STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675690	A. Building B. Wing	07/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Estates Rehabilitation Center	130 Spencer LN San Antonio, TX 78201

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** 47564 Based on observation, interview and record review, the facility failed to immediately inform the resident's physician when there was a significant change in resident's physical, mental, or psychosocial status for 1 of 17 residents (Resident #63) reviewed for physician notification of changes. The facility failed to consult with Resident #63's physician and provide all necessary details to the DON when Resident #63 had a significant change in condition on [DATE], that included pain, vomiting, diarrhea, and low oxygenation and subsequently died . An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:28 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could affect residents by placing them at risk for a delay in medical treatment, decline in health, and death. The findings included: Record review of the Admission Record reflected Resident #63 was a [AGE] year-old male, admitted on [DATE] with a primary diagnosis of encephalopathy [group of disorders referring to brain disease, damage, or malfunction], noninfective gastroenteritis [inflammation in stomach or intestine] and colitis [inflammation in the colon], rhabdomyolysis [condition that causes muscles to disintegrate leading to muscle tissue death], and acute kidney failure. [Admission Record did not reflect presence of gastrostomy tube, or advanced directive code status.] (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the comprehensive MDS assessment dated [DATE], reflected that Resident #63 entered the facility from a short-term general hospital. Resident #63 had unclear speech, but usually was able to make self-understood, and sometimes had the ability to understand others. Further in the document contained conflicting data indicating that a BIMS should not be conducted due to the resident was rarely/never understood. Resident #63 was coded as having both short-term, and long-term memory problems, and had some difficulty only in new situations requiring modified independence for daily decision making. Resident #63 was coded as partial/moderate assistance with eating at admission. Resident #63 was coded as not rated for both urinary and bowel continence as resident had a urinary catheter and had an ostomy [surgical procedure that creates an opening in the abdominal wall] or did not have a bowel movement. Resident #63 had health conditions noted of vomiting. Nutritional approaches included feeding tube with 25% or less total calories received thru the feeding tube; 500 CC [milliliters] per day by tube feeding. Record review of the Order Summary Report, printed [DATE] at 4:05 PM, reflected Resident #63 had physician's orders for CPR/Full Code status, dated [DATE]. Resident #63 had physician's orders for enteral feeding orders: two times a day 70 milliliters per hour [did not reflect formula type, total volume, time of administration, or contraindications]. Record review of Resident #63's Progress Note, effective date [DATE] at 5:45 PM and written by RN B reflected, Resident arrived via [redacted] Ambulance. EMS stated that nothing significant happened during transfer. [Medical Director] was informed of patients arrival. Stated to continue orders and medications from hospital as well as lab orders of CBC, CMP, Prealbumin, and Ammonia level. Orders to continue Osmolite [complete balanced nutritional formula for tube-fed individuals] at 70mL/hour and to check residuals on PEG tube [percutaneous endoscopic gastrostomy tube, or g-tube] every shift. Patient's emergency contact [Emergency Contact Name] was called at [Emergency Contact Phone Number] to inform her patient arrived. Patient resting comfortably. Record review of Resident #63's Progress Note, effective date [DATE] at 8:09 AM and written by LVN A reflected, Resident was restless throughout the night especially after midnight. He was receiving Osmolite 1. 5 @ 70 ml/hr via g tube. Resident complained of stomach discomfort and started having emesis [vomiting] episodes x3. After the first emesis the feeding was turned off and the DON was called. I really wanted to see if we could send this resident out to the emergency room for eval[uation]. Vital ,d+[DATE] [blood pressure; according to the American Heart Association, a normal blood pressure for adults is less than ,d+[DATE], and low blood pressure is less than ,d+[DATE]], o2 stat [sic] was 90 [normal oxygen saturation is between 95% and 100%]. I immediately got O2 and applied it when notice his sat[uration] had increased with the oxygen. She [the DON] stated that I should call the doctor and see what he wanted to do and that was done. Doctor did not return my call. Bed was changed at 0200 [2:00 AM] with stool and emesis. Changed again at 0315 [3:15 AM], 0400 [4:00 AM]. I decided to go back in the room to check on him with some fresh sheets just in case they were needed, and he was looking straight up to the ceiling, his eyes wide open and that alerted me to assess him pulled him off the bed onto the floor and get the Crash cart Started CPR at 0445 [4:45 AM] called EMS. they came and took charge. (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 #63's Progress Note, effective date [DATE] at 9:00 AM and written by LVN A reflected, 1800 [6:00 PM] Initial head to toe assessment was completed, Observed and assessed the g-tube and the feeding, Osmolite 1.5@ 70 ml per hour. @ being set up by the off going nurse. Family came in to visit and to sit with the resident. They introduced themselves and were very pleasant and attentive of [Resident #63's] care. They left after 2 hours at around 2200 [10:00 PM]. Re-evaluated residents g-tube area due to his complaint of pain. The stomach area was slightly red, but it was not an open area or a rash, g-tube site was not red or draining, abdomen was slightly distended and firm to touch. Resident had his first small BM which was soft around 2300 [11:00 PM]. Cleaned resident and changed his bed linen. He ask [sic] me to place something at his bedside because he was feeling nauseated and he thought he had to throw up. He did throw up brownish color secretion, 150 ml. Assisted resident to clean his mouth and placed a pad on the side of the bed so if he had another vomiting episode, he would have some type of covering over his bedding. He had another episode of nausea and vomiting and also he had medium size BM around 0000. Resident became restless and voiced general discomfort. Vital signs were B[lood]/P[ressure] ,d+[DATE], Heart Rate 99, O2 sat was 90% on RA [room air]. At this time O2 [oxygen] was applied at 4 lpm via face mask and it brought his O2 sat up to 97% on 4 lpm. Resident continued to be restless and complaining of discomfort to abdomen. Around 0445 [4:45 AM] DON was called and notified of residents change of condition, DON instructed me to call the Doctor. Dr. was called around 0445 [4:445 AM] and message left. Resident continues to be restless and vomits again with another BM around 0500 [5:00 AM]. Changed the bed linen and provided peri care to the resident and placed clean gown on the patient. I checked resident around 0530 [5:30 AM] and noted restlessness, nausea and vomiting, I emptied out his container at his bedside 200 ml brownish colored vomit. As I assessed the resident, noted he had another bowel movement, abdomen remained firm and slightly distended at this time, no change noted. Cleaned up the resident's area with fresh clean linen after peri care applied. I took the soiled linen to the soiled linen area, went to the nurses' station, and then returned to check on resident and noted he was staring straight up to the ceiling with his eyes wide open. I immediately assessed him for his response by calling his name, assessed him breathing and heart rate. They were absent, no heart rate or respiration, immediately I pulled resident off the bed onto the floor started CPR, I had to go and get crash cart came back and called EMS at 0647 [6:47 AM] and started CPR again. Checked for pulse again and initiated CPR. The EMS dispatcher stayed on the line with me until EMS arrived person and was giving instructions and gathering information on the resident while I continue CPR. EMS arrived and assessed the resident and pronounced him @06:56 [6:56 AM]. Record review of Resident #63's Progress Note, effective date [DATE] at 9:15 AM and written by the Treatment Nurse reflected, Contacted Medical Examiner to obtain release of body. Writer was advised additional information is needed. Contacted [family member]. Per [family member] resident was living with [family member] in an apartment prior to hospital admission. The [family member] stated that resident had been losing weight, and stopped eating and began rapidly declining after [family member] received dx [diagnosis] of metastatic breast cancer that had spread to her lungs. Per [family member], resident was admitted for malnutrition. The [family member] advised resident was not previously following with a PCP and was last evaluated by [Physician] ,d+[DATE] years ago. Per hospital records resident was found on floor with altered mental status and admitted . Imaging done in hospital and PEG tube placed. Per hospital records no suspicion of abuse. SNF Medical director to sign death certificate. ME notified. Advised by ME per resident age, and no suspicion of abuse/neglect/APS case resident does not meet criteria for autopsy. Resident body ok to release to funeral home. ME #[number], case #[number]. Called [funeral home] and notified them of TOD: 0656AM and that ME released the body. [Funeral Home] advised they would arrive for p/u in 30 min to 2 hours. (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 #63's Progress Note, effective date [DATE] at 11:00 AM and written by the DON reflected, Time of death was pronounced by EMS at 0656 [6:56 AM]. Record review of Resident #63's Progress Note, effective date [DATE] at 11:25 AM and written by the Treatment Nurse reflected, 2 staff from [Funeral Home] picked up resident body. Family aware. Interview on [DATE] at 6:59 PM, LVN A stated that on [DATE], he arrived for his first shift at 6:00 PM after completing training [new hire orientation] at the facility and was assigned to Station 3. LVN A stated that throughout the course of the night Resident #63 seemed very antsy, the skin of his stomach was red, and he would use his call light to call LVN A every 30 to 45 minutes and LVN A would attempt to comfort the resident. LVN A stated that at one point, Resident #63's oxygen saturation was lower than 90%, and he provided Resident #63 with supplemental oxygen, which raised Resident #63's oxygen saturation back up to 97%. LVN A stated that he changed Resident #63's bed linens multiple times that night due to the linens being soiled from Resident #63's dark brown vomit and bowel movement, and after answering a different resident's call light, he went to check on Resident #63. LVN A stated that he then found Resident #63 staring straight up at the ceiling and called Resident #63's name. After Resident #63 did not answer, LVN A walked to the resident, attempted to rouse him, said his name again, and noticed his eyes were fixed and dilated and Resident #63 had no respirations or pulse. LVN A stated that at that time, he lowered the resident from his bed onto the floor to initiate CPR and noticed emesis in Resident #63's mouth. LVN A stated that he attempted to clear the emesis from the resident's mouth by turning him on his side and continued CPR. LVN A stated that he left Resident #63 during CPR to obtain Station 3's Crash Cart and AED. LVN A stated that during CPR, he called the DON who instructed him to call 911 and the MD. LVN A stated that, according to the EMT's, when EMT's arrived at the facility, they made their way to Station 1 instead of Station 3, and it took a while for them to get to Station 3. LVN A stated once the EMT's arrived to Resident #63's room, they took over CPR on Resident #63. LVN A stated that there was no way for him to have contacted anyone at Nurses' Station 1 or Nurses' Station 2 because he did not know the phone numbers to Station 1 [100-hallway] or 2 [200-hallway] and instead used his personal phone to call the DON and 911. LVN A stated that since there were only 3 residents on Station 3 [300-hallway], there were no CNAs assigned to assist him that night on Station 3. LVN A stated that he did not think to call the MD or DON when Resident #63's oxygen saturation became low due to the resident's oxygen saturation going back up after LVN A had administered oxygen, and the color of the vomit was not concerning to him. LVN A stated the time line of events was as follows: around 11:00 PM Resident #63 complained of pain, had vomiting and fecal incontinence that soiled his linens; Resident #63 had another bout of emesis and fecal incontinence around midnight but also noted his oxygen saturation dropped and LVN A put supplemental oxygen on Resident #63 at 4 liters per minute which raised his oxygen saturation to acceptable levels; Resident #63 had emesis and fecal incontinence three more times at 2:00 AM, 3:15 AM, and 4:00 AM. LVN A stated he returned to check on the resident shortly after the 4:00 AM bout of emesis, around 5:30 AM, when LVN A realized that Resident #63 required CPR. LVN A started CPR immediately, called the DON and 911, and attempted to notify the MD, but did not receive a call back from the MD prior to EMS arriving at approximately 5:45 AM, at which time EMS took over CPR and ultimately pronounced Resident #63 as deceased . LVN A stated that at the time of the incident he did not have any co-workers phone numbers saved in his personal phone and only had the contact information for the DON. (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.	