STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675525	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Park Rehabilitation Health Care Center	1000 Fm 3220 Clifton, TX 76634

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47030 Based on interview and record review it was determined the facility failed to ensure the discharge summary was document in Resident #81's medical record. Resident #81 did not have a discharge summary or documentation of the discharge on 08/21/24. This failure could put residents at risk of not getting the necessary care and services with the possibility of the resident returning to the facility. Findings include: Resident #81 Record review of Resident #81's clinical record revealed he was admitted to the facility on [DATE]. His care plan, undated due to discharge, reflects he had chronic pain related to arthritis with interventions of 1) Anticipating the resident's need for pain relief and respond immediately to complaint of pain, 2) Monitor/document for probable cause of each pain episode. Further record review of LVN A progress notes on 8/21/2024 revealed Resident #81 was discharged on [DATE] with no discharge summary documentation. No discharge summary was found in Resident #81's medical records In an interview on 9/27/24 at 1:00 p.m., LVN A revealed management and defined management as the DON or the ADON did the discharge summaries. In an interview on 09/27/24 at 1:31 PM, the ADON revealed the floor nurse did the discharge summaries. The ADON revealed the discharge summaries are completed in the Electronic Medical Records in the Evaluations Interdisciplinary discharge tab. The ADON revealed the importance of the discharge summary was the communication of why the resident was sent out and had information such as vitals of the resident at the time of discharge. In an interview on 09/26/24 at 1:38 PM, the Regional RN revealed when a resident left 911 to hospital a note was done in the evaluation tab in the electronic medical records. (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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 09/26/24 at 1:52 PM, the DON revealed a discharge note was customarily done in the evaluation tab in the electronic medical records but was not found in the electronic medical records . Review of the facility's Transfer or Discharge Documentation Policy revealed: Policy Statement When a resident is transferred or discharged , details of the transfer or discharge will be documented in the medical record and appropriate information will be communicated to the receiving health care facility or provider. Policy Interpretation and Implementation When a resident is transferred or discharged from the facility, the following information will be documented in the medical record: a. The basis for the transfer or discharge. (1) If the resident is being transferred or discharged because his or her needs cannot be met at the facility, documentation will include: (a) the specific resident needs that cannot be met. (b) this facility's attempt to meet those needs; and (c) the receiving facility's service(s) that are available to meet those needs. (d) That an appropriate notice was provided to the resident and/or legal representative. (e) The date and time of the transfer or discharge. (f) The new location of the resident. (g) The mode of transportation. (h) A summary of the resident's overall medical, physical, and mental condition. (i) Disposition of personal effects. (j) Disposition of medications. (k) Others as appropriate or as necessary; and (l) The signature of the person recording the data in the medical record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and time frames to meet residents' medical needs for one (Resident #68) of six residents reviewed for care plans. The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #68's diagnosis of diabetes. This failure could place residents at risk of receiving inadequate individualized care and services. Findings included: Record review of Resident #68's quarterly MDS assessment, dated 09/12/24, revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included pneumonia, diabetes mellitus, hyperlipidemia, cerebrovascular accident, Non-Alzheimer's Dementia, anxiety disorder, depression, and schizophrenia. Her BIMS score was 3 of 15, which indicated he was cognitively impaired. Review of Resident #39's Comprehensive Care Plan, undated, reflected the care plan did not address the resident's diagnosis of diabetes. Review of Resident #68's Physician orders, dated 09/27/24, reflected she was prescribed Novolog Flexpen U-100 Insulin diabetes. Review of Resident #68's MAR dated 09/01/24-09/30/24, reflected she was administered Novolog Flexpen per physician's order. An interview with Resident #68 on 09/27/24 at 5:00 PM, revealed she was diabetic and received insulin. In an interview on 07/21/21 at 05:10 PM, with the MDS Coordinator revealed Resident #68 received insulin and was a diabetic. She stated she was responsible for updating Resident #68's care plan. She stated the purpose of a comprehensive care plan was to paint a picture of Resident #68's care. She stated Resident #68's care plan should include her diagnosis of diabetes. She stated she was not aware Resident #68 was not care planned for diabetes and insulin. She stated without Resident #68's care plan updated, the staff would not have knowledge related to care for diabetes with insulin. A policy regarding care plans was requested from the Administrator on 09/27/24 and not provided.