STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675988	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hilltop Park Rehabilitation and Care Center	970 Hilltop Dr Weatherford, TX 76086

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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	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** 41944 Based on interview and record review, the facility failed to immediately inform the resident, consult with the resident's physician; and notify, consistent with his or her authority, the resident representative where there was a significant change in the resident's physical, mental, or psychosocial status and when there was a need to alter treatment significantly for one of six (Resident #1) residents reviewed for notification of change in condition. The facility failed to notify Resident #1's attending physician of nausea, vomiting and diarrhea which lasted from 12/22/2024 to 12/30/2024 without improvement. An Immediate Jeopardy (IJ) situation was identified on 01/29/2025 at 4:21 pm . The IJ was removed on 01/31 /2025 at 10:24 AM. The facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of a delay in medical intervention, decline in health, serious injury, harm, impairment, or death. Findings include: Record review of Resident #1's face sheet, dated 01/03/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had relevant diagnoses which included cerebral infarct (a condition where blood flow to the brain is interrupted, causing brain tissue to die), dysphagia (difficulty swallowing), other signs and symptoms concerning food and fluid intake, unspecified signs and symptoms involving cognitive function after stroke, speech and language deficits, hypertension (high blood pressure), and long-term use of anticoagulants. Record review of Resident #1's Discharge MDS assessment dated [DATE], reflected she had both short-term and long-term memory problems. She was dependent for bed mobility, transfers, feeding, and maximum assistance with wheelchair mobility wheelchair for mobility. She was incontinent of both bowel and bladder and she had a feeding tube; (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's Comprehensive Care Plan reflected the following, Focus: Resident has a potential fluid deficit related to tube feedings, goal - the resident will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor, interventions - monitor and document frequency of bowel movements, monitor vital signs and report significant abnormalities to physician. Focus, G-tube feeding required due to dysphagia (feeding via a tube inserted through the abdomen surgically into the stomach due to difficulty swallowing). Interventions included: Give 150ml water every shift via gastrostomy tube to equal 450ml/24hrs, Glucerna 1.5 at 57ml/hour with 39ml/hour continuous water flush for 20 hours a day via GT = 1133 ml formula, 1700 kcals, 91gms protein, 2066ml water/24 hours (excludes med flushes), monitor/document/report PRN any signs or symptoms of aspiration, fever, shortness of breath, tube dislodgment, Infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, or dehydration. Record review of Resident #1's active physician orders from the nursing facility, dated 12/30/2024 reflected The resident also had an order for Zofran 4 mg every 6 hours as needed for nausea and vomiting. The order had a start date of 07/13/2023. Record review of Resident's #1's MAR for the month of December 2024 revealed she did not receive Zofran 4 mg in the month of November or December until the date of 12/22/2024. Record review of Resident #1's facility nursing progress notes dated 12/22/2024 to 12/30/2024 reflected documentation in the nursing progress notes on 12/22/2024, 12/24/2024, 12/25/2024 x2, 12/27/24 2 times, and 12/30/24 showing the resident received Zofran 4 mg for nausea and vomiting. The order had a start date of 07/13/23. Record review of Resident # 1's physician progress notes authored by NP L with an encounter date 12/19/2024 reflected no evidence of nausea or vomiting and documented pharmacotherapy reviewed, patient on 23 medications. Recommendation for discontinuation of Mylanta Oral Suspension, Ondansetron (Zofran) HCL tablet, and MOM (milk of magnesia)suspension PRN medications as they have not been utilized in the past three months. Record review of Resident #1's Nursing Progress Notes, with a look-back period between 12/22/2024 - 12/30/2024, reflected no documentation related to a completed assessment or notification to a medical provider of Resident #1's continued nausea, vomiting and diarrhea nor any other concerns until 12/30/2024 when LVN A documented the primary care physician was notified. Her blood pressure was documented to be 70/46 with a pulse of 46 by LVN A. Record review of Resident #1's electronic medical record revealed no lab work had been ordered since November 2024. Her Comprehensive Metabolic Panel and Complete Blood Count were within Normal limits at that time. Throughout the course of the investigation 01/03/25 to 01/31/25), Resident # 1 was no longer at the facility and was unavailable for interview due to the decline in her condition. (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 physician ER notes in the ER hospital records, dated 12/30/25, indicated the resident presented with nausea, diarrhea, and abdominal pain. She was diagnosed with hypovolemic shock (shock caused by major blood or fluid loss), sepsis (an extreme reaction by the body to infection) , and abdominal pain. The ER Physician stated in the note Overall, I feel the shock is multifocal, rectus sheath hematoma (a collection of blood cause by a tear in the rectus abdominus muscle of the abdomen) with volume loses secondary to reported nausea and vomiting. Record Review of clinical chart documentation dated 12/30/24, the ER Physician stated The high probability of sudden, clinically significant deterioration in the patient's condition required the highest level of my preparedness to intervene urgently. The service I provided to this patient were to treat and/or prevent clinically significant deterioration that could result In severe disability or death. Further review of the Physician ER note, dated 12/30/24, revealed the resident required transfer to a higher level of care and hospitalization on [DATE] for hypovolemic shock, sepsis, and required emergency surgical intervention for treatment of a rectus abdominus hematoma, the resident was also found to have a UTI. Record review of the lab results, dated 12/30/24, from the ER Record revealed her Lactic Acid was 3.2 H (normal range 0.5 to 2.2 millimolesa condition where the level of lactic acid in the blood is elevated indicating the liver and kidneys are not are not able to metabolize lactic avid or are producing too much), WBC's 25.31 H,(blood cells that fight infection, the normal range is 4.000 to 11,000. Her urine had many bacteria, 3-4, RBC's (red blood cells carry oxygen to cells and tissues normal range 4.2 to 5.4) Sodium was 128 L (sodium normal range between 135 - 145 an electrolyte that helps regulate water in the body , Chloride 88 L (normal range 96 to 106 it is an elctrolye that main tains fluid volume an acid base balance in the body), Co2 32 H(normal range between 23 and 29 regulates the respiratory rate and the affinity of hemoglobin for oxygen) , BUN 33 H (normal range 6 to 24 high BUN indicates how well the kidneys are removing urea which is a waste product from the blood), Albumin 2.9 L(normal range 3.4 to 5.4 albumin helps transport fluids throughout then body). During an interview on 01/03/2025 at 8:00 AM with Resident # 1's family member, she stated the resident had been in the facility since March of 2024. She stated Resident #1 took her medication and all fluids and nourishment through a tube in her stomach. She stated Resident #1 was in ICU at that time. She stated the resident was admitted to the hospital on 12/30/24. and that was the first time the facility had let the family know how sick she was. She stated the resident was septic and severely dehydrated when she arrived at the hospital with a blood pressure of 48/28. The family member stated Resident #1's room was electronically monitored, and she could see the feeding tube was turned off intermittently from the 21st of December until the time she went to the hospital on 12/30/24. She stated the ER physician told her there was a foul smell emitting from her gastrostomy tube at the time of her transfer to the hospital. She stated the ER staff told her the odor was so bad there was no way the facility staff could have not known about it. She stated her urine was so concentrated it was the color of tea or coffee. She stated on 12/29/24 she was told by a nurse at the facility (she did not know her name) that Resident #1's color was ashen, and she was concerned about her. She stated the nurse stated she was trying to reach the physician. They finally notified her that they had received orders for transfer, and transferred her to the emergency roiagnom on the 30th of [DATE]. An attempt to interview the ER Physician was unsuccessful on 01/27/2025 at 2:30 PM and 4:30 PM, the purpose of the call and a call back number was left on voicemail. In interview with NP L, on 1/03/2025 at 1:00 PM, she stated she never saw or treated Resident #1 from 12/22/2024 until 12/30/2024 and she was not called by the facility or informed of her nausea, vomiting and diarrhea. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with Resident #1's primary care physician W, on 1/03/2025 at 1:40 PM, he stated he was not notified of a condition change in Resident #1 from 12/22/2024 until 12/30/2024, and was not informed of her nausea, vomiting and diarrhea over the course of 8 days. He stated he was notified on 12/30/2024 and he sent her to the hospital for evaluation. He stated he was never notified that her gastrostomy tube feedings were held. He stated he would have expected the nursing staff to notify him of the condition change after 24 hours with no improvement. He stated that he would have intervened sooner if he had been notified and ordered IV fluids and lab work. In a follow up interview with Primary care physician W on 1/27/2025 at 2:30 PM, he stated he did not know if early intervention would have prevented her hospitalization . He stated interventions such as fluids and labs might have prevented her hospitalization , but it was hard to say. He stated in his opinion in general, most elderly residents in nursing homes did suffer from some degree of dehydration. He stated he did not lay eyes on Resident #1 before he gave orders for her transfer to the hospital for evaluation, therefore he could not say what her condition was at the time of transfer. In an interview on 01/03/2025 at 1:30 PM CNA D stated she worked the 23rd and 24th of December. She stated on the 23rd she doesn't think Resident #1 had nausea or diarrhea during her shift from 6:00 AM until 2:00 PM when she worked. But on the 24th she had diarrhea and vomiting, but she's not sure how many times it occurred. She stated the diarrhea was runny and brownish, reddish in color and the vomit was brown. She stated she reported it to LVN A who also helped her clean Resident #1 up. In an interview on 01/03/2025, CNA E at 1:40 PM stated she took care of the resident 12/23/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/27/2024, and 12/30/2024. She stated the resident vomited and had diarrhea during her 8-hour shift (6am-2pm). She stated she reported this to the charge nurse (LVN A). She stated she remembered Resident # 1 had diarrhea and vomiting for a long time and she reported it to the nurse each time the nausea, vomiting and diarrhea occurred, because it needed to be stopped. She stated she did not remember anything unusual about the color. She also stated several residents on the 500 hall had been sick, but Resident #1 had it longer than the other residents. She stated she did not notice if Resident #1's tube feeding was connected to the pump or if the charge nurse turned the pump off on the 6:00 AM - 2:00 PM shift, because that was the nurse's responsibility. She stated she did not remember how long Resident #1 the vomiting and diarrhea had, but it was for about a week. She stated several of the staff and other residents also had the diarrhea and vomiting at the same time, but Resident #1 had it longer than anyone else. CNA E was not available for a follow up interview. She did not work again during the course of the investigation, and attempts on 01/27/2025 at 2:00 PM and 5:00 PM for a phone interview were unsuccessful. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with LVN A on 01/03/2025 at 2:40 PM, she stated she worked days on 12/23/2024, 12/24/2024, 12/25/2024, 12/26/24, and 12/30/2024. She stated she sent the resident to the hospital. She stated she knew the resident had the diarrhea and vomiting for several days. She stated Dr W had standing orders for Zofran as needed every 6 hours for nausea and vomiting. She stated she heard in the change of shift report given to her by LVN C that Resident #1 vomited and had diarrhea on the night shift. She stated she immediately went down to Resident #1's room to check on her. She stated Resident #1's B/P was 70/46, and she was complaining that her stomach hurt, so she immediately called the physician. She stated Resident #1 was on her way to the hospital by 7:00 Am. She stated she had been off for a few days prior to 12/30/2024 with symptoms of vomiting and diarrhea and 12/30/2024 was her first day back at work since 12/26/2024. She stated she notified the physician on 12/30/2024. She stated she did not notify the physician or the POA of Resident # 1's condition change prior to 12/30/2024 because she didn't think about doing it. In an interview on 01/03/2025 at 3:20 PM, LVN F stated she was the charge nurse and worked 2:00 PM to 10:00 PM on 12/24/2024. She stated on 12/24 /25, LVN A told her she had unhooked her from her feeding and stopped the pump due to nausea and vomiting during the 6:00 AM to 2:00 PM shift. She stated she assessed the resident, and she asked her if she felt better. She stated the resident told her she was not nauseated, and her vital signs were within normal range, so she resumed the feeding. She stated she had never seen Resident #1 have any brown or coffee ground emesis. She stated the tube flushed very well and she never noticed an odor. In a follow up interview on 1/8/2025 at 1:41 PM, LVN A stated she did not recall that Resident #1 ever had emesis of a brownish or coffee ground color as stated by CNA D . She stated it was always the color of the tube feeding. She stated Resident #1 had physician orders for her pump to be off for 4 hours each day . She reviewed her nursing progress notes and the MAR for the month of December during the interview and stated she did turn the pump off on 12/24/24 on the 6 AM -2 PM shift and also held her medications due to nausea and vomiting. She stated she did not notify the physician on 12/24/2024. In an Interview on 01/08/25 at 3:30 PM1/8/ , LVN C stated she took care of Resident #1 during the time period of 12/21/24 to 12/30/24. She stated she had turned the feeding pump off several times during that time period due to the resident's nausea, vomiting and diarrhea. She stated she did not notify the physician of the resident's condition. She stated she gave the resident Zofran for nausea through the g-tube like everyone else did. She stated, I just never thought about calling the doctor to notify him the resident was not getting better. In an interview with LVN B on 01/08/2025at 3:00 PM, she stated she worked on 12/27/2024 thru 12/29/2024. She stated she stopped Resident #1's pump, and held her medications due to nausea on 12/27/2024. She stated she did not notify the physician. She stated she did not think of notifying the physician. She stated she thought he knew because she had the Zofran ordered for nausea. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the DON on 01/03/2025 at 1:15 PM, she stated she was responsible for monitoring and providing oversight for the Nursing staff of the facility. She stated she was responsible for providing in-services to the staff. She stated she was not aware of Resident #1 having had diarrhea with nausea and vomiting which continued over the course of 8 days from 12/22/2024 to 12/30/2024. She stated her expectation was that staff would notify the resident's physician, POA, or responsible party of any change of condition in a resident. She stated she would have expected a nurse to recognize the symptoms and report the changes. She stated there was a 24-hour communication book that nurses could communicate changes of condition to other shifts. She stated she had looked in the nurses' notes from 12/21/2024 - 12/30/2024 the day of transfer, and she only saw the one notification to the family which was at the time of the transfer. She stated she would have expected them to do an Interact form which should have been done to gather and communicate assessment findings . She stated the nurses were supposed to do an Interact form with a condition change which would assist in cueing the nurse to notify the physician and send them to the hospital. She stated she saw no documentation of that occurring. Review of the 24hour communication book revealed no documentation that the physician had been notified of the condition change or that feedings were held. In an interview with the Administrator on 01/06/2025 at 11:35 AM, he stated