STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675820	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	8017 W Virginia Dr Dallas, TX 75237

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 - Some	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** 33552 Based on interview and record review, the facility failed to immediately consult with the residents' physicians when there was a significant change in the resident's physical, mental or psychosocial status in either life-threatening conditions or clinical complications; or when there is a need to alter treatment significantly, for two (Residents ##3 and #4) of five residents reviewed for resident rights. 1. The facility failed to consult with the physician when Resident #3 had a change in condition which resulted in a dangerously low blood sugar of 40. Resident #3 died at the facility unexpectedly within 24 hours of his change of condition. 2. The facility failed to notify the physician [MD O] or physician extender [NP M] of Resident #4's x-ray results when he had a change in condition on [DATE]. The x-ray results indicated there were abnormal findings which included widespread bilateral nodular lung opacities and small right pleural effusion opacities which was consistent with severe pulmonary edema or pneumonia. Resident #4 died at the facility unexpectedly within 24 hours of his change of condition. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 1:25 PM. The IJ template was provided to the facility's VPCO on [DATE] at 1:30 PM. While the Immediate Jeopardy was removed on [DATE] the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to implement and monitor the effectiveness of its corrective systems. This failure could place residents at risk for not receiving timely medical intervention as needed and ordered by the physician, of not having their health condition monitored timely for changes in condition, which could result in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. Findings included: 1) Record review of Resident #3's Face Sheet (not dated) reflected he was a [AGE] year old male admitted to the facility on [DATE] with active diagnosis of Diabetes Type 2 without complications. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected he had no hearing, speech or vision issues and a BIMS score of 08, which indicated moderate cognitive impairment. Resident #3 has no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #3 had limited function range of motion in both of his lower extremities, used a wheelchair for mobility and required substantial/maximum assistance from staff for all ADLs. He had an ostomy and indwelling catheter and was always incontinent of bowel and bladder. Resident #3 had identified shortness of breath when laying flat (dyspnea), was five feet two and weight 162 pounds. Resident #3 has one unhealed and unstageable pressure ulcer and one arterial/venous stasis ulcer. He received high-risk drug medication that included an anticoagulant, a diuretic and hypoglycemic medication. Resident #3 did not receive hospice services. Record review of Resident #3's care plan dated [DATE] reflected, Focus Area: Diabetes Mellitus-I will be free from any s/sx of hypoglycemia through the review date; Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #3's [DATE] physician orders reflected he was prescribed Metformin HCl Oral Tablet 500 MG two tablets by mouth two times a day for diabetes (start date [DATE]). Resident #3 also had the following orders, 1. If blood sugar below 70 and resident unable to swallow immediately administer oral glucose paste to buccal mucosa, glucagon as ordered, and re-check BS in 15 minutes and may repeat protocol if indicated remaining with the resident, keep resident comfortable and safe and monitor VS. Hold all diabetic medications and if no improvement notify MD; 2. If blood sugar is less than 70 and patient is ABLE to swallow immediately give 4 oz juice or ,d+[DATE] oz soda recheck BS in 15 minutes and repeat juice if needed. If resident is UNABLE to swallow immediately administer oral glucose paste to buccal mucosa, glucagon as directed and re-check BS in 15 minutes remaining with the resident, keep comfortable and safe, monitor VS, hold all diabetic medications and notify MD as needed; 3. If BS less than 70 and patient is unresponsive immediately administer oral glucose paste, glucagon as directed. Remain with resident, monitor VS, keep safe and hold all diabetic (medication). Further review revealed Resident #3 did not have a physician's order to check his blood sugar routinely or PRN. Record review of Resident #3's clinical chart reflected the following blood sugar readings were documented in his e-chart: [DATE] (40), [DATE] (100), [DATE] (139) (Note: Hypoglycemia occurs when the sugar level in the blood is below 60 mg; extremely low blood sugar can trigger seizures, loss of consciousness, impaired cognitive function and increased risk of falls). Record review of Resident #3's [DATE] MAR reflected he was administered the Metformin as ordered for diabetes. Record review of Resident #3's prealbumin, CMP and CBC dated [DATE] reflected abnormal values: for *pre-albumin of 11 which was considered low (reference range was ,d+[DATE]); *creatinine low at 0.5 (reference range was ,d+[DATE].3); *glucose was high at 144 (reference range was ,d+[DATE]); *white blood cell count was high at 10.6 (reference range was 3XXX,d+[DATE].20, (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*red blood cell count was low at 2.81 (reference range was 4XXX,d+[DATE].63) and *platelet count was high at 469 (reference range was ,d+[DATE]). Further review revealed PA I was notified by the charge nurse and no new orders were given related to the labs. Record review of Resident #3's nursing progress notes reflected: -[DATE]- Resident was readmitted back into the facility at 7pm from [hospital] on a stretcher with eyes open respiration even heart sound normal- Dx Sepsis, Diabetes , HTN, Asthma ,and decompressive laminectomies. Resident is alert and oriented x 1 able to make needs known wound noted on the coccyx and the left tibia, swollen to both hand and staples to the neck and back was removed, trach was intact, catheter was draining at gravity , resident was resting calmly in his room with no difficulty MD notified and the DON [e-signed by LVN B]. -[DATE]-eINTERACT SBAR Summary for Providers Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition-At the time of evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure: BP ,d+[DATE] Position: Lying r/arm; Pulse: 68, Respirations 18.0, Temp 97.6, Weight 165.1 lb, Pulse Oximetry: O2 96%, Blood Glucose 40.0-[DATE] 08:15; . Resident/Patient had the following medications changes in the past week: no; .Resident/Patient is on: Hypoglycemic medication(s)/Insulin; Outcomes of Physical Assessment : Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Other, Functional Status Evaluation: General Weakness, Behavioral Status Evaluation: [blank] Respiratory Status Evaluation: [blank], Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50, Abdominal/GI Status Evaluation: [blank], GU/Urine Status Evaluation: [blank], Skin Status Evaluation: [blank], Pain Status Evaluation: Does the resident/patient have pain? [blank]; Neurological Status Evaluation: [blank]; Nursing observations, evaluation, and recommendations are: Pt b/s is up to 81; Primary Care Provider Feedback : Primary Care Provider responded with the following feedback: A. Recommendations: continue to monitor pt.; B. New Testing Orders: Other-- glucagon Injection; C. New Intervention Orders: Other- glucagon injection [e-signed by DON and LVN K]. -[DATE] (2:05 AM): Nurse making round at this time, noticed resident not responsive, assessed by nurse, resident did not respond to touch /verbal command. This nurse call code blue, CPR initiated while other nurse call 911. [e-signed by LVN L]. -[DATE]: 911 crew arrived and took over from nurse [e-signed by LVN L]. -[DATE]: 911 crew left the facility after all efforts made by them to resuscitate resident failed [e-signed by LVN L]. -[DATE]: Upon assessment resident noted without active signs of life. skin cool and dry no respirations no rise and fall of the chest, no carotid or apical pulse no blood pressure pupils non-reactive to light. death pronounced at 4:12 A.M/ [e-signed by the DON]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN A on [DATE] at 2:27 PM revealed when a resident's blood sugar was low when checked, the charge nurse was supposed to check the physician's standing orders for blood sugar, if it got to a certain level, then orange juice was given if the resident was able to swallow and there was also glucagon. LVN A stated when the blood sugar was checked and below a certain level, there were protocols to follow and the doctor had to be notified. LVN A stated a dangerously low blood sugar was anything below 70. She stated blood sugar checks were documented on the MAR, as well as in a nursing progress notes if it had to be re-checked. LVN A stated a change of condition was anything that was not ordinary for the resident, such as a change in consciousness, labs, blood pressure and blood sugar changes. When a change of condition occurred, LVN A stated a change of condition form, nursing note and SBAR had to be completed. LVN A stated that she had been the nurse for Resident #3 in the past and thought he had recently come back from a hospital visit and all she remembered was he had a trach and was always pleasant. She stated she was not working with him on the day his blood sugar was 40. An interview with LVN B on [DATE] at 2:49 PM revealed Resident #3 was on her hall and he had a recent surgery on his back the week prior. He had gone to the hospital to for a planned appointment to remove staples from his neck and was there for three to four days when the hospital had originally stated it would only take one day. When he readmitted to the facility, LVN B stated he was not the same as he was prior but did not give specifics. She stated