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on observation, interview, and record review, the facility failed to ensure personnel provided basic life support, which included CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives for 1 of 5 residents (Resident #82) reviewed for cardio-pulmonary resuscitation. LVN B failed to initiate CPR when she found Resident #82, who was full code status, unresponsive and not breathing. Resident #82 was declared deceased . An Immediate Jeopardy (IJ) situation was identified on [DATE] at 4:42 PM. While the IJ was removed on [DATE] at 12:57 PM, the facility remained out of compliance at a scope of isolated identified as no actual harm with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of death from not receiving life-saving measures if needed. Findings included: Record review of Resident #82's Admission Record dated [DATE] revealed she was an [AGE] year-old female admitted to the facility on [DATE]. The area of the document under the title Advanced Directives was blank. Record review of Resident #82's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 12 indicating she had moderately impaired cognition. She required supervision during eating, maximum assistance for toileting and bathing, and was totally dependent on staff for bed to chair transfers. Her diagnoses included dementia with agitation (loss of memory or other thinking abilities that interferes with daily life); cognitive communication deficit (difficulty with communication caused by disruption in cognition); anemia (lack of red blood cells needed to carry oxygen throughout the body); hypertension (high blood pressure), anxiety disorder and depression. Record review of Resident #82's care plan reflected the following entry dated initiated [DATE], I and/or responsible party have been provided the information explaining the Advanced Directive process and following the education have decided that I am a FULL CODE .Goal: My Full Code will be honored by my family and staff .Interventions/Tasks: My family and staff are aware of my FULL CODE status .Review my Advanced Directive options and Resident Rights quarterly and PRN with me and my family . An entry initiated [DATE] reflected the following: admitted to [hospice company name] Hospice for dx of Dementia .Goal: I will have all needs met, over the next 90 days .Interventions/Tasks: Staff will monitor and report any changes to RP, hospice and physician . Record review of Resident #82's Order Recap Report dated [DATE] reflected the following orders: Full code status with a start date of [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Admit patient to [hospice company name] .call [hospice company name and phone number] for change in condition, falls, labs, Xray, transfer to hospital or in the event of death. Start date [DATE]. Record review of Resident #82's Progress notes reflected the following entries: Entry dated [DATE] at 11:12 AM: Spoke with resident RP [name] via telephone and informed him of resident's decline over the last two weeks. resident has had a loss of appetite, not eating meals normally, she requires more assistance from staff with eating, and now has pressure wounds to her ankles. resident expresses she is in pain lately as well. RP wishes to speak to brother regarding resident's decline so a decision may be made about a possible referral to hospice. social worker verbalized understanding and RP to reach back out once a decision is made. Signed by Social Worker. Entry dated [DATE] at 9:55 AM: Patient refuses to be fed by CNA for breakfast. Patient is lying peacefully with eyes closed unlabored breathing noted. No distress noted. Signed by LVN A. Entry dated [DATE] at 1:38 PM: family requesting hospice eval. social worker to send hospice referral to . hospice agency. Signed by Social Worker. Entry dated [DATE] at 12:38 PM: Patient admitting to hospice. Call [hospice company name and phone number] for change in condition, falls, labs, XRAY, transfer to hospital or in the event of death. PCP notified. Signed by LVN A. Entry dated [DATE] at 9:23 AM: [Hospice company name] hospice nurse visited patient