for change in condition and reviewed blood pressure and heart for the last seven days for the one current resident with orders for Midodrine to identify any significant alterations and will report to Physician/Nurse Practitioner if there are significant alterations and there were none identified. Action Taken/ System Change: Beginning 4/17/2026, 100% of Licensed Nurses will be reeducated by the Director of Nursing and/or designee on: The process for changes in resident condition and physician notification. Licensed Nurse to inform the Medical Provider where there is a change in resident condition requiring notification to include significant changes in vital signs i.e., hypotension, bradycardia, and required use of PRN Midodrine medication that has not been administered before. Licensed Nurse will perform an evaluation where there is a change in condition identified and document the evaluation and monitoring in the medical record. The Licensed nurse will notify Medical Provider once evaluation is complete if change of condition is noted.Resident neurological assessments and timely documentation of assessment findings. Reeducation included when to complete a neurological assessment, what to assess, identification of abnormal findings such as hypotension and/ or bradycardia and necessary action to take including completing a change of condition with notification to the Attending physician/ Nurse Practitioner, as well as monitoring of the identified change.Completion date: 4/17/2026 Beginning 4/17/2026, 100% of CNAs/CMAs will be reeducated by the Director of Nursing and/or designee on: Resident changes in condition with examples and reporting observed and/ or reported changes in condition to the charge nurse. Reeducation included reporting changes in condition to the Director of Nursing and/or Asst. Director of Nursing if a change in condition is not addressed including afterhours and weekends. Comprehension of training was verified by having CNAs and CMAs voice and understanding and repeat back training content.Beginning 4/17/2026, Licensed Nurses, CNAs and CMAs who are PRN, are out on PTO/ FMLA/ Leave of Absence will not be allowed to provide direct resident care until training has been completed.On 4/17/26, The Director of Nursing was educated on above educational components and system changes by the Regional Clinical Specialist.Beginning 4/17/2026 and ongoing, newly hired Licensed Nurses and facility staff will receive this training. The training will include the above-stated educational componentsChanges in resident condition, significant alterations in vital signs and neurological assessments will be reviewed during clinical morning meeting by DON/Designee ensuring assessments and appropriate notifications were completed and documented.Facility policy and procedure titled ?Notification of Changes' was reviewed by Medical Director, Administrator and/ or designee and the Director of Nursing and/ or designee with no changes indicated.Completion date: 4/17/2026Monitoring: Beginning 4/17/2026 and going forward, the Director of Nursing and/or designee will monitor compliance with changes in resident condition, notification of Attending Physician/ Nurse Practitioner, monitoring and documentation by completion of the following:Review of the 24-hour reportReview Change of Condition Assessments and progress note documentationReview of Neurological Assessment documentationReview of Vital signs for random residents. On 4/17/2026, an Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, Regional Clinical Specialist and Regional [NAME] President of Operations to discuss the immediate jeopardy and review the plan of removal. Monitoring of the Plan of Removal included the following: Record review of the facility's in-service training report dated 4/17/2026 revealed the Regional Clinical Specialist provided education to the Director of Nursing (DON) on identified system changes and educational components, including:Identification and reporting of changes in conditionExamples of changes in conditionAssessment of residents with identified or reported changes in conditionCompletion of change in condition documentationPhysician and responsible party (RP) notificationMonitoring and documentation requirementsNotification of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	04/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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 - Few Note: The nursing home is disputing this citation.	DON/ADON when changes in condition are not addressed timely Additionally, education addressed the requirement that PRN medications or treatments not previously used, or not used within the last 30 days, require a change in condition evaluation, documentation in the medical record, timely physician notification, and follow-up documentation. Further education included the neurological assessment process, including required equipment, timing and frequency of assessments, timely documentation, identification of changes in condition, and required actions, including physician/NP and RP notification and documentation of interventions and outcomes. Record review of the facility's in-service training report dated 4/17/2026 further revealed the DON subsequently provided education to licensed nursing staff and certified nursing assistants (CNAs) on the above topics. Record review of an audit report dated 4/17/2026 and signed by the DON revealed all facility residents were assessed for recent changes in condition and significant alterations in vital signs, with no new findings identified. Record review of facility monitoring tools dated 4/17/2026 and 4/18/2026 revealed the DON conducted audits of:24-hour reports to ensure appropriate action was taken for identified changes in conditionNeurological assessments to ensure timely completion and appropriate response to changesResident charts to identify alterations in vital signsNo negative findings were identified during these audits. Record review of Quality Assurance and Performance Improvement (QAPI) meeting minutes dated 4/17/2026 at 4:50 PM revealed a meeting was held with the Administrator, DON, Medical Director, Regional Clinical Specialist, and Regional [NAME] President of Operations to address the Immediate Jeopardy related to physician notification and quality of care. Interviews conducted on 4/17/2026 from 12:12pm -12:50pm and 4/18/2026 from 1:00pm - 3:45pm with licensed nursing staff and CNAs from both day and night shifts (CNA A, CNA B, CNA C, RN D, RN G, LVN B, LVN E, and LVN F) revealed staff were able to verbalize understanding of the in-service education and related expectations. Interview and observation on 4/18/2026 starting at 12:10pm - 12:35pm with five residents (Resident #1, #2, #3, #4, and #5) identified as having recent changes in condition revealed appropriate interventions were in place, with no evidence of harm or potential for harm observed. Record review of Resident #2, #3, #4, #5, and #6 clinical records dated 4/17/2026 through 4/18/2026 revealed they had appropriate documentation of assessment, physician notification, and follow-up monitoring Interview on 4/19/2026 at 12:43 PM, the DON demonstrated understanding of expectations for staff regarding assessment, physician notification, and monitoring of changes in condition. The DON also described ongoing monitoring processes, including re-education if deficiencies are identified. Interview on 4/19/2026 at 4:16 PM, the Administrator demonstrated understanding of expectations for staff to recognize and respond to changes in condition. The Administrator stated that if the DON was unavailable, staff were expected to notify him to ensure appropriate actions are taken. The Administrator acknowledged that failure to assess, notify, and monitor changes in condition could result in deterioration of resident status. The Administrator reported plans to monitor compliance through daily meetings, review of audit tools, and weekly staff huddles. The Administrator was informed the Immediate Jeopardy was removed on 4/19/2026 at 4:28 PM. 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 isolated due to the need to evaluate the effectiveness of corrective actions implemented.