STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675924	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodway Rehabilitation and Healthcare Center	7801 Woodway Dr Waco, TX 76712

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on interview and record review, the facility failed to implement a comprehensive care plan to meet the medical and nursing needs and the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being of 1 (Resident #1) of 5 residents reviewed for care plans. The facility failed to complete an accurate comprehensive care plan for Resident #1, by not care planning her Hospice services received on 1/20/25. This failure could place residents at risk of not having their care and treatment needs met to ensure necessary care and services were provided for specific to Hospice specialized services. Findings included: Record review of Resident #1's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis of Alzheimer Disease (A brain disorder that slowly destroys a person's memory), Dementia (the loss of cognitive function, remembering, thinking, and reasoning), Hypertension (elevated blood pressure), Bradycardia (a slow heart rate). Record review of Resident #1's Significant change in status MDS dated [DATE] reflected she Had a BIMS score of 00 indicating she had severe cognitive impaired. Resident #1 required Substantial/maximal assistance indicating the helper does more than half the effort or the helper lifts or holds trunk or limbs and provides more than half the effort for ADL care showering, upper and lower body dressing, and toileting hygiene. The MDS reflected Resident #1 was receiving hospice services. Record review of Resident #1's care plan dated 02/06/2025 reflected there was no care plan in place for her hospice services provided. Record review of Resident #1s' Physician orders for March 2025 reflected an order to admit to Hospice services on 01/20/2025. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/12/25 at 12:05 the MDS Coordinator RN stated upon a significant change MDS she was required to update the comprehensive care plan. She stated Resident #1 should have had a care plan updating the resident's services to include hospice care. She stated she just missed it. The MDS Coordinator stated it was important to update the plan of care as changes occur in residents' status to ensure the staff were aware of changes in care needs provided by staff. She stated the charge nurses the unit mangers were responsible for updating the care plan with acute changes. The MDS Coordinator stated the negative effects for not updating a care plan would be the resident would not receive proper care or care that was ordered. In an interview on 3/12/25 at 12:15PM the Unit Manager for Resident #1 stated The MDS coordinator should have initiated the hospice care plan. She stated she would update the care plan with acute changes in status. She stated updates were necessary for communication with staff resident's care needs. By not updating the care plan it could cause miscommunications and changes in condition that would not be noted or documented. Record review of facility policy titled Care Plan Revision Upon Status Change dated 04/2024 and revised on 01/2025 reflected: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. The care plan will be updated with the new or modified interventions. Staff involved in the care of the resident will report resident response to new or modified interventions. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs.

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observation, interview and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices reviewed for 1 (Resident #1) of 5 residents reviewed for quality of care. The facility nurses failed to hold Resident #1s health shakes and administered them through a 60ML syringe by mouth while she was not responsive on 3/10/25 at 10:20pm and 3/11/25 at 12:10pm. These failures resulted in an identification of an Immediate Jeopardy (IJ) On 3/12/2025 at 4:35 p.m. While the IJ was removed on 3/14/25, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures placed residents who have had a decline or change in condition at risk for aspiration, choking, and death. Findings included: Record review of Resident #1's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis of Alzheimer Disease (A brain disorder that slowly destroys a person's memory), Dementia (the loss of cognitive function, remembering, thinking, and reasoning), Hypertension (elevated blood pressure), Bradycardia (a slow heart rate). Record review of Resident #1's Significant change in status MDS dated [DATE] reflected she Had a BIMS score of 00 indicating she had severe cognitive impaired. Resident #1 required substantial/maximal assistance indicating the helper does more than half the effort or the helper lifts or holds trunk or limbs and provides more than half the effort for ADL care showering, upper and lower body dressing, and toileting hygiene. The MDS reflected Resident #1 required set up or clean up assistance with eating and was receiving hospice services. Record review of Resident #1's care plan dated 02/06/2025 reflected a significant/Un-expected weight loss due to decline in overall health and decline in oral intake. Goal: Will receive adequate nutrition and fluid intake and weight will stabilize through the next review. Interventions included Provide supplements as ordered. Provide/offer hydration throughout the day. Serve diet as ordered and offer substitution if intake less than 50%. Record review of Resident #1s progress notes dated 3/10/25 at 10:20pm reflected Resident was able to consume 180ml of Ensure (health shake) via syringe. No signs or symptoms of chocking noted. Head of bed up right. No signs and symptoms of pain or distress noted. Resident Family Member notified of residents' intake of Ensure. Call light within reach. Care needs met. Signed by LVN C. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1s' Physician orders for March 2025 reflected an order for a fortified diet, mechanical soft ground meats dated 01/02/2025 and health shakes or equivalent three times a day dated 02/23/2025. The physicians' orders also reflected that Resident #1 was admitted to Hospice services on 01/20/2025. Resident #1 had an order for a stat (without delay) chest x-ray to rule our aspiration dated 03/11/2025. Record review of Resident #1s Chest X ray ordered for Resident #1 on 3/11/25 at 5:59pm reflected there was no aspiration seen. In an observation completed on 3/11/25 at 11:00am Resident #1was fidgeting with her fingers in the air, unresponsive to verbal stimuli. The head of her bead was elevated 45 degrees, she had her mouth open, and head leaned back looking upward to the ceiling. There was a bottle of health shake with a straw in it next to a 60cc syringe in a clear package on the bedside table. In a second observation and interview of Resident #1 and CNA A on 3/11/25 at 12:10 when Resident #1 appeared in the same position. At 12:13pm CNA A entered the room as this surveyor was inquiring about Resident #1s lunch tray. CNA A stated Resident #1 was too weak to eat. She stated the Resident #1 had not been offered a food tray. CNA A was putting on gloves and drawing up a 60cc syringe full of health shake. As CNA A was talking with the surveyor, she then proceeded over to the Resident #1 and placed the syringe in the resident's mouth. This surveyor asked CNA A to stop at that time. CNA A Stated she worked with agency and today was her first day in the facility. She stated there was an orientation on the agency app prior to taking a shift at the facility, she did not know if feeding was part of that orientation. CNA A Stated Resident #1 did not have the strength to eat and that she was told in report (employee to employee review of residents' conditions) this morning by the night nurse to feed and give fluids to Resident #1 with the syringe so she would not be dehydrated. CNA A stated she had given Resident #1 two full 60 cc syringes of health shake this morning. She stated she had not been instructed by the building DON or ADON to feed or give fluids to a resident with a syringe. In an interview on 3/11/25 at 12:20pm the DON stated Resident #1 had been unresponsive for about 2-3 days. The DON stated it was not normal practice to feed or give fluids to residents with a syringe. She stated The Family Member was insistent with hospice that it could be done. The DON stated the CNAs have not been trained to feed or give fluids using a syringe unless the hospice nurse instructed them to do so. She stated Resident #1 could get aspiration pneumonia (an infection that is the results of food or fluids going into the lungs instead of the stomach). The DON stated feeding residents with a syringe is not facility protocol. She stated the 60cc syringe came from Hospice. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 3/11/25 at 1:02pm LVN B stated she had worked at the facility for 3 days and she was the charge nurse for Resident #1. She stated she was aware Resident #1 was on hospice for a cardiac condition and Resident #1 had a hip injury that was nonoperational. She stated Resident #1s family was upset she was not eating, and she had talked to the family about reasons including end of life. She stated she also explained to the family that she could aspirate (a condition where the fluid goes into the lung) if she was not swallowing. LVN B stated at no time did CNA A report that the night nurse had instructed her to feed or give fluids to Resident #1 with a syringe. She stated it also was not passed along in their nursing report from the night nurse. She stated the Resident #1 was unresponsive this morning. LVN B stated feeding or giving fluids through a syringe to a resident who was not responsive could lead to the resident aspirating. LVN B stated she did an assessment on Resident #1, and her lungs were clear (free from abnormal sounds of respirations). LVN B stated a Chest x ray was ordered by the physician, and the facility was waiting on that to be completed. Attempted to contact LVN C who works night shift (6pm -6am) on 3/10/25 on 3/11/25 at 1:42 pm with no answer. In an interview with a Family Member of Resident #1 on 3/11/25 at 2:51 stated when she had mentioned giving Resident #1 fluids through a syringe, she was not talking about a large syringe full of fluids. She stated she was asking for the staff to give her drips out of a small syringe. She stated something to keep Resident #1's mouth moist. She stated she did