| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675809 | A. Building<br>B. Wing | 04/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Avir at Lancaster | 1241 Westridge Ave<br>Lancaster, TX 75146 |

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 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review, the facility failed to provide a safe environment and adequate supervision for 1 (Resident #1) of 5 residents reviewed for falls. The facility failed to ensure Resident #1 received adequate supervision when she had a fall that resulted in a fractur to her right thigh and right knee. This failure could place residents at risk for injuries and a decline in health. Findings included:Record review of Resident #1's electronic admission record, 04/11/2026 revealed an [AGE] year-old female, admitted [DATE], with diagnoses that included traumatic hemorrhage of cerebrum (a life threatening, often fatal emergency caused by bleeding within the brain tissue), fracture of left femur (a severe injury causing intense, immediate thigh pain, inability to bear weight), anxiety disorder (mental health condition characterized by excessive persistent fear or worry), hypothyroidism (the thyroid gland fails to produce sufficient hormones, slowing the body's metabolism), dementia (a progressive, umbrella term for cognitive decline), and epilepsy (a chronic neurological disorder, unprovoked seizures).Record review of Resident #1's Part A (Medicare Part A, hospital insurance) PPS Discharge MDS assessment, dated 03/28/26, reflected the resident was unable to verbally respond. Resident #1 had a BIMS score of 00, indicating severe cognitive impairment. Resident #1 needed supervision or touching assistance to roll left and right. Resident #1 needed partial/moderate assistance sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. Record review of Resident #1's care plan , dated 12/10/25, reflected focus she had an actual fall in room beside the bed, no injuries noted (12/10/25). The care plan was updated 12/12/25 the goal was to resume usual activities without further incident. Interventions/task were after a fall and before moving Resident #1, evaluate for changes in range of motion and notify the nurse, check on resident at frequent intervals at least q 2 hours to see if any assistance was needed and to offer reassurance. Increase supervision by positioning Resident #1 in staff-visible area, pharmacy consult for drug regimen review as needed, provide first aid if indicated and obtain emergency assistance from EMS (911) if appropriate. Remind her to use assistive devices w/c. Evaluate the environment at the time and location of the fall and attempt to identify any factors that may have contributed to the fall, such as uneven surfaces, bed not in lowest position, poor lighting or glare present, not wearing foot ware with non-skid soles. Focus was Resident had altered neurological status (clinical evaluation of the nervous system's function), goal was that Resident would maintain baseline neurological status, intervention/tasks were to monitor behavioral changes, monitor for complaints of headache, monitor for signs/symptoms of dysphagia.During a confidential interview on an undisclosed date at an undisclosed time, the interviewee stated Resident #1 was currently in the hospital heavily sedated due to pain after surgery and would not be able to participate in an interview. The interviewee stated they preferred an interview not to be attempted. The interviewee stated he had not been given an explanation of how the injury could have happened. The interviewee stated they were notified by hospice of the injury and had told hospice staff it was preferred that Resident #1 not be sent to the hospital until x-ray results had been received.Record review of progress notes reflected Resident #1 was assessed by LVN-A nurse at 10:56 a.m. on<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 04/06/26, reflected Resident #1 had swelling to her right knee and bruising to the underside of right knee, LVN-A notified Hospice Nurse. Resident #1 was later assessed by Hospice Nurse on 04/06/26 at 12:00 p.m., who ordered the x-ray STAT. Hospice Nurse contacted the facility on 04/06/26 at 2100 (9:00 p.m .) to check on Resident #1 and was told by the facility nurse Resident #1 had not had the x-ray completed. The Hospice Nurse sent the x-ray order to the facility at that time (8:00 p.m .) to order a second x-ray request from the facility vender. On 04/07/26 at 9:17 a.m., the x-ray was done on Resident #1.The results, a fractured tibia, were received on 04/07/26 at 12:00 p.m., which was twenty-four hours from the initial x-ray request (12:00 p.m.). The physician then requested an additional x-ray. Resident #1 received repeat