she was working the ,d+[DATE]pm shift the day of his death and he had been in the dining room for dinner eating. She brought him back to his room after dinner and rounded on him again before her shift was over and everything was okay. The next morning, she found out he had died after her shift. LVN B stated, There was nothing acute happening with him on my shift. He did not have a low blood sugar on my shift. If he had a low blood sugar, he was in the dining room, I fed him .even if it went low, he would have been given Glucagon after my shift was over. We checked his blood sugars. He can talk, he can tell us what he wants. There was nothing out of the ordinary for me. He ate, I didn't have any reason to worry. LVN B stated if a resident's blood sugar was 40, she would have called the doctor but already be in the process of sending the resident out to the hospital even before the doctor said so, because 40 is too low on my watch, that is an automatic send out for me unless the doctor says to keep and give medications. But 40 is too low for glucagon to help enough. LVN B stated symptoms of low blood sugar could be nausea and vomiting, aggression, sweating and sleeplessness. LVN B stated the protocol for a low blood sugar reading was for the nurse to initial the MAR to ensure that the blood sugar was checked and was okay. If the blood sugar was not okay and low, then the nurse would administer Glucagon, document in nursing notes and do and E-Interact form. LVN B stated there was not a place on the MAR to indicate emergency glucose was given, only in the nursing notes. If the nurse administered glucagon, the nurse was supposed to re-check it in 15 minutes to see where blood sugar level was and document it in a nursing progress note because it was an issue and also document in the 24 hour report. The doctor would also be contact and if the blood sugar value did not elevate with intervention, notify doctor again to get further orders. LVN B stated she did not remember being told on that date of the low blood sugar of 40 ([DATE]) that there had been a change of condition. She said if an agency nurse was working that morning, she would not have rounded with them because they are always wanting to leave, so I don't remember anything about a low blood sugar. LVN B stated when a resident's blood sugar was low, the charge nurse was supposed to consult with the doctor, then give Glucagon or an orange juice supplement that can push the blood sugars back up, then re-assess the resident. LVN B stated a dangerously low blood sugar was anything below 70. She said blood sugars were documented on the MAR. LVN B stated a change of condition was if a resident's vitals were below their norm or they were restless or in pain. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN L on [DATE] at 3:21 PM LVN L stated she was the charge nurse for Resident #3 on the night he died . She had picked up the overnight shift and came in around 11:00 PM on [DATE]. She stated nothing had been reported to her by the afternoon/evening nurse [LVN B]. She said during her first rounds, Resident #3 was asleep in his room but woke up and said hello when LVN L came into the room. Then on her second round about two in the morning, LVN L stated she went into his room and discovered he was not breathing. She said most of the time when she rounded, she went into the residents' rooms and turned the light on and pat them and say hello, just checking. When she did that with Resident #3, she said papacita, when nothing, he did not respond and he had no pulse. LVN L stated they started CPR and someone called 911. EMTs arrived and worked on him for a long time but could not bring him back. LVN L stated there were protocols for hypoglycemia on every resident and if the resident could still talk and was alert, the first protocol was to give oral glucose and if the blood sugar did not come up, Glucagon was available. If the resident was still unresponsive, the nurses could then use glucose gel. She stated it was whatever the facility protocol said on the MAR and it had to be followed step by step. LVN L stated a dangerously low blood sugar was anything less than 70. Once Glucagon was given, LVN L stated the nurse would go back and check the blood sugar in 15 minutes, document the findings in a nursing note all that had been done, call 911 if the blood sugar does not rise and notify the doctor. LVN L stated a change of condition was anything different from the residents' norm. An interview with the DON on [DATE] at 4:40 PM revealed she was working at the facility the morning of [DATE], Resident #3's low blood sugar reading of 40. She stated a CNA came to tell her one of the nurses wanted her help. When the DON got to Resident #3's room, the nurse was at the door and said his blood sugar reading was 40. The DON assessed Resident #3 and his breathing and vitals at that time were normal, But he was doing what they do when their blood sugar is low, like they try to respond but can't, but want to. I told him [Resident #3] he was fine and his blood sugar was low. The DON stated Resident #3 was given Glucagon, and she told the nurse [LVN K] to check it again in ,d+[DATE] minutes. When LVN K checked it again, she gave a glucagon injectable, did not know remember what the blood sugar value was. The DON stated, When someone's blood sugar is in the 40s, they can't swallow so I don't like using the gel. The DON stated, So he came back around and it was a normal day after that. The DON stated she felt Resident #3 died because of his disease process. She stated his health was already poor and he had been getting treatment for multiple venous/stasis ulcers and wound care for pressure ulcers. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with CNA D on [DATE] at 12:30 PM revealed she was working the morning on [DATE] when Resident #3's blood sugar was 40. CNA D stated she was passing breakfast trays to the rooms and went into Resident #3's room and he was snoring but would not wake up when she tried to rouse him; she felt something was not right. She knew he was a diabetic so went to tell the nurse who was a PRN nurse (LVN K) who came to his room. LVN K also tried to wake Resident #3 up, but he would not wake up and it was then they knew something was wrong. The charge nurse checked his blood sugar and it was 40. CNA D stated she was present when the reading of 40 was done. She said LVN K did the glucose gun on him twice. After that, he woke up, was thirsty and wanted to get up out of bed. Soon after, a family member was present who sat with him in the dining room while he ate, he was talking and chatting with the family member and staff. CNA D stated Resident #3 told LVN K thank you so much for helping him while he was in the dining room, So he perked back up. CNA D stated LVN K told the family member about the low blood sugar and that he needed to be watched by the following shifts and she would leave a note for the nurses on the shifts. CNA D stated she remembered the morning PRN charge nurse telling the afternoon oncoming charge nurse [LVN B] to check Resident #3's blood sugar because it had been 40. Then the very next day, CNA D stated that Resident #3 was gone and they had already picked up his body by the time she got into work CNA D was worried Resident #3 may have died from a diabetic coma and said, I know from experience you need to monitor at least 48 hours. An attempt to interview MD H on [DATE] at 1:34 was unsuccessful; there was no option to leave a voice mail. An attempt to interview PA I on [DATE] at 1:36 PM was unsuccessful and there was no option to leave a voice mail. An interview with the secondary physician extender listed on Resident #3's Face Sheet [PA J] occurred on [DATE] at 1:43 PM. PA J stated she stopped going to the facility three weeks prior and her role was to work in physiatry and rehab only. However, speaking in general terms, PA J stated from a provider's point of view, the facility should notify the doctor for any low blood sugar, they had standing order to follow which included glucose tablet, then they should re-check the blood sugar and call the doctor back to see what they want to do. An interview with ADON E on [DATE] at 1:53 PM revealed she was week new to the facility so her information was limited. ADON E stated for a low blood sugar of 40, the resident would be at risk of a diabetic coma, so the doctor should be contacted to let them know what the charge nurse's interventions were, the blood sugar reading, the medications administered and then find out what they want the charge nurse to do. ADON E stated that for a blood sugar of 40, her nursing judgement would have sent Resident #3 to the hospital. ADON E stated Resident #3 should have been monitored after his change of condition for three days. She said the charge nurse would monitor and look for confusion, diaphoresis (cold and clammy), paleness of skin, confusion, agitation and anxiety. ADON E stated the nurses did chart by exception, but for an acute condition, they were supposed to chart for three days or as long as the treatment was in place. An interview with CNA F on [DATE] at 2:25 PM revealed he remember Resident #3 and was talking to him around 10:00 PM, a few hours before he died . He said they were talking about sports and two local sports teams and nothing seemed off or out of the ordinary. CNA F stated Resident #3 had been in the hospital recently but he did not know what for, but that night, he was up in his wheelchair and then CNA F laid him down for bed before his shift was over. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the VPCS on [DATE] at 2:47 PM revealed after Resident #3's low blood sugar reading of 40 and subsequent intervention of Glucagon, the nurses on the oncoming shifts that day should have been monitoring the resident for signs and symptoms of hypoglycemia such a confusion and lethargy. She stated the shift to shift report should be given between nurses and they were supposed to print out the 24 hour report and utilize that as well when they did their walking rounds for continuity of care. If there was a change in the resident's condition, such as a fall, a blood sugar that had to be recovered for example and there was any intervention done, it should be reported to the oncoming nurse. VPCS stated, That is what I expect for out of the norm, a prudent nurse to communicate to the oncoming shift so there is continuity of care. 2) Record review of Resident #4's Face Sheet (not dated) reflected he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Hypertension, Major Depressive Disorder, Atherosclerotic Heart Disease, Angina Pectoris, Dementia, Generalized Anxiety Disorder, Diabetes, Hyperlipidemia, Schizophrenia and Parkinson's Disease. Resident #4's attending physician was listed as [MD O] and the nurse practitioner was listed as [NP M]. Review of Resident #4's quarterly MDS assessment dated [DATE] revealed no hearing, speech or vision issues, a BIMS score of 03 which indicated severe cognitive impairment, no signs of delirium, psychosis or rejection of care. Resident #4 had no range of motion limitations but did need help from staff with all ADLs. Resident #4 did not have any assessed health conditions related to shortness of breath, did not use oxygen therapy and was not on hospice services. Resident #4 was prescribed high-risk medication which included an antipsychotic, antidepressant and an anticoagulant. Review of Resident #4's care plan initiated on [DATE] and last revised on [DATE] did not reflect any care areas related to respiratory issues or need for oxygen or related interventions. Record review of NP M's last documented visit on [DATE] with Resident #4 reflected a chief complaint/nature of presenting problem as, Leukocytosis (a condition where your blood has too many white blood cells, which fight infections and diseases), AMS, Abnormal labs, falls x 2. Resident #4 had a non-healing ankle wound that was being treated and a recent white blood cell count of 14 and continued leukocytosis. He was on an antibiotic and seen and examined in his room. He reported malaise and workup so far negative. The Nursing staff report decreased appetite. NP M reviewed Resident #1's recent labs from [DATE] and documented, CBC 16.1, 8.5, 25.5, 561; BMP 131, 4.4, 101, 22, 25, 1.1, 68. NP M documented her plan as, Plan 1. Leukocytosis: Workup so far negative. Currently on cefdinir until [DATE]; 2. Obtain blood cultures x 2 both negative, no growth after 5 days; 3. Obtain echocardiogram; 4. Consult hemo/Onco for further workup: new onset leukocytosis, thrombocytosis, anemia, weakness, negative infection workup; 5. Health shake 3 times daily with each meal; 6. Continue weekly lab work as ordered previously; 7. Continue all medication as ordered in PCC. Record review of Resident #4's physician order [initiated by NP M] dated [DATE] reflected, 2-view Chest X-ray to rule out infiltrates (abnormality in the lung). (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's x-ray-Chest 1-view dated [DATE] reflected it was reviewed by the radiology clinic at 6:01 PM and reported at 6:01 PM. The chest x-ray was noted on the findings to be compared to his last x-ray a year earlier on [DATE]. The findings indicated Resident #4 had widespread bilateral nodular lung opacities (haziness around the lung with nodule growth) and a small right pleural effusion (fluid around the lungs). The impression reflected, There are widespread bilateral nodular lung opacities. This is consistent with severe pulmonary edema or pneumonia. Consider CT correlation to exclude neoplasm. The findings are worse compared with prior. Record review of nursing progress notes from [DATE] for Resident #4 reflected no indication the physician or physician extender [NP M] and RP was notified of Resident #4's chest x-ray results. Record review of the following pertinent nursing notes for Resident #4 reflected: -[DATE] 12:52 PM- Type: eINTERACT SBAR Summary for Providers-Situation : The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition. At the time of evaluation resident/patient vital signs, weight and blood sugar were: BP ,d+[DATE], Pulse:70; R 18; Temp: 97.9; Weight: 202.2 lb; O2 96 %; Blood Glucose: 123.0 . Outcome of Physical Assessment : Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Other; Functional Status Evaluation: General weakness . Primary Care Provider responded with the following feedback: A. Recommendations: obtain Urine for UA with C&S; New Testing Orders: [blank]; C. New Intervention Orders: [blank] [e-signed by LVN A]. - [DATE]- Nurse's Note- PA in facility to visit with her residents today. Information given to PA regarding noted increased weakness and sleepiness. The resident is afebrile and without noted signs and symptoms of respiratory distress. New orders received to obtain urine for UA with C&S to rule out UTI and a 2-view chest x-ray to rule out infiltrates [e-signed by LVN A]. -[DATE]- Upon shift change at [10:05 PM], CNA called this nurse into resident's room. On getting to room, resident found in his wheelchair unresponsive in the bathroom. Resident assessed, put in bed and CPR initiated immediately while the other nurse, [staff] called 911. 911 crew arrived at [10:25 PM] and took over from the nurses. All efforts made by 911 crew to resuscitate the resident failed. The 911 crew left at [11:00 PM]. DON, resident family and MD notified of the change of condition. At [11:30 PM] Police arrived and took report from the nurses. At [midnight] resident pronounced by DON [e-signed by LVN P]. -[DATE]-Resident laying in bed. intubated with IV to right AC. skin cold and clammy. No signs of life present. No respirations, no rise and fall of chest. no carotid or Apical Pulse. Pupils set non-reactive to light. Death pronounced at 12:00 A.M. [e-signed by DON]. An interview with LVN A on [DATE] at 2:27 PM revealed when a charge nurse starts their shift, they should look in the lab book and the radiology book to see who has pending results and then continue to check throughout the shift to see if they have come in. If the charge nurse does not see the results, then they should call and follow up with a phone call. If the findings come back negative, the physician should still be notified to see if there are any new orders. With Resident #4, LVN A could not remember if NP M was notified of his chest x-ray findings. She said the results for Resident #4's x-ray would have come in after her shift was over at 2:00 PM that day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN C on [DATE] at 3:21 PM revealed the results of any x-rays were supposed to be logged under the resident's name in PCC with the results. LVN C stated she was at the facility the night Resident #4 died , but was not assigned to his hall. LVN C stated her shift was over and she heard his nurse calling for help so she went to see what happened and ended up helping the nurse do CPR. LVN C stated when she saw Resident #4, staff had already started CPR and she thought he was already expired by then. An interview with the DON on [DATE] at 4:40 PM revealed she did not remember Resident #4, but if a lab or x-ray came back with abnormal findings or normal findings, the charge nurse should still contact the doctor to let them know the results because the doctor may order antibiotics or prn oxygen. The DON said, But if the resident was already on antibiotics and no respiratory issue, the doctor probably would have just continued with current orders with antibiotics. The DON stated she was not sure what was going on with Resident #4 and she was new to the facility in [DATE]. The DON stated, But if he was already having respiratory issues, the doctor may not have done more intervention, but they should have been notified. An interview with ADON E [DATE] at 1:53 PM revealed she was one week new to the facility so she was not familiar with Resident #4. However, for x-ray results, ADON E stated the doctor should be called with the results regardless if the resident had a pre-existing condition or was already on medications for an infection. She reviewed the x-ray which reflected Resident #4 had lung opacities that were white spots which could mean usually pneumonia. She said it also reflected pulmonary edema which was water in lungs and pleural effusion was water around the lung. ADON E stated, These things are ordered because there was a concern, you would notify them because they doctor might want to change the antibiotic. An interview with the VPCS on [DATE] at 2:47 PM revealed if a resident had known issues to the point where the doctor ordered an x-ray, then the doctor should be contacted with the results of that x-ray. VPCS stated, How do we know there are no new orders because we haven't reached out to the doctor? (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with NP M on [DATE] at 3:27 PM revealed she recalled that Resident #4 was not critical but she remembered doing a workup on him and was surprised he had passed way. She said he had a slightly elevated white blood cell count on [DATE] prior to his death but he was not on her radar to be declining. NP M stated, As a matter of fact, he walked and went to the dining room every day. NP M remembered ordering a chest x-ray on the day of his death and thought she got the results, but then said she may have been notified after his death. She reviewed her clinical notes and charting system and looked at the x-ray image and findings. NP M then stated she had seen Resident #4 on [DATE] and he died later that night. She said she did not see where his chest x-ray results were told her prior to his death but she was notified when he died . When she had seen Resident #4 that morning on [DATE], she ordered a work up on him. He had an elevated white blood cell count and the nursing staff said he had altered mental status and recent falls. NP M stated Resident #4's labs had been abnormal prior to that visit because he had recently been in the hospital for an ankle wound which caused the elevated white blood cell count. When Resident #4 returned