this AM. Patient is gurgling, possible aspiration. Will change diet to pureed and thicken liquids for next meal. Patient is showing signs of swallowing issues. Patient is showing signs of pain PRN morphine given at 9:20AM. Signed by LVN A. Entry dated [DATE] at 6:35 PM: Residents medications were held this evening as she was unable to swallow medications. Resident had audible wet/congestion this afternoon. When resident was checked on prior to dinner resident was breathing, with increased secretions. After dinner resident had no respirations. DON notified. Hospice notified, awaiting response from Hospice Nurse at this time. Signed by LVN B. Entry dated [DATE] at 7:51 PM: Resident passed, awaiting hospice arrival Signed by LVN B. Entry dated [DATE] at 9:13 PM: Hospice nurse in facility for resident. Emergency contact [RP name] Notified of residents passing. MD Notified. Resident to be picked up by [transportation company name] services and taken to funeral home. Awaiting arrival. Signed by LVN B. Entry dated [DATE] at 9:58 PM: Resident taken by [company name] transportation services going to the funeral home. Signed by LVN B. Record review of Resident #82's hospice documentation-Visit Note Report dated [DATE] reflected the following: Visit Type: RN Hospice Start of Care. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Narrative: [Resident #82] is an [AGE] year-old female who is being admitted to hospice services on [DATE] with a primary diagnosis of dementia under the care of medical director, [Hospice MD name]. patient's additional diagnoses include: cognitive communication deficit, htn, anemia, mdd [major depressive disorder], mood disorder, muscle weakness, unspecified abnormalities of gait and mobility [difficulty with walking], muscle wasting, insomnia, anxiety, abnormal uterine and vaginal bleeding, pain, rls [restless leg syndrome-an irresistible urge to move the legs], atrial fibrillation [abnormal heart rhythm], osteoarthritis. Patient is a full code . Patient has been a resident of [nursing facility name] since 2019. Patient is disoriented and unaware of time, place, and situation. Neurological deficits noted as follows: nonverbal, unable to make eye contact, incontinent of bowel and bladder, contractures (permanent or temporary tightening of muscles and tendons causing limited movement of a joint) of bilateral legs, patient unable to make needs known. lung sounds clear to auscultation. respirations even and unlabored. bowel sounds active in all quadrants. Bilateral legs contracted with noted redness to outer left ankle and inner right ankle due to pressure. Area being cleansed with skin prep and monitored. Patient nonambulatory [sic] and is max assist with transfers. six months ago, patient was able to get out of bed and participate with activities and sit up in wheelchair. Per staff, decline has been rapid. appetite is poor as currently patient is consuming ,d+[DATE] bites of 3 meals a day. Three months ago, patient was consuming 50% of three meals a day. Patient has lost 2 lbs in the past two weeks. Patient is bedbound and no longer getting out of bed. Patient has no history of falls . The document was signed by Hospice RN C. During an interview on [DATE] at 8:55 AM, LVN A stated she had worked at the facility for 2 years any worked the 7 AM to 2 PM shift. She stated she had cared for Resident #82 during the day shift on [DATE]. She stated a hospice nurse had been in to see Resident #82 that morning and she appeared to be very uncomfortable. She stated Resident #82 had been grimacing and yelling out. She stated Resident #82 had been declining for a while and her family had decided to place her on hospice services. LVN A stated she did not do a full assessment or get vital signs because the hospice nurse was with her. She stated she never checked the resident's code status because, when on hospice, you think DNR. When shown her progress note and asked about her possibly aspirating, LVN A stated she asked the hospice nurse about it and she wanted to try Resident #82 on a pureed diet. She stated she administered some morphine to the resident and she had slept a lot the remainder of her shift. She stated Resident #82 would not accept any food when the CNAs had attempted to feed her lunch. LVN A stated she knew how to locate the resident's code status by checking their electronic medical records or the binder at the nurse's station. LVN A stated she never checked the status for Resident #82 because she assumed she was DNR because she was on hospice. She stated the risk of not knowing a resident's code status was failing to do CPR which would result in death and not following the resident's rights. LVN A stated facility management had called her on [DATE] and she had received in-service training. She stated they added a binder to the crash cart that included a list of all resident's code status that would be updated daily. She stated, if a resident was DNR, she was supposed to check the documentation to ensure it was complete. If the resident had no code status or was full code, they should initiate CPR immediately and call emergency services. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:27 AM with MA D, she stated she had worked at the facility for the past 2 and a half years and had known Resident #82 for a while. She stated Resident #82's health had been declining and she had not been eating or drinking as much and she had begun to crush some of her medications for her. MA D stated, on [DATE], she thought she recalled the resident was able to take her meds that morning and she had seen her again around lunchtime. She stated she had opened her eyes and was able to reply, hey when greeted but did not speak any more than that. She stated that was the last time she had seen her before she passed away. MA D stated she could tell a resident's code status because it was in the computer and on their Medication Administration Records. She stated she did not know Resident #82's code status the day she passed, did not recall looking for it and was not present when she had stopped breathing. MA D stated she had received in-service training that day related to code status. She stated, she should always get the nurse if there was a change in a resident's condition. She stated, if a resident was unresponsive-they should yell for help, check the code status on the computer, in a binder at the nurse's station and on the crash chart. She stated CPR should be initiated immediately for any resident who was a full code or unknown status. MA D stated she was CPR certified and should assist the nurse as needed in emergency situations. She stated the risk of not knowing a resident's code status was not honoring the resident's wishes and death. On [DATE] at 4:10 PM, an attempt to reach LVN B via telephone was unsuccessful. During a telephone interview on [DATE] at 8:32 AM, LVN B stated she had worked for the facility for about 6 months and usually worked the 2 PM to10 PM shift. She stated she understood how to check a resident's code status and it could be found in the electronic medical record as well as a binder which was kept at the nurse's station. She stated, if a resident was DNR, they were to also check the document for the appropriate signatures. When asked about Resident #82's care on [DATE], she stated she arrived for work around 3:30 PM that day and it had been about 3 weeks since she had worked at the facility. She stated she checked Resident #82 during her initial rounds and noticed she had changed condition. LVN B stated she asked the CNAs and Medication Aide about her and learned Resident #82 was on hospice and had been declining. She stated she checked her vital signs and could not recall if she had documented them but remembers they were stable. She stated the resident would open her eyes and follow her with her eyes but did not speak. LVB B stated she checked on Resident #82 again before dinner and there had been no change. LVN B stated she then went to the dining room to feed residents. She stated she checked on Resident #82 after dinner, and she was very pale and was not breathing. She stated she reported it to the DON and Administrator who had told her to call the hospice company. LVN B stated she called the hospice company and believed it was the answering service. She stated they told her they would contact Resident #82's family and send a nurse out to pronounce death. LVN B stated she did not initiate CPR or call emergency services because she assumed, because Resident #82 was on hospice services, she was DNR status and had not looked for the information. LVN B stated she received a call from facility management on [DATE] and they conducted an in-service over the phone. She stated in-service included the importance of checking the resident's code status and contacting emergency services and initiating CPR for residents who were full-code status. She the facility was implementing an additional binder with all the resident's code status to be kept with the crash cart. LVN B stated the risk of not knowing a resident's code status was, like this, I messed up. I should have coded her and potentially brought her back. She stated the risk was death and not following the resident's wishes. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Social Worker on [DATE] at 2:57 PM, she stated Resident #82's family was provided advanced directive information upon admission. She stated, if a resident does not have a DNR order, they typically review the advance directive information with them and provide a copy of the information for their review. The information is periodically reviewed again during subsequent care plan meetings. If no signed advanced directives are provided by a resident or their responsible party (RP), they resident is considered a full code. The Social Worker stated Resident #82 had begun to physically decline and she had conversations with her RP about the possibility of hospice services. She stated, initially, the RP wanted to send a family member to visit the resident first. She stated the family came to see Resident #82 and decided to place her on hospice services so she set up the referral. The Social Worker stated she did not bring up the issue of Advanced Directives or a Do Not Resuscitate order at that time because they had always opted out of the idea in the past. She stated she asked the hospice company to discuss it with her family during admission. The Social Worker stated she knew the hospice company was working toward getting a DNR order in place but she had not received any information from them. During an interview on [DATE] at 3:40 PM, Hospice RN C stated she was the nurse who admitted Resident #82 to hospice services and pronounced her death. She stated the resident had just come on hospice services three days before she died . Hospice RN C stated they were in the process of getting her DNR orders signed, and her RP had verbalized his wishes for a DNR verbally to her stating he knew she had stopped eating, was declining and losing weight. Hospice RN C stated Resident #82's RP was homebound and unable to physically travel to the facility. An employee of their company had travelled to his home to have him sign her admission documents and was planning another trip to have him sign the DNR documents, but the resident passed away before getting the paperwork done. She stated the physician would not enter an order for DNR without the signed document from the patient's RP. When asked about their protocol for a resident who was possibly aspirating (breathing food or fluids into the lungs) as noted in the nurse's notes on [DATE], she stated there was another Hospice nurse there that morning who had reported those concerns to her and she advised to administer hyoscyamine (a medication to decrease secretions such as excess saliva) and try pureed food or thick liquids. Hospice Nurse C stated she was contacted later that evening about Resident #82's passing and went to the facility to pronounce her death. She stated she contacted the resident's family and physicians. She stated she would not have advised the facility to call 911 because she knew the wishes of her family and she thought the resident had likely been deceased a while before they found her. During an interview on [DATE] at 4:42 PM the DON stated she was notified by LVN B after Resident #82 had passed away. She stated she knew Resident #82 was on hospice services but was unaware at the time the resident was a full code. She stated she was leaving the facility for the day when the nurse notified her, and she did not pronounce the resident's death because she was told the hospice nurse was on her way to the facility. She stated she told LVN B to call her if there was any delay and she would come right back. The DON stated she asked LVN B if the family had been notified and she said no. She stated she directed her to check with the hospice nurse to determine whether they had contacted the family. She stated she did not communicate with the hospice company when they were at the facility earlier the same day. The DON stated the risk of failure to perform CPR when it was appropriate to do so was death. In an interview on [DATE] at 12:59 PM, the Administrator stated she did not recall a nurse telling her Resident #82 had died while she was at the facility. She stated she had gone home sometime after dinner and learned later that she had passed away. She had previously been unaware Resident #82 was a full code at the time she died . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The following Plan of removal submitted by the facility was accepted on [DATE] at 12:57 PM and reflected the following: POR [LVN B] who was the nurse on duty did not perform CPR on a patient who she believed was a DNR. [Resident #82's RP] had not executed the DNR paperwork as Hospice was working out logistics to get the paperwork over to him. [LVN B] was inserviced by DON on [DATE] regarding CPR policy that included education on full code status, when to initiate a full code, and following physicians' orders in regard to code status. Competency was verified via quiz. Immediately on [DATE], CCS [Regional RN] inserviced Administrator and DON on CPR policy to included education on full code status, when to initiate a full code, and following physicians' orders in regard to code status. Competency was verified via quiz. On [DATE], DON/Designee initiated inserviced [sic] with the licensed nurses on CPR policy to include education on full