x-ray 04/07/26 at 16:00 (4:00 p.m.). The results of the repeat x-ray were received 04/07/26 at 20:01 (8:01 p.m.) indicated Resident #1 had a fractured right knee. MD notified of result and order given to send Resident #1 to the ER on [DATE] at 9:24 p.m. Thirty-three hours lapsed from time of original x-ray request before the resident was sent to the hospital.During an observation of the room assigned to Resident #1 on 04/11/26 at 9:56 a.m., revealed a w/c next to the head of the bed, a low bed with a fall mat under the side of the bed. No other obstacles were observed around the bed.During an interview with the Administrator on 04/11/26 at 10:00 a.m., he stated he was notified of Resident #1's swollen leg on 04/06/26 during the morning after the DON had completed her assessment of the leg/knee of Resident #1, he stated on 04/07/26 after they received the x-ray results, he began his investigation to determine how the injuries could have happened. He stated he interviewed the roommate and the staff who worked with Resident #1 on 04/05/26 and the morning of 04/06/26 and none of them knew when or how Resident #1 could have sustained the injuries. He stated he checked the area around Resident #1's living space and did not observe any tripping hazards. During an interview with the DON on 04/11/26 at 10:19 a.m., she stated that on 04/06/26 during incontinent care, the staff noticed bruising and swelling on the right leg of Resident #1. She stated she did an assessment of Resident #1 and there was swelling to the right leg and knee and some discoloration on the inner thigh and right knee. She stated the resident was given Tramadol for pain. She stated Resident #1's hospice agency was notified. She stated Resident #1 did not provide an explanation of how the injury could have happened. She stated she observed the area around the bed and did not observe any tripping hazards. She stated Resident #1 was at risk of falls and the care plan had been updated in January after she had a fall with the fall mat and having her in an area where staff could keep an eye on her during waking hours. During an interview with CNA-B on 04/11/26 at 1:30 p.m ., he said he went to Resident #1's room at about 7:30 a.m. and when he pulled the cover back, he saw that her right leg was bigger than her left leg. He stated that when he began to touch Resident #1's leg to change her, Resident #1 started screaming. He stated he asked Resident #1 how her leg became swollen and she was unable to give an explanation. He stated he notified LVN-A and he did not attempt to move Resident #1 again. CNA B said he changed her and left her in bed. He stated he worked with Resident #1 before and had not seen her leg swollen. He stated when he entered the room Resident #1's fall mat was on the floor beside her bed, and her w/c was parked by the door near the head of the bed. He stated he did not observe any other objects near the area. During an interview with LVN-A on 04/11/26 at 2:22 p.m ., she stated she was notified by CNA-B at about 7:30 a.m. that Resident #1's knee looked swollen. She stated when she went into the room to assess Resident #1 her knee looked swollen, bruised, and twisted. She stated she notified hospice. She stated Resident #1 had been on hospice, so she notified hospice of her assessment. She stated Resident #1 was previously able to get on and off of the bed without assistance. She stated that they would always encourage her to ask for help. She stated sometimes she would go into the room and Resident #1would be on the fall mat that was placed beside her bed or in her chair. She stated per the care plan Resident #1's bed was placed in the lowest position; she had a fall mat next to her bed and her bedroom was across from the nurse station. When she was out of bed she was in the common area or in the hallway next to the nursing station. She stated while they were waiting for the x-ray technician they monitored Resident #1's pain and provided pain medication. She stated that hospice<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | provided an order for morphine. She stated she observed the area around the bed and saw the fall mat next to the bed and the wheelchair next to the head of the bed. She stated the resident was a fall risk and getting up without assistance had placed her at risk of harm.Record review of progress note dated 4/6/2026 17:11(5:11 p.m.) Order Note: Morphine given, Note Text: This order is outside of the recommended dose or frequency. Morphine Sulfate Oral Solution 20 mg/5ml *Controlled Drug* **DAW** given 0.5 ml by mouth every 2 hours as needed for Pain: Shortness of Breath.Record review of progress note dated 4/7/2026 05:00 a.m. reflected Note Text: Morphine Sulfate Oral Solution 20 