not ask for them to force feed her. She stated she just wanted Resident #1s mouth moist, not as dry; she wanted her to have oral care, swab her mouth out, not force feed her though a syringe. In an interview on 3/11/25 at 3:00 pm with The Medical Director and Primary Care Physician for Resident #1 stated it was not recommend feeding or give fluids by mouth a resident with a syringe. He stated he was over the Resident#1s hospice company as well and he had called hospice, and they had no recommendations for feeding or giving fluids through a syringe either. He stated if a person were to squirt a bunch of thin liquids at one time into Resident#1s mouth she would aspirate, causing choking, and pneumonia. He stated the resident was not eating. He stated he did listen to Resident #1s lungs, and they sounded clear and did not see any harm from the resident receiving the thin liquids per the syringe. He stated he did instruct the nursing staff not to feed or give fluids to her through the syringe. He stated he ordered routine oral care to be completed to ensure the residents mouth was moist. In an interview on 3/11/25 at 3:46 pm RN D Resident #1's hospice nurse stated hospice did not recommend feeding or giving fluids to Resident #1 with a syringe. He stated The Family Member had called him and was upset that the facility would not feed Resident #1 with a syringe. He stated he educated the family on risk of feeding and giving fluids with a syringe. He stated that he instructed the family that hospice would not feed or give fluids to Resident #1 with a syringe. He stated there was never an order to do that. The Family Member stated the night nurse told her that she got her to take a half of a bottle of health shake and she did not elaborate how she got her to take the fluid. He stated he had instructed the family on the death and dying process and that it was a traumatic event such as a hip fracture that causing the resident to further decline and that not having an appetite and not eating was part of that decline. He stated the resident has not been responsive the last 3-4 days. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the DON and ADM on 3/12/25 at 3:09 when the DON stated there was never any formal training to feed or give residents any fluids through a syringe because it was not the facility practice to do so. She stated here was never any order for food or fluids to be given through a syringe because that it not the facility practice. The DON stated agency staff were aware of the Residents#1s plan or care through verbal report. She stated the agency staff were also given a point click care password so they could access the plan or care and be aware of resident's needs. The DON stated there was a book with specific instructions at the nurses' station on how to navigate point click care and facility policy and procedures provided to agency staff. She stated they encourage agency staff to ask questions if needed. Record review of facility policy titled Competency Evaluation dated 04/2024 and revised 01/2025 reflected: It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job. An Immediate Jeopardy was identified on 3/12/2025 at 4:35 p.m. and an IJ template was provided to the ADM and DON. The following Plan of Removal submitted by the facility was accepted on 03/13/2025 at 10:28 a.m. PLAN OF REMOVAL Problem: The facility failed to ensure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychological well-being. An audit was completed by nurse management to ensure no other residents were at risk. Resident #1 had a chest x-ray completed on 3/11/25 that showed no aspiration. Resident # 1 was assessed by the DON & the facility medical director. Resident #1 remains in the facility in stable condition. Immediate action: 11. As soon as the DON was made aware of the situation on 3/11/25 she immediately removed the syringe from the resident's room. 12. CNA #1 was given a one-on-one education by ADON on 3/11/25 that a resident should never be syringe fed. Our investigation revealed that an overnight nurse instructed the CNA to administer the resident ensure through a syringe. A telephone call was placed to the night nurse & a message left for her to call the facility. The night nurse had not returned our phone call. A message was left that she could not return to the facility until she spoke with the DON. 13. DON started In-servicing facility & agency licensed nurses & CNAS on 3/11/25 at 1300 that residents were never to fed via a syringe. All 6-2 & 2-10 nursing staff on duty were educated. In-services for facility licensed nurses & CNAS will be completed on 3/13/25. Any agency staff that has not previously been in-serviced will be required to complete the in-services prior to starting their shift. 14. DON/ADON started In-servicing on 3/12/25 with agency staff to ensure they were educated on where to find the residents plan of care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	15. DON/ADON started In-servicing on 3/12/25 with all CNAs both facility & agency on the importance of not attempting to feed a resident that is unresponsive. Any new facility or agency CNA will be provided the education prior to working. 