STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675672	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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** 49157 Based on interviews and record reviews, the facility failed to immediately notify the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications) for 1 (Resident #21) of 3 residents reviewed for change in condition. 1. The facility failed to immediately notify Resident #21's physician on 11/27/23 when Resident #21 had a substantial increase in pain to her left leg and left shoulder two days after Resident #21 fell in the facility's dining room and landed on her left side on 11/25/23. 2. The facility failed to immediately notify Resident #21's physician before 11/29/23 at 8:30am when Resident #21's radiology report dated 11/28/23 at 5:51pm reflected that Resident #21 had a displaced fracture of her left femur neck (top of the thigh bone at the hip) that occurred when Resident #21 fell in the facility's dining room three days before the x-ray was completed on 11/28/23. On 9/18/24 at 2:06pm an Immediate Jeopardy was identified. While the Immediate Jeopardy was removed on 9/20/24 at 1:35pm, the facility remained out of compliance at a scope of isolated with a severity of no actual harm with potential for more than minimal harm that was not Immediate Jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk of a delay in treatment, decline in physical, mental, and/or psychosocial status, hospitalization , and even death. The findings included: (continued on next page)

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.	Record review of Resident #21's face sheet reflected an [AGE] year-old female that was admitted to the facility on [DATE] with a primary diagnosis of encounter for palliative care (care focused on improving quality of life for people with serious illnesses). Other pertinent diagnoses included congestive heart failure (the heart didn't pump blood effectively and could cause fluid buildup in the lungs), dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), inflammatory polyneuropathy (an auto immune attack on the peripheral nerves that can cause progressive muscle weakness, numbness, loss of reflexes, and pain or tingling in the arms, hands, legs, and feet), major depressive disorder, chronic kidney disease-stage 3 (mild to moderate kidney damage), dyspnea (shortness of breath), edema (swelling), muscle weakness, and muscle atrophy (wasting or loss of muscle tissue). There were no diagnoses related to liver damage or liver failure. Record review of Resident #21's Admission MDS dated [DATE] reflected she had a BIMS score of 00 which indicated she had severe cognitive impairment. Record review of Resident #21's care plan dated 10/27/23 with revisions on 10/30/23, 11/29/23 and 12/6/23 reflected in part: Focus: I have impaired cognitive function/dementia or impaired thought process r/t (Specify). Goal: I will (Maintain or improve) current level of cognitive function through the review date. Interventions/Tasks: Communicate with me, my family/caregivers regarding my capabilities and needs, Notify MD of any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Focus: I have a communication problem: Goal: I will be able to make basic needs known by (verbally/however able to express) on a daily basis through the review date. Interventions/Tasks: Anticipate and meet my needs. Notify MD PRN for changes in ability to communicate, potential contributing factors for communication problems, potential for improvement. Focus: I am at risk for falls r/t [left blank] Goal: I will be free from falls and/or will not experience significant injuries associated with falls through the next review date. Interventions/Tasks: Refer to therapy for screen and/or eval as indicated. Focus: Advanced care planning choices for end-of-life care: Hospice care elected. Goal: I will have my comfort, quality of life and dignity protected an honored through my next review date. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a phone interview on 9/12/24 at 10:05am Resident #21's family member stated that Resident #21 had a history of breast cancer and colon cancer but had received PET (Positron emission tomography) scans for at least the last 3 to 5 years prior to her admission to the facility that showed no cancer anywhere. Resident #21's family member stated that Resident #21 did not have any history of liver damage or liver failure and that Resident #21's primary care physician prior to going on hospice had told Resident #21 and her family member that her kidney disease was stable. Resident #21's family member stated that the reason Resident #21 went into the facility with hospice care was because Resident #21's dementia had progressed to the point that the family member could not take care of her at home anymore. Resident #21's family member stated that Resident #21 went back to the family member's house on 11/30/23 with hospice services because the emergency room physician and the surgeon told the family member that surgery for Resident #21's left hip fracture was not an option due to the resident now having kidney and liver failure. Resident #21 passed away at home on 12/1/23. Record review of Resident #21's progress notes section in the facility's PCC system reflected an entry dated 11/25/23 at 2:38pm by RN I that stated, Resident stood up on her own out of her wheelchair in dining room, did not take any steps but lost her balance and CNA was standing near resident and resident went to the floor, landed on her left side, CNA who witnessed the fall cradled residents head and resident did not hit her head or face on the floor Resident checked for injuries, denies pain, and assisted by 3 staff members back into her wheelchair, DON, RP, and Medical provider notified. Resident taken to her room and vital signs taken and head to toe assessment completed. [sic] Record review of the facility's PCC assessments page for Resident #21 reflected an eINTERACT Change in Condition Evaluation that was entered on 11/25/23 in reference to Resident #21's fall in the facility's dining room on the same date that stated in part, Resident #21 had no complaints of pain. Resident [#21] had a witnessed fall with neuro checks intact, moves all extremities, and no s/s of injuries, skin checked for discoloration none noted at this time [sic]. This document reflected that the physician was notified of Resident #21's fall on 11/25/23 at 2:45pm and the physician's recommendation was to refer Resident #21 for a physical therapy evaluation In an interview on 9/11/24 at 3:50pm, the DON stated, We did not do x-rays at the time [of the fall] because when I looked at the camera, she was self-propelling in the dining room. She was shaking a doorknob and kind of slid out of her chair onto the floor. She did not actually stand and fall. She did not have any bruising at that time. She was being medicated for pain on the 25th (November 2023) because she was post fall and couldn't tell us I have pain here. She just had signs and symptoms of pain. We got an x-ray on the 28th. I don't remember why or what her signs and symptoms were. With hospice patients, hospice won't order x-rays, so we contacted our doctor instead of the hospice physician and that's why there was a delay from the complaint of pain on the 27th to the order on the 28th (of November 2023) In an interview on 9/13/24 at 12:48pm, CNA M stated, On 11/25/23, Resident #21 was in the dining room toward the kitchen washroom area. I was passing by taking people out of the dining room. I saw her getting up off the wheelchair and standing. Once I saw her taking some steps and was unbalanced, I knew she was going to fall so I sprinted over there to try to catch her. It was kind of a slow fall. She was not quite on the floor when I got to her, so I made sure she did not hit her head. When she was on the floor, she was kind of on her left side. Two other people saw it as well and came in to assist me to get her back to her chair. She said she was in pain after that. I can't remember if she said her arm or her hip, but she was saying, ow- it hurts, it hurts. She was just kind of whimpering and saying she hurt when she was assisted back into the wheelchair. (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 Resident #21's MAR dated November 2023 reflected that Resident #21 had an order for Tramadol HCl (a pain medication) oral tablet 50mg to be given by mouth every six hours as needed for pain. Resident #21 did not have any other medications ordered for pain relief. Resident #21 was given Tramadol 50mg on 11/25/23 at 6:25pm for generalized pain at level 5 out of 10 (10 being the worst pain), 11/26/23 at 3:53pm for generalized pain at level 2 out of 10, and 11/26/23 at 10:00pm for generalized pain at level 5 out of 10. On 11/27/23 at 5:44am, LVN J gave Resident #21 Tramadol 50mg for left shoulder and left leg pain at level 10 out of 10. Record review of Resident #21's progress notes page dated 11/6/23 to 12/6/23, assessments page dated 10/27/23 to 11/29/23 in the facility's PCC system and a telephone interview of LVN J on 9/16/24 at 11:48am reflected that Resident #21's physician was not notified of her significant increase in pain on 11/27/23 by LVN J at the time she medicated Resident #21, nor any other time that day. LVN J stated she did not recall why she did not notify the doctor when Resident #21 complained of a 10 out of 10 pain level. LVN J stated if someone fell , she would do range of motion and check them out; if the resident had complained of pain during that, LVN J stated she would have notified the doctor and gotten an x-ray. LVN J stated when an x-ray was done, the nurse would have had to look for the results and that there was no flag or anything to let the nurse know that the results were posted. LVN J stated if she was going off shift, she would pass it on to the next shift to look for the results. LVN J stated they would not be notified by the radiology company. LVN J stated sometimes the x-ray technician would let them know if something did not look right and to keep an eye out for the report. LVN J stated if she pulled up an x-ray report and something looked abnormal or bad, she would notify the physician right away- as soon as she saw the result. LVN J stated she did not know if anyone at the facility got notified automatically of results. LVN J stated that she worked at the facility until March 2024 and had been there for about a year. LVN J stated they discussed notification of changes almost every day and had once a month in-services on various topics. Record review of Resident #21's Physician Orders reflected a left shoulder and hip/pelvis x-ray ordered by RN K on 11/28/23 at 11:30am. Record review of Resident #21's printable view progress notes dated 11/29/23 at 8:34am reflected an entry by RN I that stated, Xray report from Xray of 11/28/23 reviewed and reported to medical provider left shoulder x ray showed no acute fracture, RP states she will think about the situation, but shows grossly displaced femoral neck fracture of left hip, acute fracture. Medical provider recommends send resident too [sic] ER (emergency room) for evaluation of left hip fracture. DON notified. And RP notified and will think about whether she wants notify Nurse when she makes a decision on sending the resident sent out to ER, states she will call back to notify this facility. Call out to the hospice company to notify of positive left hip fracture, left msg to have hospice return my call. [sic] (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 the facility's PCC assessments page for Resident #21 reflected an unsigned eINTERACT Change in Condition Evaluation that was dated 11/29/23 and revealed the situation being reported was Trauma (fall related or other) and that Resident #21 had new pain, left hip pain/left iliac crest (rear)/Left trochanter (hip) and intensity of pain 2 of 10. In the area for observation and evaluation summary, the author documented, Results of x ray to hip positive for Grossly displaced femoral neck fracture of left hip with no discoloration to area. Resident does have pain on left hip, with pain medication. Medical provider notified and recommends to send resident out to ER for evaluation, DON notified of Results of left hip X RAY and RP notified states since resident is hospice, she will need to decide whether she wishes to send resident out to ER, will notify nurses of her decision [sic]. This document also stated that Resident #21's physician was notified on 11/29/23 at 8:40am and the physician recommended Resident #21 be taken by non-emergent transfer ambulance for evaluation of left hip fracture to the ER. In a telephone interview on 9/13/24 at 10:21am a supervisor for the facility's contracted radiology company stated that the result of the left shoulder and hip/pelvis x-ray was automatically delivered by email to the facility's DON and administrator on 11/28/23 at 5:51pm. The supervisor stated that the result was also automatically faxed to the facility's fax number on record on 11/28/23 at 5:51pm, but that it failed. The supervisor stated there was no documentation that the radiology company called the facility to report the significant findings of the x-ray. In an interview on 9/11/23 at 3:56pm the DON stated, If there is a significant finding for an x-ray, I receive an email and they call the facility within, I think, 24 hours. I received the email at 5:51pm (on 11/28/23). Even if I was gone for the day, I would check my email from home. I may have been out with the flu or COVID at that time, but I remember calling the facility that evening. I can't say why the physician was not notified until 8:30 the next morning or why the nurse didn't document anything. The physician and RP should have been notified that evening. A lot of the longer tenure nurses will want to notify the hospice doctor before the facility doctor because they are hospice, but we don't have documentation of that either. If the physician and RP are not notified, it could lead to negative outcomes including untreated pain or worsening of a fracture. The physician and RP should be notified immediately when critical results are received. The DON did not state who she talked to when she called the facility on 11/28/23 about the x-ray results. In a telephone interview on 9/13/24 at 11:00am the MD stated he would expect the doctor or nurse practioner to be notified of any critical/significant results with 30-45 minutes. The MD stated he did not know if it would have made a difference if he had been notified of Resident #21's fractured femur the evening before. The MD stated, if for some reason the facility was unable to contact either the NP or himself, they should just go ahead and send the resident out to the ER. The MD stated that when Resident #21 was treated for 10 of 10 pain specifically to her left leg and shoulder on 11/27/23 following a fall on her left side on 11/25/23, he or the NP should have been notified. The MD stated, What we know of hip fractures in older adults, we need to intervene sooner rather than later because being in bed for three days, especially if they are in pain and probably not eating or drinking well, it can lead to multi organ failure. If we had known about the fracture and intervened earlier, she may have lived a little longer. The MD stated that it was ultimately a hospice decision to x-ray a hospice patient, but if she had not been a hospice patient, it would have been prudent to do an x-ray at the time of the fall. (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.	In an interview on 9/13/24 at 1:11pm the ADON stated for critical findings, the lab or radiology would call the facility and would ask for the nurse of that specific resident. The nurse would talk to them and get the results. After the nurse received the critical or significant finding information, he/she would then call the doctor and see if there were any new orders. The ADON stated, We call the doctor immediately when we have critical results. The ADON stated, That I know of there isn't a specific policy in writing about when to notify the doctor of critical results. In an interview on 9/16/24 at 10:15am, CNA B stated that Resident #21 was on pain meds and would complain of pain mostly in the mornings and later in the day. CNA B stated when Resident #21 was first admitted she was good until the fall on 11/10/23 . After that fall, she got more confused and complained of more pain. I know she was always getting in and out of her chair. CNA B stated if a resident had a bad fall or had to be assessed by physical therapy, the CNAs would not get the resident out of bed until physical therapy saw and assessed them. CNA B stated, I don't recall her (Resident #21) falling at all when I worked on 11/27/23 or 11/28/23 and it was not reported to me that she fell any time after 11/25/23. After the fall, family was here more often than before. I don't think she was eating very well that week. There's nothing more that I can recall. In an interview on 9/16/24 at 11:12am, RN K stated she kind of remembered Resident #21 but did not remember anything specific about the week after Resident #21 fell on [DATE]. RN K stated if she had a resident that had fallen two days prior and then started complaining of a significant increase in pain, she would notify the NP or the doctor to advise them of the increase in pain on the side the resident had fallen on two days before. RN K stated if it was a hospice patient, she would notify the facility (primary) doctor or NP, then hospice. RN K stated in most cases, she would call the facility attending and then let hospice know that she notified the primary doctor. RN K stated if there was an abnormal finding on an x-ray, the radiology company posted the results on the website. RN K stated she did not think the facility got called if there were significant findings. RN K stated she thought that once the results got posted, the facility doctor looked at the results and it went from there. RN K stated she did not recall any time when the DON or ADON went to her and said that there was an abnormal x-ray result and for her to notify the physician. RN K stated if the nurse found something (a significant finding) before the doctor did, then the nurse would call the doctor immediately. RN K stated if the nurse was not able to contact the doctor, he/she was to contact the DON to let her know so that she could follow up. RN K stated the x-ray technician would not tell the nurse if they saw something abnormal on the x-ray. RN K stated that sometimes x-rays would result right away, but sometimes they took a very long time. (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.	