Interview on [DATE] at 7:33 PM, RN B stated that she assisted in the admission of Resident #63 and set up his peg tube before leaving the facility after completing her shift. RN B stated that when Resident #63 came in, he seemed depressed and had told her he did not want his PEG tube. RN B stated that her interaction with Resident #63 was brief, and the resident did not appear to be feeling ill before she left for the evening. RN B stated that with 3 residents on Station 3 [300-hallway], there was only one nurse per shift scheduled. RN B stated that a resident suddenly needing and being provided with supplemental oxygen was a change in condition and that the MD and DON should be notified immediately if that occurred. RN B stated that if staff need help, they usually called or texted from their personal cell phones to other staff on duty. RN B stated that other staff have always been very good about responding and assisting when need. RN B stated that, in her experience on day shift, staff would promptly respond or show up to provide hands on assistance as needed. RN B stated she was unsure if the other staff on duty had shared their personal cell phone numbers with LVN A at the time of the incident. Record review of the facility schedule and timecards for [DATE] and [DATE], dated [DATE], reflected that CNA M, CNA P, and NA U worked overnight. The facility schedule reflected that CNA M worked from 2:30 PM on [DATE] until 6:30 AM on [DATE], CNA P worked from 10:30 PM on [DATE] until 6:30 AM on [DATE], and NA U worked from 10:30 PM on [DATE] until 6:30 AM on [DATE]. In an interview on [DATE] at 7:09 AM, CNA M stated that she was the float CNA on her shift on [DATE]-[DATE]. CNA M stated she did not recall Resident #63. CNA M stated she did not recall any problems on the 300-hallway. CNA M stated that when she was assigned the responsibility to be the float CNA for her shift, the expectation was that she would go between the 100-hallway and the 200-hallway. CNA M stated the 300-hallway was not a part of the responsibility for the person assigned as a float CNA. CNA M stated she was not asked to assist with the 300-hallway, or to float to the 300-hallway, as the census was too low. CNA M stated the nurse was expected to perform all care tasks on the 300-hallway, due to extremely low census on that hallway. CNA M stated the 300-hallway reopened around [DATE]. A phone interview was attempted on [DATE] at 8:58 AM with CNA U that was unsuccessful. A phone interview was attempted on [DATE] at 9:24 AM with CNA P that was unsuccessful. (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.	Interview on [DATE] at 12:27 PM, the DON stated that on [DATE] around the 4:00 AM hour, LVN A called her and told her that he had put oxygen on Resident #63 and that Resident #63 did not feel good and had a distended stomach, and the DON informed LVN A to call the physician. The DON stated that she did not receive another call until after 6:00 AM when she was informed that Resident #63 had expired. The DON stated she did not receive any calls informing her that LVN A was conducting CPR. The DON stated that she was not on site while the resident was in the building and never met the resident. When asked if, in this incident, there was a change of condition that should have been reported to the MD, the DON stated that a resident who needed supplemental oxygen was a change in condition and that it was her expectation that staff call her and the MD if a resident was put on supplemental oxygen. The DON stated that while there was no CNA assigned to Station 3, there was generally a floating CNA who would assist where necessary. The DON stated that the MD had an after-hours phone number, and it was in a notebook at every nurses' station. The DON stated that the incident was brought to QAPI. The DON stated that if staff knew the phone number to the nurses' station, they would call from any resident room, but if they do not know the phone number, they would have to use the phone at the nurse's station. The DON stated that her expectation was that if CPR was being performed, the staff would call for assistance to another hall if necessary . The DON stated she was not aware that EMS went to the incorrect hallway, and believed LVN A called another hall for assistance but was not sure who LVN A called. The DON stated she did not receive a call from LVN A while he was performing CPR, and Resident #63 was stable when LVN A called her. The DON stated LVN A an experienced LVN but was new to the facility at the time of the incident. The DON stated this was LVN A's first shift after new hire orientation. The DON stated there was not a curriculum or training manual; but that she was in the process of developing one to include a check list of items all nurses needed to know. The DON stated new hires were trained on what to do, when to do it, and what forms were necessary in the EHR for change of conditions or emergency situations, or accidents and incidents. A phone interview was attempted on [DATE] at 1:38 PM with the MD that was unsuccessful. In an interview on [DATE] at 1:45 PM the DON stated the MD was on vacation. In an interview on [DATE] at 9:05 AM, LVN V stated she did not work with Resident #63 and was not aware of any issues on the 300-hallway until later. LVN V stated she was not aware of EMS being called until she saw the ambulance in the parking lot as she was exiting at the end of her shift at approximate 6:30 AM to 7:00 AM on [DATE]. LVN V stated prior to that she was not told there were any problems on the 300-hallway, was not asked for her assistance and was not directed by anyone to help out on that hallway. LVN V stated she normally worked on the 100-hallway. LVN V stated typically staff called or texted each other on their personal cell phones, but one could also call the facility's main phone number and it would ring at each of the nurses' station. LVN V stated she later heard that EMS went to 200-hallway first and that was how staff found out there was something happening on the 300-hallway. LVN V could not recall when or who told her that information. Record review of facility policy titled, Change in a Resident's Condition or Status, dated [DATE], reflected, The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . significant change in the resident's physical/emotional/mental condition, and A 'significant change' of condition is a major decline or improvement in the resident's status that: a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. (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.	This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 5:28 PM and the ADM, VP RN, and DON were notified at 5:28 PM and was provided with the IJ Template on [DATE]. The following Plan of Removal (POR) was accepted on [DATE] at 3:59 PM: 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: [DATE]) - Facility Medical Director was notified of the incident. Completed [DATE]. Physical assessments were completed by ADON and Charge Nurses on all residents to identify any changes in condition and notification was made to the physician of any noted changes. Concerns were not identified. Completed [DATE] Licensed nurse who was aware of significant change was suspended pending 1:1 education by the Director of Nursing. Completed [DATE] 2. Actions to Prevent Occurrence/Recurrence: - The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: [DATE]). - All licensed nurses were educated by DON/designee on change of condition and physician notification regulations, as well as facility policy and procedure. Including notification of MD and DON after you have identified a change of condition, implementation of new orders received from doctor and completion of the eInteract Assessment in Point Click Care . [EHR form utilized to streamline communications among providers and staff.] Completed [DATE] Nurse aides were educated by the DON/designee on change of condition regulations to promote their situational understanding and facilitate communication with licensed nurses. The nurse aides have been educated that for emergent changes in a resident condition they are to immediately notify the charge nurse verbally. For non-emergent changes the nurse aides were educated on the Stop and Watch alert in Point Click Care that they can complete. The alerts trigger to the nursing dashboard for the Charge Nurses to evaluate the resident upon alert and proceed as clinically appropriate to address the change. The DON or Designee will review the alert trigger dashboard and run the alert trigger report in morning meeting to ensure all alert triggers have been reviewed and addressed. Completed [DATE] Staff members were not permitted to work a shift until education was completed. New hires (licensed nurses and nurse aides) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly. A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented with a focus on physician notification of significant changes. Completed [DATE] (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.	Interviews between [DATE] at 7:10 PM and [DATE] at 2:56 PM with 74% of nursing staff to include LVN's, RN's, CNA's, and NA's employed at the facility revealed trainings were conducted prior to the nurses' shift began on change in condition, notifying the physician and DON of change in condition, and CPR. All nurse staff interviewed voiced that they had no concerns regarding implementing the trainings in their day-to-day assignments. Of the staff interviewed, the included 6 staff who worked 6:30 AM - 2:30 PM, 3 staff who worked 2:30 PM - 10:30 PM, 3 staff who worked 10:30 PM - 6:30 AM, 2 staff who worked 6:00 AM - 6:00 PM, 2 staff who worked 8:00 AM - 8:00 PM, and 5 staff who worked 8:00 AM - 5:00 PM, 2 staff who work 6:30 AM - 10:30 PM, and 5 staff who worked PRN. Record review of staff training reflected 37 of 47 nursing staff across all shifts had been in-serviced. Record review of staff training reflected 37 of 37 staff who worked on [DATE] and [DATE] were in-serviced on change in condition to include what to look for in a change in condition and notifying the charge nurse of a change in condition. Interview on [DATE] at 1:45 PM with the DON and ADM, stated that change in condition training was completed with all staff available, some came in on their days off; and those who have not received training will be required to have the training before being allowed to work on their next shift. During interviews between [DATE] at 7:10 PM and [DATE] at 2:56 PM with 56% of Nurse Aide staff, it was revealed that nurse aide staff had been trained on change in resident condition, notifying charge nurses, and alerts on point-click-care and the trainings were completed prior to beginning their shifts and that they each understood the trainings and had no concerns on implementing the trainings in their day-to-day work. Of the staff interviewed, this included 6 staff who worked 6:30 AM - 2:30 PM, 3 staff who worked 2:30 PM - 10:30 PM, 3 staff who worked 10:30 PM - 6:30 AM, 2 staff who worked 6:00 AM - 6:00 PM, 2 staff who worked 8:00 AM - 8:00 PM, and 5 staff who worked 8:00 AM - 5:00 PM, 2 staff who work 6:30 AM - 10:30 PM, and 5 staff who worked PRN. Record review of staff training reflected 100% of staff who worked on [DATE] and [DATE] were trained prior to working their shift. Record review of New Hire Orientation reflected that trainings relating to change in condition, enteral feeding, physician notification, and communication between staff had been added. Interview on [DATE] at 1:49 PM, the ADM stated that any staff who had not participated in training were PRN staff who would be trained prior to their next shift. The DON/ADON planned to ensure they were available for training the PRN staff prior to their shift. The ADM further stated that all new hire orientation would include training related to the incident to include any training on changes in condition, physician notification, enteral feeding, and communication between staff. Observation on [DATE] at 2:30 PM revealed staff receiving training prior to beginning their shift. Interview on [DATE] at 1:45 PM, the DON stated that education on change of condition and physician notification regulation would be part of new hire orientation. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Estates Rehabilitation Center	130 Spencer LN San Antonio, TX 78201

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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 Quality Assessment & Performance Improvement Plan, dated [DATE], reflected that the DON, ADON, and Charge Nurses would ensure compliance with notifying the physician and DON of any significant changes in condition and documenting notification and any new interventions in the resident's medical record through Resident Chart audits. Tasks listed to ensure that included, but was not limited to: Educating nursing staff on facility protocol for notification of changes, monitoring nursing documentation of 24-hour report during morning meeting for any clinical changes, etc. Interview on [DATE] at 1:53 PM, the DON and ADM stated that the QAPI Performance Improvement Project would be the responsibility of the DON, ADON, and Nursing staff and would be consistently reviewed in the morning meetings as well as QAPI meetings. Record review of Quality Assessment & Performance Improvement Plan, dated [DATE], reflected that the Clinical Team would be responsible for a task titled Monitor nursing documentation of 24hr. Report during morning clinical meeting for any change in condition. Interview on [DATE] at 1:53 PM, the DON stated that they would audit on the 24-hour report during the morning meeting and any changes in condition would be on the 24-hour report. The DON stated that the whole nursing leadership team would be looking at the 24-hour report during morning meetings to ensure any changes in condition were monitored. Record review of Quality Assessment & Performance Improvement Plan, dated [DATE], reflected that the DON/Designee would be responsible for a task titled, Three resident charts will be audited weekly x 4 weeks then two resident charts weekly for two weeks, then two resident charts a month of two months. Interview on [DATE] at 1:54 PM, the DON stated that she or someone from the nursing leadership team would be performing chart audits, using the paper document, to ensure resident charts were reviewed for any change in condition. Record review of Quality Assessment & Performance Improvement Plan, dated [DATE], reflected that the DON/Designee would be responsible for a task titled, Three resident charts will be audited weekly x 4 weeks then two resident charts weekly for two weeks, then two resident charts a month of two months. Interview on [DATE] at 1:57 PM, the ADM stated that the VP RN, would be visiting frequently during the 30-day period to provide insight, the ADM stated the VP RN visited frequently anytime she or the DON needed assistance. The ADM was informed the Immediate Jeopardy was removed on [DATE] at 5:24 PM. While the IJ was removed, the facility remained out of compliance at a severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47564 Based on observations, interviews, and record review the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment including both the comprehensive and quarterly review assessments person-centered care plan to reflect the current condition for 4 of 8 residents (Residents #29, #36, #50, and #35) reviewed for care plan revisions, in that: 1. The facility failed to ensure Resident #29's care plan had updated fall interventions after 2 major falls with injury. 