to the facility, his WBC was 15.2 and stayed that way but she did blood cultures and the WBC count started trending down. When NP M saw Resident #4 on [DATE], his WBC was 14 and he had no issues with breathing that she observed. She stated the chest x-ray she ordered was standard procedure to look for something. NP M stated she thought Resident #4 had pneumonia back in February 2024, so if she was looking for something going on, she would typically order a 2-view x-ray, a UA and some lab work. She stated on [DATE], Resident #4 was already on cefdinir, an antibiotic for the ankle wound. When she reviewed the x-ray she ordered during the interview, she stated, I am thinking it came back after he expired. I am reading it now. Looks like he had pulmonary edema. He was not short of breath when I saw him, that would have been a whole different ballgame. That morning he was up, went to dining room, went to breakfast and then he came back to his room and going to the bathroom. NP M continued and stated, You can get flash pulmonary edema and they can literally die right on the floor. It can happen for whatever reason, maybe a little CHF, fine one minute, not the next. NP M said with flash pulmonary edema, usually there would be a report that the resident was foaming at the mouth and that was flash edema. She said there were no reports of that. NP M stated she was working up the change of condition with the two fall and was looking for a possible UTI. She did not feel the WBC was a concern because he admitted with that and his wound, So that in and of it itself is not concerning. NP M stated that had she received the x-ray results prior to his death the night of [DATE], she probably would have sent him out to the hospital but could not say for sure. She said his vitals were stable, he did not appear to have any acute issues and if he was normal, t [TRUNCATED]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain personal hygiene for one (Resident #1) of four residents reviewed for ADLs. The facility failed to provide shower/bath ADL care according to resident preference for May 2024 and June 2024. This failure had the potential to affect residents who were dependent on staff for bathing by placing them at risk for poor personal hygiene, odors, embarrassment, low self-worth and a decline in their quality of life. Findings included: Record review of Resident #1's Face Sheet (not dated) reflected she was an [AGE] year old female who admitted to the facility on [DATE] with active diagnosis that included Parkinson's Disease, dementia, major depressive disorder, generalized anxiety disorder, seizures, glaucoma, peripheral vascular disease, cerebral vascular accident/stroke and hypertension. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had a BMS score of 10, which indicated moderate cognitive impairment. Resident #1 did not have any mood issues, delirium, behavioral symptoms, or rejection of care issues. She had functional limitation in her range of motion on both lower extremities and used a wheelchair for mobility, was always incontinent of urine and frequently incontinent of bowel. Resident #1 required partial/moderate assistance in bathing (where the staff lifts, holds, or supports trunk or limbs, but provides less than half the effort) as well as with all areas of mobility (shower/tub transfers, bed transfers, rolling in bed, and sitting and lying in bed). Review of Resident #1's care plan initiated on 03/24/20 and last revised on 06/04/24 revealed a focus area under the category ADL Care which reflected she needed bathing/hygiene assistance of one staff. An interview with Resident #1 on 06/12/24 at 10:45 AM revealed she did not get a shower or bed bath the day prior (Tuesday 06/11/24) and her scheduled days were Tuesdays, Thursdays and Saturdays. Resident #1 stated she did not know why her CNA did not provide her with one and no one ever came to tell her why she did not get one. Resident #1 stated, I just figured they were busy and forgot about me. I would like one. They make me feel relaxed and fresh. I don't like not getting one. Resident #1 could not recall the exact date she last received a shower, but knew she had not received on the day prior as scheduled. Review of the shower schedule (undated) posted at the nurses' station reflected Resident #1 was to receive a shower on Tuesdays, Thursdays and Saturdays on the 2pm-10pm shift. In reviewing the shower sheets provided in the shower book, there were no showers for Resident #1 for all of May 2024 through June 12th, 2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's online charting system/Point of Care completed by the staff when ADLs were performed reflected from 06/01/24 through 06/12/24 Resident #1 was bathed on 06/01/24 at 8:45 PM, 06/04/24 at 4:13 PM by (CNA F), 06/06/24 at 5:25 PM by CNA F, 06/08/24 at 7:43 PM by CNA F, and on 06/11/24 at 7:50 PM by CNA F. An interview with LVN A on 06/11/24 at 2:27 PM reflected the charge nurse assigned to a resident ensured that resident received showers according to the facility schedule by checking the shower sheets. LVN A stated no resident was refusing showers that were assigned to her (including Resident #1). LVN A stated the potential result of a resident not being bathed could result in, Odor, odor odor. An interview with LVN B on 06/11/24 at 2:49 PM revealed all the residents have their own shower days and times, A beds are done in the mornings and B beds are done in the afternoon/evenings. LVN B stated a result of not being bathed consistently could result in a resident having a strong odor and looking unkempt. An interview with LVN L on 06/11/24 at 3:21 PM revealed there was a shower book that had residents' scheduled on it, so the charge nurses could look at it to see what residents needed to be showered on what days and then know which CNA was scheduled that day to complete it. LVN L stated most of the time she saw the CNAs take their residents for their showers. If the resident refuses, the charge nurse was supposed to be notified by the CNA and then the family could be notified to step in to encourage if needed. LVN L stated the residents on her hall (not Resident #1) loved to get showered except the ones that may be too cold, then the CNAs would try the following day. An interview with CNA D on 06/12/24 at 12:30 PM revealed she worked on Resident #1's hall but was responsible on her shift to complete the showers for residents in the A beds (which would be the roommate of Resident #1) She stated the shower schedule was Odd numbered rooms with A beds were done on Monday, Wednesdays and Fridays on the 6am-2pm shift, which what she did, and the evening shift did the B beds. Then on Tuesdays, Thursdays and Saturdays the even numbered rooms were done the same way. CNA D stated that both the A and B beds for the same room were done on the same day, just on different shifts. She stated the facility just started doing shower sheets about two months ago and they were also supposed to include documentation on how the resident's skin looked during the shower/bath. Then they were turned into the charge nurse and the charge nurse was supposed to sign them and then they are stored in the shower book at the nurses' station. An interview with ADON E on 06/12/24 at 1:53 PM revealed she was one week new to the facility and did not know all the residents yet. However, when it came to showers, ADON E stated in general, the charge nurses were supposed to review and sign the residents' shower sheets when they were completed, so the charge nurse would know if someone's did not get done on their shift. Any refusals should be told to the charge nurse and the family should be notified as well. ADON E stated if a resident did not want a shower, then they should be offered a bed bath. An interview with CNA F on 06/12/24 at 2:25 PM reflected he worked with Resident #1 on the 2nd shift (2pm-10pm). He stated he worked on 06/11/24 and gave Resident #1 a shower and she did not refuse very often. He stated that she will take either a bed bath or a shower and the last time he gave her one (which he stated was the day prior), he did not complete a shower sheet but said he documented it in POC online. He said he knew he was supposed to complete a shower sheet but did not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the DON on 06/12/24 at 3:29 PM revealed the CNAs knew they were supposed to complete the shower sheets for a resident when they are given as well as document it in POC. Review of the facility's policy titled, Bathing and Hair Care (not dated), reflected, The facility strives to ensure that a Resident/Patient entering the facility will maintain the same personal hygiene habits that they held while in the community; .Other considerations- sponge bathing if resident refuses a shower/bath .If a resident refuses to be bathed/showered after being approached three times, CNA will notify the charge nurse of the residents refusal.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on interview and record, the facility failed to provide treatment and care in accordance with professional standards of practice, the comprehensive resident-centered care plan for two (Residents #3 and #4) of five residents reviewed for quality of care. 1. The facility failed to ensure Resident #3 was accurately assessed, monitored, and treated for a change of condition he had with a blood sugar of 40 at 8:15 AM during the morning shift on [DATE]. There was no documented evidence the facility monitored the residents' change of condition after that shift. Resident #3 died later that night on the overnight shift around 2:05 AM with a cause of death as unknown. 2. The facility failed to ensure Resident #4 was accurately assessed, monitored and treated for a change in condition on [DATE]. The facility had no documented evidence they monitored the resident after the initial change was observed. The NP was notified and ordered a chest x-ray. The x-ray results indicated there were abnormal findings which included widespread bilateral nodular lung opacities and small right pleural effusion opacities which was consistent with severe pulmonary edema or pneumonia. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 1:25 PM. The IJ template was provided to the facility's VPCO on [DATE] at 1:30 PM. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm and at a scope of pattern due to the facility's need to implement and monitor the effectiveness of its corrective systems. This failure could place residents at risk for not receiving timely medical intervention as needed and ordered by the physician, of not having their health condition monitored timely for changes in condition, which could result in a delay in medical intervention and decline in health or possible worsening of symptoms, including death. Findings included: 1) Record review of Resident #3's Face Sheet (not dated) reflected he was a [AGE] year old male admitted to the facility on [DATE] with active diagnosis of Diabetes Type 2 without complications. Record review of Resident #3's quarterly MDS assessment dated [DATE] reflected he had no hearing, speech or vision issues and a BIMS score of 08, which indicated moderate cognitive impairment. Resident #3 has no mood issues, no behaviors, psychosis, rejection of care or wandering. Resident #3 had limited function range of motion in both of his lower extremities, used a wheelchair for mobility and required substantial/maximum assistance from staff for all ADLs. He had an ostomy and indwelling catheter and was always incontinent of bowel and bladder. Resident #3 had identified shortness of breath when laying flat (dyspnea), was five feet two and weight 162 pounds. Resident #3 has one unhealed and unstageable pressure ulcer and one arterial/venous stasis ulcer. He received high-risk drug medication that included an anticoagulant, a diuretic and hypoglycemic medication. Further review revealed Resident #3 did not receive hospice services. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #3's care plan dated [DATE] reflected, Focus Area: Diabetes Mellitus-I will be free from any s/sx of hypoglycemia through the review date; Interventions: Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Record review of Resident #3's [DATE] physician orders reflected he was prescribed Metformin HCl Oral Tablet 500 MG two tablets by mouth two times a day for diabetes (start date [DATE]). Resident #3 also had the following orders, 1. If blood sugar below 70 and resident unable to swallow immediately administer oral glucose paste to buccal mucosa, glucagon as ordered, and re-check BS in 15 minutes and may repeat protocol if indicated remaining with the resident, keep resident comfortable and safe and monitor VS. Hold all diabetic medications and if no improvement notify MD; 2. If blood sugar is less than 70 and patient is ABLE to swallow immediately give 4 oz juice or ,d+[DATE] oz soda recheck BS in 15 minutes and repeat juice if needed. If resident is UNABLE to swallow immediately administer oral glucose paste to buccal mucosa, glucagon as directed and re-check BS in 15 minutes remaining with the resident, keep comfortable and safe, monitor VS, hold all diabetic medications and notify MD as needed; 3. If BS less than 70 and patient is unresponsive immediately administer oral glucose paste, glucagon as directed. Remain with resident, monitor VS, keep safe and hold all diabetic (medication). Further review revealed Resident #3 did not have a physician's order to check his blood sugar routinely or PRN. Record review of Resident #3's clinical chart reflected the following blood sugar readings were documented in his e-chart: [DATE] (40), [DATE] (100), [DATE] (139) (Note: Hypoglycemia occurs when the sugar level in the blood is below 60 mg; extremely low blood sugar can trigger seizures, loss of consciousness, impaired cognitive function and increased risk of falls). Record review of Resident #3's [DATE] MAR reflected he was administered the Metformin as ordered for diabetes. Record review of Resident #3's prealbumin, CMP and CBC dated [DATE] reflected abnormal values: for *pre-albumin of 11 which was considered low (reference range was ,d+[DATE]); *creatinine low at 0.5 (reference range was ,d+[DATE].3); *glucose was high at 144 (reference range was ,d+[DATE]); *white blood cell count was high at 10.6 (reference range was 3XXX,d+[DATE].20, *red blood cell count was low at 2.81 (reference range was 4XXX,d+[DATE].63) and *platelet count was high at 469 (reference range was ,d+[DATE]). Further review revealed PA I was notified by the charge nurse and no new orders were given related to the labs. Record review of Resident #3's nursing progress notes reflected: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-[DATE]- Resident was readmitted back into the facility at 7pm from [hospital] on a stretcher with eyes open respiration even heart sound normal- Dx Sepsis, Diabetes , HTN, Asthma ,and decompressive laminectomies. Resident is alert and oriented x 1 able to make needs known wound noted on the coccyx and the left tibia, swollen to both hand and staples to the neck and back was removed, trach was intact, catheter was draining at gravity , resident was resting calmly in his room with no difficulty MD notified and the DON [e-signed by LVN B]. -[DATE]-eINTERACT SBAR Summary for Providers Situation: The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition-At the time of evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure: BP ,d+[DATE] Position: Lying r/arm; Pulse: 68, Respirations 18.0, Temp 97.6, Weight 165.1 lb, Pulse Oximetry: O2 96%, Blood Glucose 40.0-[DATE] 08:15; . Resident/Patient had the following medications changes in the past week: no; .Resident/Patient is on: Hypoglycemic medication(s)/Insulin; Outcomes of Physical Assessment : Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Other, Functional Status Evaluation: General Weakness, Behavioral Status Evaluation: [blank] Respiratory Status Evaluation: [blank], Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50, Abdominal/GI Status Evaluation: [blank], GU/Urine Status Evaluation: [blank], Skin Status Evaluation: [blank], Pain Status Evaluation: Does the resident/patient have pain? [blank]; Neurological Status Evaluation: [blank]; Nursing observations, evaluation, and recommendations are: Pt b/s is up to 81; Primary Care Provider Feedback : Primary Care Provider responded with the following feedback: A. Recommendations: continue to monitor pt.; B. New Testing Orders: Other-- glucagon Injection; C. New Intervention Orders: Other- glucagon injection [e-signed by DON and LVN K]. -[DATE] (2:05 AM): Nurse making round at this time, noticed resident not responsive, assessed by nurse, resident did not respond to touch /verbal command. This nurse call code blue, CPR initiated while other nurse call 911. [e-signed by LVN L]. -[DATE]: 911 crew arrived and took over from nurse [e-signed by LVN L]. -[DATE]: 911 crew left the facility after all efforts made by them to resuscitate resident failed [e-signed by LVN L]. -[DATE]: Upon assessment resident noted without active signs of life. skin cool and dry no respirations no rise and fall of the chest, no carotid or apical pulse no blood pressure pupils non-reactive to light. death pronounced at 4:12 A.M/ [e-signed by the DON]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN A on [DATE] at 2:27 PM revealed when a resident's blood sugar was low when checked, the charge nurse was supposed to check the physician's standing orders for blood sugar, if it got to a certain level, then orange juice was given if the resident was able to swallow and there was also glucagon. LVN A stated when the blood sugar was checked and below a certain level, there were protocols to follow and the doctor had to be notified. LVN A stated a dangerously low blood sugar was anything below 70. She stated blood sugar checks were documented on the MAR, as well as in a nursing progress notes if it had to be re-checked. LVN A stated a change of condition was anything that was not ordinary for the resident, such as a change in consciousness, labs, blood pressure and blood sugar changes. When a change of condition occurred, LVN A stated a change of condition form, nursing note and SBAR had to be completed. LVN A stated that she had been the nurse for Resident #3 in the past and thought he had recently come back from a hospital visit and all she remembered was he had a trach and was always pleasant. She stated she was not working with him on the day his blood sugar was 40. An interview with LVN B on [DATE] at 2:49 PM revealed Resident #3 was on her hall and he had a recent surgery on his back the week prior. He had gone to the hospital to for a planned appointment to remove staples from his neck and was there for three to four days when the hospital had originally stated it would only take one day. When he readmitted to the facility, LVN B stated he was not the same as he was prior but did not give specifics. She stated she was working the ,d+[DATE]pm shift the day of his death and he had been in the dining room for dinner eating. She brought him back to his room after dinner and rounded on him again before her shift was over and everything was okay. The next morning, she found out he had died after her shift. LVN B stated, There was nothing acute happening with him on my shift. He did not have a low blood sugar on my shift. If he had a low blood sugar, he was in the dining room, I fed him .even if it went low, he would have been given Glucagon after my shift was over. We checked his blood sugars. He can talk, he can tell us what he wants. There was nothing out of the ordinary for me. He ate, I didn't have any reason to worry. LVN B stated if a resident's blood sugar was 40, she would have called the doctor but already be in the process of sending the resident out to the hospital even before the doctor said so, because 40 is too low on my watch, that is an automatic send out for me unless the doctor says to keep and give medications. But 40 is too low for glucagon