code status, when to initiate a full code, and following physician orders regarding code status. Competency was verified via quiz. Nursing staff will not be allowed to work until inservicing has been completed on [DATE]. At this time, we do not use agency. However, the above content was incorporated into new hire orientation by Administrator effective [DATE]. On [DATE], an audit was completed of all resident code status by DON/Designee. The audit did not find any additional concerns. Medical Director was notified on [DATE]. In order to monitor current residents for potential risks, SW/designee will audit the code status of all residents weekly x4 weeks and monthly thereafter to ensure accuracy. Any negative findings will be corrected and reported to the QAPI committee to ensure continued compliance. The facility QA Committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. Record review of the attached in-service content dated [DATE] revealed it included a copy of the facility's CPR-AED Policy dated revised [DATE] as well as the following: *CODE STATUS TO BE PRINTED NIGHTLY AND PLACED IN BINDER ON CRASH CART-BY NIGHT SHIFT (,d+[DATE]) *CPR MUST BE INITIATED ON ANY RESIDENT THAT DOES NOT HAVE AN OUT OF HOSPITAL DNR. THIS INCLUDES RESIDENTS THAT ARE ON HOSPICE (continued on next page)

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	675525	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	*PHYSICAN ORDERS MUST BE FOLLOWED- FULL CODE/DNR *CODE STATUS IS ON THE PROFILE PAGE- IF YOU CLICK ON HYPERLINK YOU WILL VIEW THE DNR *THE CPR/AED POLICY MUST BE FOLLOWED- EACH NURSE WILL BE EDUCATED AND GIVEN A COPY *IF THE DNR IS NOT SIGNED BY A PHYSICIAN IT IS NOT COMPLETE-AND RESIDENT IS CONSIDERED A FULL CODE *IF FAMILY STATES THEIR LOVED ONE IS A DNR BUT NO DNR HAS BEEN FILLED OUT, CPR MUST BE INNITIATED [sic] *A RESIDENT THAT HAS A COMPLETE OUT OF HOSPITAL DNR AND PHYSICIAN ORDER FOR DNR. THE DNR MUST BE FOLLOWED AND NO CPR PROVIDED An attached Attendance/In-service Record dated [DATE] reflected the training had been conducted by the DON, ADON, and Regional RN and had been completed by 22 nursing staff with completed competency quizzes. Monitoring of the facility's Plan of Removal included the following: Observation on [DATE] at 4:35 PM, the facility's crash cart (a cart that contains emergency supplies to be used during CPR) revealed a binder that contained an Order Listing Report for Advanced Directives dated [DATE]. The report reflected there were 36 residents in the facility who had Full Code status. During an interview on [DATE] at 1:40 PM, the ADON stated she knew Resident #82's health had been declining but had been unaware of her placement on hospice services. She stated she was working in the facility on [DATE] and thought she left sometime around 6:00 PM that day. She stated she learned later in the evening Resident #82 had passed away. The ADON stated she knew Resident #82 had been full code status in the past but did not know whether anything had changed. She stated she was out of the facility a lot that week due to a personal family issue. The ADON stated she had received in-service training for her corporate management on [DATE] and had assisted with providing in-service training to the facility staff afterward. She stated, if a resident was found unresponsive, staff should call for help, have someone check code status and retrieve the crash cart, and call emergency services. If a resident is DNR and on hospice, they should contact the hospice company. She stated they added a list of residents along with their code status to the crash cart and the list would be updated daily. The ADON stated the risk of not knowing a resident's code status included death if the resident was full-code status and performance of CPR against the wishes of someone who desired DNR status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 2:47 PM, the Medical Director stated he had cared for Resident #82 for more than three years. He stated she had deteriorated quickly and had been transferred to hospice services. He stated he did not contract with the particular hospice company used by Resident #82 and he had been notified by the facility of Resident #82's death. The Medical Director stated he had been notified by the facility Administration about the IJ. He stated he had a huge ethical issue if they had done CPR on someone in [Resident #82's] state because of the trauma it would have caused her. When asked about the risk of failure to perform CPR on a resident who was full code status, the Medical Director stated, as a general rule, not taking into account anything else-you should initiate CPR or the resident could pass. The Medical Director stated he had spoken with the Administrator and her superiors about addressing this and other issues on a weekly basis. He stated