2. The facility failed to document how Resident #36 was supposed to be transferred by staff. 3. The facility failed to update care plan to include Resident #50 and Resident #35 were appropriate for 1 person transfers instead of just a 2 person Hoyer transfer. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: 1. Record review of the Admission Record reflected Resident #29 was a [AGE] year-old female admitted on [DATE]. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #29 had summary BIMS score of 12, indicative of moderately impaired cognition. Resident #29's primary medical condition for admission was coded as other neurological conditions related to cerebral infarction [stroke, death of an area of brain tissue due to loss of blood supply]. Other active diagnoses included hemiplegia or hemiparesis (paralysis to one side of the body). Resident #29 was coded as supervision for lower body dressing, putting on/taking off footwear, personal hygiene, left and right rolling, sit to lying, lying to sitting, sit to stand, and chair/bed-to-chair transfer, and toilet transfer. Record review of the Care Plan , undated, revealed a focus area for Resident #29 as risk for falls with the following associated interventions: need frequent reminders to ask for assistance, maintaining non-weight bearing status due to right lower extremity surgery, initiated 10/05/2022; frequent reminders to ask for assist with transfers, initiated 1/19/2023; require extensive assistance with 1 staff for transfers; initiated 11/09/2021. During a combined interview with Nurse Aide T and Nurse Aide S on 07/26/24 at 03:38 PM, they were able to reveal Resident #29 was a fall risk and reveled interventions they did for Resident #29 to prevent her from future falls that had not been documented, like having to follow her to activities to ensure she did not fall and rounding frequently. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/27/24 at 02:53 PM, the MDS Coordinator (with the DON present) revealed Resident #29 was a fall risk. The MDS Coordinator further revealed care plan interventions were important to prevent a fall from occurring. He further revealed during care plan review, if there were additional interventions that could be added, they would add those. He revealed there were no new interventions after a 04/2023 fall (with hospitalization) and no new fall interventions added after a 12/2023 fall (with hospitalization). He revealed the physician had been notified and they did a medication review. 1. Record review of the Admission Record reflected Resident #36 was a [AGE] year-old male admitted on [DATE]. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #36 was not assessed for mental status [no summary BIMS score; no documentation of short/long term memory problems]. Resident #36's primary medical condition for admission was coded as traumatic brain dysfunction related to diffuse traumatic brain injury with loss of consciousness between 1-6 hours. Other active diagnoses included quadriplegia [symptoms of paralysis that affect all a person's limbs and body from the neck down]. Resident #36 was coded as totally dependent for upper body dressing, lower body dressing, personal hygiene, shower/bathe self, ability to roll, sit to lying, lying to sitting, sit to stand, chair/bed-to-chair transfers. Resident #36 was coded as always incontinent for bladder and bowel. Resident #36 was at risk of developing pressure injuries. Record review of the Care Plan, undated, revealed a focus area for Resident #36 as having an ADL self-care deficit with the following associated interventions: totally dependent on staff for repositioning and turning in bed, initiated 06/30/2023. The Care Plan did not address Resident #36's transfer needs. During a combined interview with Nurse Aide T and Nurse Aide S on 07/26/24 at 03:38 PM, revealed Resident #36 was a Hoyer lift and it was in their POC (a place that shows the nursing staff what to do in order to care for residents). They revealed it was important to follow their POC for the resident's safety. During an interview on 07/27/24 at 02:53 PM, the MDS Coordinator (with the DON present) revealed Resident #36 was a 2 person assist. Upon review of Resident #36's care plan, the MDS Coordinator revealed transfers should be documented under ADL's or mobility, and transfers were not documented on Resident #36's care plan. He further revealed it was important to document how a resident was transferred in the care plan for safety reasons. He further revealed the care plan interventions allowed the CNAs to know how to care for the residents. 3. Record review of the Admission Record reflected Resident #35 was a [AGE] year-old male admitted on [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the quarterly MDS assessment dated [DATE], reflected Resident #35 had a summary BIMS score of eight, indicative of moderate cognitive impairment. Resident #35's primary medical condition for admission was coded as other neurological conditions related to nontraumatic intracerebral hemorrhage [bleeding from a blood vessel in the brain]. Other active diagnoses included hemiplegia or hemiparesis [one sided weakness or paralysis]. Resident #35 was coded as totally dependent for toileting hygiene, shower/bathe self, putting on/taking off footwear, chair/bed-to-chair transfer, and sit to stand; moderate assistance for upper and lower body dressing, personal hygiene, lying to sitting on side of bed, and sitting to lying. Resident #35 was coded as always incontinent for bladder and bowel. Record review of the care plan , undated, revealed a focus area for Resident #35 as having hemiplegia/hemiparesis with the following associated interventions: require the assist of 2 staff to transfer with a [mechanical] lift, initiated 11/16/2021. Record review of the Admission Record reflected Resident #50 was a [AGE] year-old female admitted on [DATE]. Record review of the quarterly MDS assessment dated [DATE], reflected Resident #50 was not assessed for mental status [no summary BIMS score; no documentation of short/long term memory problems]; Resident #50 was code as severely impaired for the ability for daily decision making. Resident #50's primary medical condition for admission was coded as non-traumatic brain dysfunction related to cerebral infarction. Other active diagnoses included hemiplegia or hemiparesis [one sided weakness or paralysis]. Resident #50 was coded as totally dependent for toileting hygiene, shower/bathe self, putting on/taking off footwear, chair/bed-to-chair transfer, and sit to stand, upper and lower body dressing, personal hygiene, lying to sitting on side of bed, and sitting to lying. Record review of Resident #50's care plan, dated 07/24/24, reflected TRANSFER: I require Mechanical Aid (Sling, Hoyer) for transfers. Date Initiated: 06/01/2023 Revision on: 06/01/2023 CNA o TRANSFER: I require total assistance with transfers x2 staff. Record review of Resident #50's hospital records dated 04/10/23, reflected patient diagnoses to include fall. Record review of Resident #50's hospital records dated 12/15/23, reflected patient diagnosis to be a closed head injury; fall. During a combined interview with CNA CC and Resident #35 on 07/24/24 at 10:15 AM, CNA CC revealed she did not use a Hoyer lift to transfer Resident #35 and sometimes she transferred Resident #35 by herself . Resident #35 revealed he did not need a Hoyer to be transferred and he even transfers himself at times. During an interview and observation on 07/25/24 at 04:17 PM, revealed Resident #50 was lying in bed and Nurse Aide BB stated, patient care. The door was closed to respect resident's privacy. It was observed Nurse Aide BB opened the door with Resident #50 in a wheelchair. Nurse Aide BB revealed she was the only nursing staff in the room to get Resident #50 out of bed. Nurse Aide BB revealed Resident #50 did not require a Hoyer lift according to her POC. She further revealed she was able to transfer Resident #50 by herself and smaller or shorter staff needed to use a Hoyer lift. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/26/24 at 09:42 AM, CNA N revealed Resident #35 was able to be transferred with one person and not a Hoyer lift. CNA N revealed the POC (used to provide care to the residents) reflected Resident #35 was a 2 person Hoyer lift. She revealed that should probably be updated because the staff didn't transfer Resident #35 via an Hoyer lift. CNA N revealed there had been no injuries related to Resident #35 being transferred by one person because he was able to help staff transfer him. During a combined interview with Nurse Aide T and Nurse Aide S on 07/26/24 at 03:38 PM, they revealed Resident #50 would be transferred sometimes with 1 person when she was more alert, however, they'd have help from a second person when they didn't feel safe. They further revealed Resident #50 was not a Hoyer lift in their POC. They verbally confirmed Resident #35 was a Hoyer lift in their POC. During an interview on 07/27/24 at 02:53 PM, the MDS Coordinator (with the DON present) revealed Resident #35 did not have it care planned for Resident #35 to be transferred by 1 person. He further revealed that needed to be and would be updated, to include that Resident #35 was able to be transferred by 1 person, along with 2 person transfers. The MDS coordinator revealed Resident #50 was being transferred by 1 or 2 people but it was care planned to be transferred with a 2 person Hoyer lift. The MDS coordinator further revealed it was important for care plans to be updated appropriately for resident safety and this allows the POC to be updated for CNAs to provide appropriate resident care. Record review of Incident and Accidents report from February 2024 to August 2024 revealed no incidents and accidents related to transfers in the last 6 months. Record review of the facility's policy, titled Care Plans, Comprehensive, revised December 2023, reflected, The comprehensive, person-centered care plan will: b. Described the services that are to be furnished to attain and maintain the resident's highest practicable physical, mental, and psychosocial well-being; h. Incorporate risk factors associated with identified problems; l. Identify the professional services that are responsible for each element of care and The Interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desire outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on observation, interview and record review LVN A failed to provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders follow physician orders and the resident's advance directives for 1 of 17 residents (Resident #63) reviewed for Full Code status. The facility failed to ensure emergency protocol was followed and failed to ensure Resident #63, who had a Full Code order in place, was provided continuous and uninterrupted CPR, after the resident was found unresponsive with no pulse or respirations, according to professional standards of practice on [DATE] when LVN A stopped CPR once and continued after obtaining an AED, and Resident #63 subsequently died . An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:28 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy because all staff had not been trained on providing basic life support, including CPR, to a resident requiring emergency care. This deficient practice could contribute to a resident's decline in emotional, physical, and psychological health and result in serious injury and or death. Findings include: Record review of the Admission Record reflected Resident #63 was a [AGE] year-old male, admitted on [DATE] with a primary diagnosis of encephalopathy [group of disorders referring to brain disease, damage, or malfunction], noninfective gastroenteritis [inflammation in stomach or intestine] and colitis [inflammation in the colon], rhabdomyolysis [condition that causes muscles to disintegrate leading to muscle tissue death], and acute kidney failure. [Admission Record did not reflect presence of gastrostomy tube, or advance directive code status.] Record review of the comprehensive MDS assessment dated [DATE], reflected that Resident #63 entered the facility from a short-term general hospital. Resident #63 had unclear speech, but usually was able to make self-understood, and sometimes had the ability to understand others. Further in the document was conflicting data indicating that a BIMS should not be conducted due to the resident was rarely/never understood. Resident #63 was coded as having both short-term, and long-term memory problems, and had some difficulty only in new situations requiring modified independence for daily decision making. Nutritional approaches included feeding tube with 25% or less total calories received thru the feeding tube; 500 CC [milliliters] per day by tube feeding. Record review of the Order Summary Report, printed [DATE] at 4:05 PM, reflected Resident #63 had physician's orders for CPR/Full Code status, dated [DATE]. Resident #63 had physician's orders for enteral feeding orders: two times a day 70 milliliters per hour [did not reflect formula, or volume]. (continued on next page)