In an interview on 9/16/24 at 12:24pm, the DON stated, At that time when abnormal or critical x-rays were received, the facility would receive a phone call with the results. I would also get an email for significant findings. Normally, if I wasn't at the facility, I would call to make sure the nurse knew of the findings. Let's say I didn't see the email or get the email; the x-ray people would call the facility and we could get into the portal and print out the x-ray results. X-ray will call, but sometimes they don't call until the next day. If it was the next day, it was like a follow up call when they'd ask if we saw it. If the facility is notified of an abnormal result (for hospice) it would depend on the nurse whether the primary physician or hospice would get notified first, but they would both be notified. The nurse would need to notify the doctor as soon as they found out about it. In reference to (Resident #21's) x-ray result, I got the email on 11/28/23 at 5:51pm. I was not here (at the facility) at the time, and I don't remember if I called the facility or not. The DON stated that the floor nurse would have had to go into the portal to see if the x-ray result was there. The PCC system did not flag or alert when an x-ray was resulted, the nurse would have to check. The DON stated if the x-ray was not resulted during the day shift, the day shift nurse would pass on to the night shift nurse to look out for the result. If for some reason the night shift nurse did not get the result, then the day shift nurse would follow up the next morning. The DON stated, In general, if there was a critical or significant finding, the physician should have been notified right away. Notification 15 hours later is generally not acceptable. There may be times when that would be ok, but in this particular case, no. The DON stated, She (Resident #21) wasn't x-rayed the day of the fall because she didn't display any signs or symptoms of pain; not even when they were getting her off the floor initially. If she had a significant increase in pain 2 days post fall, it would warrant a notification to the doctor. The DON stated it was important to notify the physician of any significant change in condition or results of diagnostics so that they could provide the best quality of care for the resident. The DON stated if the physician was not notified of changes, the resident's quality of care could have been affected, the resident may not have gotten needed treatment, services, or medication, the resident could have been hospitalized , or it could have even led to death. The DON stated, The policy does not have a specific time frame for notification. The DON stated when a physician was notified of results or a change of condition, documentation included dated and time of notification of provider and RP and any new orders. In an interview on 9/16/24 at 2:14pm the Admin stated, I do get the emails that say significant findings from radiology. If I see that email come through, I contact the DON and make sure she saw it and ask what it is about. If it is a night or weekend, I will still talk to the DON about it, and she will contact facility staff. The Admin stated, If there are significant or critical findings on any diagnostics, the physician should be notified in a timely manner- ASAP. It shouldn't be more than 2 hours once the nurse finds out that they try to notify the physician. 15 hours is not an acceptable time frame. The Admin stated he did not recall seeing a timeframe on the policy. The Admin stated the physician should always be notified if a resident complained of a significant increase in pain. The Admin stated it was important to notify the physician right away for changes in condition so that they could plan the next steps in the resident's care. The Admin stated if they did not notify the physician, the resident may not receive the appropriate care, they could have an adverse effect, they could be hospitalized , or it could lead to death. (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.	In a phone interview on 9/18/24 at 10:56am LVN L stated he worked PRN (as needed) at the facility, usually on weekends. LVN L stated it had been a while since he last worked there and he could not recall what date he worked there last. LVN L stated he remembered Resident #21's name but did not remember anything specific about her. LVN L stated if an x-ray was done, the results may have been faxed to the facility. LVN L stated that he thought had seen a couple of chest x rays come through on the fax before but did not recall that anyone got any significant x-ray results while he was on shift. LVN L stated if he ordered an x-ray and had not received a result after about a couple of hours, he would call the x-ray place and ask about it. LVN L stated that x-ray results could go straight to the resident's profile now. LVN L stated they could go into the results tab and see if the x-ray was resulted. LVN L stated there was not a pop up or anything to remind you to go look at the result. LVN L stated if he got a significant finding, he would call the doctor to let them know as soon as he got the result. LVN L stated in his orientation they went over the things you were supposed to notify the physician for. LVN L stated, I don't remember them saying when specifically, the doctor should be notified after receiving the results. LVN L stated if an x-ray was done on his shift and he had not gotten the result yet, he, as the off going nurse, reported it to the oncoming nurse who would keep an eye out for the result. LVN L stated there was also a piece of paper that stuff was written on to pass along to the next shift. In an interview on 9/18/24 at 2:10pm the DON stated that she never opened the email from the radiology company on 11/28/23. The DON provided a copy of the radiology company's print out of the details of Resident #21's x-ray that was done on 11/28/23. The print-out reflected that a SIGNIFICANT report was emailed to the DON and the Admin on 11/28/23 at 5:51pm. This print-out also reflected that a text message was sent to a phone number and a fax was sent to the facility's fax number with the x-ray findings on 11/28/23 at 5:51pm. The DON and the Admin stated that the fax number that the radiology company had was not the facility's fax number and they did not know why the radiology company had that number. The DON and the Admin also stated that they did not know who the phone number belonged to that the text message was sent to. An internet search on 9/20/24 revealed the fax number that the radiology company sent the result to had been associated with this facility and the phone number that the text message was sent to belonged to the person who was the DON at the facility at the time the contract with the radiology company was signed in 2022. Record review of Resident #21's Nursing Progress Notes reflected an entry by RN I dated 11/29/23 effective at 11:17am that stated, RP present, resident being transported per (non-emergent ambulance) stretcher report given to ambulance driver, and resident transported with paperwork and copy of DNR to ER, DON aware. [sic] Record review of Resident #21's Medication Administration Note reflected an entry by LVN J dated 11/29/23 effective 10:12pm that stated, admitted to hospital. Record review of Resident #21's Medication Administration Note reflected an entry by RN I dated 11/30/23 effective 11:23am that stated, At hospital. In an interview on 9/12/24 at 10:47am, the ME stated that Resident #21 passed away at home on 12/1/23 and that she ruled Resident #21's death as, Accident- Accidental fall/ complications of femur fracture, fall, dementia, hypertension, and COPD. The ME stated she did not do an autopsy, but rather reviewed all of Resident #21's medical records. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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.	Record review on 9/18/24 of the facility's radiology company contract that was signed on 2/8/22 reflected in part: SERVICES: 4. REPORTS The Radiologist will dictate a report to the attending physician for each examination. (The x-ray company) will provide a written copy of the written report to the community and to the attending physician. 6. WEB ACCESS (The x-ray company) agrees to provide the Community with direct access to patient records on the (x-ray company's) website. There was no part of the provided contract that discussed if, how, or when the facility would be notified of significant findings. Record review of this contract also revealed that it was signed by the current Admin on 2/8/22. Record review of the facility's Changes in Resident Condition Policy revealed in part: Compliance Guidelines: The resident, medical provider (MD/NP/PA) and resident representative or designated family member should be notified when changes in condition or certain events occur. Communication with the interdisciplinary team and caregivers is important to facilitate consistency and continuity of care. Guidelines: 1. The resident, medical provider (MD/NP/PA) and resident representative or designated family member should be notified when there is: c. a significant change in the resident's physical, mental, or psychosocial status; 1) assess and document changes in; 2) provide assessment information to physician and 3) provide clear comprehensive documentation g. when laboratory, radiology or other diagnostic results fall outside the clinical reference ranges set by the contracted service provider or per physician orders. This policy did not indicate a timeframe for notifying the resident's physician or nurse practitioner after diagnostic results that fell outside of the clinical reference ranges were received. (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.	An Immediate Jeopardy was identified on 9/18/24 at 11:15am. The Admin was informed of the Immediate Jeopardy, given the Immediate Jeopardy template, and a Plan of Removal was requested on 9/18/24 at 2:06pm . The facility's Plan of Removal was accepted on 9/19/24 at 8:49pm. The facility's Plan of Removal included: [Facility] Plan of Removal F580 Notification of Changes in Condition Date: September 18, 2024 Corrective Action: Resident #21 who was admitted on [DATE] under hospice services for end-of-life care for diagnoses of Renal Failure, Liver Failure, Congestive Heart Failure, and Malignant Neoplasm of Left Breast sustained a witnessed fall on 11/25/23. Resident assessed by charge nurse and risk management report completed and MD/RP/hospice notification made. Non stat X-ray order obtained on 11/28/23 and positive fracture results received on 11/29/23 and reported to MD and hospice with hospice collaboration for RP notification. Resident discharged to hospital on 11/29/23. Resident #21 is no longer an active resident within our community. Resident #21 was assessed and being monitored by the nurses prior to being sent to the hospital on 11/29/23. Per hospital report, resident did not receive any treatment for fracture and was discharged home with family. Identification: All residents with change in condition may be at risk for the alleged deficient practice. Director of Nursing/Assistant Director of Nursing conducted an audit of all residents with recent (in last 60 days) to identify any changes in condition to include increased pain needs in order to ensure the MD/NP/PA have been notified and appropriate interventions were in place, as well as to ensure family representatives have been notified. Outcome: Date Completed: 9/18/24. Systematic Changes: The Regional Nurse (DCO) conducted an in-service to the Director of Nursing/Assistant Director of Nursing regarding the process for nurses to assess resident changes in condition to include pain and report any significant increase in pain and changes in condition identified to the MD/NP/PA. The nurse should ensure interventions are in place to address the resident's change in condition and/or pain needs and nurse should document in the electronic health record. Date Completed: 9/18/24. (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.	Director of Nursing/Assistant Director of Nursing conducted in-service training to all licensed nurses prior to next scheduled shift regarding: a. The process for ensuring that changes in condition have been identified to include pain and reported to MD/NP/PA. Orders given should be implemented as ordered and nursing should document in the electronic health record. b. Nurses will communicate during change of shift nursing report any changes in condition to include pain and ensure proper interventions are in place and notifications to the MD/NP/PA have been completed. c. Charge Nurses educated to follow HHSC guidance that indicates that the nurse should conduct a post fall assessment following the fall event. The nurse will continue ongoing monitoring of the resident following a fall event and should conduct follow up assessments upon any changes in condition identified. The nurse should then notify the medical provider upon identifying the change in condition or abnormal findings. The physician should be notified promptly upon identification of a change in condition and/or significant/critical abnormal diagnostic report. Typically, the notification will occur immediately but no more than two hours of being identified. The nurse will then attempt to contact the physician at minimum once per shift until the notification has been made. Date Completed: 09/19/24 The Regional Nurse (DCO) conducted an in-service to the Director of Nursing/Assistant Director of Nursing regarding the

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident, consistent with the resident's rights, that includes measurable short-term and long-term objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment for 1 (Resident #21) of 3 residents reviewed for care plans in that: 1. The facility failed to retain Resident #21's DNR (Do Not Resuscitate) code status on the comprehensive care plan when Resident #21 was transferred to the hospital. 2. The facility failed to ensure Resident #21's DNR code status was included in Resident #21's comprehensive care plan when it was signed by the physician on [DATE]. 3. The facility failed to ensure Resident #21's comprehensive care plan was updated to reflect an unwitnessed fall in Resident #21's room on [DATE] at 9:30pm. 4. The facility failed to ensure Resident #21's comprehensive care plan was updated to reflect an unwitnessed fall in Resident #21's room on [DATE] at 4:30am. 5. The facility failed to ensure Resident #21's comprehensive care plan was updated to reflect a witnessed fall in the facility dining room on [DATE] at 2:30pm. 6. The facility failed to retain Resident #21's Latex allergy on the comprehensive care plan when Resident #21 was transferred to the hospital on [DATE]. These failures could place residents at risk of not receiving individualized care and services to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing. The findings included: Record review of Resident #21's face sheet reflected an [AGE] year-old female that was admitted to the facility on [DATE] with a primary diagnosis of Encounter for Palliative Care (care focused on improving quality of life for people with serious illnesses). Other pertinent diagnoses included congestive heart failure (the heart didn't pump blood effectively and could cause fluid buildup in the lungs), dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), inflammatory polyneuropathy (an auto immune attack on the peripheral nerves that can cause progressive muscle weakness, numbness, loss of reflexes, and pain or tingling in the arms, hands, legs, and feet), major depressive disorder, chronic kidney disease-stage 3 (mild to moderate kidney damage), dyspnea (shortness of breath), edema (swelling), muscle weakness, and muscle atrophy (wasting or loss of muscle tissue). There were no diagnoses related to liver damage or liver failure. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview on [DATE] at 9:03am Resident #21's family member stated that Resident #21 had a history of breast cancer and colon cancer but had received PET (Positron emission tomography) scans for at least the last 3 to 5 years prior to her admission to the facility that showed no cancer anywhere. Resident #21's family member stated that Resident #21 did not have any history of liver damage or liver failure and that Resident #21's primary care physician prior to going on hospice had told Resident #21 and her family member that her kidney disease was stable. Resident #21's family member stated that the reason Resident #21 went into the facility with hospice care was because Resident #21's dementia had progressed to the point that the family member could not take care of her at home anymore. Record review of Resident #21's Admission MDS dated [DATE] reflected she had a BIMS score of 00 which indicated she had severe cognitive impairment. Record review of Resident #21's Care Plan dated [DATE] with revisions on [DATE], [DATE] and [DATE] reflected in part: The original care plan had some correct information, however when Resident #21 went to the hospital on [DATE], the DON revised the care plan and did not retain the original necessary information or added necessary information that was not on the original care plan. **Note: The following part of Resident #21's Care Plan was not visible unless the Care Plan with Revisions was reviewed: 1.) FOCUS: o RESOLVED: I/Family/RP has completed documentation for DNR status. I wish to be designated as DNR Date Initiated: [DATE] Created on: [DATE]. Created by: SW. Revision on: [DATE] Revision by: DON. Resolved Date: [DATE]. GOAL: o RESOLVED: Community will follow DNR status request through review date Date Initiated: [DATE] Created on: [DATE]. Created by: SW. Revision on: [DATE] Revision by: DON. Target Date: [DATE] Resolved Date: [DATE]. INTERVENTIONS / TASKS: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	INTERVENTIONS/ TASKS: o *Anticipate & meet needs & keep call bell within reach as indicated. Date Initiated: [DATE] Created on: [DATE]. Created by: NAC. o *Keep commonly used items close to resident for easy access. Date Initiated: [DATE] Created on: [DATE]. Created by: NAC. o *Bed at appropriate height when unattended. Date Initiated: [DATE] Created on: [DATE]. Created by: DON. o *Educate on importance of wearing non-slippery shoes when standing, walking or moving about in w/c. Date Initiated: [DATE] Created on: [DATE]. Created by: DON. o *Refer to therapy for screen and/or eval as indicated. Date Initiated: [DATE] Created on: [DATE]. Created by: DON. **Note: The following part of Resident #21's Care Plan was not visible unless the Care Plan with Revisions was viewed: 5.) FOCUS: o RESOLVED: I am allergic to Latex Date Initiated: [DATE] Created on: [DATE]. Created by: NAC. Revision on: [DATE] Revision by: DON. Resolved Date: [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GOAL: o RESOLVED: I will not have any adverse reactions to allergies through review date. Date Initiated: [DATE] Created on: [DATE]. Created by: NAC. Revision on: [DATE] Revision by: DON. Resolved Date: [DATE]. INTERVENTIONS / TASKS: o RESOLVED: Ensure a list of my allergies go with me to the physician, pharmacy, and hospital Date Initiated: [DATE] Created on: [DATE]. Created by: NAC. Revision on: [DATE] Revision by: DON. Resolved Date: [DATE]. Record review of Resident #21's Assessments page in the facility's PCC system reflected an entry dated [DATE] for Nrsg: Neuro checks tscv2, TYPE: Fall Neuro. Resident #21's Assessments page also revealed 2 entries dated [DATE] for Nrsg: Neuro Checks tscv2, TYPE: Admission and Nrsg: Post Fall Review (SBAR), TYPE: Post fall review as well as 2 entries dated [DATE] for eINTERACT Change in Condition Evaluation-V5. 1, TYPE: Initial and Nrsg: Post Fall Review (SBAR), TYPE: Post Fall Review. Record review of Resident #21's Progress Notes- All Notes page in the facility's PCC system reflected on entry written by the DON on [DATE] at 4:38pm with an effective date and time of [DATE] at 4:37am that stated, LATE ENTRY Note Text : SN was making rounds resident was observed in bed and as SN returned to nurse's station heard yell from 100 hall and went to investigated and found that this resident's room, upon entering the room, patient was observed on the floor faced down and laying on her belly with her right arm underneath her, next to her bed, her head was at the foot of the bed. Upon skilled nurse assessment, skin tear noted to top of the right hand, c/o pain to right wrist when touched, a small open area noted to bridge of her nose with blood observed to site. Door open to room, call light on. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:12pm, the DON stated the initial care plan was done on admission and within 48 hours of admission. The DON stated the initial care plan was generated from the admission assessment and included comorbidities such as risk for infection, anticoagulants, heart disease, hospice, end of life, tracheostomy and/or ventilator, transfers and lifts, dialysis, cardiac issues, cognition, vision, hearing, skin concerns, bowel and bladder, antidepressants, antianxiety medications, hypnotics, antipsychotics, exit seeking, allergies, code status, preferred name, self-care deficits, dementia, nutrition and hydration, feeding tube, fall risk, discharge planning, and mental health behaviors or issues. The DON stated that the facility did not have the DNR paperwork when the resident was admitted . The DON stated the DNR was signed by the physician and uploaded into the system on [DATE] and she did not know why it did not get put on the care plan until [DATE]. The DON stated she did not know why or how the DNR status was, Resolved on the care plan on [DATE]. The DON stated, [DATE] was the date that the nursing admission assessment was locked. My guess is at the time of admission we did not have the DNR and she (Resident #21) was put in as a full code. When I went back in to lock the assessment, it locked in as a full code, maybe. The DON stated that everything that was in the initial assessment should show in the care plan, including the things that were not locked until [DATE]. The DON stated that it was everyone's responsibility to update the care plan and that they did DNR audit as needed to make sure that they had the correct code status. The DON stated, The nursing staff doesn't have any set schedule to do DNR audits, but the social worker probably does. The DON stated that not having a resident's code status on the care plan could potentially cause an issue because if the resident had a DNR order and coded but the code status was unclear, CPR might be started, which would not have been the resident's or the RP's wishes. In an interview on [DATE] at 3:01pm, the NC stated that Focus, Goal, and Interventions/ Tasks items that were created and initiated on the same day that the DON entered them would normally be new things (focuses, goals, interventions/tasks) that were entered. The NC stated, If I do the admission assessment and lock it by signing it, that will show up in the care plan for that day. For something to show as Resolved, someone has to go in and actually resolve that specific area. The NC stated she was not sure why the DNR code status showed Resolved and reverted to full code on Resident #21's care plan. When asked about the Focus of, I wish to be called by my preferred name (specify), The NC stated it was the responsibility of the person who initiated that focus to update the care plan and specify the name. The NC stated that anyone who could have updated the care plan, should have updated the care plan. The NC stated she did not know why Resident #21's DNR status did not get put on the care plan until [DATE], 21 days after admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 11:50am, LVN D stated, Admission assessments are signed by putting in your log in information once you are done with each section. It is signed to show that you completed it. It gets flagged if not completed, but I am not sure where that shows up. I think if it does not get signed, the DON and ADON get notified. LVN D stated the baseline care plan was created by the admission assessment. LVN D stated certain things would get triggered once each section was completed and she would go in and check all the appropriate boxes. LVN D stated she had never not completed an assessment, so she did not know what happened if a section was not signed. LVN D stated her preceptor gave her specific training on admission assessments and helped her with the first few that she did. LVN D stated she did not recall getting in services on admission assessments. LVN D stated code status was established during the admission assessment; if the resident wanted to be a DNR, they had to have a valid OOH (out of hospital) DNR form. LVN D stated for the OOH DNR form to be valid, it had to have the resident's (or RP's) signature, 2 witness signatures, and the physician's signature. LVN D stated if the resident had the form and it was valid, it had to be scanned into the system and the order for DNR was entered. LVN D stated that the form was placed in the medical records folder at the nurse's station, the medical records person picked it up every morning and scanned it into the system. LVN D stated as far as she knew, medical records had the hard copy of the DNR forms. LVN D stated if she had a resident with a DNR form that was missing the physician's signature, she would call the physician to make him or her aware of it, and that the social worker or MDS nurse would help with that, also. LVN D stated if a resident coded before the DNR got a physician signature, she would initiate CPR (Cardiopulmonary Resuscitation). In an interview on [DATE] at 12:43pm, LVN A stated when she was hired, she shadowed a nurse the first day, then did skills check offs on the second day. LVN a stated she was specifically trained on admission assessments. LVN A stated after an LVN did an admission the RN, usually the MDS nurse, would go over it and add or take away things as needed. LVN A stated admission assessments were done as soon as the resident entered the facility and included a head-to-toe assessment, skin assessment, dentures, hearing aids, any other devices, the resident's abilities, diet, and code status. LVN A stated if the resident was a DNR, she would make sure the form was complete, then filed it in the medical records folder for the medical records people to scan it into the computer. LVN A stated if a resident came in on the weekend and had a valid DNR form she would make a copy of it and put it on her pass down. LVN A stated typically, Hospice would meet the resident at the facility to make sure that the medications were there, the orders were done, and all the necessary paperwork was done. LVN A stated if the DNR was not signed by the hospice physician, they would typically call the hospice doctor to get the signature. LVN A stated at the end of the admission assessment they would enter their electronic signature into the box that asked, Sign and save? LVN A stated the admission assessment was supposed to be answered completely and signed, and if it was not signed, the DON and/or ADON would get a report that showed what was incomplete. LVN A stated the DON or ADON would go to the nurse and had them fix it, but sometimes it was a couple of weeks later. LVN A stated a baseline care plan was developed from the admission assessment. LVN A stated if there were things that were getting missed often, the nursing staff would be in serviced on those topics. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 2:40pm, the SW stated she reviewed code status on admission (the first or second business day after admission) and quarterly. The SW stated she would update care plans with other information such as discharge planning, evacuation plan, and social history. The SW stated if the resident presented a completed OOH DNR, she would go into the care plan, resolve the full code status and put in the DNR status. The SW stated she would take the completed DNR form to the nurse's station, ask the nurse to get the order for DNR and update it in PCC, then place the form in the medical records folder for it to be uploaded. The SW stated she thought that medical records kept a hard copy of DNRs in their office. The SW stated she did not know why there would be a delay in putting a DNR on the care plan. The SW stated there was no specific time frame for doing code status audits, but that they had to be done on admission and quarterly and she would sometimes just check over things. The SW stated there was no specific policy except quarterly because that was when they had care plan meetings. The SW stated the code status was updated on the care plan so that everything matched in the resident's chart. The SW stated if something was not updated in the care plan, it would cause issues with the resident's plan of care. The SW stated that she was out on leave for over a month and did not return until 4 days after Resident #21 was admitted . The SW stated she had to go back and review all the residents that were admitted while she was out and that was why there was a delay in care planning Resident #21's DNR status. In an interview on [DATE] at 3:48pm, the NAC stated the baseline care plan was developed when the resident got admitted and it was developed from the nursing admission assessment. The NAC stated she did not know if the admission assessment being signed or locked at a later date would Resolve a code status if the original status was different than what was care planned. The NAC stated she oversaw the care plans and when a resident was admitted , she would review it on the next business day and edit or complete the care plan as needed. The NAC stated, I have no idea if the admission assessment being signed/locked after I put something directly into the care plan would resolve my entry. The NAC stated they had 48 hours to enter a baseline care plan and until the 21st day after admission to make it comprehensive. The NAC stated she did not know when or how the comprehensive assessment would be done. The NAC stated they did a 72-hour care plan meeting and confirmed the code status with the resident and family at that time and that the code status should be care planned within the first couple of days. The NAC stated that Resident #21's DNR states should have been care planned sooner than 17 days after it was signed by a physician and 21 days after admission. The NAC stated she may have waited to care plan Resident #21's DNR status because the admission assessment was not completed. The NAC stated if she found an admission assessment that had not been completed, she would let the DON and/or ADON know that it needed to be completed. The NAC stated, Now I go in and complete what needs to be completed so that the care plan reflects the resident's and/or family member's wishes about the plan of care. The NAC stated the created date and the initiated date on the care plan could be different if the admission/ readmission assessment was started on one date and signed/locked on a later date or in the case of a readmission such as a resident that transferred back from the hospital, the created date would be from the original admission assessment and the initiated date could be from the readmission assessment. The NAC stated she did not know of a way to see who filled out which sections of the admission assessment or when it was filled out if it was not signed by the admitting nurse when it was done. The NAC stated she thought the care plan would show both code statuses if the admitting status was different than what was entered later. In an interview on [DATE] at 11:00am, the MD stated he would expect the admitting nurse to notify him if there was a DNR that needed his signature so that there would not be a significant delay in entering a DNR order. The MD stated he had the ability to have a DNR form emailed or faxed to him so that he could sign it and send it back, whether it was during business hours or a night/weekend. (continued on next page)

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River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on [DATE] at 1:11pm, the ADON stated the comprehensive care plan was a team effort; LVNs could do the baseline care plan through the admission assessment, but an RN had to view it and make modifications if needed. The ADON stated there was not any one person who was responsible for the comprehensive care plan. The ADON stated in the admission assessment you could click the save and next button once each section was finished and then click the option to sign all for the whole assessment. The ADON stated if there were sections that were already signed and someone went in and clicked the sign all button, it would not over sign the sections that were already signed. The ADON stated she thought if the admission assessment had a full code but there was a DNR put into the care plan later, it would just show both if the admission assessment was locked after the DNR was put into the care plan. The ADON stated anyone could add to the care plan as necessary. Record review of the facility's Care Plans policy dated ,d+[DATE] and revised ,d+[DATE] reflected in part: Guidelines: The community develops a comprehensive care plan for each resident that includes measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan should be reflective of the identified problem or risk, a measurable outcome objective and appropriate intervention(s) in relation to the identified problem or risk, outcome objective, and the resident's ability, needs, medical condition, preventative measures. The care plan may also include the expressed preferences. The care plan in conjunction with the plan of care throughout the medical record is developed and or recommended to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The IDT should include within the care plan the right to refuse any recommended care, treatment or services identified but that is not provided due to the resident exercising his or her right to refuse care, service, or treatment, as well as the resident's legal representative acting on behalf of the resident. The care plan should be initiated upon admission, continued to be developed during the initial ,d+[DATE] hrs. , throughout the completion of the admission comprehensive assessment. The care plan should be updated and reviewed at least quarterly thereafter, then annually and with significant changes in condition as defined in the RAI manual. Additional updates to the care plan may be done as indicated. The care plan should be developed no later than seven days following the completion of the comprehensive assessment.