16. The agency binder was reviewed to ensure that agency staff know where to look to review the residents plan of care. Interventions 17. Any new agency staff will be in-serviced by nurse management on how to find the residents plan of care prior to starting their shift. The education started on 3/12/25 & will be ongoing when new facility or agency staff are scheduled. 18. Shift Key will download the process of where to find the residents plan of care prior to accepting a shift. The ADON will be responsible for the communication to Shift Key. 19. Nurse management will review the residents' care plan to ensure that it reflects the resident's needs. The care plan review will be completed by 3/14/25. 20. When a resident experiences a change of condition the care plan will be updated to reflect the resident's current needs. The DON/ADON/ Unit Manager will be responsible for updating resident care plan when a change of condition is identified. Ongoing Projected completion 3/13/25 for facility nursing staff. Care Plan review will be completed by 3/14/25. Any staff member who was not present during initial in-servicing/training will not be allowed to assume their duties until in-service was completed. The DON/ADON/WC NURSE will complete Ongoing In-service/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 5. Nurse management will question random CNAs 3 X's a week to ensure they understand Resident #1s plan of care. Nurse management will perform random questions 3 X's a week for 6 weeks. 6. Staff will complete a questionnaire related to providing care that reflects the resident's needs. 7. On 3/13/25 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DON/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 3/14/25. 8. On 3/12/25 An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval. 3/13/25 Surveyor Monitoring included the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	10. Observation completed on 3/13/25 at 12:50PM reflected there was no longer a syringe for feeding In Resident #1s room. 11. Record review of Momentum Skilled Services 1:1 in service dated 3/11/25 signed by CNA#1 reflected that CNA A was given a one-on-one education by The ADON that read a resident should never be syringe fed. 12. Record review of Inservice dated 03/11/25 and 03/12/25 provided to licensed nurses and certified nurse aides reflected they had been educated by The DON that no residents would be fed or given fluids orally with a syringe for any reason. 13. Record review of facility in-service provided to agency staff working within the building dated 3/12/25 reflected that the residents plan of care was in the EMR (electronic medical record) under the Kardex tab (a tab that contains certain needs for residents that staff may review). If they were to have any questions after reading the residents plan of care they must find their charge nurse for clarification. 14. Record review of facility in-service dated 03/12/25 provided to all certified nursing assistance both agency and facility staff reflected staff members must never attempt to feed or give fluids to a resident that was unresponsive. If they had a resident that was unresponsive, they must find the charge nurse for clarification. 15. The DON reviewed the agency binder to ensure the agency staff would be able to locate the residents plan of care to provide services. 16. Interviewed 22 nursing staff (CNA D, E,F,G,H,I,J,K,L,M,N,O,P,Q and LVN R,S,T,U,V,W,X) from all shifts and they stated they had been educated on not syringe feeding residents. They stated they had been educated on not attempting to feed unresponsive residents. They stated the risk for resident would be aspiration or choking. They stated they had been educated on where and how to locate a resident's plan of care to provide and meet the resident's needs. The agency staff were able to locate the facility binder with their expectations and EMR directions to provide services and care to residents. They stated if a plan of care did not seem accurate for a resident they would go to their charge nurse for clarification. They stated even if a nurse told them to do something that was out of their scope, they would report it to the ADON or DON for further clarification. The agency staff stated they were instructed prior to their shift to review the blue binder at the nurses' station. They stated within the binder there was current in-services for staff, policy and procedures for pain and falls, abuse, and neglect, also directions on how to navigate the electronic medical record to see the residents current plan of care. The binder also included current in-services for staff. Included in in-services within the blue binder were: no resident will be fed by syringe, Staff members must never attempt to feed a resident that is unresponsive, and where the plan of care is located within the EMR. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	17. In an interview with The ADON on 3/13/25 at 2:46PM- The ADON stated the facility had posted an automatic notification that must be acknowledged to review in-services prior to the start of agency staffs shift instructing staff they must sign in at the nurses' station and all agency staff must read and abide by the blue binder located at the nurse's station. Within the blue binder was found an emergency phone list, items to report immediately, sign in sheets, facility management contacts. The binder also included current in-services for staff. Included in in-services within the blue binder were: no resident will be fed by syringe, Staff members must never attempt to feed a resident that is unresponsive, and where the plan of care is located within the EMR. Record review of shift key logs reflected the notification of in-services prior to coming on shift had been signed and acknowledged by 6 agency staff working 3/13/25. 