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F 0678 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 #63's Progress Note, effective date [DATE] at 8:09 AM and written by LVN A reflected, Resident was restless throughout the night especially after midnight. He was receiving Osmolite 1. 5 [complete balanced nutritional formula for tube-fed individuals] @ 70 ml/hr via g tube. Resident complained of stomach discomfort and started having emesis [vomiting] episodes x3. After the first emesis the feeding was turned off and the DON was called. I really wanted to see if we could send this resident out to the emergency room for eval[uation]. Vital ,d+[DATE] [blood pressure; according to the American Heart Association, a normal blood pressure for adults is less than ,d+[DATE], and low blood pressure is less than , d+[DATE]], o2 stat [sic] was 90 [normal oxygen saturation is between 95% and 10] . I immediately got O2 and applied it when notice his sat[uration] had increased with the oxygen. She [the DON] stated that I should call the doctor and see what he wanted to do and that was done. Doctor did not return my call. Bed was changed at 0200 [2:00 AM] with stool and emesis. Changed again at 0315 [3:15 AM], 0400 [4:00 AM]. I decided to go back in the room to check on him with some fresh sheets just in case they were needed, and he was looking straight up to the ceiling, his eyes wide open and that alerted me to assess him pulled him off the bed onto the floor and get the Crash cart Started CPR at 0445 [4:45 AM] called EMS . they came and took charge. Record review of facility schedule and timecards for [DATE] and [DATE], dated [DATE], reflected that CNA M, CNA P, and NA U worked overnight. The facility schedule reflected that CNA M worked from 2:30 PM on [DATE] until 6:30 AM on [DATE], CNA P worked from 10:30 PM on [DATE] until 6:30 AM on [DATE], and NA U worked from 10:30 PM on [DATE] until 6:30 AM on [DATE]. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 6:59 PM, LVN A stated that on [DATE], he arrived for his first shift at 6:00 PM after completing training [new hire orientation] at the facility and was assigned to Station 3. LVN A stated that throughout the course of the night Resident #63 seemed very antsy, the skin of his stomach was red, and he would use his call light to call LVN A every 30 to 45 minutes and LVN A would attempt to comfort the resident. LVN A stated that at one point, Resident #63's oxygen saturation was lower than 90%, and he provided Resident #63 with supplemental oxygen, which raised Resident #63's oxygen saturation back up to 97%. LVN A stated that he changed Resident #63's bed linens multiple times that night due to the linens being soiled from Resident #63's dark brown vomit and bowel movement, and after answering a different resident's call light, he went to check on Resident #63. LVN A stated that he then found Resident #63 staring straight up at the ceiling and called Resident #63's name. After Resident #63 did not answer, LVN A walked to the resident, attempted to rouse him, said his name again, and noticed his eyes were fixed and dilated and Resident #63 had no respirations or pulse. LVN A stated that at that time, he lowered the resident from his bed onto the floor to initiate CPR and noticed emesis in Resident #63's mouth. LVN A stated that he attempted to clear the emesis from the resident's mouth by turning him on his side and continued CPR. LVN A stated that he left Resident #63 during CPR to obtain Station 3's Crash Cart and AED. LVN A stated that during CPR, he called the DON who instructed him to call 911 and the MD. LVN A stated that, according to the EMT's, when EMT's arrived at the facility, they made their way to Station 1 instead of Station 3, and it took a while for them to get to Station 3. LVN A stated once the EMT's arrived to Resident #63's room, they took over CPR on Resident #63. LVN A stated that there was no way for him to have contacted anyone at Nurses' Station 1 or Nurses' Station 2 because he did not know the phone numbers to Station 1 [100-hallway] or 2 [200-hallway] and instead used his personal phone to call the DON and 911. LVN A stated that since there were only 3 residents on Station 3 [300-hallway], there were no CNAs assigned to assist him that night on Station 3. LVN A stated that he did not think to call the MD or DON when Resident #63's oxygen saturation became low due to the resident's oxygen saturation going back up after LVN A had administered oxygen, and the color of the vomit was not concerning to him. LVN A stated the time line of events was as follows: around 11:00 PM Resident #63 complained of pain, had vomiting and fecal incontinence that soiled his linens; Resident #63 had another bout of emesis and fecal incontinence around midnight but also noted his oxygen saturation dropped and LVN A put supplemental oxygen on Resident #63 at 4 liters per minute which raised his oxygen saturation to acceptable levels; Resident #63 had emesis and fecal incontinence three more times at 2:00 AM, 3:15 AM, and 4:00 AM. LVN A stated he returned to check on the resident shortly after the 4:00 AM bout of emesis, around 5:30 AM, when LVN A realized that Resident #63 required CPR. LVN A started CPR immediately, called the DON and 911, and attempted to notify the MD, but did not receive a call back from the MD prior to EMS arriving at approximately 5:45 AM, at which time EMS took over CPR and ultimately pronounced Resident #63 as deceased . LVN A stated that at the time of the incident he did not have any co-workers phone numbers saved in his personal phone and only had the contact information for the DON. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 7:33 PM, RN B stated that she assisted in the admission of Resident #63 and set up his peg tube before leaving the facility after completing her shift. RN B stated that when Resident #63 came in, he seemed depressed and had told her he did not want his PEG tube. RN B stated that her interaction with Resident #63 was brief, and the resident did not appear to be feeling ill before she left for the evening. RN B stated that with 3 residents on Station 3 [300-hallway], there was only one nurse per shift scheduled. RN B stated that a resident suddenly needing and being provided with supplemental oxygen was a change in condition and that the MD and DON should be notified immediately if that occurred. RN B stated that if staff need help, they usually called or texted from their personal cell phones to other staff on duty. RN B stated that other staff have always been very good about responding and assisting when need. RN B stated that, in her experience on day shift, staff would promptly respond or show up to provide hands on assistance as needed. RN B stated she was unsure if the other staff on duty had shared their personal cell phone numbers with LVN A at the time of the incident. Interview on [DATE] at 7:09 AM, CNA M stated that she was the float CNA on her shift on [DATE]-[DATE]. CNA M stated she could not recall any issues that evening, or Resident #63. CNA M stated she was not asked to assist with Station 3, or to float to Station 3, as the census was too low. CNA M stated that when she was assigned the responsibility to be the float CNA for her shift as the float CNA, the expectation was that she would go between the 100-hallway and the 200-hallway. CNA M stated the 300-hallway was not a part of the responsibility for the person assigned as a float CNA. CNA M stated the nurse was expected to perform all care tasks on the 300-hallway, due to extremely low census on that hallway. CNA M stated it reopened around [DATE]. A phone interview was attempted on [DATE] at 8:58 AM with CNA U that was unsuccessful. A phone interview was attempted on [DATE] at 9:24 AM with CNA P that was unsuccessful. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Estates Rehabilitation Center	130 Spencer LN San Antonio, TX 78201

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 12:27 PM, the DON stated that on [DATE] around the 4:00 AM hour, LVN A called her and told her that he had put oxygen on Resident #63 and that Resident #63 did not feel good and had a distended stomach, and the DON informed LVN A to call the physician. The DON stated that she did not receive another call until after 6:00 AM when she was informed that Resident #63 had expired. The DON stated she did not receive any calls informing her that LVN A was conducting CPR. The DON stated that she was not on site while the resident was in the building and never met the resident. The DON stated that a resident needing supplemental oxygen was a change in condition and that it was her expectation that staff call her and the MD if a resident was put on supplemental oxygen. The DON stated that while there was no CNA assigned to Station 3 (300 hallway), there was generally a floating CNA who would assist where necessary. The DON stated that the MD had an after-hours phone number, and it was in a notebook at every nurses' stations. The DON stated that the incident was brought to QAPI. The DON stated that if staff know the phone number to the nurses' stations, they can call it from any resident room, but if they do not know the phone number, they would have to use the phone at the nurses' station. The DON stated that her expectation was that if CPR was being performed, the staff would call for assistance to another hall if necessary. The DON stated she was not aware that EMS went to the incorrect hallway, and believed LVN A called another hall for assistance but was not sure who that was. The DON stated she did not receive a call from LVN A while he was performing CPR, and Resident #63 was stable when LVN A called her the first time. The DON stated this was LVN A's first shift after new hire orientation. The DON stated there was not a curriculum or training manual; but that she was in the process of developing one to include a check list of items all nurses needed to know. The DON stated new hires were trained on what to do, when to do it, and what forms were necessary in the EHR for change of conditions or emergency situations, or accidents and incidents. A phone interview was attempted on [DATE] at 1:38 PM with MD that was unsuccessful. In an interview on [DATE] at 1:45 PM the DON stated the MD was on vacation. I In an interview on [DATE] at 9:05 AM, LVN V stated she did not work with Resident #63 and was not aware of any issues on the 300-hallway until later. LVN V stated she was not aware of EMS being called until she saw the ambulance in the parking lot as she was exiting at the end of her shift at approximately 6:30 to 7:00 AM. LVN V stated prior to that she was not told there were any problems on the 300-hallway, was not asked for her assistance and was not directed by anyone to help out on that hallway. LVN V stated she normally worked on the 100-hallway. LVN V stated typically staff call or text each other on their personal cell phones, but one could also call the facilities main phone number and it would ring at each of the nurses' station . LVN V stated she later heard that EMS went to 200-hallway first and that was how staff found out there was something happening on the 300-hallway. LVN V could not recall when or who told her that information. Record review of the facility's Emergency Procedure - Cardiopulmonary Resuscitation, reviewed [DATE], policy reflected if an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR: a. Instruct a staff member to activate the emergency response system (code) and call 911. b. Instruct a staff member to retrieve the automatic external defibrillator. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	c. Verify or instruct staff member to verify DNR or code status of the individual. d. Initiate the basic life support (BLS) sequence of events. 8. Continue with CPR/BLS until emergency medical personnel arrive. The following Plan of Removal (POR) was accepted on [DATE] at 3:59 PM: 1. Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: [DATE]). - Facility Medical Director was notified of the incident. [DATE] - The DON or designee completed a chart audit on every resident and compared the advance directives to the physician order for accuracy. Inaccuracies were not identified. Completed [DATE] 2. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: [DATE]) - Disciplinary action was taken with licensed nurse who did not initiate CPR on the resident. Employee was suspended until 1:1 education with Director of Nursing on the procedure for initiating CPR and the location of code status for each resident. Completed [DATE]. The DON or designee educated all licensed nurses on the facility's policy and procedure for initiating CPR and location of code status for each resident. Licensed nurses were not permitted to work a shift until education was completed. Nurses on leave will receive education prior to their next scheduled shift. Resident care units will be staffed with a minimum of 2 employees. A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented. DON to monitor for code status compliance by interviewing licensed nurses about facility CPR policy and procedure, as well as requesting return demonstration of CPR process . Compliance checks will be conducted 2 times weekly for three months and recorded using a paper audit tool. Findings will be reported at monthly QAA Committee meeting. DON or designee will audit new admissions to compare the resident's advance directives to the physician orders for accuracy. This audit will continue daily for three months and recorded using a paper audit tool. Findings will be reviewed at the monthly QAA Committee meeting. A Code Blue drill was performed with licensed nursing staff on all shifts until every nurse had participated at least once. Code Blue drills will continue to be held 2 times a month for 3 months and recorded using a paper audit tool. Findings will be reviewed at the monthly QAA Committee meeting. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	POR Verification: Record review of the email to Medical Director reflected the Medical Director was informed of the incident on [DATE] at 6:17 PM. Interview on [DATE] at 2:00 PM, the DON stated she informed the Medical Director of the incident. Record review of Order Listing Report dated [DATE] at 7:39 PM, reflected a completed review of advanced directives for current census of 64. Interview on [DATE] at 1:35 PM, the DON and ADM stated there were no inaccuracies or inconsistencies found in the chart audit on every resident. Record review of the 1:1 In-Service Record dated [DATE] at 7:30 AM reflected LVN A's training topics included: initiated CPR and location of Code Status for each resident in EHR; Identifying factors that would constitute a Change in Condition; who and how to notify when a Change of Condition has been identified; and Completion of the Change of Condition Evaluation form in the EHR. Training was conducted by the DON. Interview on [DATE] at 1:35 PM, the ADM stated 1:1 training was completed with LVN A on [DATE] at 7:30 AM. Record review of In-Service Record dated [DATE] at 6:00 AM reflected the following topics: where to locate the code status for each resident; when to initiate CPR and what steps are taken during a code status; when and who to call for help during a cardiac arrest. 19 of 22 nurses staff trained; exceptions included: LVN W; LVN X; and LVN Y. Record review of In-Service Record dated [DATE] at 6:00 AM reflected the following topics: where to locate the code status for each resident; when to initiate CPR and what steps are taken during a code status; when and who to call for help during a cardiac arrest. 19 of 22 nurses have been in-serviced. 19 of 19 nursing staff who have worked on [DATE] and [DATE] have received in-servicing. Interview on [DATE] at 1:35 PM, the ADM and DON stated that all staff who had worked had been trained before they began their shift, and all staff who had not worked would be trained before beginning their next scheduled shift. Interviews between [DATE] at 7:10 PM and [DATE] at 2:56 PM with 74% of nursing staff employed at the facility revealed trainings were conducted prior to the nurses' shift began on change in condition, notifying the physician and DON of change in condition, and CPR. All nurse staff interviewed voiced that they had no concerns regarding implementing the trainings in their day-to-day assignments . Of the staff interviewed, this included 6 staff who worked 6:30 AM - 2:30 PM, 3 staff who worked 2:30 PM - 10:30 PM, 3 staff who worked 10:30 PM - 6:30 AM, 2 staff who worked 6:00 AM - 6:00 PM, 2 staff who worked 8:00 AM - 8:00 PM, and 5 staff who worked 8:00 AM - 5:00 PM, 2 staff who work 6:30 AM - 10:30 PM, and 5 staff who worked PRN. Each staff member was asked to describe their knowledge based on the in-service and was able to. Record review of the Employee Schedule for [DATE] and [DATE] reflected that each resident care unit had a minimum of 2 employees staffed . (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on [DATE] at 8:30 PM reflected appropriate staffing on night shift with no staffing shortage observed. During observation and interviews starting on [DATE] at 10:07 AM around the facility at least 2 nursing staff were present at each station (3 of 3 stations). A sample of 7 residents, including 1 RP, revealed there have been more nursing staff and they were receiving timely care. Observation revealed call lights being answered in a timely manner. Interview on [DATE] at 1:39 PM, the ADM stated they would ensure daily staffing has 2 staff on all halls and the staff schedule would include the hall assignment next to each person's schedule. They would ensure there was a minimum of 2 employees per hall, not including a floating staff member who may be scheduled in addition to the 2 employees per hall. Record review of the Performance Improve Plan, with a started date of [DATE], reflected the following tasks: educate nursing staff on facility protocol for CPR and location of code status for each resident; audit new admissions for advance directives x 3 months; monitor code status via interview nurses about CPR policy and procedures with a return demo of CPR process 2 times weekly for 3 months; code blue mock drill with all nurses over all shifts until all nurses have participated at least once; drills will then be held 2 times a month for 3 months; and weekly audit review in SOC meeting and monthly QAPI meeting. Interview on [DATE] at 1:53 PM, the DON and ADM stated that the QAPI Performance Improvement Project would be the responsibility of the DON, ADON, and nursing staff and would be consistently reviewed in the morning meetings as well as QAPI meetings. Record review of the Order Listing Report dated [DATE] at 7:39 PM, reflected a completed review of advanced directives for current census of 64. Interview on [DATE] at 1:35 PM, the DON and ADM stated there were no inaccuracies or inconsistencies found in the chart audit on every resident. There were no concerns or inconsistencies in the residents advanced directive orders. Record review of POR Binder included a blank template for a Mock code Drill Audit Tool, a blank template for Code Blue Worksheet, and a blank template for In-Service training roster, and an employee list with all nurses' names highlighted. Interview on [DATE] at 1:35 PM, the DON and ADM stated the Code Blue drills were still in the process of being planned and coordinated and had not yet occurred. The ADM was informed the Immediate Jeopardy was removed on [DATE] at 5:24 PM. While the IJ was removed, the facility remained out of compliance at a severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy and a scope of isolated, due to the facility still monitoring the effectiveness of their Plan of Removal.

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on interview and record review, the facility failed to ensure residents who were fed by enteral means, received the appropriate treatment and services to prevent complications of enteral (intake of food through a tube in the gastrointestinal tract) feeding for 1 of 7 residents (Resident #63) reviewed for enteral feedings. 1. The facility failed to ensure all the necessary components of an order for enteral feeding were included for Resident #63 when Resident #63 was admitted to the facility on [DATE]; the order did not include formula type, total volume, time of administration, or contraindications. 2. The facility failed to recognize and respond appropriately when Resident #63 had a significant change in condition on [DATE], that included pain, decreased oxygenation, multiple emesis, and fecal incontinence and subsequently died . This deficient practice could place residents with enteral feeding at risk for vomiting, aspiration pneumonia, pain and diarrhea. The findings included: An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:28 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of No actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. The findings include: Record review of the Admission Record reflected Resident #63 was a [AGE] year-old male, admitted on [DATE] with a primary diagnosis of encephalopathy [group of disorders referring to brain disease, damage, or malfunction], noninfective gastroenteritis [inflammation in stomach or intestine] and colitis [inflammation in the colon], rhabdomyolysis [condition that causes muscles to disintegrate leading to muscle tissue death], and acute kidney failure. [Admission Record did not reflect presence of gastrostomy tube, or advanced directive code status.] (continued on next page)

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F 0693 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 comprehensive MDS assessment dated [DATE], reflected that Resident #63 entered the facility from a short-term general hospital. Resident #63 had unclear speech, but usually was able to make self-understood, and sometimes had the ability to understand others. Further in the document contained conflicting data indicating that a BIMS should not be conducted due to the resident was rarely/never understood. Resident #63 was coded as having both short-term, and long-term memory problems, and had some difficulty only in new situations requiring modified independence for daily decision making. Resident #63 was coded as partial/moderate assistance with eating at admission. Resident #63 was coded as not rated for both urinary and bowel continence as resident had a urinary catheter and had an ostomy [surgical procedure that creates an opening in the abdominal wall] or did not have a bowel movement. Resident #63 had health conditions noted of vomiting. Nutritional approaches included feeding tube with 25% or less total calories received thru the feeding tube; 500 CC [milliliters] per day by tube feeding. Record review of the Order Summary Report, printed [DATE] at 4:05 PM, reflected Resident #63 had physician's orders for CPR/Full Code status, dated [DATE]. Resident #63 had physician's orders for enteral feeding orders: two times a day 70 milliliters per hour [did not reflect formula type, total volume, time of administration, or contraindications]. Record review of Resident #63's Progress Note, effective date [DATE] at 5:45 PM and written by RN B reflected, Resident arrived via [redacted] Ambulance. EMS stated that nothing significant happened during transfer. [Medical Director] was informed of patients arrival. Stated to continue orders and medications from hospital as well as lab orders of CBC, CMP, Prealbumin, and Ammonia level. Orders to continue Osmolite [complete balanced nutritional formula for tube-fed individuals] at 70mL/hour and to check residuals on PEG tube [percutaneous endoscopic gastrostomy tube, or g-tube] every shift. Patient's emergency contact [Emergency Contact Name] was called at [Emergency Contact Phone Number] to inform her patient arrived. Patient resting comfortably. Record review of Resident #63's Progress Note, effective date [DATE] at 8:09 AM and written by LVN A reflected, Resident was restless throughout the night especially after midnight. He was receiving Osmolite 1. 5 @ 70 ml/hr via g tube. Resident complained of stomach discomfort and started having emesis [vomiting] episodes x3. After the first emesis the feeding was turned off and the DON was called. I really wanted to see if we could send this resident out to the emergency room for eval[uation]. Vital ,d+[DATE] [blood pressure; according to the American Heart Association, a normal blood pressure for adults is less than ,d+[DATE], and low blood pressure is less than ,d+[DATE]], o2 stat [sic] was 90 [normal oxygen saturation is between 95% and 100%]. I immediately got O2 and applied it when notice his sat[uration] had increased with the oxygen. She [the DON] stated that I should call the doctor and see what he wanted to do and that was done. Doctor did not return my call. Bed was changed at 0200 [2:00 AM] with stool and emesis. Changed again at 0315 [3:15 AM], 0400 [4:00 AM]. I decided to go back in the room to check on him with some fresh sheets just in case they were needed, and he was looking straight up to the ceiling, his eyes wide open and that alerted me to assess him pulled him off the bed onto the floor and get the Crash cart Started CPR at 0445 [4:45 AM] called EMS. they came and took charge. (continued on next page)

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F 0693 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 #63's Progress Note, effective date [DATE] at 9:00 AM and written by LVN A reflected, 1800 [6:00 PM] Initial head to toe assessment was completed, Observed and assessed the g-tube and the feeding, Osmolite 1.5@ 70 ml per hour. @ being set up by the off going nurse. Family came in to visit and to sit with the resident. They introduced themselves and were very pleasant and attentive of [Resident #63's] care. They left after 2 hours at around 2200 [10:00 PM]. Re-evaluated residents g-tube area due to his complaint of pain. The stomach area was slightly red, but it was not an open area or a rash, g-tube site was not red or draining, abdomen was slightly distended and firm to touch. Resident had his first small BM which was soft around 2300 [11:00 PM]. Cleaned resident and changed his bed linen. He ask [sic] me to place something at his bedside because he was feeling nauseated and he thought he had to throw up. He did throw up brownish color secretion, 150 ml. Assisted resident to clean his mouth and placed a pad on the side of the bed so if he had another vomiting episode, he would have some type of covering over his bedding. He had another episode of nausea and vomiting and also he had medium size BM around 0000. Resident became restless and voiced general discomfort. Vital signs were B[lood]/P[ressure] ,d+[DATE], Heart Rate 99, O2 sat was 90% on RA [room air]. At this time O2 [oxygen] was applied at 4 lpm via face mask and it brought his O2 sat up to 97% on 4 lpm. Resident continued to be restless and complaining of discomfort to abdomen. Around 0445 [4:45 AM] DON was called and notified of residents change of condition, DON instructed me to call the Doctor. Dr. was called around 0445 [4:445 AM] and message left. Resident continues to be restless and vomits again with another BM around 0500 [5:00 AM]. Changed the bed linen and provided peri care to the resident and placed clean gown on the patient. I checked resident around 0530 [5:30 AM] and noted restlessness, nausea and vomiting, I emptied out his container at his bedside 200 ml brownish colored vomit. As I assessed the resident, noted he had another bowel movement, abdomen remained firm and slightly distended at this time, no change noted. Cleaned up the resident's area with fresh clean linen after peri care applied. I took the soiled linen to the soiled linen area, went to the nurses' station, and then returned to check on resident and noted he was staring straight up to the ceiling with his eyes wide open. I immediately assessed him for his response by calling his name, assessed him breathing and heart rate. They were absent, no heart rate or respiration, immediately I pulled resident off the bed onto the floor started CPR, I had to go and get crash cart came back and called EMS at 0647 [6:47 AM] and started CPR again. Checked for pulse again and initiated CPR. The EMS dispatcher stayed on the line with me until EMS arrived person and was giving instructions and gathering information on the resident while I continue CPR. EMS arrived and assessed the resident and pronounced him @06:56 [6:56 AM]. Record review of Resident #63's Progress Note, effective date [DATE] at 9:15 AM and written by the Treatment Nurse reflected, Contacted Medical Examiner to obtain release of body. Writer was advised additional information is needed. Contacted [family member]. Per [family member] resident was living with [family member] in an apartment prior to hospital admission. The [family member] stated that resident had been losing weight, and stopped eating and began rapidly declining after [family member] received dx [diagnosis] of metastatic breast cancer that had spread to her lungs. Per [family member], resident was admitted for malnutrition. The [family member] advised resident was not previously following with a PCP and was last evaluated by [Physician] ,d+[DATE] years ago. Per hospital records resident was found on floor with altered mental status and admitted . Imaging done in hospital and PEG tube placed. Per hospital records no suspicion of abuse. SNF Medical director to sign death certificate. ME notified. Advised by ME per resident age, and no suspicion of abuse/neglect/APS case resident does not meet criteria for autopsy. Resident body ok to release to funeral home. ME #[number], case #[number]. Called [funeral home] and notified them of TOD: 0656AM and that ME released the body. [Funeral Home] advised they would arrive for p/u in 30 min to 2 hours. (continued on next page)