mg/5ml, given 0.5 ml by mouth every 2 hours as needed for Pain; Shortness of Breath.Record review of progress note dated 4/7/2026 at 9:30 a.m. reflected, Note Text: Morphine Sulfate Oral Solution 20 mg/5ml; was given 1 ml by mouth every 2 hours as needed for Pain; Shortness of Breath.Record review of progress note dated 4/7/2026 at 13:17(1:17 p.m.) reflected Morphine Sulfate Oral Solution 20 mg/5ml was given for Pain; Shortness of Breath PRN Administration was: Effective, Follow-up Pain Scale was: 4Record review of Provider Investigation Report dated 04/07/26, reflected Resident #1 was seen on the floor by her roommate on the morning of 04/06/26, who was not certain how Resident #1 ended up on the floor. Resident #1 got herself up off the floor and back into her wheelchair. [Resident #1] was assessed by DON on 04/06/26 around 10:50 AM. [Resident #1] had swelling and pain noted to her right leg. X-rays were conducted in-house. On 04/07/26 at around 10:30 a.m., the [provider] was provided x-ray results, which indicated [Resident #1] suffered an acute distal femoral fracture (a serious break in the thighbone just above the knee joint on her right leg, often caused by simple falls in the elderly). [Resident #1] was on [hospice], so pain management will be provided. [Resident #1's] family elected to not send her to the hospital x-rays of the right knee will be repeated on 04/07/26. [sic]Record review of the facility policy titled, Falls and Fall Risk, managing dated March 2018, reflected risk factors could be poor lighting, lower extremity weakness, delirium and other cognitive impairment, incontinence, and neurological disorders. Staff will monitor and document each resident's response to interventions intended to reduce fall or the risks of falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. |

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| F 0776<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide or obtain radiology and other diagnostic services to meet the needs of its residents for 1 (Resident #1) of 3 residents reviewed for radiology services.The facility failed to obtain the x-ray and results for Resident #1's leg and knee in a timely manner, resulting in a delay to diagnoses of Resident #1's right femur and right knee. The STAT x-ray should be completed as soon as possible. On 04/11/26 at 2:14 PM an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 04/11/26, the facility remained out of compliance at a severity level of Immediate Jeopardy to resident health or safety and a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.On 04/11/26 at 2:14 PM an Immediate Jeopardy (IJ) was identified. The Administrator and DON were notified. The Administrator was provided with the IJ template, and a Plan of Removal (POR) was requested at that time. This failure could place the residents at risk of further injury, pain, and a delay in treatment. Findings included :Record review of Resident #1's electronic admission record, 04/11/2026 revealed an [AGE] year-old female, admitted [DATE], with diagnoses that included traumatic hemorrhage of cerebrum (a life threatening, often fatal emergency caused by bleeding within the brain tissue), fracture of left femur (a severe injury causing intense, immediate thigh pain, inability to bear weight), anxiety disorder (mental health condition characterized by excessive persistent fear or worry), hypothyroidism (the thyroid gland fails to produce sufficient hormones, slowing the body's metabolism), dementia (a progressive, umbrella term for cognitive decline), and epilepsy (a chronic neurological disorder, unprovoked seizures).Record review of Resident #1's Part A (Medicare Part A, hospital insurance) PPS Discharge MDS assessment, dated 03/28/26, reflected the resident was unable to verbally respond. Resident #1 had a BIMS score of 00, indicating severe cognitive impairment. Resident #1 needed supervision or touching assistance to roll left and right. Resident #1 needed partial/moderate assistance sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. Record review of Resident #1's care plan , dated 12/10/25, reflected focus she had an actual fall in room beside the bed, no injuries noted (12/10/25). The care plan was updated 12/12/25the goal was to resume usual activities without further incident. Interventions/task were after a fall and before moving Resident #1, elevate for changes in range of motion and notify the nurse, check on resident at frequent intervals at least q 2 hours to see if any assistance was needed and to offer reassurance. Increase supervision by positioning Resident #1 in staff-visible area, pharmacy consult for drug regimen review as needed, provide first aid if indicated and obtain emergency assistance from EMS (911) if