18. Record review of a Care Plan Audit on 3/14/25 completed by the DON was 100% completed. The DON stated there were no further negative findings within the Care plan audit for all residents. She stated the care plans were accurate for Residents to reflects the resident's needs. 10. Signed QAPI minutes reviewed for 3/12/25 and reflected a meeting was held that included the facilities ADM, DON, ADON, MDS, and Medical Director The ADM and DON were informed the Immediate Jeopardy was removed on 03/14/2025 at 11:53 a.m. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy and a scope of Isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47926 Based on observation, interview, and record review, the facility failed to assure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being for 1 (Resident #1) of 5 residents reviewed. The facility nurses failed to hold Resident #1's health shakes and administered them through a 60 ML syringe by mouth while she was not responsive on 3/10/25 at 10:20pm and 3/11/25 at 12:10pm. These failures resulted in an identification of an Immediate Jeopardy (IJ) On 3/12/2025 at 4:35 p.m. While the IJ was removed on 3/14/25, the facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These failures placed residents who have had a decline or change in condition at risk for aspiration, choking, and death. Findings included: Record review of Resident #1's undated face sheet reflected she was a [AGE] year-old female who was admitted to the facility on [DATE] with diagnosis of Alzheimer Disease (A brain disorder that slowly destroys a person's memory), Dementia (the loss of cognitive function, remembering, thinking, and reasoning), Hypertension (elevated blood pressure), Bradycardia (a slow heart rate). Record review of Resident #1's Significant change in status MDS dated [DATE] reflected she Had a BIMS score of 00 indicating she had severe cognitive impaired. Resident #1 required substantial/maximal assistance indicating the helper does more than half the effort or the helper lifts or holds trunk or limbs and provides more than half the effort for ADL care showering, upper and lower body dressing, and toileting hygiene. The MDS reflected Resident #1 required set up or clean up assistance with eating and was receiving hospice services. Record review of Resident #1's care plan dated 02/06/2025 reflected a significant/Un-expected weight loss due to decline in overall health and decline in oral intake. Goal: Will receive adequate nutrition and fluid intake and weight will stabilize through the next review. Interventions included Provide supplements as ordered. Provide/offer hydration throughout the day. Serve diet as ordered and offer substitution if intake less than 50%. Record review of Resident #1's progress notes dated 3/10/25 at 10:20pm reflected Resident was able to consume 180 ml of Ensure (health shake) via syringe. No signs or symptoms of chocking noted. Head of bed up right. No signs and symptoms of pain or distress noted. Resident Family Member notified of residents' intake of Ensure. Call light within reach. Care needs met. Signed by LVN C. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's Physician orders for March 2025 reflected an order for a fortified diet, mechanical soft ground meats dated 01/02/2025 and health shakes or equivalent three times a day dated 02/23/2025. The physicians' orders also reflected that Resident #1 was admitted to Hospice services on 01/20/2025. Resident #1 had an order for a stat (without delay) chest x-ray to rule our aspiration dated 03/11/2025. Record review of Resident #1's Chest X ray ordered for Resident #1 on 3/11/25 at 5:59pm reflected there was no aspiration seen. In an observation completed on 3/11/25 at 11:00am Resident #1 was fidgeting with her fingers in the air, unresponsive to verbal stimuli. The head of her bead was elevated 45 degrees, she had her mouth open, and head leaned back looking upward to the ceiling. There was a bottle of health shake with a straw in it next to a 60 cc syringe in a clear package on the bedside table. In a second observation and interview of Resident #1 and CNA A on 3/11/25 at 12:10 when Resident #1 appeared in the same position. At 12:13pm CNA A entered the room as this surveyor was inquiring about Resident #1's lunch tray. CNA A stated Resident #1 was too weak to eat. She stated the Resident #1 had not been offered a food tray. CNA A was putting on gloves and drawing up a 60 cc syringe full of health shake. As CNA A was talking with the surveyor, she then proceeded over to the Resident #1 and placed the syringe in the resident's mouth. This surveyor asked CNA A to stop at that time. CNA A Stated she worked with agency and today was her first day in the facility. She stated there was an orientation on the agency app