to help enough. LVN B stated symptoms of low blood sugar could be nausea and vomiting, aggression, sweating and sleeplessness. LVN B stated the protocol for a low blood sugar reading was for the nurse to initial the MAR to ensure that the blood sugar was checked and was okay. If the blood sugar was not okay and low, then the nurse would administer Glucagon, document in nursing notes and do and E-Interact form. LVN B stated there was not a place on the MAR to indicate emergency glucose was given, only in the nursing notes. If the nurse administered glucagon, the nurse was supposed to re-check it in 15 minutes to see where blood sugar level was and document it in a nursing progress note because it was an issue and also document in the 24 hour report. The doctor would also be contact and if the blood sugar value did not elevate with intervention, notify doctor again to get further orders. LVN B stated she did not remember being told on that date of the low blood sugar of 40 ([DATE]) that there had been a change of condition. She said if an agency nurse was working that morning, she would not have rounded with them because they are always wanting to leave, so I don't remember anything about a low blood sugar. LVN B stated when a resident's blood sugar was low, the charge nurse was supposed to consult with the doctor, then give Glucagon or an orange juice supplement that can push the blood sugars back up, then re-assess the resident. LVN B stated a dangerously low blood sugar was anything below 70. She said blood sugars were documented on the MAR. LVN B stated a change of condition was if a resident's vitals were below their norm or they were restless or in pain. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN L on [DATE] at 3:21 PM LVN L stated she was the charge nurse for Resident #3 on the night he died . She had picked up the overnight shift and came in around 11:00 PM on [DATE]. She stated nothing had been reported to her by the afternoon/evening nurse [LVN B]. She said during her first rounds, Resident #3 was asleep in his room but woke up and said hello when LVN L came into the room. Then on her second round about two in the morning, LVN L stated she went into his room and discovered he was not breathing. She said most of the time when she rounded, she went into the residents' rooms and turned the light on and pat them and say hello, just checking. When she did that with Resident #3, she said papacita, when nothing, he did not respond and he had no pulse. LVN L stated they started CPR and someone called 911. EMTs arrived and worked on him for a long time but could not bring him back. LVN L stated there were protocols for hypoglycemia on every resident and if the resident could still talk and was alert, the first protocol was to give oral glucose and if the blood sugar did not come up, Glucagon was available. If the resident was still unresponsive, the nurses could then use glucose gel. She stated it was whatever the facility protocol said on the MAR and it had to be followed step by step. LVN L stated a dangerously low blood sugar was anything less than 70. Once Glucagon was given, LVN L stated the nurse would go back and check the blood sugar in 15 minutes, document the findings in a nursing note all that had been done, call 911 if the blood sugar does not rise and notify the doctor. LVN L stated a change of condition was anything different from the residents' norm. An interview with the DON on [DATE] at 4:40 PM revealed she was working at the facility the morning of [DATE], Resident #3's low blood sugar reading of 40. She stated a CNA came to tell her one of the nurses wanted her help. When the DON got to Resident #3's room, the nurse was at the door and said his blood sugar reading was 40. The DON assessed Resident #3 and his breathing and vitals at that time were normal, But he was doing what they do when their blood sugar is low, like they try to respond but can't, but want to. I told him [Resident #3] he was fine and his blood sugar was low. The DON stated Resident #3 was given Glucagon, and she told the nurse [LVN K] to check it again in ,d+[DATE] minutes. When LVN K checked it again, she gave a glucagon injectable, did not know remember what the blood sugar value was. The DON stated, When someone's blood sugar is in the 40s, they can't swallow so I don't like using the gel. The DON stated, So he came back around and it was a normal day after that. The DON stated she felt Resident #3 died because of his disease process. She stated his health was already poor and he had been getting treatment for multiple venous/stasis ulcers and wound care for pressure ulcers. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with CNA D on [DATE] at 12:30 PM revealed she was working the morning on [DATE] when Resident #3's blood sugar was 40. CNA D stated she was passing breakfast trays to the rooms and went into Resident #3's room and he was snoring but would not wake up when she tried to rouse him; she felt something was not right. She knew he was a diabetic so went to tell the nurse who was a PRN nurse (LVN K) who came to his room. LVN K also tried to wake Resident #3 up, but he would not wake up and it was then they knew something was wrong. The charge nurse checked his blood sugar and it was 40. CNA D stated she was present when the reading of 40 was done. She said LVN K did the glucose gun on him twice. After that, he woke up, was thirsty and wanted to get up out of bed. Soon after, a family member was present who sat with him in the dining room while he ate, he was talking and chatting with the family member and staff. CNA D stated Resident #3 told LVN K thank you so much for helping him while he was in the dining room, So he perked back up. CNA D stated LVN K told the family member about the low blood sugar and that he needed to be watched by the following shifts and she would leave a note for the nurses on the shifts. CNA D stated she remembered the morning PRN charge nurse telling the afternoon oncoming charge nurse [LVN B] to check Resident #3's blood sugar because it had been 40. Then the very next day, CNA D stated that Resident #3 was gone and they had already picked up his body by the time she got into work CNA D was worried Resident #3 may have died from a diabetic coma and said, I know from experience you need to monitor at least 48 hours. An attempt to interview MD H on [DATE] at 1:34 was unsuccessful; there was no option to leave a voice mail. An attempt to interview PA I on [DATE] at 1:36 PM was unsuccessful and there was no option to leave a voice mail. An interview with the secondary physician extender listed on Resident #3's Face Sheet [PA J] occurred on [DATE] at 1:43 PM. PA J stated she stopped going to the facility three weeks prior and her role was to work in physiatry and rehab only. However, speaking in general terms, PA J stated from a provider's point of view, the facility should notify the doctor for any low blood sugar, they had standing order to follow which included glucose tablet, then they should re-check the blood sugar and call the doctor back to see what they want to do. An interview with ADON E on [DATE] at 1:53 PM revealed she was week new to the facility so her information was limited. ADON E stated for a low blood sugar of 40, the resident would be at risk of a diabetic coma, so the doctor should be contacted to let them know what the charge nurse's interventions were, the blood sugar reading, the medications administered and then find out what they want the charge nurse to do. ADON E stated that for a blood sugar of 40, her nursing judgement would have sent Resident #3 to the hospital. ADON E stated Resident #3 should have been monitored after his change of condition for three days. She said the charge nurse would monitor and look for confusion, diaphoresis (cold and clammy), paleness of skin, confusion, agitation and anxiety. ADON E stated the nurses did chart by exception, but for an acute condition, they were supposed to chart for three days or as long as the treatment was in place. An interview with CNA F on [DATE] at 2:25 PM revealed he remember Resident #3 and was talking to him around 10:00 PM, a few hours before he died . He said they were talking about sports and two local sports teams and nothing seemed off or out of the ordinary. CNA F stated Resident #3 had been in the hospital recently but he did not know what for, but that night, he was up in his wheelchair and then CNA F laid him down for bed before his shift was over. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with the VPCS on [DATE] at 2:47 PM revealed after Resident #3's low blood sugar reading of 40 and subsequent intervention of Glucagon, the nurses on the oncoming shifts that day should have been monitoring the resident for signs and symptoms of hypoglycemia such a confusion and lethargy. She stated the shift to shift report should be given between nurses and they were supposed to print out the 24 hour report and utilize that as well when they did their walking rounds for continuity of care. If there was a change in the resident's condition, such as a fall, a blood sugar that had to be recovered for example and there was any intervention done, it should be reported to the oncoming nurse. VPCS stated, That is what I expect for out of the norm, a prudent nurse to communicate to the oncoming shift so there is continuity of care. 2) Record review of Resident #4's Face Sheet (not dated) reflected he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses that included Hypertension, Major Depressive Disorder, Atherosclerotic Heart Disease, Angina Pectoris, Dementia, Generalized Anxiety Disorder, Diabetes, Hyperlipidemia, Schizophrenia and Parkinson's Disease. Resident #4's attending physician was listed as [MD O] and the nurse practitioner was listed as [NP M]. Review of Resident #4's quarterly MDS assessment dated [DATE] revealed no hearing, speech or vision issues, a BIMS score of 03 which indicated severe cognitive impairment, no signs of delirium, psychosis or rejection