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F 0693 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 #63's Progress Note, effective date [DATE] at 11:00 AM and written by the DON reflected, Time of death was pronounced by EMS at 0656 [6:56 AM]. Record review of Resident #63's Progress Note, effective date [DATE] at 11:25 AM and written by the Treatment Nurse reflected, 2 staff from [Funeral Home] picked up resident body. Family aware . Interview on [DATE] at 6:59 PM, LVN A stated that on [DATE], he arrived for his first shift at 6:00 PM after completing training [new hire orientation] at the facility and was assigned to Station 3. LVN A stated that throughout the course of the night Resident #63 seemed very antsy, the skin of his stomach was red, and he would use his call light to call LVN A every 30 to 45 minutes and LVN A would attempt to comfort the resident. LVN A stated that at one point, Resident #63's oxygen saturation was lower than 90%, and he provided Resident #63 with supplemental oxygen, which raised Resident #63's oxygen saturation back up to 97%. LVN A stated that he changed Resident #63's bed linens multiple times that night due to the linens being soiled from Resident #63's dark brown vomit and bowel movement, and after answering a different resident's call light, he went to check on Resident #63. LVN A stated that he then found Resident #63 staring straight up at the ceiling and called Resident #63's name. After Resident #63 did not answer, LVN A walked to the resident, attempted to rouse him, said his name again, and noticed his eyes were fixed and dilated and Resident #63 had no respirations or pulse. LVN A stated that at that time, he lowered the resident from his bed onto the floor to initiate CPR and noticed emesis in Resident #63's mouth. LVN A stated that he attempted to clear the emesis from the resident's mouth by turning him on his side and continued CPR. LVN A stated that he left Resident #63 during CPR to obtain Station 3's Crash Cart and AED. LVN A stated that during CPR, he called the DON who instructed him to call 911 and the MD. LVN A stated that, according to the EMT's, when EMT's arrived at the facility, they made their way to Station 1 instead of Station 3, and it took a while for them to get to Station 3. LVN A stated once the EMT's arrived to Resident #63's room, they took over CPR on Resident #63. LVN A stated that there was no way for him to have contacted anyone at Nurses' Station 1 or Nurses' Station 2 because he did not know the phone numbers to Station 1 [100-hallway] or 2 [200-hallway] and instead used his personal phone to call the DON and 911. LVN A stated that since there were only 3 residents on Station 3 [300-hallway], there were no CNAs assigned to assist him that night on Station 3. LVN A stated that he did not think to call the MD or DON when Resident #63's oxygen saturation became low due to the resident's oxygen saturation going back up after LVN A had administered oxygen, and the color of the vomit was not concerning to him. LVN A stated the time line of events was as follows: around 11:00 PM Resident #63 complained of pain, had vomiting and fecal incontinence that soiled his linens; Resident #63 had another bout of emesis and fecal incontinence around midnight but also noted his oxygen saturation dropped and LVN A put supplemental oxygen on Resident #63 at 4 liters per minute which raised his oxygen saturation to acceptable levels; Resident #63 had emesis and fecal incontinence three more times at 2:00 AM, 3:15 AM, and 4:00 AM. LVN A stated he returned to check on the resident shortly after the 4:00 AM bout of emesis, around 5:30 AM, when LVN A realized that Resident #63 required CPR. LVN A started CPR immediately, called the DON and 911, and attempted to notify the MD, but did not receive a call back from the MD prior to EMS arriving at approximately 5:45 AM, at which time EMS took over CPR and ultimately pronounced Resident #63 as deceased . LVN A stated that at the time of the incident he did not have any co-workers phone numbers saved in his personal phone and only had the contact information for the DON. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Estates Rehabilitation Center	130 Spencer LN San Antonio, TX 78201

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 7:33 PM, RN B stated that she assisted in the admission of Resident #63 and set up his peg tube before leaving the facility after completing her shift. RN B stated that when Resident #63 came in, he seemed depressed and had told her he did not want his PEG tube. RN B stated that her interaction with Resident #63 was brief, and the resident did not appear to be feeling ill before she left for the evening. RN B stated that with 3 residents on Station 3 [300-hallway], there was only one nurse per shift scheduled. RN B stated that a resident suddenly needing and being provided with supplemental oxygen was a change in condition and that the MD and DON should be notified immediately if that occurred. RN B stated that if staff need help, they usually called or texted from their personal cell phones to other staff on duty. RN B stated that other staff have always been very good about responding and assisting when need. RN B stated that, in her experience on day shift, staff would promptly respond or show up to provide hands on assistance as needed. RN B stated she was unsure if the other staff on duty had shared their personal cell phone numbers with LVN A at the time of the incident. Record review of the facility schedule and timecards for [DATE] and [DATE], dated [DATE], reflected that CNA M, CNA P, and NA U worked overnight. The facility schedule reflected that CNA M worked from 2:30 PM on [DATE] until 6:30 AM on [DATE], CNA P worked from 10:30 PM on [DATE] until 6:30 AM on [DATE], and NA U worked from 10:30 PM on [DATE] until 6:30 AM on [DATE]. In an interview on [DATE] at 7:09 AM, CNA M stated that she was the float CNA on her shift on [DATE]-[DATE]. CNA M stated she did not recall Resident #63. CNA M stated she did not recall any problems on the 300-hallway. CNA M stated that when she was assigned the responsibility to be the float CNA for her shift, the expectation was that she would go between the 100-hallway and the 200-hallway. CNA M stated the 300-hallway was not a part of the responsibility for the person assigned as a float CNA. CNA M stated she was not asked to assist with the 300-hallway, or to float to the 300-hallway, as the census was too low. CNA M stated the nurse was expected to perform all care tasks on the 300-hallway, due to extremely low census on that hallway. CNA M stated the 300-hallway reopened around [DATE]. A phone interview was attempted on [DATE] at 8:58 AM with CNA U that was unsuccessful. A phone interview was attempted on [DATE] at 9:24 AM with CNA P that was unsuccessful. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 12:27 PM, the DON stated that on [DATE] around the 4:00 AM hour, LVN A called her and told her that he had put oxygen on Resident #63 and that Resident #63 did not feel good and had a distended stomach, and the DON informed LVN A to call the physician. The DON stated that she did not receive another call until after 6:00 AM when she was informed that Resident #63 had expired. The DON stated she did not receive any calls informing her that LVN A was conducting CPR. The DON stated that she was not on site while the resident was in the building and never met the resident. When asked if, in this incident, there was a change of condition that should have been reported to the MD, the DON stated that a resident who needed supplemental oxygen was a change in condition and that it was her expectation that staff call her and the MD if a resident was put on supplemental oxygen. The DON stated that while there was no CNA assigned to Station 3, there was generally a floating CNA who would assist where necessary. The DON stated that the MD had an after-hours phone number, and it was in a notebook at every nurses' station. The DON stated that the incident was brought to QAPI. The DON stated that if staff knew the phone number to the nurses' station, they would call from any resident room, but if they do not know the phone number, they would have to use the phone at the nurse's station. The DON stated that her expectation was that if CPR was being performed, the staff would call for assistance to another hall if necessary . The DON stated she was not aware that EMS went to the incorrect hallway, and believed LVN A called another hall for assistance but was not sure who LVN A called. The DON stated she did not receive a call from LVN A while he was performing CPR, and Resident #63 was stable when LVN A called her. The DON stated LVN A an experienced LVN but was new to the facility at the time of the incident. The DON stated this was LVN A's first shift after new hire orientation. The DON stated there was not a curriculum or training manual; but that she was in the process of developing one to include a check list of items all nurses needed to know. The DON stated new hires were trained on what to do, when to do it, and what forms were necessary in the EHR for change of conditions or emergency situations, or accidents and incidents. A phone interview was attempted on [DATE] at 1:38 PM with the MD that was unsuccessful. In an interview on [DATE] at 1:45 PM the DON stated the MD was on vacation. In an interview on [DATE] at 9:05 AM, LVN V stated she did not work with Resident #63 and was not aware of any issues on the 300-hallway until later. LVN V stated she was not aware of EMS being called until she saw the ambulance in the parking lot as she was exiting at the end of her shift at approximate 6:30 AM to 7:00 AM on [DATE]. LVN V stated prior to that she was not told there were any problems on the 300-hallway, was not asked for her assistance and was not directed by anyone to help out on that hallway. LVN V stated she normally worked on the 100-hallway. LVN V stated typically staff called or texted each other on their personal cell phones, but one could also call the facility's main phone number and it would ring at each of the nurses' station. LVN V stated she later heard that EMS went to 200-hallway first and that was how staff found out there was something happening on the 300-hallway. LVN V could not recall when or who told her that information. Record review of the facility policy entitled, Enteral Nutrition, reviewed [DATE], reflected, in step 13.) Staff will be trained on how to recognize and report complications associated with the insertion and/or use of a feeding tube; such as: aspiration [inhalation of fluids in to lungs]; leading and skin breakdown around insertion site; perforation of the stomach or small intestine leading to peritonitis. In step 14.) Staff will be trained on how to recognize and report complications relating to the administration of enteral nutrition products such as: nausea, vomiting, diarrhea, and abdominal cramping; aspiration. (continued on next page)

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F 0693 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 policy entitled, Change in a Resident's Condition or Status, reviewed [DATE], reflected a policy statement, .shall promptly notify the resident, his or her attending physician and representative of changes in the resident's medical/mental condition and or status. Under the heading, Policy Interpretation and Implementation: the nurse will notify the attending physician or physician on call when there has been a (an) .significant change in the resident's physical/emotional/mental condition; need to alter the resident's medical treatment significantly; need to transfer the resident to a hospital/treatment center. Further definitions included a significant change of condition is a major decline . that will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting). The following Plan of Removal (POR) was accepted on [DATE] at 3:59 PM: 1. Identification of Residents Affected or Likely to be Affected: o The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date: [DATE]) o Facility Medical Director was notified of the incident. [DATE] o Physical assessments were completed by ADON and Charge Nurses on all residents to identify any changes in condition and notification was made to the physician of any noted changes. Concerns were not identified. [DATE] o Licensed nurse who was aware of significant change was suspended pending 1:1 education by the Director of Nursing. [DATE] 2. Actions to Prevent Occurrence/Recurrence: o The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: [DATE]) o All licensed nurses were educated by DON/designee on change of condition and physician notification regulations, as well as facility policy and procedure. Including notification of MD and DON after you have identified a change of condition, implementation of new orders received from doctor and completion of the eInteract Assessment in Point Click Care. Completed [DATE] o Nurse aides were educated by DON/designee on change of condition regulations to promote their situational understanding and facilitate communication with licensed nurses. The nurse aides