prior to taking a shift at the facility, she did not know if feeding was part of that orientation. CNA A Stated Resident #1 did not have the strength to eat and that she was told in report (employee to employee review of residents' conditions) this morning by the night nurse to feed and give fluids to Resident #1 with the syringe so she would not be dehydrated. CNA A stated she had given Resident #1 two full 60 cc syringes of health shake this morning. She stated she had not been instructed by the building DON or ADON to feed or give fluids to a resident with a syringe. In an interview on 3/11/25 at 12:20pm the DON stated Resident #1 had been unresponsive for about 2-3 days. The DON stated it was not normal practice to feed or give fluids to residents with a syringe. She stated The Family Member was insistent with hospice that it could be done. The DON stated the CNAs have not been trained to feed or give fluids using a syringe unless the hospice nurse instructed them to do so. She stated Resident #1 could get aspiration pneumonia (an infection that is the results of food or fluids going into the lungs instead of the stomach). The DON stated feeding residents with a syringe is not facility protocol. She stated the 60 cc syringe came from Hospice. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 3/11/25 at 1:02pm LVN B stated she had worked at the facility for 3 days and she was the charge nurse for Resident #1. She stated she was aware Resident #1 was on hospice for a cardiac condition and Resident #1 had a hip injury that was nonoperational. She stated Resident #1's family was upset she was not eating, and she had talked to the family about reasons including end of life. She stated she also explained to the family that she could aspirate (a condition where the fluid goes into the lung) if she was not swallowing. LVN B stated at no time did CNA A report that the night nurse had instructed her to feed or give fluids to Resident #1 with a syringe. She stated it also was not passed along in their nursing report from the night nurse. She stated the Resident #1 was unresponsive this morning. LVN B stated feeding or giving fluids through a syringe to a resident who was not responsive could lead to the resident aspirating. LVN B stated she did an assessment on Resident #1, and her lungs were clear (free from abnormal sounds of respirations). LVN B stated a Chest x ray was ordered by the physician, and the facility was waiting on that to be completed. Attempted to contact LVN C who works night shift (6pm -6am) on 3/10/25 on 3/11/25 at 1:42pm with no answer. In an interview with a Family Member of Resident #1 on 3/11/25 at 2:51pm stated when she had mentioned giving Resident #1 fluids through a syringe, she was not talking about a large syringe full of fluids. She stated she was asking for the staff to give her drips out of a small syringe. She stated something to keep Resident #1's mouth moist. She stated she did not ask for them to force feed her. She stated she just wanted Resident #1's mouth moist, not as dry; she wanted her to have oral care, swab her mouth out, not force feed her though a syringe. In an interview on 3/11/25 at 3:00pm with The Medical Director and Primary Care Physician for Resident #1 stated it was not recommend feeding or give fluids by mouth a resident with a syringe. He stated he was over the Resident#1's hospice company as well and he had called hospice, and they had no recommendations for feeding or giving fluids through a syringe either. He stated if a person were to squirt a bunch of thin liquids at one time into Resident#1's mouth she would aspirate, causing choking, and pneumonia. He stated the resident was not eating. He stated he did listen to Resident #1's lungs, and they sounded clear and did not see any harm from the resident receiving the thin liquids per the syringe. He stated he did instruct the nursing staff not to feed or give fluids to her through the syringe. He stated he ordered routine oral care to be completed to ensure the residents mouth was moist. In an interview on 3/11/25 at 3:46pm RN D Resident #1's hospice nurse stated hospice did not recommend feeding or giving fluids to Resident #1 with a syringe. He stated The Family Member had called him and was upset that the facility would not feed Resident #1 with a syringe. He stated he educated the family on risk of feeding and giving fluids with a syringe. He stated that he instructed the family that hospice would not feed or give fluids to Resident #1 with a syringe. He stated there was never an order to do that. The Family Member stated the night nurse told her that she got her to take a half of a bottle of health shake and she did not elaborate how she got her to take the fluid. He stated he had instructed the family on the death and dying process and that it was a traumatic event such as a hip fracture that causing the resident to further decline and that not having an appetite and not eating was part of that decline. He stated the resident has not been responsive the last 3-4 days. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview with the DON and ADM on 3/12/25 at 3:09pm when the DON stated there was never any formal training to feed or give residents any fluids through a syringe because it was not the facility practice to do so. She stated here was never any order for food or fluids to be given through a syringe because that it not the facility practice. The DON stated agency staff were aware of the Residents#1's plan or care through verbal report. She stated the agency staff were also given a point click care password so they could access the plan or care and be aware of resident's needs. The DON stated there was a book with specific instructions at the nurses' station on how to navigate point click care and facility policy and procedures provided to agency staff. She stated they encourage agency staff to ask questions if needed. Record review of facility policy titled Competency Evaluation dated 04/2024 and revised 01/2025 reflected: It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job. An Immediate Jeopardy was identified on 3/12/2025 at 4:35pm and an IJ template was provided to the ADM and DON. The following Plan of Removal submitted by the facility was accepted on 03/13/2025 at 10:28am PLAN OF REMOVAL Problem: The facility failed to ensure that all nursing staff possess the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychological well-being. An audit was completed by nurse management to ensure no other residents were at risk. Resident #1 had a chest x-ray completed on 3/11/25 that showed no aspiration. Resident # 1 was assessed by the DON & the facility medical director. Resident #1 remains in the facility in stable condition. Immediate action: 1. As soon as the DON was made aware of the situation on 3/11/25 she immediately removed the syringe from the resident's room. 2. CNA #1 was given a one-on-one education by ADON on 3/11/25 that a resident should never be syringe fed. Our investigation revealed that an overnight nurse instructed the CNA to administer the resident ensure through a syringe. A telephone call was placed to the night nurse & a message left for her to call the facility. The night nurse had not returned our phone call. A message was left that she could not return to the facility until she spoke with the DON. 3. DON started In-servicing facility & agency licensed nurses & CNAS on 3/11/25 at 1:00pm that residents were never to fed via a syringe. All 6-2 & 2-10 nursing staff on duty were educated. In-services for facility licensed nurses & CNAS will be completed on 3/13/25. Any agency staff that has not previously been in-serviced will be required to complete the in-services prior to starting their shift. 4. DON/ADON started In-servicing on 3/12/25 with agency staff to ensure they were educated on where to find the residents plan of care. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	5. DON/ADON started In-servicing on 3/12/25 with all CNAs both facility & agency on the importance of not attempting to feed a resident that is unresponsive. Any new facility or agency CNA will be provided the education prior to working. 6. The agency binder was reviewed to ensure that agency staff know where to look to review the residents plan of care. Interventions 7. Any new agency staff will be in-serviced by nurse management on how to find the residents plan of care prior to starting their shift. The education started on 3/12/25 & will be ongoing when new facility or agency staff are scheduled. 8. Shift Key will download the process of where to find the residents plan of care prior to accepting a shift. The ADON will be responsible for the communication to Shift Key. 9. Nurse management will review the residents' care plan to ensure that it reflects the resident's needs. The care plan review will be completed by 3/14/25. 10. When a resident experiences a change of condition the care plan will be updated to reflect the resident's current needs. The DON/ADON/ Unit Manager will be responsible for updating resident care plan when a change of condition is identified. Ongoing Projected completion 3/13/25 for facility nursing staff. Care Plan review will be completed by 3/14/25. Any staff member who was not present during initial in-servicing/training will not be allowed to assume their duties until in-service was completed. The DON/ADON/WC NURSE will complete Ongoing In-service/or weekend nurse supervisor, until all staff, weekend, prn, and agency staff in completed. Monitoring 1. Nurse management will question random CNAs 3 X's a week to ensure they understand Resident #1s plan of care. Nurse management will perform random questions 3 X's a week for 6 weeks. 2. Staff will complete a questionnaire related to providing care that reflects the resident's needs. 3. On 3/13/25 The DON/designee began a questionnaire to validate the effectiveness of the training. The questionnaire is conducted with facility staff. Immediate re-education will be completed by the DON/designee if any staff is unable to answer appropriately to the questions on the questionnaire. Staff will not be allowed to work until after completion of the questionnaire. Projected completion 3/14/25. 4. On 3/12/25 An impromptu QAPI meeting was conducted with the facility's Medical Director to notify of the potential for non-compliance and the action plan implemented for approval. 3/13/25 Surveyor Monitoring included the following: (continued on next page)

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