appropriate. Remind her to use assistive devices w/c. Evaluate the environment at the time and location of the fall and attempt to identify any factors that may have contributed to the fall, such as uneven surfaces, bed not in lowest position, poor lighting or glare present, not wearing foot ware with non-skid soles. Focus was Resident had altered neurological status (clinical evaluation of the nervous system's function), goal was that Resident would maintain baseline neurological status, intervention/tasks were to monitor behavioral changes, monitor for complaints of headache, monitor for signs/symptoms of dysphagia.During a confidential interview on an undisclosed date at an undisclosed time, the interviewee stated Resident #1 was currently in the hospital heavily sedated due to pain after surgery and would not be able to participate in an interview. The interviewee stated they preferred an interview not to be attempted. The interviewee stated he had not been given an explanation of how the injury could have happened. The interviewee stated they were notified by hospice of the injury and had told hospice staff it was preferred that Resident #1 not be sent to the hospital until x-ray results had been received. Record review of progress notes reflected Resident #1 was assessed by LVN-A nurse at 10:56 a.m. on 04/06/26, reflected Resident #1 had swelling to her right knee and bruising to the underside of right<br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | knee, LVN-A notified Hospice Nurse. Resident #1 was later assessed by Hospice Nurse on 04/06/26 at 12:00 p.m., who ordered the x-ray STAT. Hospice Nurse contacted the facility on 04/06/26 at 2100 (9:00 p.m.) to check on Resident #1 and was told by the facility nurse Resident #1 had not had the x-ray completed. The Hospice Nurse sent the x-ray order to the facility at that time (8:00 p.m.) to order a second x-ray request from the facility vender. On 04/07/26 at 9:17 a.m., the x-ray was done on Resident #1.The results, a fractured tibia, were received on 04/07/26 at 12:00 p.m., which was twenty-four hours from the initial x-ray request (12:00 p.m.). The physician then requested an additional x-ray. Resident #1 received repeat x-ray 04/07/26 at 16:00 (4:00 p.m.). The results of the repeat x-ray were received 04/07/26 at 20:01 (8:01 p.m.) indicated Resident #1 had a fractured right knee. MD notified of result and order given to send Resident #1 to the ER on [DATE] at 9:24 p.m. Thirty-three hours lapsed from time of original x-ray request before the resident was sent to the hospital.During an interview with the DON on 04/11/26 at 10:19 a.m., she stated that on 04/06/26 during incontinent care, the staff noticed bruising and swelling on the right leg of Resident #1. She stated she did an assessment of Resident #1 and there was swelling to the right leg and knee and some discoloration on the inner thigh and right knee. She stated the resident was given Tramadol for pain. She stated Resident #1's hospice agency was notified, and x-rays were ordered by the hospice nurse on 04/06/26 after the hospice nurse had assessed the resident. She stated usually when a resident was on hospice, all invasive interventions would be stopped, and the facility would defer to hospice for all treatment. She stated that it was the facility's responsibility to carry out orders from the hospice agency. She stated the facility staff followed up with hospice regarding the x-ray. She denied she knew which staff followed up with hospice regarding the x-ray or what times the staff had followed up. She stated when Resident #1 had not received the x-ray timely she was at risk of more pain and not knowing if Resident #1 had a significant injury. During an interview with CNA-B on 04/11/26 at 1:30 p.m., he said he went to Resident #1's room at about 7:30 a.m. and when he pulled the cover back, he saw that her right leg was bigger than her left leg. He stated that when he began to touch Resident #1's leg to change her, Resident #1 started screaming. He stated he asked Resident #1 how her leg became swollen and she was unable to give an explanation. He stated he notified LVN-A and he did not attempt to move Resident #1 again. CNA B said he changed her and left her in bed. He stated he worked with Resident #1 before and had not seen her leg swollen. During an interview with LVN-A on 04/11/26 at 2:22 p.m., she stated she was notified by CNA-B that Resident #1's knee looked swollen. She stated when she went into the room to assess Resident #1 her knee looked swollen, bruised, and twisted. She stated she notified hospice, who stated they would order the x-ray STAT.LVN A stated hospice said their nurse was on her way to the facility to assess Resident #1. She stated Resident #1 was