his expectations were for the nurse to have reported Resident #1's condition change to the RP and the physician. He stated it was important for facility nursing staff to notify the doctor of any change of condition that required holding of a resident's feedings and of her condition change and continued nausea and vomiting. He stated that he would have intervened sooner if he had known. In an interview with the Administrator at 9:50 AM on 1/13/25, the Administrator stated he was not aware of the situation with Resident #1 until it was brought to his attention by the surveyor. He stated he felt like it was poor nursing care. In an interview with DON on 1/13/2025 at 9:45 AM, she stated that she wanted to let me know that she had suspended LVN C on the 10:00 PM to 6:00 AM shift . She stated that the nurse should have completed an interact form and notified the physician if Resident #1 was unable to tolerate the prescribed tube feeding due to nausea and vomiting. She stated she felt like it was poor nursing care, and she suspended LVN C to investigate the circumstances. She stated she would have notified the physician if she had been the nurse during that shift. She stated she would not want her family treated in that manner. She stated the nurses that worked during that time period should have contacted the physician. She stated turning off the feeding pump could result in dehydration and malnutrition. She stated the physician, the dietician or somebody should have been contacted. She stated LVN A had also quit. She stated Dr W talked to her after talking with the surveyor and he stated that he was not notified and would have expected the nursing staff to notify him of the continued nausea and vomiting and that the feedings were held. He stated he would have intervened sooner. In an interview on 01/13/2025 at 9:15 AM, Resident # 1's POA stated Resident #1 transferred to another SNF on 01/09/2025. She stated she was still concerned with the lack of care she received from 12/22/2024 to 12/30/2024. She stated she felt they almost let her die. Record review of the facility's staffing sheets, provided by the DON, reflected: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN A worked day shift 6:00 AM to 2:00 PM 500 hall on 12/23/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/30/24 LVN B worked 6:00 AM to 10:00 PM 500 hall on 12/27/2024, 12/28/2024, and on 12/29/2024 LVN C worked night shift 10:00 PM to 6:00 AM 500 hall on 12/24/2024, 12/25/2024, 12/26/2024, and 12/29/2024 LVN F worked evening shift on 12/25/2024, and 12/26/2024 CNA D worked 6:00 AM to 2:00 PM on 12/23/2024, 12/24/2024, 12/26/2024, and 12/30/2024 CNA E worked 6:00 AM to 2:00 PM on 12/23/2024, 12/4/2024, 12/25/2024, 12/26/2024, 12/27/2024, and 12/30/2024. Record review of the facility's policy, Change In a Resident's Condition or Status dated revised May of 2017, reflected in part: Our facility shall promptly notify the resident, his or her attending physician or Nurse Practitioner and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the physician or nurse practitioner or the physician on call when there has been an accident or incident involving the resident, discovery of injuries of an unknown source, adverse reaction to medication, significant change in the resident's physical/emotional/mental condition, a need to alter the resident's treatment significantly, refusal of medications or treatment 2 or more consecutive times, need to transfer the resident to a hospital, specific instruction to notify the physician of a change in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. Impacts more than 1 area of a resident's health, requires interdisciplinary review and/or revision to the care plan. This was determined to be an Immediate Jeopardy (IJ) on 01/29/2025 at 4:20 PM. The Administrator and Clinical Compliance Director were notified. The Administrator, DON, and the CCD were provided with the IJ template on 01/29/2025 at 4:20 PM and a POR was requested. The following Plan of Removal submitted by the facility was accepted on 01/30/2025 at 10:56 PM POR F580 - Notify of Changes (Injury/Decline/Room, Etc.) Resident #1 was sent to Hospital on 12/30/24. On 1/3/25 due to HHSC entrance of the facility that there was a complaint of resident #1. Facility began to review any other residents with G-tubes no other residents with a G-tube remains in the facility and/or changes in condition, that would result with any required changes of condition and physician notification. oThe Charge nurses reviewed for any other changes of condition, and none were identified on 1/3/25 by oversight from 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	The underlying cause is the facility failed to ensure the Physician was notified when a resident experienced a change in condition. All residents could have been affected by this alleged deficient practice. oOn 1/3/2025 - Verbal policy review of Policy of Change of Condition or Status/SBAR change of condition was provided by the Corporate Quality Improvement Nurse to DON/ADON, (The policy was reviewed, and verbal comprehension was acknowledged via Q&A and discussion with return demonstration of Situation Background Assessment Recommendations). oIn-services were initiated by the Director of Nursing/Quality Improvement Nurse on 1/6/2025 to educate on notifying physicians immediately following detailed assessment with any resident change of condition to include the use of the SBAR/eInteract (Situation, Background, Assessment and Recommendations to enhance the communication information among team members). Completed on 1/30/2025. oOn 1/6/2025 Education/In-service was initiated to the DON, ADONs by the Corporate Quality Improvement Nurse on the morning clinical start-up process to ensure that any changes of condition would be addressed. Completed 1/6/2025 [NAME] alter the process or system failure the Stop and Watch (early warning communication tool to alert a nurse or manager if they notice something different in a person's daily care routine) was initiated, training and education started to the certified nurses' aides utilizing the alert system on 1/8/25. (Verbal instruction and application along with monitoring of use to ensure understanding and compliance of the communication system) completion date 1/30/2025. oThe SBAR/eInteract is being monitored in the clinical morning startup daily by DON/ADON/Designee. oOversight will be provided by the Administrator/DON/Designee oOn 1/6/25 LVN A resigned and then called in on 1/9, 1/10, 1/13 resignation was accepted immediately. oOn 1/13/25 LVN B resigned with resignation accepted immediately oOn 1/5/25 - LVN C was terminated. oOn 1/17/25 - LVN A, LVN B and LVN C license was referred to the Texas Board of Nursing for further review. Notification protocol and SBAR understanding will be tested by giving a test to LVNs and RNs that cover SBAR education and notification of physician regarding change of condition. Oversite of the testing will be managed by DON/ADON. (Initiated: 1/30/25) To ensure understanding. This test will be given to new nurses hired during orientation and yearly with competencies. Completion date 1/30/2025. oChange of condition will be reported from shift to shift up to nurse management by utilizing the SBAR/eInteract process and 24-hour report tool and reviewed daily in clinical start-up with oversite provided by DON/ADON/Designee. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON/ADON/Designee will be responsible for reviewing SBAR/24-hour report/nurse to nurse huddle and hand-off, daily at morning clinical start up. This will be with the oversight of the administrator. Discrepancies will be addressed immediately with root-cause analysis and brought to QAPI with the oversite with the Medical Director monthly for six months. Administrator/DON/Designee will review and ensure that understanding comprehension of the protocol. [Facility] Medical Director notified of IJ (01/29/2025) [Facility] Monitoring of the POR Included the following: Verification of POC. 1/31/25 at 9:30 AM with DON present. Reviewed on 01/31/2025 at 9:39 am - Completed. Reviewed 01/31/2025 at 9:43 am - Completed. Reviewed 01/31/2025 at 9:50 am. Completed. On-going 3 staff left, cannot work until in-service completed. oOn 1/06/2025 LVN A resigned and then called in on 01/9, 01/10, 01/13 resignation was accepted immediately. oOn 01/13/2025 LVN B resigned with resignation accepted immediately oOn 01/05/2025 - LVN C was terminated. oOn 1/17/2025 - LVN's A, B, and C license was referred to the Texas Board of Nursing for further review. Reviewed the employee files of Nurses A, B, and C with the documentation of the disciplinary actions taken with the DON 01/31/2025 at 9:56 am. Completed. Reviewed the inservice sheet and the employee list provided by the facility with the D atat 1/31/25 at 9:57 am. The inservice efforts are on-going required for agency and new staff before they are allowed to work All nurses employed at the facility with the exception of 2 nurses on the staff list had completed the inservices. They cannot work until completed. This information stating they should not clock in before they had received the inservice and taken the competency based test. was posted on time clock by the DON. Reviewed letter of notification of Immediate Jeopardy Signed by Medical Director on 01/20/2025. Reviewed signed document with DON. Interview Verification: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	, On 01/30/2025 at In interviews from 2PM 12:30 AM with LVN G, Charge Nurse (6 AM-2 PM) LVN H (6 AM-2 PM) shift, LVN F(2 PM-10 PM) shift, LVN I (2 PM-10 PM) shift, CMA FF (6 Am -6 PM) shift, LVN K, (6 AM-2PM) shift, LVN L (2 PM -10 PM) shift LVN M PRN, LVN N Agency, CNA D (6am-6pm) shift, LVN O (2 PM - 10 PM) shift, CNA Q (2 PM-10 PM) shift, Agency CNA R. (2 PM - 10 PM) shift, LVN S (6 am - 2 pm)shift, LVN T (10pm-6am) shift, . LVN GG (10 AM-6 PM), RN U (10 PM- 6 AM) shift, CNA V (10 PM -6 AM) shift, CNA X (2 PM- 6 AM) shift, LVN Z (10 PM-6 AM), CNA AA, CNA CC (10am-6pm) shift, and LVN BB (10 AM-6 PM) shft all stated a change of condition was anything that is outside of resident's normal state. They stated Information can come from a CNA, Therapy, other staff and should be reported to the charge nurse immediately, who in turn should notify the physician. They stated the eInteract (SBAR) should be used to assess the resident for a change in condition because it was very specific to conditions. They were all able to demonstrate how to fill out the e-interact form, and a provided sample. They stated it would be passed on in shift report and documented on the communication sheet for each hall and the SBAR form would stay open in the electronic medical record until the physician was notified. They stated nurses go in for morning report, with management to go over any change that has occurred or new orders on a physician. They stated the inservice was held on, 01/30/2025 for e-interac (SBAR) The Inservice was mandatory. A competency based test was given to each staff member over the information in the Inservice after the inservice . Record review of In-service, Notification of Change in Condition, conducted by CCN, Admin and DON included facility definition, purpose, process for provider notification as it related to all changes or decline in condition are required to be reported to the attending physician by utilizing the facility sanctioned communication documents. Record review of In-service titled, SBAR, conducted by Corporate Nurse, included the SBAR definition, purpose, process, relevant examples, and specific procedure as it related to all surgical wounds/incisions changes or decline in condition to be reported to the surgeon and attending physician by utilizing the facility's SBAR document. Facility Administrator and DON's signatures were included. In interview with the Administrator on 01/31/2025 at 9:50 AM , he stated failure to report a change a change in condition to the resident's nurse could be considered neglect. He stated Immediate notification to a provider for any resident change in condition was important. He Knew what a change in condition was and was able to state signs and symptoms that would indicate a condition change such as change in LOC and the signs and symptoms his staff should be monitoring for infection such as fever, increased behaviors or confusion etc He further stated what and where his staff should be documenting any change in condition in the electronic medical record (EMR) and the other parties that should be notified in addition to the provider. He sufficiently defined abuse, neglect, and/or exploitation and the expectations of his staff to report any observed, reported, or suspected abuse, neglect, and/or exploitation to him immediately. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with the DON on 01/31/2024 at 10:00 AM, she sufficiently explained the importance of immediate notification to a provider for any resident change in condition in order to prevent further decline in health status. She sufficiently stated what would constitute a change in condition and the signs and symptoms her staff should be monitoring for infection. She further stated what and where her staff should be documenting any change in condition in the electronic medical record (EMR) and the other parties that should be notified in addition to the provider. She further stated all nurses were in-serviced and knowledgeable on facility's SBAR document and will utilize it for any change in condition. The Administrator, DON, ADO, and Corporate Nurse was informed the Immediate Jeopardy was removed on 01/31/2025 at 10:24 AM. The facility remained out of compliance at a severity level of actual harm with the potential for more than minimal harm that is not immediate and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems

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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** 41944 Based on interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice and the comprehensive care plan for one of six (Resident #1) residents reviewed for notification of change in condition. The facility failed to ensure Resident #1's feedings were administered as ordered by the physician over a period of 8 days, from 12/22/2024 to 12/30/2024. The facility failed to notify Resident #1's attending physician of feedings being held due to nausea, vomiting and diarrhea. On 12/30/24 Resident #1 required hospitalization for hypovolemic shock, sepsis, UTI, and required emergency surgical intervention for treatment of a rectus abdominus hematoma. An Immediate Jeopardy (IJ) situation was identified on 01/29/2025 at 4:20 pm . The IJ was removed on 01/31 /2025 at 10:24 AM. The facility remained out of compliance at a scope of a pattern with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of a delay in medical intervention, decline in health, serious injury, harm, impairment, or death. Findings include: Record review of Resident #1's face sheet, dated 01/03/2025, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had relevant diagnoses which included cerebral infarct (a condition where blood flow to the brain is interrupted, causing brain tissue to die), dysphagia (difficulty swallowing), other signs and symptoms concerning food and fluid intake, unspecified signs and symptoms involving cognitive function after stroke, speech and language deficits, hypertension (high blood pressure), and long-term use of anticoagulants. Record review of Resident #1's Discharge MDS assessment dated [DATE], reflected she had both short-term and long-term memory problems. She was dependent for bed mobility, transfers, feeding, and maximum assistance with wheelchair mobility wheelchair for mobility. She was incontinent of both bowel and bladder and she had a feeding tube; Record review of Resident #1's Comprehensive Care Plan reflected the following, Focus: Resident has a potential fluid deficit related to tube feedings, goal - the resident will be free of symptoms of dehydration and maintain moist mucous membranes and good skin turgor, interventions - monitor and document frequency of bowel movements, monitor vital signs and report significant abnormalities to physician. Focus, G-tube feeding required due to dysphagia (feeding via a tube inserted through the abdomen surgically into the stomach due to difficulty swallowing). Interventions included: Give 150ml water every shift via gastrostomy tube to equal 450ml/24hrs, Glucerna 1.5 at 57ml/hour with 39ml/hour continuous water flush for 20 hours a day via GT = 1133 ml formula, 1700 kcals, 91gms protein, 2066ml water/24 hours (excludes med flushes), monitor/document/report PRN any signs or symptoms of aspiration, fever, shortness of breath, tube dislodgment, Infection at tube site, self-extubating, tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pain, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, or dehydration. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Throughout the course of the investigation, Resident # 1 was no longer at the facility and was unavailable for interview due to the decline in her condition . Record review of Resident #1's active physician orders from the nursing facility, dated 12/30/2024 reflected her attending physician as Dr W, and contained an order which stated, remove from feeding pump for 4 hours one time a day, and then reconnect to pump one time a day. The orders also stated Resident #1 was NPO (nothing by mouth). Her feeding order was give 150ml water q shift via feeding tube to equal 450ml/24hours, Glucerna 1.5 at 57ml/hour with 39ml/hour continuous water flush for 20 hours a day via g-tube to equal 1133 ml formula, 1700 kcals, 91 gm's protein, and 2066 ml water/24 hours (excludes med flushes). The order had a start date of 07/13/2023. Record review of Resident #1's active physician orders from the nursing facility, dated 12/30/2024 reflected The resident also had an order for Zofran 4 mg every 6 hours as needed for nausea and vomiting. The order had a start date of 07/13/2023. Record review of Resident's #1's MAR for the month of December 2024 revealed she did not receive Zofran 4 mg in the month of November or December until the date of 12/22/2024. Record review of Resident #1's facility nursing progress notes dated 12/22/2024 to 12/30/2024 reflected documentation in the nursing progress notes on 12/22/2024, 12/24/2024, 12/25/2024 x2, 12/27/24 2 times, and 12/30/24 showing the resident received Zofran 4 mg for nausea and vomiting. The order had a start date of 07/13/23. Record review of Resident # 1's physician progress notes authored by NP L with an encounter date 12/19/2024 reflected no evidence of nausea or vomiting and documented pharmacotherapy reviewed, patient on 23 medications. Recommendation for discontinuation of Mylanta Oral Suspension, Ondansetron (Zofran) HCL tablet, and MOM (milk of magnesia)suspension PRN medications as they have not been utilized in the past three months. Record review of Resident #1's Nursing Progress Notes, with a look-back period between 12/22/2024 - 12/30/2024, reflected no documentation related to a completed assessment or notification to a medical provider of Resident #1's continued nausea, vomiting and diarrhea nor any other concerns until 12/30/2024 when LVN A documented the primary care physician was notified. Her blood pressure was documented to be 70/46 with a pulse of 46 by LVN A. Record review of Resident #1's electronic medical record revealed no lab work had been ordered since November 2024. Her Comprehensive Metabolic Panel and Complete Blood Count were within Normal limits at that time. Throughout the course of the investigation 01/03/25 to 01/31/25), Resident # 1 was no longer at the facility and was unavailable for interview due to the decline in her condition. (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 physician ER notes in the ER hospital records, dated 12/30/24, indicated the resident presented with nausea, diarrhea, and abdominal pain. She was diagnosed with hypovolemic shock (shock caused by major blood or fluid loss), sepsis (an extreme reaction by the body to infection) , and abdominal pain. The ER Physician stated in the note Overall, I feel the shock is multifocal, rectus sheath hematoma (a collection of blood cause by a tear in the rectus abdominus muscle of the abdomen) with volume loses secondary to reported nausea and vomiting. Record Review of clinical chart documentation dated 12/30/24, the ER Physician stated The high probability of sudden, clinically significant deterioration in the patient's condition required the highest level of my preparedness to intervene urgently. The service I provided to this patient were to treat and/or prevent clinically significant deterioration that could result In severe disability or death. Further review of the Physician ER note, dated 12/30/25, revealed the resident required transfer to a higher level of care and hospitalization on [DATE] for hypovolemic shock, sepsis, and required emergency surgical intervention for treatment of a rectus abdominus hematoma, the resident was also found to have a UTI. Record review of the lab results, dated 12/30/24, from the ER Record revealed her Lactic Acid was 3.2 H (normal range 0.5 to 2.2 millimoles, a condition where the level of lactic acid in the blood is elevated indicating the liver and kidneys are not are not able to metabolize lactic avid or are producing too much), WBC's 25.31 H,(blood cells that fight infection, the normal range is 4.000 to 11,000. Her urine had many bacteria, 3-4, RBC's (red blood cells carry oxygen to cells and tissues normal range 4.2 to 5.4) Sodium was 128 L (sodium normal range between 135 - 145 an electrolyte that helps regulate water in the body , Chloride 88 L (normal range 96 to 106 it is an elctrolye that main tains fluid volume an acid base balance in the body), Co2 32 H(normal range between 23 and 29 regulates the respiratory rate and the affinity of hemoglobin for oxygen) , BUN 33 H (normal range 6 to 24 high BUN indicates how well the kidneys are removing urea which is a waste product from the blood), Albumin 2.9 L(normal range 3.4 to 5.4 albumin helps transport fluids throughout then body). During an interview on 01/03/2025 at 8:00 AM with Resident # 1's family member, she stated the resident had been in the facility since March of 2024. She stated Resident #1 took her medication and all fluids and nourishment through a tube in her stomach. She stated Resident #1 was in ICU at that time. She stated the resident was admitted to the hospital on 12/30/24. and that was the first time the facility had let the family know how sick she was. She stated the resident was septic and severely dehydrated when she arrived at the hospital with a blood pressure of 48/28. The family member stated Resident #1's room was electronically monitored, and she could see the feeding tube was turned off intermittently from the 21st of December until the time she went to the hospital on 12/3020/24. She stated the ER physician told her there was a foul smell emitting from her gastrostomy tube at the time of her transfer to the hospital. She stated the ER staff told her the odor was so bad there was no way the facility staff could have not known about it. She stated her urine was so concentrated it was the color of tea or coffee. She stated on 12/29/24 she was told by a nurse at the facility (she did not know her name) that Resident #1's color was ashen, and she was concerned about her. She stated the nurse stated she was trying to reach the physician. They finally notified her that they had received orders for transfer, and transferred her to the emergency roiagnom on the 30th of [DATE]. An attempt to interview the ER Physician was unsuccessful on 01/27/2025 at 2:30 PM and 4:30 PM, the purpose of the call and a call back number was left on voicemail. In interview with NP L, on 1/03/2025 at 1:00 PM, she stated she never saw or treated Resident #1 from 12/22/2024 until 12/30/2024 and she was not called by the facility or informed of her nausea, vomiting and diarrhea. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with Resident #1's primary care physician W, on 1/03/2025 at 1:40 PM, he stated he was not notified of a condition change in Resident #1 from 12/22/2024 until 12/30/2024, and was not informed of her nausea, vomiting and diarrhea over the course of 8 days. He stated he was notified on 12/30/2024 and he sent her to the hospital for evaluation. He stated he was never notified that her gastrostomy tube feedings were held. He stated he would have expected the nursing staff to notify him of the condition change after 24 hours with no improvement. He stated that he would have intervened sooner if he had been notified and ordered IV fluids and lab work. In a follow up interview with Primary care physician W on 1/27/2025 at 2:30 PM, he stated he did not know if early intervention would have prevented her hospitalization . He stated interventions such as fluids and labs might have prevented her hospitalization , but it was hard to say. He stated in his opinion in general, most elderly residents in nursing homes did suffer from some degree of dehydration. He stated he did not lay eyes on Resident #1 before he gave orders for her transfer to the hospital for evaluation, therefore he could not say what her condition was at the time of transfer. In an interview on 01/03/2025 at 1:30 PM CNA D stated she worked the 23rd and 24th of December. She stated on the 23rd she doesn't think Resident #1 had nausea or diarrhea during her shift from 6:00 AM until 2:00 PM when she worked. But on the 24th she had diarrhea and vomiting, but she's not sure how many times it occurred. She stated the diarrhea was runny and brownish, reddish in color and the vomit was brown. She stated she reported it to LVN A who also helped her clean Resident #1 up. In an interview on 01/03/2025, CNA E at 1:40 PM stated she took care of the resident 12/23/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/27/2024, and 12/30/2024. She stated the resident vomited and had diarrhea during her 8-hour shift (6am-2pm). She stated she reported this to the charge nurse (LVN A). She stated she remembered Resident # 1 had diarrhea and vomiting for a long time and she reported it to the nurse each time the nausea, vomiting and diarrhea occurred, because it needed to be stopped. She stated she did not remember anything unusual about the color. She also stated several residents on the 500 hall had been sick, but Resident #1 had it longer than the other residents. She stated she did not notice if Resident #1's tube feeding was connected to the pump or if the charge nurse turned the pump off on the 6:00 AM - 2:00 PM shift, because that was the nurse's responsibility. She stated she did not remember how long Resident #1 the vomiting and diarrhea had, but it was for about a week. She stated several of the staff and other residents also had the diarrhea and vomiting at the same time, but Resident #1 had it longer than anyone else. CNA E was not available for a follow up interview. She did not work again during the course of the investigation, and attempts on 01/27/2025 at 2:00 PM and 5:00 PM for a phone interview were unsuccessful. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with LVN A on 01/03/2025 at 2:40 PM, she stated she worked days on 12/23/2024, 12/24/2024, 12/25/2024, 12/26/24, and 12/30/2024. She stated she sent the resident to the hospital. She stated she knew the resident had the diarrhea and vomiting for several days. She stated Dr W had standing orders for Zofran as needed every 6 hours for nausea and vomiting. She stated she heard in the change of shift report given to her by LVN C that Resident #1 vomited and had diarrhea on the night shift. She stated she immediately went down to Resident #1's room to check on her. She stated Resident #1's B/P was 70/46, and she was complaining that her stomach hurt, so she immediately called the physician. She stated Resident #1 was on her way to the hospital by 7:00 Am. She stated she had been off for a few days prior to 12/30/2024 with symptoms of vomiting and diarrhea and 12/30/2024 was her first day back at work since 12/26/2024. She stated she notified the physician on 12/30/2024. She stated she did not notify the physician or the POA of Resident # 1's condition change prior to 12/30/2024 because she didn't think about doing it. In an interview on 01/03/2025 at 3:20 PM, LVN F stated she was the charge nurse and worked 2:00 PM to 10:00 PM on 12/24/2024. She stated on 12/24 /25, LVN A told her she had unhooked her from her feeding and stopped the pump due to nausea and vomiting during the 6:00 AM to 2:00 PM shift. She stated she assessed the resident, and she asked her if she felt better. She stated the resident told her she was not nauseated, and her vital signs were within normal range, so she resumed the feeding. She stated she had never seen Resident #1 have any brown or coffee ground emesis. She stated the tube flushed very well and she never noticed an odor. In a follow up interview on 1/8/2025 at 1:41 PM, LVN A stated she did not recall that Resident #1 ever had emesis of a brownish or coffee ground color as stated by CNA D . She stated it was always the color of the tube feeding. She stated Resident #1 had physician orders for her pump to be off for 4 hours each day . She reviewed her nursing progress notes and the MAR for the month of December during the interview and stated she did turn the pump off on 12/24/24 on the 6 AM -2 PM shift and also held her medications due to nausea and vomiting. She stated she did not notify the physician on 12/24/2024. In an Interview on 01/08/25 at 3:30 PM, LVN C stated she took care of Resident #1 during the time period of 12/21/24 to 12/30/24. She stated she had turned the feeding pump off several times during that time period due to the resident's nausea, vomiting and diarrhea. She stated she did not notify the physician of the resident's condition. She stated she gave the resident Zofran for nausea through the g-tube like everyone else did. She stated, I just never thought about calling the doctor to notify him the resident was not getting better and not able to tolerate her feedings. In an interview with LVN B on 01/08/2025at 3:00 PM, she stated she worked on 12/27/2024 thru 12/29/2024. She stated she stopped Resident #1's pump, and held her medications due to nausea on 12/27/2024. She stated she did not notify the physician. She stated she did not think of notifying the physician. She stated she thought he knew because she had the Zofran ordered for nausea. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the DON on 01/03/2025 at 1:15 PM, she stated she was responsible for monitoring and providing oversight for the Nursing staff of the facility. She stated she was responsible for providing in-services to the staff. She stated she was not aware of Resident #1 having had diarrhea with nausea and vomiting which continued over the course of 8 days from 12/22/2024 to 12/30/2024. She stated her expectation was that staff would notify the resident's physician, POA, or responsible party of any change of condition in a resident. She stated she would have expected a nurse to recognize the symptoms and report the changes. She stated there was a 24-hour communication book that nurses could communicate changes of condition to other shifts. She stated she had looked in the nurses' notes from 12/21/2024 - 12/30/2024 the day of transfer, and she only saw the one notification to the family which was at the time of the transfer. She stated she would have expected them to do an Interact form which should have been done to gather and communicate assessment findings . She stated the nurses were supposed to do an Interact form with a condition change which would assist in cueing the nurse to notify the physician and send them to the hospital. She stated she saw no documentation of that occurring. Review of the 24hour communication book revealed no documentation that the physician had been notified of the condition change or that feedings were held. In an interview with the Administrator on 01/06/2025 at 11:35 AM, he stated his expectations were for the nurse to have reported Resident #1's condition change to the RP and the physician. He stated it was important for facility nursing staff to notify the doctor of any change of condition that required holding of a resident's feedings and of her condition change and continued nausea and vomiting. He stated that he would have intervened sooner if he had known. In an interview with the Administrator at 9:50 AM on 1/13/25, the Administrator stated he was not aware of the situation with Resident #1 until it was brought to his attention by the surveyor. He stated he felt like it was poor nursing care. In an interview with DON on 1/13/2025 at 9:45 AM, she stated that she wanted to let me know that she had suspended LVN C on the 10:00 PM to 6:00 AM shift . She stated that the nurse should have completed an interact form and notified the physician if Resident #1 was unable to tolerate the prescribed tube feeding due to nausea and vomiting. She stated she felt like it was poor nursing care, and she suspended LVN C to investigate the circumstances. She stated she would have notified the physician if she had been the nurse during that shift. She stated she would not want her family treated in that manner. She stated the nurses that worked during that time period should have contacted the physician. She stated turning off the feeding pump could result in dehydration and malnutrition. She stated the physician, the dietician or somebody should have been contacted. She stated LVN A had also quit. She stated Dr W talked to her after talking with the surveyor and he stated that he was not notified and would have expected the nursing staff to notify him of the continued nausea and vomiting and that the feedings were held. He stated he would have intervened sooner. In an interview on 01/13/2025 at 9:15 AM, Resident # 1's POA stated Resident #1 transferred to another SNF on 01/09/2025. She stated she was still concerned with the lack of care she received from 12/22/2024 to 12/30/2024. She stated she felt they almost let her die. Record review of the facility's staffing sheets, provided by the DON, reflected: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN A worked day shift 6:00 AM to 2:00 PM 500 hall on 12/23/2024, 12/24/2024, 12/25/2024, 12/26/2024, 12/30/24 LVN B worked 6:00 AM to 10:00 PM 500 hall on 12/27/2024, 12/28/2024, and on 12/29/2024 LVN C worked night shift 10:00 PM to 6:00 AM 500 hall on 12/24/2024, 12/25/2024, 12/26/2024, and 12/29/2024 LVN F worked evening shift on 12/25/2024, and 12/26/2024 CNA D worked 6:00 AM to 2:00 PM on 12/23/2024, 12/24/2024, 12/26/2024, and 12/30/2024 CNA E worked 6:00 AM to 2:00 PM on 12/23/2024, 12/4/2024, 12/25/2024, 12/26/2024, 12/27/2024, and 12/30/2024. Record review of the facility's policy, Change In a Resident's Condition or Status dated revised May of 2017, reflected in part: Our facility shall promptly notify the resident, his or her attending physician or Nurse Practitioner and the resident representative of changes in the resident's medical/mental condition and/or status. 1. The nurse will notify the physician or nurse practitioner or the physician on call when there has been an accident or incident involving the resident, discovery of injuries of an unknown source, adverse reaction to medication, significant change in the resident's physical/emotional/mental condition, a need to alter the resident's treatment significantly, refusal of medications or treatment 2 or more consecutive times, need to transfer the resident to a hospital, specific instruction to notify the physician of a change in the resident's condition. 2. A significant change of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. Impacts more than 1 area of a resident's health, requires interdisciplinary review and/or revision to the care plan. Record review of facility's policy, titled, Enteral Tube feeding via Continuous Pump, with a revised date of 10/04/2019 reflected the following: The purpose of this procedure is to provide a guideline for the use of a pump for internal feedings. Verify the physicians order for this procedure, review the residence care plan, and provide for any special needs of the resident. Report complications such as diarrhea gastric distension, and respiratory distress promptly to the supervisor and the attending physician. Report negative consequences of tube feeding such as agitation, depression, self extubation, and infections to the supervisor and attending physician. This was determined to be an Immediate Jeopardy (IJ) on 01/29/2025 at 4:20 PM. The Administrator and Clinical Compliance Director were notified. The Administrator, DON, and the CCD were provided with the IJ template on 1/29/2025 at 4:20 PM and a POR was requested. The following Plan of Removal submitted by the facility was accepted on 01/30/2025 at 10:56 PM POR F580 - Notify of Changes (Injury/Decline/Room, Etc.) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #1 was sent to Hospital on 12/30/24. On 1/3/25 due to HHSC entrance of the facility that there was a complaint of resident #1. Facility began to review any other residents with G-tubes no other residents with a G-tube remains in the facility and/or changes in condition, that would result with any required changes of condition and physician notification. oThe Charge nurses reviewed for any other changes of condition, and none were identified on 1/3/25 by oversight from the DON. The underlying cause is the facility failed to ensure the Physician was notified when a resident experienced a change in condition. All residents could have been affected by this alleged deficient practice. oOn 1/3/2025 - Verbal policy review of Policy of Change of Condition or Status/SBAR change of condition was provided by the Corporate Quality Improvement Nurse to DON/ADON, (The policy was reviewed, and verbal comprehension was acknowledged via Q&A and discussion with return demonstration of Situation Background Assessment Recommendations). oIn-services were initiated by the Director of Nursing/Quality Improvement Nurse on 1/6/2025 to educate on notifying physicians immediately following detailed assessment with any resident change of condition to include the use of the SBAR/eInteract (Situation, Background, Assessment and Recommendations to enhance the communication information among team members). Completed on 1/30/2025. oOn 1/6/2025 Education/In-service was initiated to the DON, ADONs by the Corporate Quality Improvement Nurse on the morning clinical start-up process to ensure that any changes of condition would be addressed. Completed 1/6/2025 [NAME] alter the process or system failure the Stop and Watch (early warning communication tool to alert a nurse or manager if they notice something different in a person's daily care routine) was initiated, training and education started to the certified nurses' aides utilizing the alert system on 1/8/25. (Verbal instruction and application along with monitoring of use to ensure understanding and compliance of the communication system) completion date 1/30/2025. oThe SBAR/eInteract is being monitored in the clinical morning startup daily by DON/ADON/Designee. oOversight will be provided by the Administrator/DON/Designee oOn 1/6/25 LVN A resigned and then called in on 1/9, 1/10, 1/13 resignation was accepted immediately. oOn 1/13/25 LVN B resigned with resignation accepted immediately oOn 1/5/25 - LVN C was terminated. oOn 1/17/25 - LVN A, LVN B and LVN C license was referred to the Texas Board of Nursing for further review. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Notification protocol and SBAR understanding will be tested by giving a test to LVNs and RNs that cover SBAR education and notification of physician regarding change of condition. Oversite of the testing will be managed by DON/ADON. (Initiated: 1/30/25) To ensure understanding. This test will be given to new nurses hired during orientation and yearly with competencies. Completion date 1/30/2025. oChange of condition will be reported from shift to shift up to nurse management by utilizing the SBAR/eInteract process and 24-hour report tool and reviewed daily in clinical start-up with oversite provided by DON/ADON/Designee. DON/ADON/Designee will be responsible for reviewing SBAR/24-hour report/nurse to nurse huddle and hand-off, daily at morning clinical start up. This will be with the oversight of the administrator. Discrepancies will be addressed immediately with root-cause analysis and brought to QAPI with the oversite with the Medical Director monthly for six months. Administrator/DON/Designee will review and ensure that understanding comprehension of the protocol. [Facility] Medical Director notified of IJ (01/29/2025) [Facility] Monitoring of the POR Included the following: Verification of POC. 1/31/25 at 9:30 AM with DON present. Reviewed on 01/31/2025 at 9:39 am - Completed. Reviewed 01/31/2025 at 9:43 am - Completed. Reviewed 01/31/2025 at 9:50 am. Completed. On-going 3 staff left, cannot work until in-service completed. oOn 1/06/2025 LVN A resigned and then called in on 01/9, 01/10, 01/13 resignation was accepted immediately. oOn 01/13/2025 LVN B resigned with resignation accepted immediately oOn 01/05/2025 - LVN C was terminated. oOn 1/17/2025 - LVN's A, B, and C license was referred to the Texas Board of Nursing for further review. Reviewed the employee files of Nurses A, B, and C with the documentation of the disciplinary actions taken with the DON 01/31/2025 at 9:56 am. Completed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Reviewed the inservice sheet and the employee list provided by the facility with the D atat 1/31/25 at 9:57 am. The inservice efforts are on-going required for agency and new staff before they are allowed to work All nurses employed at the facility with the exception of 2 nurses on the staff list had completed the inservices. They cannot work until completed. This information stating they should not clock in before they had received the inservice and taken the competency based test. was posted on time clock by the DON. Reviewed letter of notification of Immediate Jeopardy Signed by Medical Director on 01/20/2025. Reviewed signed document with DON. Interview Verification: , On 01/30/2025 at In interviews from 2PM 12:30 AM with LVN G, Charge Nurse (6 AM-2 PM) LVN H (6 AM-2 PM) shift, LVN F(2 PM-10 PM) shift, LVN I (2 PM-10 PM) shift, CMA FF (6 Am -6 PM) shift, LVN K, (6 AM-2PM) shift, LVN L (2 PM -10 PM) shift LVN M PRN, LVN N Agency, CNA D (6am-6pm) shift, LVN O (2 PM - 10 PM) shift, CNA Q (2 PM-10 PM) shift, Agency CNA R. (2 PM - 10 PM) shift, LVN S (6 am - 2 pm)shift, LVN T (10pm-6am) shift, . LVN GG (10 AM-6 PM), RN U (10 PM- 6 AM) shift, CNA V (10 PM -6 AM) shift, CNA X (2 PM- 6 AM) shift, LVN Z (10 PM-6 AM), CNA AA, CNA CC (10am-6pm) shift, and LVN BB (10 AM-6 PM) shft all stated a change of condition was anything that is outside of resident's normal state. They stated Information can come from a CNA, Therapy, other staff and should be reported to the charge nurse immediately, who in turn should notify the physician. They stated the eInteract (SBAR) should be used to assess the resident for a change in condition because it was very specific to conditions. They were all able to demonstrate how to fill out the e-interact form, and a provided sample. They stated it would be passed on in shift report and documented on the communication sheet for each hall and the SBAR form would stay open in the electronic medical record until the physician was notified. They stated nurses go in for morning report, with management to go over any change that has occurred or new orders on a physician. They stated the inservice was held on, 01/30/2025 for e-interac (SBAR) The Inservice was mandatory. A competency based test was given to each staff member over the information in the Inservice after the inservice . Record review of In-service, Notification of Change in Condition, conducted by CCN, Admin and DON included facility definition, purpose, process for provider notification as it related to all changes or decline in condition are required to be reported to the attending physician by utilizing the facility sanctioned communication documents. Record review of In-service titled, SBAR, conducted by Corporate Nurse, included the SBAR definition, purpose, process, relevant examples, and specific procedure as it related to all surgical wounds/incisions changes or decline in condition to be reported to the surgeon and attending physician by utilizing the facility's SBAR document. Facility Administrator and DON's signatures were included. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In interview with the Administrator on 01/31/2025 at 9:50 AM , he stated failure to report a change a change in condition to the resident's nurse could be considered neglect. He stated Immediate notification to a provider for any resident change in condition was important. He Knew what a change in condition was and was able to state signs and symptoms that would indicate a condition change such as change in LOC and the signs and symptoms his staff should be monitoring for infection such as fever, increased behaviors or confusion etc He further stated what and where his staff should be documenting any change in condition in the electronic medical record (EMR) and the other parties that should be notified in addition to the provider. He sufficiently defined abuse, neglect, and/or exploitation and the expectations of hi [TRUNCATED]

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41944 Based on observation, interview, and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for 2 of 2 residents (Resident #2 and Resident #7) reviewed for infection control (incontinent Care). 1. The facility failed to ensure CNA J washed or sanitized her hands before and during incontinent care for Resident #2. 2. The facility failed to ensure CNA D washed or sanitized her hands before and during incontinent care for Resident #7 This deficient practice placed residents at risk for cross contamination and/or acquiring an infection. Findings include: 1. Review of Resident 2's Significant Change in Status MDS assessment dated [DATE] revealed Resident #2 was an [AGE] year-old female originally admitted to the facility on [DATE]. Her cognitive skills for daily decision making were severely impaired with a BIMS score of 2. Resident #2 required maximum assistance with the staff providing over one half of the support of toileting. Resident #2 was always incontinent of bladder and occasionally incontinent of bowel. Review of Resident #2' s Face sheet included the following diagnoses: dementia with behavioral disturbance, urinary tract infection with an onset date of 01/08/2025, diarrhea with an onset date of 01/06/2025 Review of the Care Plan dated revised on 01/04/2025 for Resident #2 revealed the following focus: resident has bowel and bladder incontinence and interventions: check every 2 hours and wash and dry peri area as necessary for incontinent episodes. Report and document for signs and symptoms of UTI pain, burning, blood-tinged urine, deepening of urine color or foul-smelling urine. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 01/07/2025 at 1:15 PM, CNA J provided incontinent care to Resident #2. CNA J entered Resident #2's room, but did not wash her hands before applying gloves. She donned a gown which was due to the resident requiring contact precautions. The gown was improperly donned . The front of the gown hanging down off of her shoulders in the front and not tied in the back leaving her upper back and the backs of her legs exposed. She used one pair of gloves throughout the entire procedure while cleaning the front and the back of Resident #2's perineum. She removed the urine soiled brief and placed a clean brief on the resident, wearing the same gloves that she used to clean the resident's perineal area. She then removed the gloves and saw there was no hand sanitizer in the room. She stated she just realized the resident's room did not have a sink to wash her hands. She then shrugged her shoulders and disposed of the gloves and soiled linen in the trash and left the room. She stated she had an in-service on infection control during her orientation and was competency checked. She stated she had been employed at the facility for 2 months. When asked if she would have done anything differently during the procedure she replied I'm not worried about itand walked away. 2. Review of Resident #7's quarterly MDS dated [DATE] revealed Resident #7 was a [AGE] year-old female originally admitted to the facility on [DATE]. Her cognitive skills for daily decision making were moderately impaired with a BIMS score of 11. Resident #2 required maximum assistance with the staff providing over one half of the support of toileting. Resident #2 was always incontinent of bladder and bowel. Review of Resident #7s Face sheet included the following diagnoses: Muscle wasting and atrophy, Huntington's Disease (a progressive inherited neurologic disease that causes involuntary body movements, memory problems and damages the brain cells), and hypertension (high blood pressure). Review of the Care Plan dated revised on 08/22/2024 for Resident #7 revealed the following focus: resident has bowel and bladder incontinence and interventions: check every 2 hours and wash and dry peri area as necessary for incontinent episodes. Report and document for signs and symptoms of UTI pain, burning, blood-tinged urine, deepening of urine color or foul-smelling urine. During an observation on 01/07/2025 at 1:45 PM, CNA D provided incontinent care to Resident #7 using the proper technique for cleaning the perineal area. CNA D did not remove and change her gloves, and sanitize her hands before touching the clean brief after she removed, and disposed of the urine soiled brief. She washed her hand before leaving the room. In an interview at 1:50 PM on 01/07/2025, CNA D stated she did not sanitize her hands and change her gloves before touching the clean brief that she applied to Resident #7 . She stated the failure to sanitize and change gloves could result in the spread of infection. She stated the reason she made a mistake was because she was so nervous. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During an interview on 01/07/2025 at 2:30 PM, the DON stated she expected staff to remove their gloves and either wash or sanitize their hands after touching a dirty area prior to moving to a clean area when performing incontinent care, and that all staff had been trained on this procedure. She stated she did not know why CNAs J and D failed to perform hand hygiene at the appropriate time. She stated all staff had been instructed on hand washing and infection control. She stated she did competency checks on all CNAs yearly and CNAs J and D had passed a competency check. She revealed that she would do additional in-service training with staff regarding Infection Control and Incontinent Care. She stated the failure to perform hand hygiene during resident care placed the residents at risk for infection. During an interview on 02/07/2025 at 2:25 PM , CNA D stated she normally washed her hands after completing incontinent care and changed her gloves when moving from a dirty area to the clean area. She stated that she was just nervous and didn't remember with the surveyor watching. She stated that she had been trained and checked off on incontinent care by the ADON. Review of the facility's policy titled Perineal Care, revised October 2010, revealed the following elements in part: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition .Steps in the procedure . 2. Wash and dry your hands thoroughly. 6. Put on gloves. 9. Remove gloves and discard into designated container. 10. Wash and dry hands thoroughly. 14. Wash and dry hands thoroughly . Review of the facility's policy titled Handwashing/Hand Hygiene dated December 22, 2023, revealed the following elements in part: The facility considers hand hygiene the primary means to prevent the spread of infection. Use an alcohol-based hand rub containing at least 65 % alcohol, or alternatively soap and water: before going from a contaminated body site to a clean site, after contact with a resident's intact skin, after removing gloves.e.