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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** 49157 Based on interview and record review the facility failed to develop a comprehensive care plan within 7 days after completion of the comprehensive assessment for 1 (Resident #21) of 3 residents reviewed for care plan timing. The facility failed to ensure that Resident #21's comprehensive care plan was developed within 7 days of a comprehensive assessment or within 21 days of Resident #21's admitted [DATE] and comprehensive assessment date of 10/31/23. These failures could place residents at risk of not receiving individualized care and services to attain or maintain the residents highest practicable physical, mental, and psychosocial wellbeing. The findings included: Record review of Resident #21's face sheet reflected an [AGE] year-old female that was admitted to the facility on [DATE] with a primary diagnosis of Encounter for Palliative Care (care focused on improving quality of life for people with serious illnesses). Other pertinent diagnoses included congestive heart failure (the heart didn't pump blood effectively and could cause fluid buildup in the lungs), dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), inflammatory polyneuropathy (an auto immune attack on the peripheral nerves that can cause progressive muscle weakness, numbness, loss of reflexes, and pain or tingling in the arms, hands, legs, and feet), major depressive disorder, chronic kidney disease-stage 3 (mild to moderate kidney damage), dyspnea (shortness of breath), edema (swelling), muscle weakness, and muscle atrophy (wasting or loss of muscle tissue). There were no diagnoses related to liver damage or liver failure. In a phone interview on 9/10/24 at 9:03am Resident #21's family member stated that Resident #21 had a history of breast cancer and colon cancer but had received PET (Positron emission tomography) scans for at least the last 3 to 5 years prior to her admission to the facility that showed no cancer anywhere. Resident #21's family member stated that Resident #21 did not have any history of liver damage or liver failure and that Resident #21's primary care physician prior to going on hospice had told Resident #21 and her family member that her kidney disease was stable. Resident #21's family member stated that the reason Resident #21 went into the facility with hospice care was because Resident #21's dementia had progressed to the point that the family member could not take care of her at home anymore. Record review of Resident #21's Admission MDS dated [DATE] reflected she had a BIMS score of 00 which indicated she had severe cognitive impairment. Record review of Resident #21's Care Plan dated 10/27/23 and revised on 10/30/23, 11/29/23 and 12/6/23 reflected in part: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The original care plan had some correct information, however when Resident #21 went to the hospital on 11/29/23, the DON revised the care plan and did not retain the original necessary information or added necessary information that was not on the original care plan. a.) FOCUS: Admission/Readmission Care Plan; I may be at risk for: self-care deficit, falls, skin concerns, pain, infection, nutritional/ hydration concerns, and emotional distress. Date Initiated: 11/29/23. Created On: 10/30/23. Created by: NAC. Revision on: 11/29/23. Revision by: DON. - Admission Care Plan; I may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns and emotional distress. c. LTC admission from home on hospice services Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. Revision on: 10/30/2023 Revision by: NAC. - Admission/Readmission Care Plan; I may be at risk for: self-care deficit, falls, skin concerns, pain, infection & nutritional/hydration concerns, and emotional distress. c. Respite care admission from home on hospice services. Date Initiated: 10/30/2023 Created on: 10/30/2023. Created by: NAC. GOAL: - Resident's condition will be stable and his/her needs will be anticipated and met as indicated. Resident's emotional needs will be supported, and resident will adjust to placement without any sign of emotional distress noted. Resident will not experience a health decline, will tolerate medication/treatment and progress towards goals established until the comprehensive plan of care can be developed. Date Initiated: 10/30/2023 Created on: 10/30/2023. Created by: NAC. INTERVENTIONS/ TASKS: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-*1. Administer medication, care, and treatments as per MD recommendation. 2. Provide ADL care as indicated. E. Monitor psycho-social status or monitor behaviors to establish targeted behaviors. 4. Monitor vital signs and health condition as indicated. 5. Notify PCP and RP of any change in condition as clinically indicated. 6. See nurse for any care related questions or concerns. Date initiated: 10/27/23. Created on:10/30/23. Created by: NAC. -**7. Therapy services as ordered by the physician. 8. Social services as indicated. Mental health providers as ordered. 9. Coordinate all essential medical and/ or mental health provider visits or telehealth visits as indicated. 10. Provide care and safety checks throughout shift. 11. Nutrition/ hydration (food/ foods) within prescribed diet. 12. Provide care and services as indicated. 13. Provide teaching regarding medication, treatment, care and health status as needed. 14. Activities as tolerated. Date initiated: 11/29/23. Created on: 11/29/23. Created by: DON. *Admission/re-admission Orient resident to the community, dining times, resident areas, activities, therapy, call bell type and usage, lights, TV, remote, bed usage, bathroom. Date initiated: 11/29/23. Created on: 11/29/23. Created by: DON. *Collaborate with IDT/Care Team and Resident/Representative to determine resident's usual functional ability within the first 3 days post admission. Date initiated: 11/29/23. Created on: 11/29/23. Created by: DON. *Interview Patient/Representative regarding: home medications, ADL and care needs/preferences, medical appointments, and discharge plans. Communicate with IDT as indicated. Date initiated: 11/29/23. Created on: 11/29/23. Created by: DON. *Collaborate with Hospice Agency Partner for orders, care and services as indicated. Date initiated: 11/29/23. Created on: 11/29/23. Created by: DON. b.) FOCUS: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o I have a Self-Care deficit r/t (DX) *Cognitive Impairment, *Poor physical functioning Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. Revision on: 10/30/2023 Revision by: NAC. GOAL: o *I will maintain or improve my ability to participate in my care with ADLs through my next review date. Date Initiated: 10/30/2023. Created on: 10/30/2023. Created by: NAC. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023 o Resident will experience safe transfers through next review date Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023. Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS/ TASKS: o Bathing/Shower Schedule: I prefer to be showered 2-3 times weekly & as needed. INDICATE SHIFT: DAY Date Initiated: 10/27/2023. Created on: 10/30/2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Created by: NAC. Revision on: 10/30/2023. Revision by: NAC. o Dressing & Grooming: x 1 person assistance Date Initiated: 10/27/2023. Created on: 10/30/2023. Created by NAC. o Bathing/Shower Schedule: I prefer to be showered 2-3 times weekly 2 or 3 days of week. INDICATE SHIFT: Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Bed Mobility: x 1 person assistance Date Initialed: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Bed Mobility: x 1 person assistance as needed only Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Eating & Drinking: Set Up Assistance Needed; then usually able to feed self but may require more physical assistance at times x 1 person assistance Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Eating & Drinking: Supervision, Coaxing and Encouragement during meals as needed. Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Hygiene: X 1 person assist. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Mobility: I use a wheelchair Date Initiated: 11/29/2023. Created on: 11/29/2023. Created by: DON. o Toileting/Incontinent Care x 1 person assistance Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o TRANSFER: x1 assistance more assistance at times / as needed only Date Initialed: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Turning & Repositioning: On rounds and as needed Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o TRANSFER: Sit To Stand x1 Team Member Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. c.) FOCUS: o I am at risk for oral care issues: Partial Dentures/ Plate noted. Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. Revision on: 10/30/2023 Revision by: NAC. GOAL: o I will not experience any problems such as infection, abscess or other oral concerns through my next review date. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 10/30/2023. Created on: 10/30/2023. Created by: NAC. Revision on: 12/06/2023 Revision by: NAC. Target date: 11/29/23. INTERVENTIONS/ TASKS: o *Provide oral care as indicated. Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. o *Report any abnormal oral findings to MD as indicated. Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. o Provide and set up oral care supplies as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Denture cleaning and care twice daily as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Coordinate referrals, appointments and transportation to dental appointments as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. d.) FOCUS: o I have dementia Date Initialed: 10/27/2023 Created on: 10/30/2023. Created by: NAC. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 10/30/2023 Revision by: NAC. GOAL: o I will current level of cognitive function through the review date. [sic] Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. Revision on: 10/30/2023 Revision by: NAC. INTERVENTIONS/ TASKS: o *Keep my routine consistent and try to provide consistent caregivers as much as possible in order to decrease confusion. Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. o Administer medications as ordered. Observe for side effects and effectiveness. Date Initiated: 10/27/2023 Created on: 10/30/2023. Created by: NAC. o Communicate with me, my family/caregivers regarding my capabilities and needs Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Discuss concerns about confusion, disease process, NH placement with me, my family/caregivers. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Notify MD of any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. e.) FOCUS: o I have a communication problem: Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will be able to make basic needs known by (verbally/ however able to express) on a daily basis through the review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS / TASKS: oAnticipate and meet my needs. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Notify MD PRN for changes in: Ability to communicate, Potential contributing factors for communication problems, Potential for improvement. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Refer to Audiology for hearing consult as ordered. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o *Report to Nurse changes in: Ability to communicate, possible factors which cause/make worse/make better, communication problems. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *When communicating ensure that the environment is suitable for adequate hearing and understanding, adjust volume of TV/Radio etc to ensure both parties are able to hear and participate in conversation. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Provide translator as necessary to communicate with me. Translator is (Specify) Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Refer to speech therapy for evaluation and treatment as ordered. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. f.) FOCUS: o I am at risk for nutritional deficits and/or dehydration risks r/t [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will maintain adequate nutritional status as evidenced by maintaining weight without s/s of significant weight changes & no s/s of malnutrition or dehydration through review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS / TASKS: o *RD to evaluate and make diet change recommendations PRN. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Offer me an alternate meal or supplement if I eat less than 50% of my foods at each meal. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Provide education to me/my representative regarding why the recommendations were made and the potential complications that may arise if the recommended diet/fluids are not followed. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Consult with and Coordinate transportation to specialty medical provider as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. g.) FOCUS: o My skin is fragile, and I am at risk for skin injury--new or worsening skin condition. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will have intact skin, free of redness, blisters, or discoloration by/through review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675672	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS / TASKS: o *Apply treatment as ordered. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Keep clean & dry and apply skin barrier cream as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Therapeutic pressure reducing w/c cushion. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Turn & Reposition regularly during rounds and more often as needed. Handle fragile skin with caution & report to nurse if any skin concerns arise. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. h.) FOCUS: o I am at risk for experiencing discomfort or pain r/t: [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will maintain a tolerable comfort level and will not experience any physical or emotional distress that will affect my daily activity through my next review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. NTERVENTIONS / TASKS: o Monitor for s/s of substance abuse, such as changes in resident behavior, increased unexplained drowsiness, lack of coordination, slurred speech, mood changes, and/or loss of consciousness, etc. If s/s are noted, notify MD and/or DON. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Administer my medication to relieve my pain as recommended by my doctor. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Attempt non-pharmacological interventions to promote comfort and relaxation. (dim lights, reposition with pillows, fluff pillows, give a gentle back rub, apply lotion by softly rubbing arms and legs, lower noise level, offer a preferred beverage or snack, a warm shower). Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *If non-medical intervention does not work or if resident does not wish to have you help this way, promptly tell the nurse that elder is in pain. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o *Coordinate with my doctor and review my medications as indicated to ensure that I am on the least amount of medications at the lowest dose to treat my pain. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Therapy referral as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Created by: DON. i.) FOCUS: o I wish to be called by my preferred name (specify) [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I wish for all team members to call me by my preferred name through all reviews Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS / TASKS: o Please call me by my preferred name of (Specify) [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. j.) FOCUS: o I have a hearing problem that may affect my ability to understand others. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will not have any further hearing loss or problems with understanding others r/t my hearing problems through my next review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Target Date: 11/29/2023. INTERVENTIONS / TASKS: [NO ANSWER] k.) FOCUS: o At risk for psycho-social issues: emotional distress or behaviors r/t: (indicated / select the appropriate etiology) [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will not experience any adverse events or have negative outcomes associated with my emotional well-being through my next review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS / TASKS: o BEHAVIOR/TRIGGERS:(indicated the behavior and/or known triggers here) [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Calm and re-assure resident/patient is safe. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Keep environment calm, quiet and avoid loud noises as much as possible. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Refer to Mental Health Providers as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Refer to social service as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. I.) FOCUS: o I require anti-depressant medication r/t [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will have no complications r/t anti-depressant medication through review date Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023. INTERVENTIONS / TASKS: o Administer medication per MD orders Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Educate me and/or my family regarding all potential side effects, and risks associated with psychotropic medications and obtain consent for medication use. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Monitor/document/report to MD prn ongoing s/sx of depression unaltered by antidepressant meds: Sad, irritable, anger, never satisfied, crying, shame, worthlessness, guilt, suicidal ideations, neg. mood/comments, slowed movement , agitation, disrupted sleep, fatigue, lethargy, does not enjoy usual activities, changes in cognition, changes in weight/ appetite, fear of being alone or with others, unrealistic fears, attention seeking, concern with body functions, anxiety, constant reassurance. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. m.) FOCUS: o I require anti-anxiety medication r/t [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will have no complications r/t anti-anxiety medication therapy through review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023 INTERVENTIONS / TASKS: o Administer medications per MD orders Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Educate me and/or my family regarding all potential side effects, and risks associated with psychotropic medications and obtain consent for medication use. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Monitor/document/report to MD PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. n.) FOCUS: o I am on hypnotic/sedative medications r/t [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will have improved rest and sleep and I will not experience drug related complications through my next review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023 INTERVENTIONS / TASKS: o Administer medications per MD orders Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Educate me and/or my family regarding all potential side effects, and risks associated with psychotropic medications and obtain consent for medication use. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Monitor/document/report to MD PRN s/sx of psychotropic drug complications: altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation, withdrawal, decline in ADLs & continence& cognition, suicidal ideations, constipation, impaction, urinary retention, shuffling gait, rigid muscles, syncope, accidents, dizziness, vertigo, Motor agitation, Tremors, tardive dyskinesia, poor balance, Diarrhea, fatigue, insomnia, loss of appetite, weight loss, N&V (nausea & vomiting). Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o.) FOCUS: o I require Anti-psychotic medication r/t [NO ANSWER] Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I will have no complications r/t anti-psychotic medication therapy through review date. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023 INTERVENTIONS / TASKS: o Administer medications as ordered by MD Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Educate me and/or my family regarding all potential side effects, and risks associated with psychotropic medications and obtain consent for medication use. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Monitor/document/report to MD PRN s/sx of psychotropic drug complications: altered mental status, decline in mood or behavior, hallucinations, delusions, social isolation, withdrawal, decline in ADLs & continence& cognition, suicidal ideations, constipation, impaction, urinary retention, Shuffling gait, rigid muscles, syncope, accidents, dizziness, vertigo, Motor agitation, Tremors, tardive dyskinesia, poor balance, Diarrhea, fatigue, insomnia, loss of appetite, weight loss, N&V (nausea & vomiting) Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. p.) FOCUS: o I wish to remain in the community as LTC Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o I would like to remain as a resident in the community at this time and not be discharged to an external community. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. Revision on: 12/06/2023 Revision by: NAC. Target Date: 11/29/2023 INTERVENTIONS / TASKS: [NO ANSWER] q.) FOCUS: o Discharge Planning: Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. GOAL: o Resident/Patient will not experience AMA (against medical advice) or will not experience any negative outcomes as a result. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	o Refer to Physician as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. o Refer to Social Service as indicated. Date Initiated: 11/29/2023 Created on: 11/29/2023. Created by: DON. In an interview on 9/11/24 at 2:12pm, the DON stated the initial care plan was done on admission and within 48 hours of admission. The DON stated the initial care plan was generated from the admission assessment and included comorbidities such as risk for infection, anticoagulants, heart disease, hospice, end of life, tracheostomy and/or ventilator, transfers and lifts, dialysis, cardiac issues, cognition, vision, hearing, skin concerns, bowel and bladder, antidepressants, antianxiety medications, hypnotics, antipsychotics, exit seeking, allergies, code status, preferred name, self-care deficits, dementia, nutrition and hydration, feeding tube, fall risk, discharge planning, and mental health behaviors or issues. The DON stated that it was everyone's responsibility to update the care plan. In an interview on 9/11/24 at 3:01pm, when asked about the Focus of, I wish to be called by my preferred name (specify), the NC stated it was the responsibility of the person who initiated that focus to update the care plan and specify the name. The NC stated that anyone who could have updated the care plan, should have updated the care plan. In an interview on 9/12/24 at 2:40pm, the SW stated she reviewed code status on admission (the first or second business day after admission) and quarterly. The SW stated she would update care plans with other information such as discharge planning, evacuation plan, and social history. The SW stated there was no specific time frame for doing code status audits, but that they had to be done on admission and quarterly and she would sometimes just check over things. The SW stated there was no specific policy on updating care plans except quarterly because that was when they had care plan meetings. The SW stated the care plan was updated so that everything matched in the resident's chart. The SW stated if something was not updated in the care plan, it would cause issues with the resident's plan of care. The SW stated that she was out on leave for over a month and did not return until 4 days after Resident #21 was admitted . The SW stated she had to go back and review all the residents that were admitted while she was out. (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.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #21) of 3 residents reviewed for quality of care. 1. The facility failed to immediately notify Resident #21's physician when Resident #21 had a substantial increase in pain to her left leg and left shoulder two days after Resident #21 fell in the facility's dining room and landed on her left side on 11/25/23. 2. The facility failed to immediately notify Resident #21's physician when Resident #21's radiology report dated 11/28/23 at 5:51pm reflected that Resident #21 had a displaced fracture of her left femur neck (top of the thigh bone at the hip) that occurred when Resident #21 fell in the facility's dining room three days before the x-ray was completed on 11/28/23. On 9/18/24 at 2:06pm an Immediate Jeopardy was identified. While the Immediate Jeopardy was removed on 9/20/24 at 1:35pm, the facility remained out of compliance at a scope of isolated with a severity of no actual harm with potential for more than minimal harm that was not Immediate Jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk of a delay in treatment, decline in physical, mental, and/or psychosocial status, hospitalization , and even death. The findings included: Record review of Resident #21's face sheet reflected an [AGE] year-old female that was admitted to the facility on [DATE] with a primary diagnosis of encounter for palliative care (care focused on improving quality of life for people with serious illnesses). Other pertinent diagnoses included congestive heart failure (the heart didn't pump blood effectively and could cause fluid buildup in the lungs), dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), inflammatory polyneuropathy (an auto immune attack on the peripheral nerves that can cause progressive muscle weakness, numbness, loss of reflexes, and pain or tingling in the arms, hands, legs, and feet), major depressive disorder, chronic kidney disease-stage 3 (mild to moderate kidney damage), dyspnea (shortness of breath), edema (swelling), muscle weakness, and muscle atrophy (wasting or loss of muscle tissue). There were no diagnoses related to liver damage or liver failure. Record review of Resident #21's Admission MDS dated [DATE] reflected she had a BIMS score of 00 which indicated she had severe cognitive impairment. Record review of Resident #21's care plan dated 10/27/23 with revisions on 10/30/23, 11/29/23 and 12/6/23 reflected in part: Focus: I have impaired cognitive function/dementia or impaired thought process r/t (Specify). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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.	Goal: I will (Maintain or improve) current level of cognitive function through the review date. Interventions/Tasks: Communicate with me, my family/caregivers regarding my capabilities and needs, Notify MD of any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Focus: I have a communication problem: Goal: I will be able to make basic needs known by (verbally/however able to express) on a daily basis through the review date. Interventions/Tasks: Anticipate and meet my needs. Notify MD PRN for changes in ability to communicate, potential contributing factors for communication problems, potential for improvement. Focus: I am at risk for falls r/t [left blank] Goal: I will be free from falls and/or will not experience significant injuries associated with falls through the next review date. Interventions/Tasks: Refer to therapy for screen and/or eval as indicated. Focus: Advanced care planning choices for end-of-life care: Hospice care elected. Goal: I will have my comfort, quality of life and dignity protected an honored through my next review date. In a phone interview on 9/12/24 at 10:05am Resident #21's family member stated that Resident #21 had a history of breast cancer and colon cancer but had received PET (Positron emission tomography) scans for at least the last 3 to 5 years prior to her admission to the facility that showed no cancer anywhere. Resident #21's family member stated that Resident #21 did not have any history of liver damage or liver failure and that Resident #21's primary care physician prior to going on hospice had told Resident #21 and her family member that her kidney disease was stable. Resident #21's family member stated that the reason Resident #21 went into the facility with hospice care was because Resident #21's dementia had progressed to the point that the family member could not take care of her at home anymore. Resident #21's family member stated that Resident #21 went back to the family member's house on 11/30/23 with hospice services because the emergency room physician and the surgeon told the family member that surgery for Resident #21's left hip fracture was not an option due to the resident now having kidney and liver failure. Resident #21 passed away at home on 12/1/23. Record review of Resident #21's progress notes section in the facility's PCC system reflected an entry dated 11/25/23 at 2:38pm by RN I that stated, Resident stood up on her own out of her wheelchair in dining room, did not take any steps but lost her balance and CNA was standing near resident and resident went to the floor, landed on her left side, CNA who witnessed the fall cradled residents head and resident did not hit her head or face on the floor Resident checked for injuries, denies pain, and assisted by 3 staff members back into her wheelchair, DON, RP, and Medical provider notified. Resident taken to her room and vital signs taken and head to toe assessment completed. [sic] (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.	Record review of the facility's PCC assessments page for Resident #21 reflected an eINTERACT Change in Condition Evaluation that was entered on 11/25/23 in reference to Resident #21's fall in the facility's dining room on the same date that stated in part, Resident #21 had no complaints of pain. Resident [#21] had a witnessed fall with neuro checks intact, moves all extremities, and no s/s of injuries, skin checked for discoloration none noted at this time [sic]. This document reflected that the physician was notified of Resident #21's fall on 11/25/23 at 2:45pm and the physician's recommendation was to refer Resident #21 for a physical therapy evaluation In an interview on 9/11/24 at 3:50pm, the DON stated, We did not do x-rays at the time [of the fall] because when I looked at the camera, she was self-propelling in the dining room. She was shaking a doorknob and kind of slid out of her chair onto the floor. She did not actually stand and fall. She did not have any bruising at that time. She was being medicated for pain on the 25th (November 2023) because she was post fall and couldn't tell us I have pain here. She just had signs and symptoms of pain. We got an x-ray on the 28th. I don't remember why or what her signs and symptoms were. With hospice patients, hospice won't order x-rays, so we contacted our doctor instead of the hospice physician and that's why there was a delay from the complaint of pain on the 27th to the order on the 28th (of November 2023) In an interview on 9/13/24 at 12:48pm, CNA M stated, On 11/25/23, Resident #21 was in the dining room toward the kitchen washroom area. I was passing by taking people out of the dining room. I saw her getting up off the wheelchair and standing. Once I saw her taking some steps and was unbalanced, I knew she was going to fall so I sprinted over there to try to catch her. It was kind of a slow fall. She was not quite on the floor when I got to her, so I made sure she did not hit her head. When she was on the floor, she was kind of on her left side. Two other people saw it as well and came in to assist me to get her back to her chair. She said she was in pain after that. I can't remember if she said her arm or her hip, but she was saying, ow- it hurts, it hurts. She was just kind of whimpering and saying she hurt when she was assisted back into the wheelchair. Record review of Resident #21's MAR dated November 2023 reflected that Resident #21 had an order for Tramadol HCl (a pain medication) oral tablet 50mg to be given by mouth every six hours as needed for pain. Resident #21 did not have any other medications ordered for pain relief. Resident #21 was given Tramadol 50mg on 11/25/23 at 6:25pm for generalized pain at level 5 out of 10 (10 being the worst pain), 11/26/23 at 3:53pm for generalized pain at level 2 out of 10, and 11/26/23 at 10:00pm for generalized pain at level 5 out of 10. On 11/27/23 at 5:44am, LVN J gave Resident #21 Tramadol 50mg for left shoulder and left leg pain at level 10 out of 10. (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.	