have been educated that for emergent changes in a resident condition they are to immediately notify the charge nurse verbally. For non-emergent changes the nurse aides were educated on the Stop and Watch alert in Point Click Care that they can complete. The alerts trigger to the nursing dashboard for the Charge Nurses to evaluate the resident upon alert and proceed as clinically appropriate to address the change. The DON or Designee will review the alert trigger dashboard and run the alert trigger report in morning meeting to ensure all alert triggers have been reviewed and addressed. Completed [DATE] o Resident care units will be staffed with a minimum of 2 employees. o Staff members were not permitted to work a shift until education was completed (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	o New hires (licensed nurses and nurse aides) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly. o A Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) was implemented with a focus on physician notification of significant changes. Completed [DATE] o The PIP resulted in implementation of daily DON/designee audits of the 24-hour report to monitor for change in resident condition. o The DON/designee will also complete chart audits/health document assessment using a paper chart audit tool: o Three resident charts weekly for four weeks then; o Two resident charts weekly for two weeks then; o Two resident charts a months for two months. o The [NAME] President of Clinical Services, [VP RN] will visit the facility frequently for 30 days to provide general oversight and monitoring of the PIP. POR Verification: Record review of email to Medical Director reflected the Medical Director was informed of the incident on [DATE] at 6:17 PM. Interview on [DATE] at 2:00 PM, the DON stated she informed the Medical Director of the incident. Record review of 100% of residents change in condition assessments were reviewed with no concerns or changes in condition noted. Interview on [DATE] at 1:43 PM, the DON stated that all residents had a change in condition assessment and no changes in condition were noted. Record review of 1:1 In-Service Record dated [DATE] at 7:30 AM reflected LVN A training topics: initiated CPR and location of Code Status for each resident in EHR; Identifying factors that would constitute a Change in Condition; who and how to notify when a Change of Condition has been identified; and Completion of the Change of Condition Evaluation form in the EHR. Training was conducted by the DON. Interview on [DATE] at 1:35 PM, the ADM stated 1:1 training was completed with LVN A on [DATE] at 7:30 AM. The ADM further stated that all new hire orientation would include training related to the incident to include any training included in the approved plan of removal. Record review of staff training reflected 37 of 47 staff have been in-serviced. Record review of staff training reflected 37 of 37 staff who worked on [DATE] and [DATE] were in-serviced on change in condition to include notifying the Medical Director and DON after identifying change in condition, implementing orders given for residents by MD, and Completion of change in condition evaluation. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 11:46 AM, LVN D revealed she worked PRN and was trained on CPR, change in condition, notifying the doctor of change in conditions especially related to new admissions, and residents with higher levels of care such as feeding tubes. Interview on [DATE] at 1:45 PM with DON and ADM, stated that change in condition training was completed with all staff available, some came in on their days off, those who have not received training will before being allowed to work on their next shift. Interviews between [DATE] at 7:10 PM and [DATE] at 2:56 PM with 74% of nursing staff employed at the facility revealed trainings were conducted prior to the nurses' shift began on change in condition, notifying physician and DON of change in condition, and CPR. All nurse staff interviewed voiced that they had no concerns regarding implementing the trainings in their day-to-day assignments. Of the staff interviewed, this included 6 staff who worked 6:30 AM - 2:30 PM, 3 staff who worked 2:30 PM - 10:30 PM, 3 staff who worked 10:30 PM - 6:30 AM, 2 staff who worked 6:00 AM - 6:00 PM, 2 staff who worked 8:00 AM - 8:00 PM, and 5 staff who worked 8:00 AM - 5:00 PM, 2 staff who work 6:30 AM - 10:30 PM, and 5 staff who worked PRN. Record review of staff training reflected 37 of 47 staff have been in-serviced. Record review of staff training reflected 37 of 37 staff who worked on [DATE] and [DATE] were in-serviced on change in condition to include what to look for in change in condition and notifying the charge nurse of a change in condition. Interview on [DATE] at 1:45 PM with DON and ADM, stated that change in condition training was completed with all staff available, some came in on their days off, those who have not received training will before being allowed to work on their next shift. During interviews between [DATE] at 7:10 PM and [DATE] at 2:56 PM with 56% of Nurse Aide staff, it was revealed that nurse aide staff had been trained on change in resident condition, notifying charge nurses, and alerts on point-click-care and the trainings were completed prior to beginning their shifts and that they each understood the trainings and had no concerns on implementing the trainings in their day-to-day work. Of the staff interviewed, this included 6 staff who worked 6:30 AM - 2:30 PM, 3 staff who worked 2:30 PM - 10:30 PM, 3 staff who worked 10:30 PM - 6:30 AM, 2 staff who worked 6:00 AM - 6:00 PM, 2 staff who worked 8:00 AM - 8:00 PM, and 5 staff who worked 8:00 AM - 5:00 PM, 2 staff who work 6:30 AM - 10:30 PM, and 5 staff who worked PRN. During observation and interviews starting on [DATE] at 10:07 AM around the facility revealed at least 2 nursing staff were present at each station (3 of 3 stations). Sample of 7 residents, including 1 RP, revealed there have been more nursing staff and they were receiving timely care. Observation revealed call lights being answered in a timely manner. Interview on [DATE] at 1:39 PM, ADM stated they will ensure daily staffing has 2 staff on all halls and the staff schedule will include the hall assignment next to each persons schedule. They will ensure there is a minimum of 2 employees per hall, not including a floating staff member who may be scheduled in addition to the 2 employees per hall. Record review of staff training reflected 37 of 47 staff have been in-serviced. Record review of staff training reflected 37 of 37 staff who worked on [DATE] and [DATE] were trained prior to working their shift. (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on [DATE] at 1:49 PM, ADM stated that any staff who have not participated in training are PRN staff who will be trained prior to their next shift. The DON/ADON plan to ensure they are available for training these PRN staff prior to their shift. Observation on [DATE] at 2:30 PM of staff receiving training prior to beginning their shift. Record review of Quality Assessment & Performance Improvement Plan, dated [DATE], reflected that the DON, ADON, and Charge Nurses will ensure compliance with notifying the physician and DON of any significant changes in condition and documenting notification and any new interventions in the resident's medical record through Resident Chart audits. Tasks listed to ensure this includes, but is not limited to: Educating nursing staff on facility protocol for notification of changes, monitoring nursing documentation of 24-hour report during morning meeting for any clinical changes, etc. Interview on [DATE] at 1:53 PM, the DON and ADM stated that the QAPI Performance Improvement Project will be the responsibility of the DON, ADON, and Nursing staff and will be consistently reviewed in morning meetings as well as QAPI meetings. Record review of Quality Assessment & Performance Improvement Plan, dated [DATE], reflected that the Clinical Team will be responsible for a task titled Monitor nursing documentation of 24hr. Report during morning clinical meeting for any change in condition. Interview on [DATE] at 1:53 PM, the DON stated that they will audit on the 24-hour report during the morning meeting and any changes in condition will be on the 24-hour report. The DON stated that the whole nursing leadership team will be looking at the 24-hour report during morning meetings to ensure any changes in condition are monitored. Record review of Quality Assessment & Performance Improv [TRUNCATED]

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47564 Based on interview and record review the facility failed to ensure that residents who had not used psychotropic drugs were are not given psychotropic drugs unless the medication was necessary to treat a specific condition as diagnosed and documented in the clinical record for 1 of 3 residents (Resident #39) reviewed for unnecessary medications. The facility failed to ensure Resident #39 was taking a psychotropic medication (Citalopram Hydrobromide (an antidepressant)), to treat a specific diagnosed condition. This deficient practice could place residents at risk for receiving medications that were not necessary for their care. The findings include: Record review of the Admission Record reflected Resident #39 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #39 had diagnoses which included fracture of unspecified part of neck of right femur, sequela (hip fracture), dementia (group of thinking and social symptoms that interferes with daily functioning), and generalized anxiety disorder. A diagnosis of depression was not documented. Record review of the comprehensive MDS assessment, dated 06/27/2024, reflected Resident #39 had an active diagnosis of anxiety disorder. Section I - Active Diagnosis section of her MDS did not reflect a diagnosis of Depression. Resident #39 ' s BIMS score reflected a BIMS of 7, which indicated severe cognitive impairment. Record review of Resident #39 ' s Order Summary Report, dated 7/25/2024, reflected an order for Citalopram Hydrobromide Oral Tablet 40 MG with the instruction, Give 1 tablet by mouth at bedtime for depression. Record review of Resident #39 ' s Medication Administration Record for July 2024, dated 7/25/2024, reflected Resident #39 was receiving Citalopram Hydrobromide Oral Tablet 40 MG for depression. Interview on 7/25/2024 at 3:47 PM, the DON stated Resident #39 did not have a diagnosis for depression, but it was in the doctors notes. The DON stated because of this, it was technically in Resident #39 ' s clinical record. The DON stated Resident #39 was being treated for depression, and there was no risk for her taking antipsychotic medication without a diagnosis. The DON stated that the prescribing physician was on vacation. Record review of the facility ' s policy titled, Medication and Treatment Orders, dated reviewed December 2022, reflected, Orders for medications and treatments will be consistent with principles of safe and effective order writing .Orders for medication must include .Clinical condition or symptoms for which the medication is prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44906 Based on observation, interview and record review the facility failed to ensure, in accordance with State and Federal laws, all drugs and biologicals were stored in locked compartments under proper temperature controls and permitted only authorized personnel to have access to the keys for 1 of 6 medication carts (the 300-hallway Nurses Medication Cart) reviewed for medication storage. The facility failed to ensure the 300-hallway Nurses Medication Cart was locked when it was left unattended in the common area in front of the 300-hallway nurses' station. This deficient practice could place residents at risk of medication misuse or drug diversion. The findings were: In an observation on 07/25/2024 at 6:52 PM, the 300-hallway Nurses Medication Cart was observed to be unlocked and unattended in the common area in front of the 300-hallway nurses' station. The cart contained prescription and over the counter medications, sharps for blood glucose monitoring, and various associated paraphernalia for administering drugs such as alcohol wipes, disinfecting wipes for equipment. There were staff, residents and visitors in the area. LVN A was discarding a cooler of ice for residents in the sink in a nutrition room with the door propped open by the rolling cart for the cooler. LVN A's back was turned, he was faced away from the common area and could not see the common area or the medication cart from his perspective. In addition, the rolling cart for the ice cooler blocked his pathway through the open door. In an interview on 07/25/2024 at 6:53 PM, LVN A stated the medication cart was his responsibility. LVN A stated he had left the cart only moments prior to empty the cooler of ice so it could be refilled with fresh ice for the residents. LVN A stated he was able to monitor it while handling the cooler of ice in the nutrition room. LVN A stated the residents on the 300-hallway included a few who were ambulatory or could self-mobilize their wheelchairs about the unit but did not include residents who would take something that did not belong to them. LVN A stated he did not believe there was any risk to the residents since he could see the 300-hallway Nurses Medication Cart and saw the cart being opened . In an interview on 07/28/2024 at 2:05 PM, the DON stated the expectation was medication carts be locked when not in active use. The DON stated there was risk to residents if items kept in the medication carts were inappropriately accessed. The DON stated staff were trained during on-boarding when hired of this principle. The DON stated this principle was included in annual refresher trainings, and as needed if an issue arose. Record review of the facility's policy entitled, Storage of Medications, revised December 2023, reflected policy statement, .store all drugs and biologicals in a safe, secure and orderly manner. Under the heading, Policy Interpretation and Implementation, step 7.) Compartments (including, but not limited to .carts and boxes) containing drugs and biologicals shall be locked when not in use .or otherwise potentially available to others.