he believed the nurses should not be placed in a position such as the one that had occurred. He stated he planned to have the issue addressed with the Quality Assurance committee. In an interview with CNA E on [DATE] at 3:39 PM, she stated she worked at the facility for 2 years and typically worked the 2 PM to 10 PM shift. She stated Resident #82 had declined over the previous weeks before she died and needed to be fed. She stated she worked with Resident #82 on the day she passed away and recalled checking on her and changing her. She stated she appeared to be sleeping during the shift and would not accept any dinner when she attempted to feed her. She stated she attempted to place a straw in her mouth and she would not take it and she did not want to push her to drink. She stated she thought she had possibly received some morphine and was on hospice. CNA E stated she had informed LVN B that Resident #82 would not accept any food or drinks. She stated she recalled LVN B checking her after dinner and she had died . CNA E stated she could check a resident's code status on the computer. She stated she had received in-service training. CNA E stated if a resident was found unresponsive, they should call for help, get the nurse, get the crash cart and follow any of the nurse's instructions to assist. She stated the resident's code status could be found in the computer, and in binders at the nurse's station and on the crash cart. During an interview with the Social Worker on [DATE] at 4:09 PM, she stated she had received in-service training related to Advanced Directives and had been assisting with the facility's Plan of Removal. The Social Worker demonstrated the binder kept at the nurse's station which included face sheets and copies of the DNR documents for all residents as applicable. She stated a full audit of all facility residents had been completed the binder was found to be up-to-date and accurate. The Social Worker stated resident status in the computer must never be changed unless all documents were in order and properly signed. She stated she and the MDS Nurse worked together to ensure any changes to a resident's code status was immediately addressed, and both ensured physician orders and properly signed documents were obtained. The Social Worker stated she would be auditing all resident records weekly for the next four weeks then monthly thereafter to ensure accuracy and ongoing compliance. She stated, if she was unable to complete the audit, the MDS Nurse or nursing administrative staff would complete the audit. The Social Worker stated the QA committee would be meeting weekly for the next 8 weeks to review the process and ensure compliance. Interviews were conducted with facility staff across all three shifts on [DATE] from 11:21 AM through 4:43 PM. The staff included, LVN A, CNA M, CNA N, RN F, LVN G, LVN H, LVN I, CNA E, LVN J, LVN K, and CNA L. The interviews revealed they had all received in-service training and could accurately describe how to determine the resident's code status, how to determine whether DNR documentation was complete, how and when to initiate CPR, and how long they should continue CPR. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Administrator on [DATE] at 4:30 PM, she stated the IJ occurred because the charge nurse failed to check code status for a resident who was on hospice and initiate CPR and call 911 when she was found unresponsive. She stated the hospice company failed to ensure they received the proper documentation timely from Resident #82's RP when he expressed his desire for a DNR order. She stated the risk to residents included failure to honor the resident's wishes and death if no CPR was initiated. During an interview on [DATE] at 4:38 PM, the Regional RN stated the IJ occurred due to a failure to check and act upon the code status of a resident and assumed they were DNR because they were on hospice. She stated the risk for failure to initiate CPR was death and failure to honor a resident's wishes. The Administrator was informed the IJ was removed on [DATE] at 6:30 PM. While the IJ was removed, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42283 Based on interview and record review, the facility failed to ensure any drug regimen irregularities identified by the pharmacist were reviewed by the attending physician and the attending physician documented in the resident's medical record their rationale when there was to be no change in the medications for one (Resident #68) of five residents reviewed for medication regimen review. The facility failed to ensure the physician documented a clinical rationale for making no changes to Resident #68's medications after the Pharmacist Consultant had recommended gradual dose reductions for psychoactive medications. This failure could place residents at risk for prolonged