of care. Resident #4 had no range of motion limitations but did need help from staff with all ADLs. Resident #4 did not have any assessed health conditions related to shortness of breath, did not use oxygen therapy and was not on hospice services. Resident #4 was prescribed high-risk medication which included an antipsychotic, antidepressant and an anticoagulant. Review of Resident #4's care plan initiated on [DATE] and last revised on [DATE] did not reflect any care areas related to respiratory issues or need for oxygen or related interventions. Record review of NP M's last documented visit on [DATE] with Resident #4 reflected a chief complaint/nature of presenting problem as, Leukocytosis (a condition where your blood has too many white blood cells, which fight infections and diseases), AMS, Abnormal labs, falls x 2. Resident #4 had a non-healing ankle wound that was being treated and a recent white blood cell count of 14 and continued leukocytosis. He was on an antibiotic and seen and examined in his room. He reported malaise and workup so far negative. The Nursing staff report decreased appetite. NP M reviewed Resident #1's recent labs from [DATE] and documented, CBC 16.1, 8.5, 25.5, 561; BMP 131, 4.4, 101, 22, 25, 1.1, 68. NP M documented her plan as, Plan 1. Leukocytosis: Workup so far negative. Currently on cefdinir until [DATE]; 2. Obtain blood cultures x 2 both negative, no growth after 5 days; 3. Obtain echocardiogram; 4. Consult hemo/Onco for further workup: new onset leukocytosis, thrombocytosis, anemia, weakness, negative infection workup; 5. Health shake 3 times daily with each meal; 6. Continue weekly lab work as ordered previously; 7. Continue all medication as ordered in PCC. Record review of Resident #4's physician order [initiated by NP M] dated [DATE] reflected, 2-view Chest X-ray to rule out infiltrates (abnormality in the lung). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #4's x-ray-Chest 1-view dated [DATE] reflected it was reviewed by the radiology clinic at 6:01 PM and reported at 6:01 PM. The chest x-ray was noted on the findings to be compared to his last x-ray a year earlier on [DATE]. The findings indicated Resident #4 had widespread bilateral nodular lung opacities (haziness around the lung with nodule growth) and a small right pleural effusion (fluid around the lungs). The impression reflected, There are widespread bilateral nodular lung opacities. This is consistent with severe pulmonary edema or pneumonia. Consider CT correlation to exclude neoplasm. The findings are worse compared with prior. Record review of nursing progress notes from [DATE] for Resident #4 reflected no indication the physician or physician extender [NP M] and RP was notified of Resident #4's chest x-ray results. Record review of the following pertinent nursing notes for Resident #4 reflected: -[DATE] 12:52 PM- Type: eINTERACT SBAR Summary for Providers-Situation : The Change In Condition/s reported on this CIC Evaluation are/were: Other change in condition. At the time of evaluation resident/patient vital signs, weight and blood sugar were: BP ,d+[DATE], Pulse:70; R 18; Temp: 97.9; Weight: 202.2 lb; O2 96 %; Blood Glucose: 123.0 . Outcome of Physical Assessment : Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Other; Functional Status Evaluation: General weakness . Primary Care Provider responded with the following feedback: A. Recommendations: obtain Urine for UA with C&S; New Testing Orders: [blank]; C. New Intervention Orders: [blank] [e-signed by LVN A]. - [DATE]- Nurse's Note- PA in facility to visit with her residents today. Information given to PA regarding noted increased weakness and sleepiness. The resident is afebrile and without noted signs and symptoms of respiratory distress. New orders received to obtain urine for UA with C&S to rule out UTI and a 2-view chest x-ray to rule out infiltrates [e-signed by LVN A]. -[DATE]- Upon shift change at [10:05 PM], CNA called this nurse into resident's room. On getting to room, resident found in his wheelchair unresponsive in the bathroom. Resident assessed, put in bed and CPR initiated immediately while the other nurse, [staff] called 911. 911 crew arrived at [10:25 PM] and took over from the nurses. All efforts made by 911 crew to resuscitate the resident failed. The 911 crew left at [11:00 PM]. DON, resident family and MD notified of the change of condition. At [11:30 PM] Police arrived and took report from the nurses. At [midnight] resident pronounced by DON [e-signed by LVN P]. -[DATE]-Resident laying in bed. intubated with IV to right AC. skin cold and clammy. No signs of life present. No respirations, no rise and fall of chest. no carotid or Apical Pulse. Pupils set non-reactive to light. Death pronounced at 12:00 A.M. [e-signed by DON]. An interview with LVN A on [DATE] at 2:27 PM revealed when a charge nurse starts their shift, they should look in the lab book and the radiology book to see who has pending results and then continue to check throughout the shift to see if they have come in. If the charge nurse does not see the results, then they should call and follow up with a phone call. If the findings come back negative, the physician should still be notified to see if there are any new orders. With Resident #4, LVN A could not remember if NP M was notified of his chest x-ray findings. She said the results for Resident #4's x-ray would have come in after her shift was over at 2:00 PM that day. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with LVN C on [DATE] at 3:21 PM revealed the results of any x-rays were supposed to be logged under the resident's name in PCC with the results. LVN C stated she was at the facility the night Resident #4 died , but was not assigned to his hall. LVN C stated her shift was over and she heard his nurse calling for help so she went to see what happened and ended up helping the nurse do CPR. LVN C stated when she saw Resident #4, staff had already started CPR and she thought he was already expired by then. An interview with the DON on [DATE] at 4:40 PM revealed she did not remember Resident #4, but if a lab or x-ray came back with abnormal findings or normal findings, the charge nurse should still contact the doctor to let them know the results because the doctor may order antibiotics or prn oxygen. The DON said, But if the resident was already on antibiotics and no respiratory issue, the doctor probably would have just continued with current orders with antibiotics. The DON stated she was not sure what was going on with Resident #4 and she was new to the facility in [DATE]. The DON stated, But if he was already having respiratory issues, the doctor may not have done more intervention, but they should have been notified. An interview with ADON E [DATE] at 1:53 PM revealed she was one week new to the facility so she was not familiar with Resident #4. However, for x-ray results, ADON E stated the doctor should be called with the results regardless if the resident had a pre-existing condition or was already on medications for an infection. She reviewed the x-ray which reflected Resident #4 had lung opacities that were white spots which could mean usually pneumonia. She said it also reflected pulmonary edema which was water in lungs and pleural effusion was water around the lung. ADON E stated, These things are ordered because there was a concern, you would notify them because they doctor might want to change the antibiotic. An interview with the VPCS on [DATE] at 2:47 PM revealed if a resident had known issues to the point where the doctor ordered an x-ray, then the doctor should be contacted with the results of that x-ray. VPCS stated, How do we know there are no new orders because we haven't reached out to the doctor? (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with NP M on [DATE] at 3:27 PM revealed she recalled that Resident #4 was not critical but she remembered doing a workup on him and was surprised he had passed way. She said he had a slightly elevated white blood cell count on [DATE] prior to his death but he was not on her radar to be declining. NP M stated, As a matter of fact, he walked and went to the dining room every day. NP M remembered ordering a chest x-ray on the day of his death and thought she got the results, but then said she may have been notified after his death. She reviewed her clinical notes and charting system and looked at the x-ray image and findings. NP M then stated she had seen Resident #4 on [DATE] and he died later that night. She said she did not see where his chest x-ray results were told her prior to his death but she was notified when he died . When she had seen Resident #4 that morning on [DATE], she ordered a work up on him. He had an elevated white blood cell count and the nursing staff said he had altered mental status and recent falls. NP M stated Resident #4's labs had been abnormal prior to that visit because he had recently been in the hospital for an ankle wound which caused the elevated white blood cell count. When Resident #4 returned to the facility, his WBC was 15.2 and stayed that way but she did blood cultures and the WBC count started trending down. When NP M saw Resident #4 on [DATE], his WBC was 14 and he had no issues with breathing that she observed. She stated the chest x-ray she ordered was standard procedure to look for something. NP M stated she thought Resident #4 had pneumonia back in February 2024, so if she was looking for something going on, she would typically order a 2-view x-ray, a UA and some lab work. She stated on [DATE], Resident #4 was already on cefdinir, an antibiotic for the ankle wound. When she reviewed the x-ray she ordered during the interview, she stated, I am thinking it came back after he expired. I am reading it now. Looks like he had pulmonary edema. He was not short of breath when I saw him, that would have been a whole different ballgame. That morning he was up, went to dining room, went to breakfast and then he came back to his room and going to the bathroom. NP M continued and stated, You can get flash pulmonary edema and they can literally die right on the floor. It can happen for whatever reason, maybe a little CHF, fine one minute, not the next. NP M said with flash pulmonary edema, usually there would be a report that the resident was foaming at the mouth and that was flash edema. She said there were no reports of that. NP M stated she was working up the change of condition with the two fall and was looking for a possible UTI. She did not feel the WBC was a concern because he admitted with that and his wound, So that in and of it itself is not concerning. NP M stated that had she received the x-ray results prior to his death the night of [DATE], she probably would have sent him out to the hospital but could not say for sure. She said his vitals w [TRUNCATED]