previously able to get on and off of the bed without assistance . She stated that they would always encourage her to ask for help. She stated sometimes she would go into the room and Resident #1would be on the fall mat that was placed beside her bed or in her [NAME] r. She stated per the care plan Resident #1's bed was placed in the lowest position, she had a fall mat next to her bed and her bedroom was across from the nurse station. When she was out of bed she was in the common area or in the hallway next to the nursing station. She stated the DON told her if no one from hospice showed up by 7:00 p.m. that she should get an order from the facility NP for the STAT x-ray. She said she was in contact with the hospice nurse several times during the wait, but she did not document that she contacted the hospice nurse. She stated the hospice nurse kept stating she had sent the order to the hospice x-ray contractor, for the x-rays to be done. She stated that while they were waiting for the x-ray technician they monitored Resident #1's pain and provided pain medication. She stated that hospice provided an order for morphine. She stated the resident was at risk of having to wait until the next day to get x-ray was pain management and the fracture could have been affecting any other vital parts of the body.During an interview on 04/11/26 at 2:53 p.m. with Hospice RN, she stated she received a phone call from the hospice aide that Resident #1's leg was swollen. She stated she asked to speak to LVN-A, who informed her Resident #1's leg was<br>(continued on next page) |

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| F 0776<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | swollen and she was grimacing in pain. She stated she informed LVN-A she was heading to the facility to do an assessment. She stated after she completed her assessment she contacted the hospice doctor and received an order for STAT x-rays. She stated after calling in the order for the x-ray, she left the facility. She stated while she was charting later in the night she called the facility at about 9:00 PM on 04/06/26, to check the status of Resident #1. She stated that when she asked about the status of Resident #1, she learned the x-ray technician had not arrived to do the x-ray. She stated this was the first time hospice had an issue with the x-ray company not showing up for an x-ray. She stated when she found out the x-ray company had not shown up, she instructed the facility to request x-rays from their x-ray provider. She stated at that time she sent the STAT x-ray order to the facility. She stated that she did not remember the name of the nurse she spoke with for that order. She stated the family stated they did not want Resident #1 sent to the hospital until x-ray results were received. She stated risk would have been minimal because Resident #1 was sent to the hospital the night of 04/07/26 and did not have surgery until Friday (04/10/26). Record review of physician's telephone orders, dated 04/06/26, no time indicated, for STAT x-ray of Resident #1's right foot, bilateral hip (pelvis-both hip joints ) 2 views, right femur (right thigh, extending from the hip to the knee).Record review of Resident #1's physician's telephone orders, dated 04/07/26, no time indicated, for x-ray of Resident #1's right knee, 3 views.Record review of Provider Investigation Report dated 04/07/26, reflected Resident #1 was seen on the floor by her roommate on the morning of 04/06/26, who was not certain how Resident #1 ended up on the floor. Resident #1 go herself up off the floor and back into her wheelchair. [Resident #1] was assessed by DON on 04/06/26 around 10:50 AM. [Resident #1] had swelling and pain noted to her right leg. X-rays were conducted in-house. On 04/07/26 at around 10:30 a.m., the [provider] was provided x-ray results, which indicated [Resident #1] suffered an acute distal femoral fracture (a serious break in the thighbone just above the knee joint on her right leg, often caused by simple falls in the elderly). [Resident #1] was on [hospice], so pain management will be provided. [Resident #1's family elected to not send her to the hospital x-rays of the right knee will be repeated on 04/07/26.Record review of facility policy titled, Lab and Diagnostic Test Results, dated 04/2007, reviewed by QAPI 3/24/26, reflected Assessment and Recognition: 2. The staff will process test requisitions and arrange for tests. Procedure: 5. Critical Values: Must be immediately communicated to the provider (within 1 hour). Document provider notification, instructions, and interventions.This was determined to be an Immediate Jeopardy (IJ) on 04/11/26 at 2:14 p.m. The Administrator and DON were notified. The Administrator was provided