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48366 Based on observations, interviews, and record reviews, the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident for 1 of 24 residents (Resident #52) reviewed for dietary needs. The facility failed to ensure Resident #52 received a vegetable side for the 07/23/24 lunch meal. This deficient practice could place residents at risk for poor food intake, weight loss, and not having their nutritional needs met. The findings were: Record review of Resident #52's Admission Record, dated 07/24/24, reflected Resident #52 was a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #52 had diagnoses which included muscle wasting and atrophy, anorexia (a potentially life-threatening eating disorder characterized by extreme food restriction and intense fear of gaining weight), and dysphagia (difficulty in swallowing). Record review of Resident #52's quarterly MDS assessment, dated 05/15/24, reflected Resident #52 had a BIMS score of 1 out of 15, indicating severe cognitive impairment. It further reflected Resident #52 did not have significant weight loss in the last 6 months. Record review of Resident #52's care plan, undated, and doctor's orders reflected no pertinent information to this deficient practice. Record review of the facility's Week 4 Week-at-a-Glance menu reflected, zucchini/tomatoes as the vegetable option for the 07/23/24 lunch meal . During an interview and observation on 07/23/24 at 12:31 PM, the RD was unable to identify what was on Resident #52's 07/23/24 lunch meal tray. The RD guessed one of the pureed foods could be a bread product but needed to go to the kitchen to confirm the other. During an observation of the 07/23/24 lunch, the CDM revealed Resident #52 received pureed cornbread because she did not want the vegetable option for lunch . The CDM could not identify what vegetable option Resident #52 had on her lunch plate. The CDM went back to the kitchen and served Resident #52 green beans with the appropriate texture for this resident. During an interview on 07/28/24 at 01:09 PM, the CDM and the RD revealed they could not obtain Resident #52's, 07/23/24, lunch meal tray ticket due to limited access. They further revealed it was important to give a meal with each food group to include vegetables for full nutrition. The RD revealed they did try to give all the calories needed to each resident, but sometimes it was hard. They further revealed Resident #52 did not like the vegetable being served for 07/23/24 lunch so she was not given a vegetable. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Policy and Procedure handbook, revised 12-14-2017, reflected Section G: Menu Policies . I. Nutritional Adequacy of Menu and Approval . The menu will promote good nutrition among the residents. V. Menu Changes/Substitutions . 1. The Nutrition Services Manager (NSM) initiates menu changes based on resident preferences making sure that substitutions selected are of equal nutritional value to the original food item on the menu.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 48366 Based on observations, interviews, and record reviews, the facility failed to ensure residents received food and drink prepared in a form designed to meet individual needs for 1 of 2 lunch meals reviewed for nutrition services. The facility failed to ensure the lunch meal served on 07/25/24 had the appropriate consistency for the minced and moist textured diet. This failure could place residents at risk of not being served the correct diet texture, which could leave residents at risk for poor intake, weight loss, and a diminished quality of life. The findings were : During an observation and an interview of the 07/25/24 lunch sample meal tray at 01:10 PM revealed the minced and moist should have been more chopped up as the browned potatoes and the carrots were not able to fit in between the prongs of a standard sized metal fork. The food particles were bigger than four prongs on a standard sized metal fork. The RD verbally stated the food particles on the 07/25/24 lunch meal tray for minced and moist should have been more chopped up. The RD further revealed it was important to follow the correct textures to prevent choking . During an interview on 07/26/24 at 10:14 AM, the CDM revealed there were no pictures or no rulers in the kitchen to compare their minced and moist foods to, to ensure foods were cut to the appropriate size. He revealed the potatoes for the 07/25 lunch meal minced and moist could have been cut up more. He revealed he had to chop the potatoes manually to get to the right consistency. He further revealed the RD was going to find him a video or resources to follow for the textured diets at this facility. The CDM revealed not following the right diet textures could cause choking, however, there have been no choking incidents in this facility due to a wrong textured diet. Record review of the facility's therapeutic spreadsheets for Week 4 reflected minced and moist browned potatoes/gravy and minced and moist BU carrots. Record review of the recipe for Diced Carrots reflected instruction to make food particles minced and moist was to Chop portions needed to desired texture. Record review of the recipe for Browned Potatoes reflected instruction to make food particles minced and moist was to Mince regular portions making sure all particles are no more 4mm x 4mm (1/8 x 1/8) . Record review of the facility's Diet Manual, revised August 2023, reflected IDDSI Testing Methods, July 2019, the fork has been chosen to assess food texture as it can be used for assessment of food particle size. It reflected: for a minced and moist textured diet, food particles should be small enough to fit in between the prongs of a standard sized metal fork. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Policy and Procedure handbook, revised 12-14-2017, reflected IV. Food Service Temperature Control . N. Textures 1. All foods will be prepared in the texture/viscosity modification-as needed by each resident's individual requirement. 2. Standard textured modifications include chopped, ground, pureed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48366 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for 1 of 1 kitchen reviewed for food service safety. 1. The facility failed to ensure [NAME] Z wore a beard restraint for his beard. 2. The facility failed to ensure foods in the refrigerators were t were dated with a prepared date and discard dates. 3. The facility failed to ensure [NAME] AA took temperatures for proteins that had the consistency of soft and bite sized and minced and moist, until after survey intervention. 4. The facility failed to ensure the CDM took temperatures of the milk until after survey intervention. These failures could place residents at risk for food borne illness. The findings were: 1. During an interview and observation on 07/23/24 at 09:26 AM, [NAME] Z had a beard with unmeasured length. The CDM revealed [NAME] Z did not need a beard guard because he had a 5 o'clock shadow in the chin area. Observation further revealed there were beard guards available at the door to the kitchen. During an interview on 07/27/24 at 01:08 PM, the RD (with the administrator present) did not want to reveal the hair restraint policy and said to read and interpret the hair restraint policy, when asked what his expectations were for hair restraints. He further revealed there were beard guards provided to the kitchen. Record review of the facility's policy Dietary Hair Covering/Restraint Policy, dated 06/30/24, reflected Personnel with facial hair will wear a beard guard during their shift in the Dietary Department. 2. Interview and observation, during initial kitchen tour on 07/23/24 at 09:26 AM, revealed cold cuts like ham, turkey, cheese (anything to make a sandwich) had a discard date after 7 days (07/29). Fruits had a discard date after 5 days. There were no prepared by dates on these food products. It was observed the other food products, not identified, did not have discard dates. The CDM revealed they did not have discard dates because they did not need to add discard dates to food products, but the kitchen staff knew to throw prepared food products out after 3 days and there was never a problem with having foods that needed to be thrown out in the refrigerator, because they used the foods right away. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 07/27/24 at 01:08 PM, the RD revealed the kitchen staff knew to through prepared foods after 3 days. He further revealed they needed to discard food products appropriately to combat food borne illness. Record review of the facility's Policy and Procedure handbook, revised 12-14-2017, reflected Recommended Storage Practices . C. Refrigerated Label all cooked and opened items with open and use by dates (00/00/00). 3. During an observation and interview on 07/26/24 at 11:37 AM, [NAME] AA was observed to not take temperatures for proteins that had the consistency of soft, bite sized, minced and moist and stated it was because there was not a space to write down a temperature for these foods on the temperature log. The CDM stated there was only 1 spot on the temperature log to write down a mechanically altered diet, when there needed to be 2 spots. The CDM revealed food needed to be at appropriate temperatures, so the residents didn't get sick. During an interview on 07/27/24 at 01:08 PM, the RD (with the administrator present) revealed the kitchen created a new temperature log which included all the protein options they offered to the residents. He revealed this was important to combat food borne illness. 4. During an observation and interview on 07/26/24 at 11:37 AM, the CDM revealed he didn't check the temperatures of cold food products, like milk, which was being served for 07/26/24 lunch. He further revealed he used the temperature that the refrigerator read. The CDM revealed food needed to be at appropriate temperatures, so the residents didn't get sick. During an interview on 07/27/24 at 01:08 PM, the RD (with the administrator present) revealed cold temperatures that needed to be taken at mealtime included: milk, dessert and juice. He revealed this was important to combat food borne illness. Record review of the facility's Policy and Procedure handbook, revised 12-14-2017, reflected IV. Food Service Temperature Control . O. Monitoring Trayline/Meal Service Temperatures . Policy: Food Temperatures will be recorded when meal service starts, when it ends, and every 30 minutes during the service. 1. Employees of the Food & Nutrition Services Department will be assigned to take and record the temperature of all hot and cold food items designated for service at each meal. Record review of the 2022 US Food Code reflected, 3-4 Destruction of Organisms of Public Health Concern . 3-401 Cooking . Commercially packaged food that bears a manufacturer's cooking instructions shall be cooked according to those instructions before use in ready-to-eat foods or offered in unpackaged form for human consumption .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44906 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and prevent the development and transmission of communicable disease and infection for two of 16 residents (Resident #46 and Resident #38) reviewed for infection control. 1.) The facility failed to ensure CNA S washed or sanitized her hands when donning clean gloves 3 times while providing incontinent care to Resident #46 on 7/26/2024. 2.) The facility failed to ensure RN O washed or sanitized her hands, until intervention by the VP RN, when donning clean gloves during medication administration for Resident #38 on 7/27/2024. These deficient practices could place residents at risk for infection due to improper care practices. The findings include: 1.) Record review of Resident #46's quarterly MDS, dated [DATE], reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #46 had a BIMS summary score of 0; indicative of being unable to complete the assessment. Resident #46's primary reason for medical condition for admission was coded as a medically complex condition related to epilepsy [brain disorder that causes repeated seizures, uncontrolled bursts of electrical activity in the brain resulting in changes in behavior, movements, feelings, and levels of consciousness]. Other active diagnoses included dementia [group of symptoms affecting memory, thinking and social abilities]. Resident #46 was coded as requiring moderate assistance for toileting. Resident #46 was coded as always incontinent of bladder and bowel. Resident #46 was coded as being at risk for skin breakdown. In an observation on 07/26/2024 at 3:45 PM, CNA S performed incontinent care with CNA T present. CNA S changed her gloves three times during the procedure but failed to wash her hands or use hand sanitizer between glove changes. CNA S was observed removing dirty gloves and donning clean gloves without washing her hands or using hand sanitizer. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 07/26/2024 at 4:20 PM, CNA S stated she failed to wash or sanitize her hands while providing incontinence care three times. CNA S stated she should have washed her hands or used hand sanitizer each time she donned clean gloves. CNA S stated the reason she changed her gloves, was because the gloves were soiled, and clean gloves would be needed for the next step of the care. CNA S stated that she knew she needed to either wash or sanitize her hands before she donned clean gloves. CAN S stated she was nervous and forgot to wash her hands or use hand sanitizer before donning clean gloves. CNA S stated the process was included in annual competencies and on occasion impromptu in-service trainings. CNA S stated she and CNA T had spoken about not having pump style bottles of hand sanitizer on the unit earlier that day. CNA S stated usually she prepared the necessary equipment for incontinence care to include a pump style hand sanitizer. CNA T stated as the backup during the procedure, she should have caught it and reminded CNA S to either wash her hands at the sink, or to use the hand sanitizer mounted on the wall near the door. CNA T stated that she was trained to change her gloves when soiled, and either hand washing, or hand sanitizer was required before donning clean gloves for resident health and safety. CNA T stated she believed housekeeping removed the pump style bottles from the unit but did not know why. CNA T stated the wall mounted hand sanitizers never went dry, and hand sanitizer was always available. 2.) Record review of the quarterly MDS assessment, dated 06/21/2024, reflected Resident #38 was an 87- year-old female who was admitted to the facility on [DATE]. Resident #38's primary medical condition for admission was progressive neurological conditions related to Parkinson's disease [age-related progressive degenerative brain condition best known for causing slowed movements, tremors, balance problems]. Other active diagnoses included dementia. Resident #38 had a summary BIMS score of 11, indicative of moderate cognitive impairment. In an observation and interview on 07/27/24 at 10:00 AM revealed RN O attempted to don gloves without washing her hands or using hand sanitizer while administering medications to Resident #38. The VP RN directed RN O to use hand sanitizer before donning the gloves. RN O stated she would not be able to get the gloves on if she used hand sanitizer first. VP RN directed RN O she must use hand sanitizer or wash her hands before donning gloves. RN O used hand sanitizer only after intervention by the VP RN. In an interview on 07/28/2024 at 10:20 AM, RN O stated she knew she had to use hand sanitizer or wash her hands prior to donning gloves. She stated the RN VP made her nervous and she made a mistake because of it. RN O stated she always used hand sanitizer and even kept a small bottle of it on her person when working. RN O stated there was always hand sanitizer readily available in resident care areas. RN O stated she did not know why she stated she would not be able to get the gloves on after using hand sanitizer, because in her experience one just needed to wait a few more moments for the sanitizer to absorb and dry before donning gloves . In an interview on 07/28/2024 at 2:05 PM, the DON stated the expectation was that hand sanitizer or hand washing would be performed prior to donning clean gloves. The DON stated that cross contamination could occur if hands were not cleaned prior to donning clean gloves. The DON stated that infections could be prevented through hand sanitizer or hand washing. The DON stated this information was trained during new hire orientation, during In-Service trainings and on annual competency trainings. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy entitled, Hand-Washing/Hand Hygiene, revised December 2021, reflected under the heading Applying and Removing Gloves, perform hand hygiene before applying non-sterile gloves.