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33552 Based on observation, interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #2) of six residents reviewed for pharmacy services. MA G failed to follow current physician orders and provide Resident #2 with her medications during the morning shift on 05/08/24, 05/09/24, 05/10/24, 05/13/24, 05/14/24, 05/15/24, 05/16/24, 05/17/24, 05/20/24, 05/21/24, 05/22/24, 05/28/24, 05/29/24, 05/30/24 and 05/31/24. Additionally, no blood pressure reading were recorded for those morning shifts to assess if Resident #2 required her blood pressure medication. MA G also failed to provide Resident #2 with her medications during the morning shift on 06/03/24, 06/04, 24, 06/05/24, 06/06/24, 06/10/24, 06/11/24 and 06/12/24. Additionally, no blood pressure readings were recorded during those morning shifts to assess if Resident #2 required her blood pressure medication. There were no other refusals of medications by the other medication aides or nurses On the dates when MA G completed the med pass, the MARS documented Resident #1 refused with no nursing follow up or intervention, no notification to the physician or the RP. The failure could place residents at risk for exacerbation of health conditions, worsening of conditions, and physical/emotional discomfort. Findings included: Record review of Resident #2's Face Sheet (not dated) reflected she was an [AGE] year old female who admitted to the facility on [DATE] with diagnoses that included heart failure, dementia, major depressive disorder, peripheral vascular disease, hypertension, chronic obstructive pulmonary disease, cognitive communication deficit, diabetes, Alzheimer's disease, osteoporosis and acute myocardial infarction. Record review of Resident #2's quarterly MDS assessment dated [DATE] reflected her BIMS score was 13, which indicated mild cognitive impairment. Resident #2 had no signs or symptoms of delirium, no negative mood issues, and no behavioral symptoms. Resident was five feet tall and weighed 93 pounds and had two arterial/venous stasis ulcers present at the time of the assessment. Resident #2 received four high-risk medications which included an antidepressant, diuretic, opioid and insulin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's care plan initiated on 12/21/17 and last revised on 06/04/24 reflected the following focus area, Resistive to care r/t-Removes dressing to lower legs and not elevating her legs; Refuses baths, medication, incontinent care and dressing changes to her leg; Attempts to get up without assist, rather than using call light and asking for help; Doesn't want the legs on her wheelchair when in it. Interventions included, Educate resident/family/ caregivers of the possible outcome(s) of not complying with treatment or care; Encourage as much participation/interaction by the resident as possible during care activities; Give clear explanation of all care activities prior to an as they occur during each contact; Instructed/reminded to use call light for assistance-not to attempt to get up or use restroom without assistance and Provide consistency in care to promote comfort with ADLs; Maintain consistency in timing of ADLs, caregivers and routine, as much as possible. Record review of Resident #2's June 2024 physician orders reflected she was prescribed the following routine medication: -Desipramine HCl Tablet 10mg twice a day for nerve pain (start date 03/08/2023); -Fosamax Tablet 70mg one tablet by mouth in the morning every Monday for osteoporosis (start date 12/07/2020); -GlycoLax Powder 17 grams by mouth once a day every Monday, Wednesday, Friday for constipation-Mix in 6 ounces of liquid (start date 07/01/20); -Hydralazine HCl tablet 25mg three times a day for HTN-HOLD FOR SBP < 110 OR DBP < 60 (Start date 09/30/2021); -Hydralazine HCl 50mg three times a day for HTN-HOLD FOR SBP < 110 OR DBP < 60 (Start date 12/30/2021); -Lasix Tablet 40mg once a day for Edema (start date 01/29/22); -Metformin HCl 500mg once a day for Diabetes (Start date 01/04/23); -Mirtazapine 7.5mg one at bedtime for Cachexia (Start date 07/07/23); -Prednisone 5mg Give once a day for steroid (Start date 02/24/18); -Rosuvastatin Calcium 10 MG once a day for lipid control (12/21/17). Record review of Resident #2's May 2024 MAR reflected she refused medication from MA G on the morning shift on 05/08/24, 05/09/24, 05/10/24, 05/13/24, 05/14/24, 05/15/24, 05/16/24, 05/17/24, 05/20/24, 05/21/24, 05/22/24, 05/28/24, 05/29/24, 05/30/24 and 05/31/24. Additionally, no blood pressure reading were recorded for those morning shifts to assess if Resident #2 required her blood pressure medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #2's June 2024 MAR reflected she refused morning medications from MA G on the morning shift on 06/03/24, 06/04, 24, 06/05/24, 06/06/24, 06/10/24, 06/11/24 and 06/12/24. Additionally, no blood pressure readings were recorded during those morning shifts to assess if Resident #2 required her blood pressure medication. There were no other refusals of medications by the other medication aides or nurses. Record review of Resident #2's nursing progress notes (including e-MAR administration order notes) dated 06/12/24 reflected, Effective Date: 06/12/2024-Orders Administration Note: Resident will not take medication!!!!!!!!!! (documented by MA G). Previous Orders Administration Notes for the following dates, MA G also reflected, Resident refused medication, however there was no documentation the charge nurse was notified-06/11/24, 06/10/24, 06/06/24, 06/05/24, 06/04/24, 06/03/24, 05/31/24, 05/30/24, 05/29/24, 05/28/2024, 05/27/2024, 05/22/2024, 05/21/2024, 05/20/2024, 05/19/24, 05/16/24, 05/15/24, 05/13/24, 05/10/24, 05/09/24 and 05/08/24. An interview with LVN A on 06/11/24 at 2:27 PM revealed if a resident refused medications, the nurse should be notified and then the doctor would be contacted as well as a family member/RP, then everyone would get together to see what could be done. An follow up interview with LVN A on 06/12/24 at 12:05 PM revealed she was the charge nurse for Resident #2 and had not been told that the resident had ever refused medications from MA G. LVN A stated if Resident #2 had been refusing medications from MA G, she should have been notified by MA G because, First, I'd try to get the resident to take it myself, then get with the physician. She has not had any refusals I am aware of. LVN A then reviewed Resident #2's clinical e-chart under progress notes for medication administration and saw all the documented refusals from MA G. LVN A stated she had no clue that was occurring and was going to speak with the DON about it. Observation of Resident #2 on 06/12/24 at 12:10 PM in a gerichair asleep in the tv room. She was not able to interviewed due to being asleep. An interview with MA G on 06/12/24 at 12:19 PM revealed Resident #2 had been refusing her medications for a while, more than a month. MA G stated the charge nurse (LVN A) had been off the floor for a while helping the DON so she probably did not remember that Resident #2 had been refusing, but I notified several nurses. MA G stated the facility had agency nurses working in the facility a month ago and she would try to let them know and those nurses would try to get Resident #2 to take her medications with no success either. MA G stated if a resident refused to take their medications, the facility wanted the medication aide to try three times, then let the nurse know who tries to administer it as well. If the resident still refused, then the nurse notified the doctor and family. MA G stated Resident #2 never gave her a reason for refusing the medications, she said stated, I don't want it. MA G stated if a resident did not receive their prescribed medications, their health and mental condition could decline and their vitals could become unstable. An interview with ADON E on 06/12/24 at 1:53 PM revealed she was one week new to employment at the facility. She stated that the facility did a stand-up meeting with management every morning and if residents were refusing medications, that was the opportunity for the nursing management to be told about it. She said the medication aides were supposed to let the charge nurses know when a resident refused medication. If a nurse could not get the resident to take it, then the ADON could try and then the DON. If a resident chronically refused medications, the family member/RP should be notified, the charge nurse and the doctor. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675820	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Lennwood Nursing and Rehabilitation	8017 W Virginia Dr Dallas, TX 75237

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the VPCS on 06/12/24 at 2:47 PM revealed if a resident was refusing medications, the charge nurse was supposed to be notified. If the nurse was administering and the resident refused, the DON was supposed to be notified. VPCS stated, I would notify the doctor immediately, especially depending on certain medications, like high risk meds, I would offer three times, make nurse aware and as nurse, if I go and have a conversation with resident, and she still refuses, my next call is to physician and family member.