with the IJ template on 04/11/26 at 2:14 p.m.The following Plan of Removal submitted by the facility was accepted on 04/11/26 at 5:27 p.m.: PLAN OF REMOVAL:Radiology Services F776Name of Facility: [Facility]Date: 04/11/2026F776 Radiology Services: The facility failed to ensure STAT x-ray results were done and reviewed timely. Resident #1 was found with fracture to her right leg and further x-rays showed Resident #1 was found with a fracture to her right knee.Immediate Action:Action: The facility immediately notified the attending physician when the final x-ray results were obtained and orders received to send the resident to the ER for evaluation. The new orders were promptly carried out, and the resident was sent to the ER on [DATE] at 9:24 p.m.Person(s) Responsible: Director of NursingDate/Time: 04/07/26Identification of Residents Affected or Likely to be Affected::Action: A retrospective audit of all STAT diagnostic orders from the last 30 days was conducted to identify any delays in completion or review. Any identified delays were immediately addressed with physician notification and follow up care as neededPerson(s) Responsible: Regional Nurse Consultant, Director of Nursing, Assistant Director of Nursing, and/or Designee Date/Time: 04/11/26Actions to Prevent Occurrence/Recurrence:Action: The facility implemented a revised STAT order protocol that includes:1. Clear definition of STAT to be completed within 4 hours.2. Follow up with Principle Labs to determine if x-ray technician is en route after 2 hours and if not assigned and in route the MD will be notified and alternate care will be arranged at the emergency room3. The DON and ADON will track/monitor all ordered labs/diagnostics (continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0776<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | and ensure they're received, resulted and communicated with MD in a timely manner. The facility will ensure proper communication between the hospice and the facility by providing education to hospice and facility staff on co-managing the residents carePerson(s) Responsible: Regional Nurse Consultant, Director of Nursing, Assistant Director of Nursing, and/or Designee Date/Time: 04/11/26Action: A tracking system will be implemented for all STAT x-rays to ensure timely follow up that includes logging of time order place, time procedure performed, time results received and time of physician notificationPerson(s) Responsible: Director of Nursing, Assistant Director of Nursing, and/or Designee Date/Time: 04/11/26Action: Licensed Nurses have been educated by the Director of Nursing on: 1. STAT orders procedures and urgency expectations2. Documentation requirementsEducation will be completed by 04/11/2026 with the attendance documented. Newly hired licensed nurses will be educated prior to working their next scheduled shift. Person(s) Responsible: Director of NursingDate/Time: 04/11/2026Action: DON/ADON will audit 100% of all STAT diagnostic orders for 4 weeks then; Weekly audits for 2 months and Monthly audits thereafterPerson(s) Responsible: Director of NursingDate/Time: 04/11/26Action: QAPI meeting held with Medical Director to discuss the Immediate Jeopardy template, F776, and the facility's plan of action to remove the immediacy. Person(s) Responsible: Administrator and Director of Nursing Date/Time:04/11/26 Monitoring for the Plan of Removal from 04/11/26 included the following: During interviews with Regional Nurse Consultant, Director of Nursing, Assistant Director of Nursing, LVN-A, RN-C, LVN-D, RN-E, and RN-F on 04/11/29 from 6:50 p.m. - 7:45 p.m., reflected they were in-serviced that STAT orders must be completed within 4 hours, staff must follow up with radiology if STAT x-ray has not been completed within 2 hours, if the x-ray technician was not assigned and enroute after 2 hours staff must notify the physician and arrange an alternate, significant x-ray findings must be immediately reported to the physician, after receiving physician orders related to x-ray results staff should carry the orders out promptly. The Administrator was informed the Immediate Jeopardy was removed on 04/11/26 at 7:50 p.m. The facility remained out of compliance at a severity level of Immediate Jeopardy to resident health or safety and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.Record review of Diagnostic Tracking audit dated 4/11/26 reflected STAT x-rays ordered on 03/14/26 and 3/16/26 were completed on their perspective days, results received and MD notified.Record review of x-ray/pain management/hospice services in-services dated 04/11/26, reflected Director of Nursing, Assistant Director of Nursing, LVN-A, RN-C, LVN-D, RN-E, and RN-F had been in-serviced in person or verbally over the phone. |