Record review of Resident #21's progress notes page dated 11/6/23 to 12/6/23, assessments page dated 10/27/23 to 11/29/23 in the facility's PCC system and a telephone interview of LVN J on 9/16/24 at 11:48am reflected that Resident #21's physician was not notified of her significant increase in pain on 11/27/23 by LVN J at the time she medicated Resident #21, nor any other time that day. LVN J stated she did not recall why she did not notify the doctor when Resident #21 complained of a 10 out of 10 pain level. LVN J stated if someone fell , she would do range of motion and check them out; if the resident had complained of pain during that, LVN J stated she would have notified the doctor and gotten an x-ray. LVN J stated when an x-ray was done, the nurse would have had to look for the results and that there was no flag or anything to let the nurse know that the results were posted. LVN J stated if she was going off shift, she would pass it on to the next shift to look for the results. LVN J stated they would not be notified by the radiology company. LVN J stated sometimes the x-ray technician would let them know if something did not look right and to keep an eye out for the report. LVN J stated if she pulled up an x-ray report and something looked abnormal or bad, she would notify the physician right away- as soon as she saw the result. LVN J stated she did not know if anyone at the facility got notified automatically of results. LVN J stated that she worked at the facility until March 2024 and had been there for about a year. LVN J stated they discussed notification of changes almost every day and had once a month in-services on various topics. Record review of Resident #21's Physician Orders reflected a left shoulder and hip/pelvis x-ray ordered by RN K on 11/28/23 at 11:30am. Record review of Resident #21's printable view progress notes dated 11/29/23 at 8:34am reflected an entry by RN I that stated, Xray report from Xray of 11/28/23 reviewed and reported to medical provider left shoulder x ray showed no acute fracture, RP states she will think about the situation, but shows grossly displaced femoral neck fracture of left hip, acute fracture. Medical provider recommends send resident too [sic] ER (emergency room) for evaluation of left hip fracture. DON notified. And RP notified and will think about whether she wants notify Nurse when she makes a decision on sending the resident sent out to ER, states she will call back to notify this facility. Call out to the hospice company to notify of positive left hip fracture, left msg to have hospice return my call. [sic] Record review of the facility's PCC assessments page for Resident #21 reflected an unsigned eINTERACT Change in Condition Evaluation that was dated 11/29/23 and revealed the situation being reported was Trauma (fall related or other) and that Resident #21 had new pain, left hip pain/left iliac crest (rear)/Left trochanter (hip) and intensity of pain 2 of 10. In the area for observation and evaluation summary, the author documented, Results of x ray to hip positive for Grossly displaced femoral neck fracture of left hip with no discoloration to area. Resident does have pain on left hip, with pain medication. Medical provider notified and recommends to send resident out to ER for evaluation, DON notified of Results of left hip X RAY and RP notified states since resident is hospice, she will need to decide whether she wishes to send resident out to ER, will notify nurses of her decision [sic]. This document also stated that Resident #21's physician was notified on 11/29/23 at 8:40am and the physician recommended Resident #21 be taken by non-emergent transfer ambulance for evaluation of left hip fracture to the ER. (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.	In a telephone interview on 9/13/24 at 10:21am a supervisor for the facility's contracted radiology company stated that the result of the left shoulder and hip/pelvis x-ray was automatically delivered by email to the facility's DON and administrator on 11/28/23 at 5:51pm. The supervisor stated that the result was also automatically faxed to the facility's fax number on record on 11/28/23 at 5:51pm, but that it failed. The supervisor stated there was no documentation that the radiology company called the facility to report the significant findings of the x-ray. In an interview on 9/11/23 at 3:56pm the DON stated, If there is a significant finding for an x-ray, I receive an email and they call the facility within, I think, 24 hours. I received the email at 5:51pm (on 11/28/23). Even if I was gone for the day, I would check my email from home. I may have been out with the flu or COVID at that time, but I remember calling the facility that evening. I can't say why the physician was not notified until 8:30 the next morning or why the nurse didn't document anything. The physician and RP should have been notified that evening. A lot of the longer tenure nurses will want to notify the hospice doctor before the facility doctor because they are hospice, but we don't have documentation of that either. If the physician and RP are not notified, it could lead to negative outcomes including untreated pain or worsening of a fracture. The physician and RP should be notified immediately when critical results are received. The DON did not state who she talked to when she called the facility on 11/28/23 about the x-ray results. In a telephone interview on 9/13/24 at 11:00am the MD stated he would expect the doctor or nurse practioner to be notified of any critical/significant results with 30-45 minutes. The MD stated he did not know if it would have made a difference if he had been notified of Resident #21's fractured femur the evening before. The MD stated, if for some reason the facility was unable to contact either the NP or himself, they should just go ahead and send the resident out to the ER. The MD stated that when Resident #21 was treated for 10 of 10 pain specifically to her left leg and shoulder on 11/27/23 following a fall on her left side on 11/25/23, he or the NP should have been notified. The MD stated, What we know of hip fractures in older adults, we need to intervene sooner rather than later because being in bed for three days, especially if they are in pain and probably not eating or drinking well, it can lead to multi organ failure. If we had known about the fracture and intervened earlier, she may have lived a little longer. The MD stated that it was ultimately a hospice decision to x-ray a hospice patient, but if she had not been a hospice patient, it would have been prudent to do an x-ray at the time of the fall. In an interview on 9/13/24 at 1:11pm the ADON stated for critical findings, the lab or radiology would call the facility and would ask for the nurse of that specific resident. The nurse would talk to them and get the results. After the nurse received the critical or significant finding information, he/she would then call the doctor and see if there were any new orders. The ADON stated, We call the doctor immediately when we have critical results. The ADON stated, That I know of there isn't a specific policy in writing about when to notify the doctor of critical results. (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.	In an interview on 9/16/24 at 10:15am, CNA B stated that Resident #21 was on pain meds and would complain of pain mostly in the mornings and later in the day. CNA B stated when Resident #21 was first admitted she was good until the fall on 11/10/23 . After that fall, she got more confused and complained of more pain. I know she was always getting in and out of her chair. CNA B stated if a resident had a bad fall or had to be assessed by physical therapy, the CNAs would not get the resident out of bed until physical therapy saw and assessed them. CNA B stated, I don't recall her (Resident #21) falling at all when I worked on 11/27/23 or 11/28/23 and it was not reported to me that she fell any time after 11/25/23. After the fall, family was here more often than before. I don't think she was eating very well that week. There's nothing more that I can recall. In an interview on 9/16/24 at 11:12am, RN K stated she kind of remembered Resident #21 but did not remember anything specific about the week after Resident #21 fell on [DATE]. RN K stated if she had a resident that had fallen two days prior and then started complaining of a significant increase in pain, she would notify the NP or the doctor to advise them of the increase in pain on the side the resident had fallen on two days before. RN K stated if it was a hospice patient, she would notify the facility (primary) doctor or NP, then hospice. RN K stated in most cases, she would call the facility attending and then let hospice know that she notified the primary doctor. RN K stated if there was an abnormal finding on an x-ray, the radiology company posted the results on the website. RN K stated she did not think the facility got called if there were significant findings. RN K stated she thought that once the results got posted, the facility doctor looked at the results and it went from there. RN K stated she did not recall any time when the DON or ADON went to her and said that there was an abnormal x-ray result and for her to notify the physician. RN K stated if the nurse found something (a significant finding) before the doctor did, then the nurse would call the doctor immediately. RN K stated if the nurse was not able to contact the doctor, he/she was to contact the DON to let her know so that she could follow up. RN K stated the x-ray technician would not tell the nurse if they saw something abnormal on the x-ray. RN K stated that sometimes x-rays would result right away, but sometimes they took a very long time. (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.	In an interview on 9/16/24 at 12:24pm, the DON stated, At that time when abnormal or critical x-rays were received, the facility would receive a phone call with the results. I would also get an email for significant findings. Normally, if I wasn't at the facility, I would call to make sure the nurse knew of the findings. Let's say I didn't see the email or get the email; the x-ray people would call the facility and we could get into the portal and print out the x-ray results. X-ray will call, but sometimes they don't call until the next day. If it was the next day, it was like a follow up call when they'd ask if we saw it. If the facility is notified of an abnormal result (for hospice) it would depend on the nurse whether the primary physician or hospice would get notified first, but they would both be notified. The nurse would need to notify the doctor as soon as they found out about it. In reference to (Resident #21's) x-ray result, I got the email on 11/28/23 at 5:51pm. I was not here (at the facility) at the time, and I don't remember if I called the facility or not. The DON stated that the floor nurse would have had to go into the portal to see if the x-ray result was there. The PCC system did not flag or alert when an x-ray was resulted, the nurse would have to check. The DON stated if the x-ray was not resulted during the day shift, the day shift nurse would pass on to the night shift nurse to look out for the result. If for some reason the night shift nurse did not get the result, then the day shift nurse would follow up the next morning. The DON stated, In general, if there was a critical or significant finding, the physician should have been notified right away. Notification 15 hours later is generally not acceptable. There may be times when that would be ok, but in this particular case, no. The DON stated, She (Resident #21) wasn't x-rayed the day of the fall because she didn't display any signs or symptoms of pain; not even when they were getting her off the floor initially. If she had a significant increase in pain 2 days post fall, it would warrant a notification to the doctor. The DON stated it was important to notify the physician of any significant change in condition or results of diagnostics so that they could provide the best quality of care for the resident. The DON stated if the physician was not notified of changes, the resident's quality of care could have been affected, the resident may not have gotten needed treatment, services, or medication, the resident could have been hospitalized , or it could have even led to death. The DON stated, The policy does not have a specific time frame for notification. The DON stated when a physician was notified of results or a change of condition, documentation included dated and time of notification of provider and RP and any new orders. In an interview on 9/16/24 at 2:14pm the Admin stated, I do get the emails that say significant findings from radiology. If I see that email come through, I contact the DON and make sure she saw it and ask what it is about. If it is a night or weekend, I will still talk to the DON about it, and she will contact facility staff. The Admin stated, If there are significant or critical findings on any diagnostics, the physician should be notified in a timely manner- ASAP. It shouldn't be more than 2 hours once the nurse finds out that they try to notify the physician. 15 hours is not an acceptable time frame. The Admin stated he did not recall seeing a timeframe on the policy. The Admin stated the physician should always be notified if a resident complained of a significant increase in pain. The Admin stated it was important to notify the physician right away for changes in condition so that they could plan the next steps in the resident's care. The Admin stated if they did not notify the physician, the resident may not receive the appropriate care, they could have an adverse effect, they could be hospitalized , or it could lead to death. (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.	In a phone interview on 9/18/24 at 10:56am LVN L stated he worked PRN (as needed) at the facility, usually on weekends. LVN L stated it had been a while since he last worked there and he could not recall what date he worked there last. LVN L stated he remembered Resident #21's name but did not remember anything specific about her. LVN L stated if an x-ray was done, the results may have been faxed to the facility. LVN L stated that he thought had seen a couple of chest x rays come through on the fax before but did not recall that anyone got any significant x-ray results while he was on shift. LVN L stated if he ordered an x-ray and had not received a result after about a couple of hours, he would call the x-ray place and ask about it. LVN L stated that x-ray results could go straight to the resident's profile now. LVN L stated they could go into the results tab and see if the x-ray was resulted. LVN L stated there was not a pop up or anything to remind you to go look at the result. LVN L stated if he got a significant finding, he would call the doctor to let them know as soon as he got the result. LVN L stated in his orientation they went over the things you were supposed to notify the physician for. LVN L stated, I don't remember them saying when specifically, the doctor should be notified after receiving the results. LVN L stated if an x-ray was done on his shift and he had not gotten the result yet, he, as the off going nurse, reported it to the oncoming nurse who would keep an eye out for the result. LVN L stated there was also a piece of paper that stuff was written on to pass along to the next shift. In an interview on 9/18/24 at 2:10pm the DON stated that she never opened the email from the radiology company on 11/28/23. The DON provided a copy of the radiology company's print out of the details of Resident #21's x-ray that was done on 11/28/23. The print-out reflected that a SIGNIFICANT report was emailed to the DON and the Admin on 11/28/23 at 5:51pm. This print-out also reflected that a text message was sent to a phone number and a fax was sent to the facility's fax number with the x-ray findings on 11/28/23 at 5:51pm. The DON and the Admin stated that the fax number that the radiology company had was not the facility's fax number and they did not know why the radiology company had that number. The DON and the Admin also stated that they did not know who the phone number belonged to that the text message was sent to. An internet search on 9/20/24 revealed the fax number that the radiology company sent the result to had been associated with this facility and the phone number that the text message was sent to belonged to the person who was the DON at the facility at the time the contract with the radiology company was signed in 2022. Record review of Resident #21's Nursing Progress Notes reflected an entry by RN I dated 11/29/23 effective at 11:17am that stated, RP present, resident being transported per (non-emergent ambulance) stretcher report given to ambulance driver, and resident transported with paperwork and copy of DNR to ER, DON aware. [sic] Record review of Resident #21's Medication Administration Note reflected an entry by LVN J dated 11/29/23 effective 10:12pm that stated, admitted to hospital. Record review of Resident #21's Medication Administration Note reflected an entry by RN I dated 11/30/23 effective 11:23am that stated, At hospital. In an interview on 9/12/24 at 10:47am, the ME stated that Resident #21 passed away at home on 12/1/23 and that she ruled Resident #21's death as, Accident- Accidental fall/ complications of femur fracture, fall, dementia, hypertension, and COPD. The ME stated she did not do an autopsy, but rather reviewed all of Resident #21's medical records. (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.	Record review on 9/18/24 of the facility's radiology company contract that was signed on 2/8/22 reflected in part: SERVICES: 4. REPORTS The Radiologist will dictate a report to the attending physician for each examination. (The x-ray company) will provide a written copy of the written report to the community and to the attending physician. 6. WEB ACCESS (The x-ray company) agrees to provide the Community with direct access to patient records on the (x-ray company's) website. There was no part of the provided contract that discussed if, how, or when the facility would be notified of significant findings. Record review of this contract also revealed that it was signed by the current Admin on 2/8/22. Record review of the facility's Changes in Resident Condition Policy revealed in part: Compliance Guidelines: The resident, medical provider (MD/NP/PA) and resident representative or designated family member should be notified when changes in condition or certain events occur. Communication with the interdisciplinary team and caregivers is important to facilitate consistency and continuity of care. Guidelines: 1. The resident, medical provider (MD/NP/PA) and resident representative or designated family member should be notified when there is: c. a significant change in the resident's physical, mental, or psychosocial status; 1) assess and document changes in; 2) provide assessment information to physician and 3) provide clear comprehensive documentation g. when laboratory, radiology or other diagnostic results fall outside the clinical reference ranges set by the contracted service provider or per physician orders. This policy did not indicate a timeframe for notifying the resident's physician or nurse practitioner after diagnostic results that fell outside of the clinical reference ranges were received. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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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.	An Immediate Jeopardy was identified on 9/18/24 at 11:15am. The Admin was informed of the Immediate Jeopardy and given the Immediate Jeopardy template on 9/18/24 at 2:06pm and a Plan of Removal was requested. The facility's Plan of Removal was accepted on 9/19/24 at 8:49pm. The facility's Plan of Removal included: [Facility] Plan of Removal F580 Notification of Changes in Condition Date: September 18, 2024 Corrective Action: Resident #21 who was admitted on [DATE] under hospice services for end-of-life care for diagnoses of Renal Failure, Liver Failure, Congestive Heart Failure, and Malignant Neoplasm of Left Breast sustained a witnessed fall on 11/25/23. Resident assessed by charge nurse and risk management report completed and MD/RP/hospice notification made. Non stat X-ray order obtained on 11/28/23 and positive fracture results received on 11/29/23 and reported to MD and hospice with hospice collaboration for RP notification. Resident discharged to hospital on 11/29/23. Resident #21 is no longer an active resident within our community. Resident #21 was assessed and being monitored by the nurses prior to being sent to the hospital on 11/29/23. Per hospital report, resident did not receive any treatment for fracture and was discharged home with family. Identification: All residents with change in condition may be at risk for the alleged deficient practice. Director of Nursing/Assistant Director of Nursing conducted an audit of all residents with recent (in last 60 days) to identify any changes in condition to include increased pain needs in order to ensure the MD/NP/PA have been notified and appropriate interventions were in place, as well as to ensure family representatives have been notified. Outcome: Date Completed: 9/18/24. Systematic Changes: The Regional Nurse (DCO) conducted an in-service to the Director of Nursing/Assistant Director of Nursing regarding the process for nurses to assess resident changes in condition to include pain and report any significant increase in pain and changes in condition identified to the MD/NP/PA. The nurse should ensure interventions are in place to address the resident's change in condition and/or pain needs and nurse should document in the electronic health record. Date Completed: 9/18/24. (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.	Director of Nursing/Assistant Director of Nursing conducted in-service training to all licensed nurses prior to next scheduled shift regarding: a. The process for ensuring that changes in condition have been identified to include pain and reported to MD/NP/PA. Orders given should be implemented as ordered and nursing should document in the electronic health record. b. Nurses will communicate during change of shift nursing report any changes in condition to include pain and ensure proper interventions are in place and notifications to the MD/NP/PA have been completed. c. Charge Nurses educated to follow HHSC guidance that indicates that the nurse should conduct a post fall assessment following the fall event. The nurse will continue ongoing monitoring of the resident following a fall event and should conduct follow up assessments upon any changes in condition identified. The nurse should then notify the medical provider upon identifying the change in condition or abnormal findings. The physician should be notified promptly upon identification of a change in condition and/or significant/critical abnormal diagnostic report. Typically, the notification will occur immediately but no more than two hours of being identified. The nurse will then attempt to contact the physician at minimum once per shift until the notification has been made. Date Completed: 09/19/24 The Regional Nurse (DCO) conducted an in-service to the Director of Nursing/Assistant Director of Nursing regarding the process for ensuring that nurses conduct post fall assessments to include assessment of pain. The nurse will report to the medical provid [TRUNCATED]

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49157 Based on interviews and record reviews, the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 (Resident #21) of 3 residents reviewed for diagnostic services. 1. The facility failed to immediately notify Resident #21's physician before 11/29/23 at 8:30am when Resident #21's radiology report dated 11/28/23 at 5:51pm revealed that Resident #21 had a displaced fracture of her left femur neck (top of the thigh bone at the hip) that occurred when Resident #21 fell in the facility's dining room on 11/25/23. On 9/18/24 at 2:06pm an Immediate Jeopardy was identified. While the Immediate Jeopardy was removed on 9/20/24 at 1:35pm, the facility remained out of compliance at a scope of isolated with a severity of no actual harm with the potential for more than minimal harm that was not Imediate Jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place residents at risk of a delay in treatment, decline in physical, mental, and/or psychosocial status, hospitalization , and even death. The findings included: Record review of Resident #21's face sheet reflected an [AGE] year-old female that was admitted to the facility on [DATE] with a primary diagnosis of Encounter for palliative care (care focused on improving quality of life for people with serious illnesses). Other pertinent diagnoses included congestive heart failure (the heart didn't pump blood effectively and could cause fluid buildup in the lungs), dementia (loss of memory, language, problem-solving and other thinking abilities severe enough to interfere with daily life), inflammatory polyneuropathy (an auto immune attack on the peripheral nerves that can cause progressive muscle weakness, numbness, loss of reflexes, and pain or tingling in the arms, hands, legs, and feet), major depressive disorder, chronic kidney disease-stage 3 (mild to moderate kidney damage), dyspnea (shortness of breath), edema (swelling), muscle weakness, and muscle atrophy (wasting or loss of muscle tissue). There were no diagnoses related to liver damage or liver failure. Record review of Resident #21's Admission MDS dated [DATE] reflected she had a BIMS score of 00 which indicated she had severe cognitive impairment. Record review of Resident #21's care plan dated 10/27/23 and revised on 10/30/23, 11/29/23 and 12/6/23 reflected in part: Focus: I have impaired cognitive function/dementia or impaired thought process r/t (Specify). Goal: I will (Maintain or improve) current level of cognitive function through the review date. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interventions/Tasks: Communicate with me, my family/caregivers regarding my capabilities and needs, Notify MD of any changes in cognitive function, specifically changes in decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Focus: I have a communication problem: Goal: I will be able to make basic needs known by (verbally/however able to express) on a daily basis through the review date. Interventions/Tasks: Anticipate and meet my needs. Notify MD PRN for changes in ability to communicate, potential contributing factors for communication problems, potential for improvement. Focus: I am at risk for falls r/t [left blank] Goal: I will be free from falls and/or will not experience significant injuries associated with falls through the next review date. Interventions/Tasks: Refer to therapy for screen and/or eval as indicated. Focus: Advanced care planning choices for end-of-life care: Hospice care elected. Goal: I will have my comfort, quality of life and dignity protected an honored through my next review date. In a phone interview on 9/12/24 at 10:05am Resident #21's family member stated that Resident #21 had a history of breast cancer and colon cancer but had received PET (Positron emission tomography) scans for at least the last 3 to 5 years prior to her admission to the facility that showed no cancer anywhere. Resident #21's family member stated that Resident #21 did not have any history of liver damage or liver failure and that Resident #21's primary care physician prior to going on hospice had told Resident #21 and her family member that her kidney disease was stable. Resident #21's family member stated that the reason Resident #21 went into the facility with hospice care was because Resident #21's dementia had progressed to the point that the family member could not take care of her at home anymore. Resident #21's family member stated that Resident #21 went back to the family member's house on 11/30/23 with hospice services because the emergency room physician and the surgeon told the family member that surgery for Resident #21's left hip fracture was not an option due to the resident now having kidney and liver failure. Resident #21 passed away at home on 12/1/23. Record review of Resident #21's progress notes section in the facility's PCC system reflected an entry dated 11/25/23 at 2:38pm by RN I that stated, Resident stood up on her own out of her wheelchair in dining room, did not take any steps but lost her balance and CNA was standing near resident and resident went to the floor, landed on her left side, CNA who witnessed the fall cradled residents head and resident did not hit her head or face on the floor Resident checked for injuries, denies pain, and assisted by 3 staff members back into her wheelchair, DON, RP, and Medical provider notified. Resident taken to her room and vital signs taken and head to toe assessment completed. [sic] (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's PCC assessments page for Resident #21 reflected an eINTERACT Change in Condition Evaluation that was entered on 11/25/23 in reference to Resident #21's fall in the facility's dining room on the same date that stated in part, Resident #21 had no complaints of pain. Resident [#21] had a witnessed fall with neuro checks intact, moves all extremities, and no s/s of injuries, skin checked for discoloration none noted at this time [sic]. This document reflected that the physician was notified of Resident #21's fall on 11/25/23 at 2:45pm and the physician's recommendation was to refer Resident #21 for a physical therapy evaluation. In an interview on 9/11/24 at 3:50pm, the DON stated, We did not do x-rays at the time [of the fall] because when I looked at the camera, she was self-propelling in the dining room. She was shaking a doorknob and kind of slid out of her chair onto the floor. She did not actually stand and fall. She did not have any bruising at that time. We got an x-ray on the 28th (11/28/23). I don't remember why or what her signs and symptoms were. With hospice patients, hospice won't order x-rays, so we contacted our doctor instead of the hospice physician and that's why there was a delay from the complaint of pain on the 27th (11/27/23) to the order on the 28th (11/28/23). In an interview on 9/13/24 at 12:48pm, CNA M stated, On 11/25/23, Resident #21 was in the dining room toward the kitchen washroom area. I was passing by taking people out of the dining room. I saw her getting up off the wheelchair and standing. Once I saw her taking some steps and was unbalanced, I knew she was going to fall so I sprinted over there to try to catch her. It was kind of a slow fall. She was not quite on the floor when I got to her, so I made sure she did not hit her head. When she was on the floor, she was kind of on her left side. Two other people saw it as well and came in to assist me to get her back to her chair. She said she was in pain after that. I can't remember if she said her arm or her hip, but she was saying, ow- it hurts, it hurts. She was just kind of whimpering and saying she hurt when she was assisted back into the wheelchair. Record review of Resident #21's Orders reflected a left shoulder and hip/pelvis x-ray ordered by RN K on 11/28/24 at 11:30am. Record review of Resident #21's printable view progress notes dated 11/29/23 at 8:34am reflected an entry by RN I that stated, Xray report from Xray of 11/28/23 reviewed and reported to medical provider left shoulder x ray showed no acute fracture, RP states she will think about the situation, but shows grossly displaced femoral neck fracture of left hip, acute fracture. Medical provider recommends send resident too [sic] ER (emergency room) for evaluation of left hip fracture. DON notified. And RP notified and will think about whether she wants notify Nurse when she makes a decision on sending the resident sent out to ER, states she will call back to notify this facility. Call out to the hospice company to notify of positive left hip fracture, left msg to have hospice return my call. [sic] (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility's PCC assessments page for Resident #21 reflected an unsigned eINTERACT Change in Condition Evaluation that was dated 11/29/23 and reflected the situation being reported was Trauma (fall related or other) and that Resident #21 had new pain, left hip pain/left iliac crest (rear)/Left trochanter (hip) and intensity of pain 2 of 10. In the area for observation and evaluation summary, the author documented, Results of x ray to hip positive for Grossly displaced femoral neck fracture of left hip with no discoloration to area. Resident does have pain on left hip, with pain medication. Medical provider notified and recommends to send resident out to ER for evaluation, DON notified of Results of left hip X RAY and RP notified states since resident is hospice, she will need to decide whether she wishes to send resident out to ER, will notify nurses of her decision [sic]. This document also stated that Resident #21's physician was notified on 11/29/23 at 8:40am and the physician recommended Resident #21 be taken by non-emergent transfer ambulance for evaluation of left hip fracture to the ER. In an interview on 9/11/24 at 3:56pm, the DON stated, If there is a significant finding for an x-ray, I receive an email and they call the facility within, I think, 24 hours. I received the email at 5:51pm (on 11/28/23). Even if I was gone for the day, I would check my email from home. I may have been out with the flu or COVID at that time, but I remember calling the facility that evening. I can't say why the physician was not notified until 8:30 the next morning or why the nurse didn't document anything. The physician and RP should have been notified that evening. A lot of the longer tenure nurses will want to notify the hospice doctor before the facility doctor because they are hospice, but we don't have documentation of that either. If the physician and RP are not notified, it could lead to negative outcomes including untreated pain or worsening of a fracture. The physician and RP should be notified immediately when critical results are received. The DON did not state who she talked to when she called the facility on 11/28/23 about the x-ray results. In a telephone interview on 9/13/24 at 10:21am a supervisor for the facility's contracted radiology company stated that the result of the left shoulder and hip/pelvis x-ray was automatically delivered by email to the facility's DON and administrator on 11/28/23 at 5:51pm. The supervisor stated that the result was also automatically faxed to the facility's fax number on record on 11/28/23 at 5:51pm, but that it failed. The supervisor stated there was no documentation that the radiology company called the facility to report the significant findings of the x-ray. In a telephone interview on 9/13/24 at 11:00am the MD stated he would expect for the physician or nurse practitioner to be notified of any critical/significant results with 30-45 minutes. The MD stated he did not know if Resident #21's outcome would have been different if he had been notified of her broken femur when the x-ray was resulted on 11/28/23 at 5:51pm. The MD stated if for some reason the facility was unable to contact either the NP or the MD, they should just go ahead and send the resident out to the ER. The MD stated that when Resident #21 was treated for 10 of 10 pain specifically to her left leg and shoulder on 11/27/23 following a fall on her left side on 11/25/23 he or nurse practitioner should have been notified. The MD stated, What we know of hip fractures in older adults, we need to intervene sooner rather than later because being in bed for three days, especially if they are in pain and probably not eating or drinking well, it can lead to multi organ failure. If we had known about the fracture and intervened earlier, she may have lived a little longer. The MD stated that it was ultimately a hospice decision to x-ray a hospice patient, but if she had not been a hospice patient, it would have been prudent to do an x-ray at the time of the fall. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 9/13/24 at 1:11pm the ADON stated for critical findings, the lab or radiology would call the facility and would ask for the nurse of that specific resident. The nurse would talk to them and get the results. After the nurse received the critical or significant finding information, he/she would then call the doctor and see if there were any new orders. The ADON stated, We call the doctor immediately when we have critical results. The ADON stated, That I know of there isn't a specific policy in writing about when to notify the doctor of critical results. In an interview on 9/16/24 at 11:12am, RN K stated if there was an abnormal finding on an x-ray, the radiology company posted the results on the website. RN K stated she did not think the facility got called if there were significant findings. RN K stated she thought that once the results got posted, the facility doctor looked at the results and it went from there. RN K stated she did not recall any time when the DON or ADON went to her and said that there was an abnormal x-ray result and for her to notify the physician. RN K stated if the nurse found something (a significant finding) before the doctor did, then the nurse would call the doctor immediately. RN K stated if the nurse was not able to contact the doctor, he/she was to contact the DON to let her know so that she could follow up. RN K stated the x-ray technician would not tell the nurse if they saw something abnormal on the x-ray. RN K stated that sometimes x-rays would result right away, but sometimes they took a very long time. In a telephone interview on 9/16/24 at 11:48am LVN J stated when an x-ray was done, the nurse would have had to look for the results and that there was no flag or anything to let the nurse know that the results were posted. LVN J stated if she was going off shift, she would pass it on to the next shift to look for the results. LVN J stated they would not be notified by the radiology company. LVN J stated sometimes the x-ray technician would let them know if something did not look right and to keep an eye out for the report. LVN J stated if she pulled up an x-ray report and something looked abnormal or bad, she would notify the physician right away- as soon as she saw the result. LVN J stated she did not know if anyone at the facility got notified automatically of results. LVN J stated that she worked at the facility until March 2024 and had been there for about a year. LVN J stated they discussed notification of changes and physician notification almost every day and had once a month in-service on various topics. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 9/16/24 at 12:24pm, the DON stated, At that time (11/28/23) when abnormal or critical x-rays were received, the facility would receive a phone call with the results. I would also get an email for significant findings. Normally, if I wasn't at the facility, I would call to make sure the nurse knew of the findings. Let's say I didn't see the email or get the email; the x-ray people would call the facility and we could get into the portal and print out the x-ray results. X-ray will call, but sometimes they don't call until the next day. If it was the next day, it was like a follow up call when they'd ask if we saw it. If the facility is notified of an abnormal result (for hospice) it would depend on the nurse whether the primary doctor or hospice would get notified first, but they would both be notified. The nurse would need to notify the doctor as soon as they found out about it. In reference to (Resident #21's) x-ray result, I got the email on 11/28/23 at 5:51pm. I was not here (at the facility) at the time, and I don't remember if I called the facility or not. The DON stated that the floor nurse would have had to go into the portal to see if the x-ray result was there. The PCC system did not flag or alert when an x-ray was resulted, the nurse would have to check. The DON stated if the x-ray was not resulted during the day shift, the day shift nurse would pass on to the night shift nurse to look out for the result. If for some reason the night shift nurse did not get the result, then the day shift nurse would follow up the next morning. The DON stated, In general, if there was a critical or significant finding, the physician should have been notified right away. Notification 15 hours later is generally not acceptable. There may be times when that would be ok, but in this particular case, no. The DON stated, She (Resident #21) wasn't x-rayed the day of the fall because she didn't display any signs or symptoms of pain; not even when they were getting her off the floor initially. The DON stated it was important to notify the physician of any significant change in condition or results of diagnostics so that they could provide the best quality of care for the resident. The DON stated if the physician was not notified of changes or diagnostic results, the resident's quality of care could have been affected, the resident may not have gotten needed treatment, services, or medication, the resident could have been hospitalized , or it could have even led to death. The DON stated, The policy does not have a specific time frame for notification. The DON stated when a physician was notified of results or a change of condition, documentation included dated and time of notification of provider and RP and any new orders. In an interview on 9/16/24 at 2:14pm the Admin stated, I do get the emails that say significant findings from radiology. If I see that email come through, I contact the DON and make sure she saw it and ask what it is about. If it is a night or weekend, I will still talk to the DON about it and she will contact facility staff. The Admin stated, If there are significant or critical findings on any diagnostics, the physician should be notified in a timely manner- ASAP. It shouldn't be more than 2 hours once the nurse finds out that they try to notify the physician. 15 hours is not an acceptable time frame. The Admin stated he did not recall seeing a timeframe on the policy. The Admin stated the physician should always be notified if a resident complained of a significant increase in pain. The Admin stated it was important to notify the physician right away for changes in condition so that they could plan the next steps in the resident's care. The Admin stated if they did not notify the physician, the resident may not receive the appropriate care, they could have an adverse effect, they could be hospitalized , or it could lead to death. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In a phone interview on 9/18/24 at 10:56am LVN L stated he worked PRN (as needed) at the facility, usually on weekends. LVN L stated it had been a while since he last worked there and he could not recall what date he worked there last. LVN L stated he remembered Resident #21's name but did not remember anything specific about her. LVN L stated if an x-ray was done, the results may have been faxed to the facility. LVN L stated that he thought had seen a couple of chest x rays come through on the fax before but did not recall that anyone got any significant x-ray results while he was on shift. LVN L stated if he ordered an x-ray and had not received a result after about a couple of hours, he would call the x-ray place and ask about it. LVN L stated that x-ray results could go straight to the resident's profile now. LVN L stated they could go into the results tab and see if the x-ray was resulted. LVN L stated there was not a pop up or anything to remind you to go look at the result. LVN L stated if he got a significant finding, he would call the doctor to let them know as soon as he got the result. LVN L stated in his orientation they went over the things you were supposed to notify the physician for. LVN L stated, I don't remember them saying when specifically, the doctor should be notified after receiving the results. LVN L stated if an x-ray was done on his shift and he had not gotten the result yet, he, as the off going nurse, reported it to the oncoming nurse who would keep an eye out for the result. LVN L stated there was also a piece of paper that stuff was written on to pass along to the next shift. In an interview on 9/18/24 at 2:10pm the DON stated that she never opened the email from the radiology company on 11/28/23. The DON provided a copy of the radiology company's print out of the details of Resident #21's x-ray that was done on 11/28/23. The print-out reflected that a SIGNIFICANT report was emailed to the DON and the Admin on 11/28/23 at 5:51pm. This print-out also reflected that a text message was sent to a phone number and a fax was sent to the facility's fax number with the x-ray findings on 11/28/23 at 5:51pm. The DON and the Admin stated that the fax number that the radiology company had was not the facility's fax number and they did not know why the radiology company had that number. The DON and the Admin also stated that they did not know who the phone number belonged to that the text message was sent to. An internet search on 9/20/24 revealed the fax number that the radiology company sent the result to had been associated with this facility and the phone number that the text message was sent to belonged to the person who was the DON at the facility at the time the contract with the radiology company was signed in 2022. Record review of Resident #21's Nursing Progress Notes reflected an entry by RN I dated 11/29/23 effective at 11:17am that stated, RP present, resident being transported per (non-emergent ambulance) stretcher report given to ambulance driver, and resident transported with paperwork and copy of DNR to ER, DON aware. [sic] Record review of Resident #21's Medication Administration Note reflected an entry by LVN J dated 11/29/23 effective 10:12pm that stated, admitted to hospital. Record review of Resident #21's Medication Administration Note reflected an entry by RN I dated 11/30/23 effective 11:23am that stated, At hospital. In an interview on 9/12/24 at 10:47am, the ME stated that Resident #21 passed away at home on 12/1/23 and that she ruled Resident #21's death as, Accident- Accidental fall/ complications of femur fracture, fall, dementia, hypertension, and COPD. The ME stated she did not do an autopsy, but rather reviewed all of Resident #21's medical records. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675672	A. Building B. Wing	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River Ridge Nursing & Rehabilitation	3922 W River Dr Corpus Christi, TX 78410

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review on 9/18/24 of the facility's radiology company contract that was signed on 2/8/22 reflected in part: SERVICES: 4. REPORTS The Radiologist will dictate a report to the attending physician for each examination. (The x-ray company) will provide a written copy of the written report to the community and to the attending physician. 6. WEB ACCESS (The x-ray company) agrees to provide the Community with direct access to patient records on the (x-ray company's) website. There was no part of the provided contract that discussed if, how, or when the facility would be notified of significant findings. Record review of this contract also revealed that it was signed by the current Admin on 2/8/22. Record review of the facility's Changes in Resident Condition Policy revealed in part: Compliance Guidelines: The resident, medical provider (MD/NP/PA) and resident representative or designated family member should be notified when changes in condition or certain events occur. Communication with the interdisciplinary team and caregivers is important to facilitate consistency and continuity of care. Guidelines: 1. The resident, medical provider (MD/NP/PA) and resident representative or designated family member should be notified when there is: g. when laboratory, radiology or other diagnostic results fall outside the clinical reference ranges set by the contracted service provider or per physician orders. This policy did not indicate a timeframe for notifying the provider after diagnostic results that fell outside of the clinical reference ranges were received. An Immediate Jeopardy was identified on 9/18/24 at 11:15am. The Admin was informed of the Immediate Jeopardy, given the Immediate Jeopardy template, and a Plan of Removal was requested on 9/18/24 at 2:06pm. The facility's Plan of Removal was accepted on 9/19/24 at 8:49pm. The facility's Plan of Removal included: [Facility] Plan of Removal F777 Radiology/Diag. Services Ordered/Notify Results (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Date: September 18, 2024 Corrective Action: Resident #21 who was admitted on [DATE] under hospice services for end-of-life care for diagnoses of Renal Failure, Liver Failure, Congestive Heart Failure, and Malignant Neoplasm of Left Breast sustained a witnessed fall on 11/25/23. Resident assessed by charge nurse and risk management report completed and MD/RP/hospice notification made. Non stat X-ray order obtained on 11/28/23 and positive fracture results received on 11/29/23 and reported to MD and hospice with hospice collaboration for RP notification. Resident discharged to hospital on 11-29-23. Resident #21 is no longer an active resident within our community. Resident #21 was assessed and being monitored by the nurses prior to being sent to the hospital on 11-29-23. Per hospital report, resident did not receive any treatment for fracture and was discharged home with family. Identification: All residents who have abnormal X-ray results may be at risk for the alleged deficient practice. Director of Nursing/Assistant Director of Nursing conducted an audit of all residents to identify any abnormal x-rays within the last 60 days to ensure the MD and family representatives have been notified and appropriate interventions are in place and prescribers orders have been carried out as ordered. Outcome: No negative outcomes identified. Date Completed: 9/18/24. Systematic Changes: The Regional Nurse (DCO) conducted an in-service to the Director of Nursing/Assistant Director of Nursing regarding the process for ensuring that abnormal x-ray have been identified, x-ray portals are being checked during shift to identify pending results, and the results are reported to the medical provider, orders provided should be implemented as ordered and nursing should document in the electronic health record the notification of abnormal x-ray results to the MD/NP/PA as well as any prescribed orders. Date Completed: 9/18/24. Director of Nursing/Assistant Director of Nursing conducted in-service training to all licensed nurses prior to next scheduled shift regarding: a. The process for ensuring that abnormal x-rays have been identified, x-ray portals are being checked once in first half of shift and once in second half of shift to identify pending results, and the results are reported to the medical provider upon receipt of abnormal x-ray findings, orders provided should be implemented as ordered and nursing should document in the electronic health record the notification of abnormal x-ray results to the MD/NP/PA as well as any prescribed orders. (continued on next page)

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F 0777 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	11:46am - LVN Q 12:00pm - ADON 12:26pm - LVN R 12:35pm - LVN S 12:48pm - NAC 1:00pm - DCE 1:04pm - RN T All staff interviewed stated the physician and responsible party are to be notified immediately anytime there is a change in a resident's condition, change in pain level, or critical lab/x-ray results. All staff stated that they were to notify the DON if they were having issues with getting x ray results. All staff stated the change in condition or critical result is to be documented in the electronic health record, as well as who was notified and when. All staff stated any new orders are to be entered as soon as they are received, and if it was an order for physical or occupational therapy, they would go tell physical therapy or occupational therapy and would place that information on the 24 hour report. All staff stated falls are to be documented in the progress notes and ongoing resident assessments should be done to include assessing for pain. All staff stated any change in resident condition or pending results for labs or x rays were to be passed on to the next shift during report and documented on the 24 hour communication report in PCC. All staff stated they received hand-outs with the information that was covered in the in-services. The Admin stated that he contacted the radiology company about notification of significant reports and requested that significant reports not be emailed to him or the DON, but rather all significant reports be called into the facility. The Admin stated he also gave the radiology company the phone numbers for the DON, himself, and the NC as back up numbers in case the radiology company was unable to contact the charge nurse at the facility. Record reviews conducted on 9/20/24 included: Review of the facility's recent in services: 9/18/24- Change in Condition Notification to MD/NP/RP 9/18/24- Notification of x-ray results and [TRUNCATED]