use of an unnecessary medication, dependence on unnecessary medications, possible adverse side effects and consequences, and decreased quality of life. Findings included: Record review of Resident #68's quarterly MDS assessment, dated 09/12/24, revealed she was a [AGE] year-old female who admitted to the facility on [DATE]. Her diagnoses included pneumonia, diabetes mellitus, hyperlipidemia, cerebrovascular accident, Non-Alzheimer's Dementia, anxiety disorder, depression, and schizophrenia. Her BIMS score was 3 of 15, which indicated he was cognitively impaired. Record review of Resident #68's care plan, dated 02/21/24, revealed she was taking anti-anxiety medications, antidepressants, and psychotropic medications. Record review of Resident #68's physician orders, dated 09/27/24, reflected she was prescribed the following medications: Hydroxyzine pamoate oral capsule 50 mg; give one capsule by mouth every six hours as needed for anxiety for 14 hours (dated 09/18/24). Lamotrigine Oral Tablet 25 mg; give one tablet by mouth two times a day related to mood disorder due to known physiological condition, unspecified (dated 02/15/24). Sertraline HCL Oral Tablet 100 mg; give one tablet by mouth one time a day related to major depressive disorder, recurrent, unspecified (dated 02/15/24). Xanax Oral Tablet 0.5 mg; give one tablet by mouth every 12 hours related to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, anxiety disorder, unspecified (dated 03/15/24). Record review of consultant pharmacist's medication regimen review dated 08/12/24 revealed lamotrigine 25mg BID consider 12.5mg BID, hydroxyzine 50mg BID since 02/24 consider 25mg BID, Zoloft 100 mg QD since 02/24 consider 50mg BID, and Xanax 0.5mg BID since 224 consider 0.25mg BID. There was no Physician/prescriber response. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #68's August (08/01/24-08/31/24) and September (09/01/24-09/30/24) MAR reflected the pharmacist's recommendation was not followed. Interview with the DON on 09/28/22 at 04:42 AM, revealed the facility did not follow up with the pharmacist recommendations for trial dose reduction of the medications for the month of August 2024. She stated she did not review the medication regimen review. She stated the Corporate Clinical Specialist informed her she was responsible for ensuring the physician was informed of pharmacy recommendations. She stated Resident #68 had minimal risk because she had been receiving the medications for a long time . A policy regarding pharmacy recommendations was requested from the Administrator on 09/27/24 at 5:04 PM and not provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42283 Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. The facility failed to ensure food was properly stored in the facility's kitchen. The facility failed to seal food and dispose of spoiled food. This failure could place residents at risk for food-borne illness. Findings Included: Observation of the facility's refrigerator on 09/24/24 beginning at 9:35 AM revealed: - 2 cantaloupes with fuzzy white and black spots; - 1 white onion with fuzzy white spots; - 1 bag of shredded carrots open and exposed to air; - 1 bag of shredded cheese open and exposed to air; - 1 red onion and small potato on the floor; and - meat thawing in a container with blood dripping on the floor. Observation of the facility's freezer on 09/24/24 beginning at 9:43 AM revealed: -1 bag of tortilla chips open and exposed to air; -1 box of pork steak fritters open and exposed to air; and - 1 box of beef patty fritters open and exposed to air. Observation of the facility's dry storage in the kitchen on 09/24/24 beginning at 9:48 AM revealed: -1 box of country style gray mix open and exposed to air; -1 box of instant puree rice open and exposed to air; and -1 instant food thickener open and exposed to air. Observation of the facility's seasoning shelf on 09/24/24 beginning at 9:56 AM revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-1 container of ground nutmeg open and exposed to air. In an interview with the Dietary Supervisor on 09/27/24 at 5:42 PM, revealed she completed walk throughs of the kitchen in the morning. She stated she checked everything including temperature logs. She stated she ensured dietary staff stored food properly by addressing issues (notifying dietary staff of improper storage and had them correct issue). She stated residents were at risk of food poisoning due to improper food storage . Record review of the facility policy titled Food Receiving and Storage, dated October 2022, revealed Food shall be received and stored in a manner that complies with safe food handling practices. Review of the Food and Drug Administration Food Code, dated 2017 , reflected, .3-305.11 Food Storage. (A) .food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .