STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675991	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Humble	19424 McKay Dr Humble, TX 77338

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45604 Based on interview and record review, that facility failed to extend to the resident representative ' s the right to make decisions on behalf of the resident for 1 of 10 residents (CR#1) reviewed for resident rights in that. 1. The facility failed to establish if CR#1 wanted to the leave the facility to the hospital when requested by the Resident Representative (RR) when he was alert and oriented times four. 2. The facility failed to arrange emergency transportation to local hospital when requested by RR for CR#1 when he expressed having trouble breathing on [DATE] and complained of abdominal pain with diarrhea. CR#1 was wheeled to a local hospital on [DATE] and expired while at the hospital on [DATE]. - An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:43pm. While the IJ was removed on [DATE], the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. This failure could place residents at risk of not receiving treatment when requested by the resident or RR. Findings included : Record review of CR#1's face sheet dated, [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] as his own responsible party with diagnoses of metabolic encephalopathy(chemical imbalance in the blood affecting the brain), sepsis(infection), pneumonia (lung infection), end stage renal disease (kidney failure), pleural effusion (excess fluid affecting the lungs), dyspnea(Shortness of breath), atherosclerotic heart disease(plaque buildup in the arteries of the heart), and atrial fibrillation(irregular heartbeat). CR#1 was discharged on [DATE] against medical advice in the care of RR who pushed him by wheelchair to the hospital Record review of CR#1 baseline care plan dated [DATE] with no information to indicate resident cognitive level. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675991	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024

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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 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's admission nursing progress note entered by RN D with effective date [DATE] read in part, .Resident awake alert oriented x4. Resident denies pain or discomfort. No acute distress noted. Lungs clear bilaterally. Respiration even and [unlaboured]. Abdomen soft. Bowel present x 4 [quadrents] . Record review of CR#1's nursing progress note entered by LVN B dated [DATE] read in part Upon arrival, resident noted saying I'm in pain, I don't know what to do repeatedly. When asked for a specific location of pain, resident touched his abdomen, RR present in room. Writer palpated residents abdomen, upper quadrants hard but non distended (enlarged), lower quadrants soft, non distended. Resident states he has frequent regular bowel movements and ,d+[DATE] nurse(LVN A) stated resident had a large bowel movement(bm) on her shift. Vitals assessed and are all wnl (within normal limits), NP (Nurse Practitioner) notified and gave orders to get STAT Chest XRAYS and KUB. Writer informed residents RR of this information however she refused stating he needs to be seen in the ER immediately. Residents RR dressed resident, transferred him into his wheelchair and rolled him out of the facility. RR informed that by making this call, resident is leaving Against Medical Advice(AMA). RR begin calling staff members idiots and continued to leave the facility. DON and NP notified. Record review of CR#1 medical records from local hospital with admitted [DATE] with chief complaint of diarrhea and shortness of breath (SOB). Computed Tomography Scan(CT SCAN a diagnostic imaging procedure) completed of abdomen and pelvis with left free intraperitoneal gas suspicious for perforated hollow viscus (air under the diaphragm suggesting a hole or series of holes in the intestine or bowel) with recommendation for surgical consult. CT SCAN revealed complete collapse of left lower lobe and partial collapse of the right lower lobe. Death summary revealed family declined surgical intervention, made CR#1 do-not-resuscitate (DNR), and resident transition care to comfort measures only. Resident expired on [DATE] while at the hospital. In a phone interview on [DATE] at 9:10 am with RR, she said that CR#1 called her on [DATE] at 5:00am saying he could not breath and his stomach hurt bad, so she went to the facility. She said a nurse came into the room when she arrived at the facility, and said she contacted a doctor, he ordered a x-ray that would take 4 hours. She said she told the nurse (name unknown) she could not wait 4 hours because CR#1 could not breathe, and the nurse said that's what the doctor said to do. She said she told the nurse she was taking him to emergency room (ER). She said that she asked nurses at the facility to help put CR#1 in the car, and she was told they were not allowed to help. She called 911 to take CR#1 to the hospital, Emergency Medical Services (EMS) told her that permission was needed to come on private property, she asked a nurse to give EMS permission to come on the property, and she was told they could not give permission. She said that she had to push CR#1 in his wheelchair to the ER(located 0.6 miles from the facility). She said that while at the hospital CR#1 had a CT scan that confirmed a perforated intestine (diagnostic imaging procedure to confirm presences of a hole or series of holes in the intestine or bowel). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:50am with ADMIN, he said he received a called from RR on [DATE], who was upset about policy and procedure regarding leaving against medical advice (AMA) and where responsibility lies. He said CR#1 was at the facility less than 10 hours, and while admitted complained of abdominal pain. He said that stat KUB (X-ray of abdominal area for causes of abdominal pain) and other tests were ordered but RR did not want to wait. He said that RR took CR#1 from the facility AMA, could not get CR#1 in the vehicle, staff explained that once she took resident from the facility help could not be provided. He said that according to the RR she called 911, was told that permission was required to come to the facility, but he had not heard of a dispatcher needing permission to come to the facility before. In an interview on [DATE] at 12:48pm with LVN C, she said that she worked from 6:00am-2:00pm on [DATE] as the treatment nurse. She said that she was going to respond to the call light of CR#1, RR came into the hall as she approached the door, she asked if RR if she needed anything, and RR said she was taking CR#1 to the hospital. She said that she told RR to allow her to get LVN B, the nurse assigned to the hall. She said that she told LVN B that RR wanted to take CR#1 to the hospital, and she went back to her duties. She said that she overheard nursing staff (names unknown) saying that CR#1 was leaving AMA, she did not hear the details why, or if staff offered assistance with transportation. In a phone interview on [DATE] at 12:59pm with LVN B, she said that she worked on [DATE] from 6:00am-2:00pm. She said that at 7:00am RR was at the facility an alerted that CR#1 was having abdominal pain and there was no mention of CR#1 having trouble breathing. She said that she assessed CR#1, his stomach was not distended, his vitals were in normal range, CR#1 said that he had pain in abdomen, RR said she wanted CR#1 to go to the hospital, and she explained to RR that she had to call the doctor first. She said that she called NP, who ordered stat labs and x-ray. She said that she returned to the room of CR#1 who had been dressed and placed in wheelchair by RR, and RR said that she was not willing to wait on labs and she was taking CR#1 to the hospital immediately. She said that she told RR to wait on labs and then they could send CR#1 out to the hospital. She said that she called DON, while RR called 911 as she was taking CR#1 to the front entrance, and she tried to explain that CR#1 would be leaving AMA. She said that RR was still on the phone with 911 as she passed LVN C, RR spoke to LVN C, RR called them idiots, and left the facility with CR#1. She said that RR never asked her for assistance or for her to speak with anyone while on the phone with 911. She said that she did not follow RR and CR#1 outside and she was unsure if other staff followed them. She said that process if resident or family was requesting to go out to the hospital was to notify the physician for an order, if physician does not give the order, the family or resident can call 911 themselves. In a phone interview on [DATE] at 1:28pm with NP, he said that he was notified CR#1 was having abdominal pain, orders given for stat x-ray and KUB, but residents family was refusing and wanted to go to the hospital. He said that if a resident or family was wanting to refuse treatment and go the hospital, he would always say send them to the hospital. He said that a resident and family have the right to refuse treatment and go to the hospital. He said that he could not see a situation where he would not give order to send resident to the hospital when requested, by resident or family as long as family has POA (Power of Attorney) and can make decision. In an interview on [DATE] at 2:03pm with CNA E, he said that he worked 6:00am-2:00pm on [DATE]. He said that he was running late to work, and it was approximately 7:00am when he saw CR#1 being pushed in a wheelchair by RR towards the hospital. He said that he reported what he saw to the DON when got to the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 3:40am with LVN A, she said that during shift change RR complained that the abdomen of CR#1 looked distended while she was giving report at the end of her shift. She said that three were two other nurses (names unknown) present to assess CR#1. She said that his stomach did not appear to be distended but RR wanted CR#1 to go to the hospital. She said that they tried explaining that it was not the facility protocol to send resident to the hospital without order from doctor and the doctor may request labs first. She said that another nurse in the room told RR that she could call 911. She said that RR wheeled CR#1 out of the facility. In an interview on [DATE] at 4:16pm with DON, she said that she started at the facility in January of 2024. She said that she was told that the RR of CR#1 signed him out AMA and took him to the hospital. She said that staff told her they saw RR pushing CR#1 to the hospital. She said that there were calls to the facility with concerns that two residents had eloped because they were seen walking to the hospital. She said that RR spoke to ADMIN and said that she called 911, but EMS was not dispatched because they needed permission to come on the property. She said that she did an in-service (training) after the incident because it was bad for optics and concerns for customer service after the facility received calls with concerns that two residents had eloped and were seen walking down the street. She said that staff should consider if resident is able to speak for themselves when the request is made by family. She said that staff should contact the doctor because a resident cannot be discharged or transferred without an order from the doctor, or it is considered AMA. She said that if staff tell doctor that family or resident is wanting to go the hospital and the physician says to let them go that is not AMA. She said that resident and family have the right to call 911, remain inside of the facility and wait on EMS to arrive. She said that staff should speak with 911 dispatcher if requested. In a follow up interview on [DATE] at 11:47am with LVN C, she said that she was nowhere near RR and CR#1 while RR was on the 911 call. She said that she was never asked to speak with 911 dispatcher, and he was not asked to help transfer CR#1 into the vehicle of RR so that he could be taken to the hospital. She said that she never entered the room of CR#1 and she only saw him briefly from the hallway. In a phone interview on [DATE] at 12:20pm with Physician, she said that a resident or responsible party have the right to refuse treatment and request transfer to hospital, and she has never not provided an order to transfer a resident when requested. She said that if a resident discharged AMA, she would expect the facility to follow their policy. She said if a resident discharged AMA and there was a concern with their safety during the discharged , she would give an order to send the resident to the hospital by 911. She said that a resident being pushed to the hospital by a relative would be considered unsafe. In a phone interview on [DATE] at 1:05pm with LVN B, she said that she worked on [DATE] from 6:00am-2:00pm. She said that RR left the facility with CR#1 before she could give her the discharge AMA documents, she left before she had a chance to do anything. She said that she did not follow RR and CR#1 to the front of the building or outside of the facility. She said RR did not ask her to speak with 911 or for assistance with getting CR#1 into her vehicle. She said that she had been trained that staff could not help with transferring to a vehicle. She said that there had been no training on what step should be taken after a resident is outside of the facility during a discharge AMA. (continued on next page)

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F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 1:16pm with LVN A, she said that both LVN B and LVN C were present in the room when CR#1 was assessed for abdominal pain, but she did not remember if it was LVN B or LVN C that told RR to call 911. She said RR did not ask her to speak with 911 or for assistance with getting CR#1 into her vehicle. She said that she had been trained that staff could not help with transferring to a vehicle. She said that there had been no training on what step should be taken after a resident was outside of the facility during a discharge AMA. In an interview on [DATE] at 2:03pm with RN I, she said that did not work on [DATE] but she knew that State Survey Agency (SSA) was investigating CR#1 being pushed in a wheelchair to the hospital by RR. She said that if she had been on duty the situation would not have gotten that far because she would have assessed resident, called the physician, and asked for order to send CR#1 to the hospital by 911 or scheduled transport depending on RR request. She said there has never been situation that a physician declined the order. She said that she would have done what ever was necessary to prevent the family from walking to the hospital because that was not safe. She said there had been no training about what step should be taken in a situation like what happened to CR#1, only that you provide care while in facility and cannot help with transferring the resident into a vehicle once the leave the facility. She said although she had not been trained to do so, she would have followed CR#1 and RR to parking lot to ensure she was going to be able to transfer the resident safely to the vehicle. She said that if she observed the transfer to be unsafe, RR was unable to get CR#1 in the car or started walking with CR#1 she would have called 911, followed by DON, Administrator, and physician. In an interview on [DATE] at 2:28pm with CSD, he said that he was a RN with corporate office. He was not made aware of situation with CR#1 being discharged AMA. He said that if a resident or responsible party requested to have a resident sent to the hospital the nurse should first ask to assess the resident so that notification could be made to the physician. He said that the physician may give orders for treatment prior to the order to go the hospital. He said that if the resident or responsible party are not in agreement with treatment then the nurse should call the physician and give information to physician for order of emergency or non-emergency transportation to the hospital based on what resident or responsible party wanted. He said that if a physician declines to provide the order the family could be educated on calling 911 but staff should be available to assist. He said if the decision is to discharge AMA, care would still be provided to a resident while inside of the facility. He said that staff are not able to help transfer a resident to vehicle because the facility can be liable if something happened during the transfer once outside of the facility. He said that staff should be contacting the DON or ADMIN when there is a discharge AMA for instructions. In an interview on [DATE] at 3:04pm with RVP, she said that she was not made aware of situation with CR#1 being discharged AMA. She said that if a resident or responsible party was requesting to be sent to the hospital, staff should notify the physician for an order to send the resident based on the request by emergency or non-emergency transport. She said that resident and responsible have the right to decline treatment and seek treatment at the hospital. (continued on next page)

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F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:13pm with local emergency service staff, he said that he reviewed the 911 call placed on [DATE] between 6:43am-7:00am by RR, and RR was clearly inside of the facility. He said that he may not have all the details correct but he could provide his account of what he remembered hearing. He said that RR said that CR#1 needed to go the hospital due to stomach pain. He said that the dispatcher asked to speak to someone inside of the facility, and RR could be heard asking for someone at the facility to speak with the dispatcher, and staff could beard in the background refusing to get on the phone. He said that the dispatcher told RR that since she was still inside of the facility EMS could not be dispatched and told her she could once she was outside of the facility. He said that there were no calls from the facility or RR from outside of the facility. In an interview on [DATE] at 4:40pm with ADMIN, he said that he spoke with the local emergency service staff about the 911 call. He said that he was not concerned about the call because RR said that CR#1 was having stomach pain and not SOB, as accounted by the staff. He said that he was told that staff was in the background saying that they were handling the situation. In an interview on [DATE] at 10:15am with Medical Director, he said that a resident or responsible party have the right to decline treatment and seek treatment at the hospital. He said that staff should call the physician to provide information on why the resident or responsible party was insisting to go to the hospital and request an order in line to what the resident or responsible party is requesting. He said that when the family is at the bed side, they may see something that staff may not see. He said that he had never heard of a situation when a physician blocked a resident or responsible party from going to the hospital when they are insisting. He said that there should never be a situation where a resident is pushed to the hospital by wheelchair because staff did not obtain an order to send the resident to the hospital by emergency or non-emergency transport when requested. He said that staff should use their best judgement and call 911 to avoid the situation. Record review on [DATE] at 12:22pm of written statement provided by local emergency service staff read in part, .On 18th of February, 2024, at 07:43:03 hrs, our dispatchers in the police department received a 911 call . On the call she states that she wanted to request an ambulance .for CR#1 because he was having some breathing issues and his stomach was hurting. The dispatcher stated that, because her husband was a patient at that medical facility, the staff would have to request us to come and take him to another medical facility. The dispatcher then asked if one of the staff members could maybe speak with her, versus having to call separately requested that t . staff speak with the dispatcher and give permission for the ambulance to come and take her husband (the patient). The staff was heard on the 911 call stating that they would not speak with the 911 dispatcher she was going to take him to the hospital herself and then disconnected the call . In a phone interview on [DATE] at 12:30pm with LVN A, she said CR#1 was alert but had some confusion, and she did not remember anyone asking CR#1 if he wanted to go to the hospital or asking RR if she had legal authority to make decisions. In a phone interview on [DATE] at 12:54pm with CNA F, she said she worked on [DATE] on double shift starting at 2:00pm, and she left at 5:00am on [DATE]. She said that during her shift CR#1 was alert but had some confusion. In an interview on [DATE] at 3:09pm with CNA E, he said that during his shift on [DATE] from 6:00am-10:00pm CR#1 was alert but had some confusion. (continued on next page)

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F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 8:30 am with LVN C, she said when RR and CR#1 were at the front lobby area near entrance there were staff at the nursing station, but she could not recall who. She said that RR was on the phone calling 911, but she did not stick around to hear what was being said. She said CR#1 appeared to be alert, and she did not remember any asking CR#1 what he wanted. In a phone interview on [DATE] at 10:57am with RR, she said that she had dual Power of Attorney (POA) executed to make medical and final decision for CR#1 since 2016. She said that no one at the facility asked if she had a POA. She said that CR#1 did have some confusion, but he was alert and able to talk. She said that no one at the facility asked CR#1 if he wanted to go to the hospital. She said that she was given an admission packet at admission, and it had information on rights and facilities policy procedures. Record review on [DATE] at 1:20pm of dual Power of Attorney (POA) executed to make medical and final decision between CR#1 and RR date [DATE]. Record review on [DATE] at 9:43am of the audio recording of the911 call provided by local city officials. In the call RR could be heard on the call with a dispatcher requesting emergency assistance for CR#1, due to CR#1 being unable to breath and abdominal pain. The dispatcher requested to speak with staff at the facility. RR responded that staff would not help, and staff would not help place CR#1 in her vehicle so that RR could transport to the hospital. The dispatcher explained to RR that emergency services could not be dispatched unless the call came from the facility. RR could be heard asking staff to speak with the dispatcher, staff could be heard saying that they could not speak with dispatcher, and RR could be heard saying that CR#1 would die because staff could not assist and emergency would not be dispatched. The dispatcher was heard explaining to RR that emergency service could not be dispatched without speaking to staff, and RR replied with staff would not speak with dispatcher, RR would push CR#1 to the hospital, they would freeze, and CR#1 would die from pneumonia. In an interview on [DATE] at 12:03pm with LVN W, she said that worked on the morning of [DATE] from 6:00am-2:00pm. She said that heard yelling at the front of the building at lobby. She said that when she approached the nurses' station, she could see CR#1 seated in wheelchair with RR, they were still inside the facility near the nurses station, and the only staff present was LVN C. She said that RR was on the phone with 911 but she did not hear the call from the beginning. She said that RR was asking for EMS, but she guessed the dispatcher was not going to send EMS because she said that, thank you for nothing, she was going to push him to the hospital, if CR#1 got pneumonia and died it would be on everyone, hung up the call, and pushed CR#1 out of the building. She said that LVN C told her that CR#1 was discharging AMA. She said she did not know if RR had legal authority to take CR#1 from the facility. She said that CR#1 appeared to be alert, and LVN C or she asked CR#1 if he wanted to leave the facility to go to the hospital. In a phone interview on [DATE] at 1:02pm with LVN B, she said that CR#1 was alert, but she did not remember asking if he wanted to go to the hospital. She did not remember asking RR if she had the legal authority to make decisions for CR#1. (continued on next page)

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F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 1:22pm with Director of Admission, she said that prior to admission she tries to obtain information on responsible party and if there was a POA. She said that if she receives the POA she files it in her office. She said that she does not have a way to document her efforts prior to admission because there was no chart. She said that if information was not received prior to admission the resident was named their own responsible party until follow up can be made by admission or social worker to confirm. She said that upon admission there was another attempt to get the information. Record review of facility policy titled, Statement of Resident Rights, undated revealed, in part, You, the resident, do not give up any rights when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law .You have a right to: 1. All care necessary for you to have the highest possible level of health and welfare; 21. Discharge yourself from the facility unless you have been adjudicated mentally incompetent; Record Review of facility policy titled Discharging a Resident without a Physician's Approval Dated Revised [DATE] revealed, in part, .A physician's order should be obtained for all discharges, unless a resident or representative is discharging himself or herself against medical advise .7. The charge nurse will assist with arranging emergency transport or regular transport as applicable upon resident or representative (sponsor) request Record Review of facility policy titled Transfer or Discharge, Emergency Dated Revised [DATE] revealed, in part, .Policy Statement. Emergency transfers or discharges may be necessary to protect the health and/or well-being of the resident(s). Policy Interpretation and Implementation. 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institutions, our facility will implement the following procedures: a. notify the residents attending physician; c. prepare the resident for transfer; f. assist in obtaining transportation; and g. others as appropriate or as necessary Record Review of facility policy titled Transportation, Social Services Dated Revised [DATE] revealed, in part, .Policy Statement. Our facility shall help arrange transportation for residents as needed. 1. Except in emergencies, the resident or his or her representative (sponsor) shall be expected to arrange for transportation This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified on [DATE]. The Administrator was provided with the IJ template on [DATE] 5:42pm. The following Plan of Removal submitted by the facility was accepted on [DATE] 9:46 AM. The plan of removal reflected the following: Facility Name: Plan of Removal -The facility failed to arrange emergency transportation to local hospital for CR#1 when requested by the responsible party on [DATE]. (continued on next page)

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F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	What corrective actions have been implemented for the identified residents? F. On [DATE] CR#1 involved in alleged deficient practice was discharged to the hospital against medical advice per(for each) RR's request and did not return to the facility. He was discharged via(by means of) non-emergency services and completed by RR. The attending physician was notified on [DATE] at 7:31 am and this was documented in the resident clinical record. G. On [DATE] at 6:30 pm Administrator notified the Medical Director, and the attending physician of alleged deficient practice. H. Facility auditing the resident's medical record from [DATE] to [DATE] to determine if a POA was listed and the POA was included. Social Workers and Medical Records will be completing the audit, and the completion date is [DATE]. I. Regional [NAME] President reviewed facility policy on [DATE] regarding resident rights and no revisions were deemed necessary. J. On [DATE] LVN A received a 1:1 training on Resident Rights Establishing from the resident if they want to go to the hospital when the POA requests and Assisting residents POA with arranging transportation when they request for the resident to be sent to the hospital. Training was provided by Director of Nursing and Assistant Director of Nursing. K. On [DATE] LVN B received a 1:1 training on Resident Rights Establishing from the resident if they want to go to the hospital when the POA requests and Assisting residents POA with arranging transportation when they request for the resident to be sent to the hospital. Training was provided by Director of Nursing and Assistant Director of Nursing. L. On [DATE] LVN C received a 1:1 training on Resident Rights Establishing from the resident if they want to go to the hospital when the POA requests and Assisting residents POA with arranging transportation when they request for the resident to be sent to the hospital. Training was provided by Director of Nursing and Assistant Director of Nursing. M. On [DATE] LVN D[LVN W] received a 1:1 training on Resident Rights Establishing from the resident if they want to go to the hospital when the POA requests and Assisting residents POA with arranging transportation when they request for the resident to be sent to the hospital. Training was provided by Director of Nursing and Assistant Director of Nursing. How were other residents at risk to be affected by this deficient practice identified? B. All residents have the potential to be affected by the alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? (continued on next page)

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	675991	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Manor of Humble	19424 McKay Dr Humble, TX 77338

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F 0551 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	D. An in-service was initiated on [DATE] by the Director of Nursing and Nurse Managers with the licensed nursing staff on the Resident Rights Policy. In-service includes, Establishing from the resident if they want to go to the hospital when the POA requests and Assisting residents POA with arranging transportation when they request for the resident to be sent to the hospital. Licensed nurses will not be allowed to return to work until they receive this in-service. Nurses who are unable to physically attend the in-service training in person will be in-serviced via (by means of) phone. The completion date was [DATE]. E. Licensed nursing staff will complete a Resident's Rights Pre/Post Test Competency. Nurses in-serviced over the phone will not be allowed to work until they complete the Resident's Rights Pre/Post Test Competency. The completion date was [DATE]. F. During the in-service training, there will be a discussion. QA to ensure understanding and competency. Learning will be measured by a pre/post-test, nurses who fail will be further educated and/or progressively disciplined as indicated. The completion date was [DATE]. G. An in-service was completed on [DATE] by the Administrator with the Admissions Director, Director of Business Director, and Social Worker on Obtaining the Power of Attorney. The completion date was [DATE]. In-service includes, Requesting a copy of the POA Before Admission. Quality Assurance An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on [DATE] with the Medical Director. The Medical Director has reviewed and agrees with this plan. The State Surveyor(SS) confirmed the Plan of Removal for the IJ by monitoring from [DATE] through [DATE] as follows: In an on [DATE] at 11:26am with Unit Manager A, she said that she was an LVN. She said that she had been trained on Residents rights. She said that if a resident with a responsible party makes a care decision, the nurse must consider the rig [TRUNCATED]

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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 - Few	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** 45604 Based on observation, interview, and record review , the facility failed to consult with the resident's physician; and notify the resident representative for 1 of 10 residents (CR#1) reviewed for change of condition, in that, 1. LVN A failed to immediately notify the physician on [DATE] when CR#1 was observed with diarrhea, and LVN A failed to immediately notify the physician when CR#1 said he was having trouble breathing on [DATE]. CR#1 was admitted to a local hospital on [DATE] and died while in the hospital on [DATE]. 2. The facility failed to establish if CR#1 wanted to the leave the facility to the hospital when requested by the Resident Representative (RR) when he was alert and oriented times four. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] 11:27am. While the IJ was removed on [DATE], the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could expose residents to low quality of care, worsening of condition, hospitalization , and death. Findings included: Record review of CR#1's face sheet dated, [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] as his own responsible party with diagnoses of metabolic encephalopathy(chemical imbalance in the blood affecting the brain), sepsis(infection), pneumonia (lung infection), end stage renal disease (kidney failure), pleural effusion (excess fluid affecting the lungs), dyspnea (Shortness of breath), atherosclerotic heart disease (plaque buildup in the arteries of the heart), and atrial fibrillation (irregular heartbeat). CR#1 was discharged on [DATE]. Record review of electronic medical records (EMR) for CR #1 did not reveal progress notes completed by LVN A on [DATE], or Situation, Background, Assessment, and Recommendation (SBAR) completed by LVN A regarding CR#1 change in condition after he expressed having trouble breathing or observed with diarrhea on [DATE]. Record review of physician order summary for CR#1 revealed no orders for anti-diarrhea medication. Record review of CR#1 baseline care plan dated [DATE] with no information to indicate CR#1 admitted with diarrhea. Record review of CR#1 medical records from local hospital with admitted [DATE] and discharge date of [DATE] revealed in the discharge summary no diagnosis for diarrhea an no orders for anti-diarrhea medication was provided at discharge. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1 medical records from local hospital with admitted [DATE] with chief complaint of diarrhea and shortness of breath (SOB). Computed Tomography Scan(CT SCAN a diagnostic imaging procedure) completed of abdomen and pelvis with left free intraperitoneal gas suspicious for perforated hollow viscus (air under the diaphragm suggesting a hole or series in the intestine or bowel) with recommendation for surgical consult. CT SCAN revealed complete collapse of left lower lobe and partial collapse of the right lower lobe. Death summary revealed family declined surgical intervention, made CR#1 do-not-resuscitate (DNR), and resident transition care to comfort measures only. Resident expired on [DATE] while at the hospital. In an interview on [DATE] at 9:10 am with RR, she said that CR#1 complained of being unable to breath and stomach pain. She said that she did not want to wait four hours while the facility had imaging done. She said that she wheeled CR#1 to a local hospital after facility staff refused to help transfer CR#1 to her vehicle, facility staff refused to help arrange transportation, and she was not able to get assistance with transportation from Emergency Medical Services (EMS) when she contacted 911. In an interview on [DATE] at 2:03pm with CNA E, he said that he worked a double on [DATE] from 6:00am-2:00pm and 2:00pm 10:00pm. He said that he rounded during shift change on second shift with another CNA (name unknown), and CR#1 was observed on the floor of his room. He said that CR#1 had diarrhea. He said that a nurse (name unknown) was alerted who came to assess CR#1. He said that CR#1 said appeared to have normal breathing. He did not know what was done to treat diarrhea. In a phone interview on [DATE] at 2:03pm with CNA F, she said that she worked from 3:20pm on [DATE] to 5:00am on [DATE]. She said that CR#1 complained his stomach was hurting and had diarrhea. She said that CR#1 went to the bathroom approximately four times with diarrhea. She said that the nurse (name unknown) gave CR#1 medication for his stomach, but she was unsure what the name of the medication was. She said that CR#1 did not say he was having trouble breathing. In a phone interview on [DATE] at 3:40am with LVN A, she said that she worked on [DATE] from 10:00pm until 6:00am on [DATE]. She said that at the start of the shift CR#1 was observed with diarrhea, and she gave him over the counter medication, loperamide. She said that CR#1 had two more episodes of diarrhea after the medication was given, and the diarrhea had subsided by the morning of [DATE]. She said that right before shift change, CR#1 said he was having trouble breathing. She said that she observed CR#1 laying down, with breathing unlabored. She said that she checked CR#1 vitals and oxygen saturation was between , d+[DATE]. She said that she elevated the head of CR#1. In a phone interview on [DATE] at 12:20pm with Physician, she said that she confirmed that nursing staff did not contact the on-call service or NP when CR#1 had trouble breathing or diarrhea, both would be considered a change in condition and required notification. She said that notification would still be required even if the oxygen saturation was in normal range. She said that notification was completed when CR#1 expressed he was having abdominal pain and after he had a fall. She said that orders would have been provided to address both diarrhea and complaint of having trouble breathing at the same time with the abdominal pain. She said that it was important to have the information since CR#1 had pneumonia and sepsis. She said that based on the information provided orders would have been given for testing and treatment of diarrhea prior to deciding to send CR#1 to the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 12:45pm with NP, he said that when he was contacted after CR#1 complained of abdominal pain he was not informed there was a concern for diarrhea or with residents breathing. He said that notification would be required if a resident had trouble breathing with an oxygen saturation in range. He said that staff should have provided the information to an on-call physician or when they spoke with him because both incidents are a change in condition. He said that it was important to have the information due to CR#1 diagnosis of pneumonia and sepsis He said that he would have given additional orders for testing and treatment of diarrhea before deciding to send CR#1 to the hospital. In a phone interview on [DATE] at 1:05pm with LVN B, she said that she worked on [DATE] from 6:00am-2:00pm. She said that LVN A, CR#1, or RR had not disclosed to her that CR#1 had diarrhea or trouble with his breathing. She said that both incidents are considered a change in condition. She said that if CR#1 said he had trouble breathing and his oxygen saturation was in normal range it would still be a change in condition. She said that notification should have been made to the physician. She said that if she had been made aware of the change in condition, she would have provided the information to NP when CR#1 expressed he had abdominal pain. In a phone interview on [DATE] at 1:16pm with LVN A, she said that CR#1 never told her that he had trouble breathing and she denied that she had provided the information in a previous interview. She said that a resident expressing they had trouble breathing with oxygen saturation in normal range is not a change of condition and she had no need to complete to a SBAR but the information should have been documented. She said that when CR#1 had diarrhea it was a change in condition, and she did notify the physician to treat the diarrhea. She said that there should have been a progress note and SBAR completed, and if tasks were not completed it, should have been done. In an interview on [DATE] at 2:20pm with DON, she said that if a resident had trouble breathing that would be a change in condition even with a normal range oxygen saturation. She said that the resident's physician should have been notified so that orders to treat the issues could have been provided. She said that without treatment the condition could progress, and the resident may need to be sent to the hospital. She said that when there is a change in condition staff should notify the physician, complete a SBAR, and progress note. In an interview on [DATE] at 2:28pm with CSD, he said that he is a RN with corporate office. He said that if a resident expressed, they had trouble breathing even when the oxygen saturation is in normal range it would be considered a change in condition. He said that the physician should be notified so it could be determined why the resident had trouble breathing, and if the physician was not notified when there was a respiratory issue the resident could end up being sent to the hospital. He said that when there is a change in condition staff should notify the physician, complete a SBAR, and progress note. Record Review of facility policy titled Change in a Resident's Condition or Status Dated Revised [DATE] revealed, in part, Policy Statement. Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Policy Interpretation and Implementation. 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . d. significant change in the resident's physical/emotional/mental condition; . i. specific instruction to notify the Physician of changes in the resident's condition . (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified on [DATE] 11:23am. The Administrator was provided with the IJ template on [DATE] 11:27 am. The following Plan of Removal submitted by the facility was accepted on [DATE] at 6:44pm. The plan of removal reflected the following: Plan of Removal Name of Facility: What corrective actions have been implemented for the identified residents? A. On [DATE] resident CR#1 involved in alleged deficient practice was discharged to the hospital against medical advice per RR's request and did not return to the facility. The attending physician was notified on [DATE] at 7:31 am and this was documented in the resident clinical record. B. On ,d+[DATE]/ 2024 at 12:16 pm Administrator notified the Medical Director, and the attending physician of alleged deficient practice. C. Nurse Managers completed a 100% respiratory assessment of all residents residing in the facility for respiratory concerns on [DATE], and none were identified. D. Facility auditing the change in conditions from [DATE] to the [DATE] for respiratory concerns and notification to the physician. Nurse Managers will be auditing, and the completion date is [DATE]. E. Clinical Services Director reviewed facility policy on [DATE] regarding notification of physician and no revisions were deemed necessary. How were other residents at risk to be affected by this deficient practice identified? A. All residents have the potential to be affected by the alleged deficient practice. What does the facility need to change immediately to keep residents safe and ensure it does not happen again? A. An in-service was initiated on [DATE] by the Corporate Clinical Service Director and Director of Nursing with the licensed nursing staff to notify the attending physician immediately when a change of condition occurs. In-service includes Report any changes from resident's baseline to the physician. Licensed nurses will not be allowed to return to work until they receive this in-service. The completion date is [DATE]. B. An in-service was initiated on [DATE] by DON and the Administrator with the facility frontline staff, CNAs, housekeeping, dietary, and rehab staff on reporting any changes immediately in resident conditions to the charge nurse. The completion date is [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. Newly hired nurses will be in-serviced by the Director of Nursing or designee on immediately notifying the attending physician of patient change of conditions. How will the system be monitored to ensure compliance? A. The 24-hour report will be reviewed daily by the Director of Nursing or designee to audit nurse documentation in progress notes notifying the attending physician of patient change of conditions. Discrepancies noted during reviews will be immediately corrected by contacting the attending physician of the change of condition and completing documentation in the patient's progress note. Further training will be provided as identified by the nurse manager who identified the discrepancy when and if necessary. Review will be documented on an audit report form. B. The DON/designee will review 24-hour report to ensure nurses document timely notification to the attending physician of resident changes of condition 2x week X 6 weeks. Review will be documented on an audit report form. C. Administrator will review the audit reports on a weekly basis to ensure nurse managers are following the plan of correction for six weeks. Review will be documented on an audit report form. Quality Assurance An impromptu Quality Assurance and Performance Improvement (QAPI) review of the plan of removal was completed on [DATE] with the Medical Director. The Medical Director has reviewed and agrees with this plan. The State Surveyor (SS) confirmed the Plan of Removal for the IJ by monitoring from [DATE] through [DATE] as follows: In a phone interview on [DATE] at 10:15am with Medical Director, he said that he participated by phone in a QAPI to discuss change of condition. He said that staff should report any change of condition to the primary physician, nurse practitioner, on call physician, and he can be contacted if other contacts fail. He said that change in condition would include respiratory issues even with normal oxygen saturation and Diarrhea. He said that a failure to report a change to a physician could cause delay in care, exacerbate the condition, require a higher level of care, and cause a resident to need hospitalization . In an interview on [DATE] at 11:26am with DON while MDS Nurse was present. She said that there was not a progress note or SBAR completed to show that CR#1 had diarrhea. If resident had diarrhea. She said that diarrhea would be considered a change in condition if the resident had not admitted with the diagnosis. She reviewed CR#1 admission medical records and admission progress note with no information regarding diarrhea. She reviewed CR#1 physician orders with no orders provided for loperamide. She said that if CR#1 had diarrhea the physician should have been notified for orders on treatment, and medication should not have been given without an order. She said that without the order the nurse would be practicing outside of the scope of a nurse. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:26am with DON while MDS Nurse was present. She said that there was not a progress note or SBAR completed to show that CR#1 had diarrhea. If resident had diarrhea. She said that diarrhea would be considered a change in condition if the resident had not admitted with the diagnosis. She reviewed CR#1 admission medical records and admission progress note with no information regarding diarrhea. She reviewed CR#1 physician orders with no orders provided for loperamide. She said that if CR#1 had diarrhea the physician should have been notified for orders on treatment, and medication should not have been given without an order. She said that without the order the nurse would be practicing outside of the scope of a nurse. In a phone interview on [DATE] at 12:30pm with LVN A , she said she did not notify a physician when CR#1 had diarrhea. She said that she had been trained on change in condition. She said that she gave CR#1 over the counter anti diarrhea medication without a physician order, she did not enter a progress or SBAR, or tell any other staff during shift change that CR#1 had been treated for diarrhea. She said that she got overwhelmed with duties, she forgot to complete the steps, and she had been trained to do so. She said that she meant to call the doctor after she gave the medication, she forgot, and it was stupid mistake. She said that she knew that an order was needed prior to giving any medication. She said that she had been suspended. She said that she practiced outside of her scope as a nurse, could have put CR#1 at risk, and if the physician was contacted, they may have provided different orders. In an interview on [DATE] at 2:48pm with LVN G, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's baseline. She said that a notification to physician, family, and facility management should be made when there is a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that anyone that was not a RN or LVN were trained to report a change in condition to a nurse immediately and they can document the change on stop and watch a form similar to a SBAR. In an interview on [DATE] at 2:54 pm with RN H, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's normal behavior or condition. She said that a notification to physician, family, and facility management should be made when there is a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that anyone that was not a RN or LVN were trained to report a change in condition to a nurse immediately and they can document the change on stop and watch a form similar to SBAR. In an interview on [DATE] at 2:58 pm with RN I, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's baseline. She said that a notification to physician, family, and facility management should be made when there is a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that anyone that was not a RN or LVN were trained to report a change in condition to a nurse immediately and they can document the change on stop and watch a form similar to SBAR. In an interview on [DATE] at 3:00pm with LVN J, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's baseline. She said that a notification to physician, family, and facility management should be made when there was a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that anyone that was not a RN or LVN were trained to report a change in condition to a nurse immediately and they can document the change on stop and watch a form similar to SBAR. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 3:03pm with CNA K, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's normal health or behavior. She said that she was trained that she has to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form or complete the documentation in the EMR for the resident. In an interview on [DATE] at 3:06pm with RA L, she said that she was trained prior to shift on topic, Change in Condition. She said that she was trained that she had to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form that are located at the nurse station. She defined a change in condition as anything medical, issue or behavior she had not seen the resident to have prior. In an interview and observation on [DATE] at 3:09pm with CNA E, he said that he was trained prior to shift on topic, Change in Condition. He said that he was trained to report a change in condition to a nurse immediately. He said that he can document the change in the EMR, but he was not sure of the name of the form the change is documented on. He demonstrated in the EMR how to complete a new alert for a resident using the stop and watch. He defined a change in condition as a new symptom or behavior he had not been aware of a resident to have prior. In an interview on [DATE] at 3:13pm with COTA, PTA, and SLP, who said that they were trained prior to shift on change in condition, they defined change in condition as change from residents baseline that must be reported immediately to a nurse, and documented on the stop and watch form if staff do not have access to EMR for residents. In an interview on [DATE] at 3:20pm with CNA M, she said that she had not received a training prior to shift 2:00pm-10:00pm. She was not able to define a change in condition, who to report a change to, or how the change would be documented. In an interview and observation on [DATE] at 3:24pm with CNA N, he said that he was trained prior to shift on topic, Change in Condition. He said that he was trained to report a change in condition to a nurse immediately. He said that he can document the change in the EMR on stop and watch. He demonstrated in the EMR how to complete a new alert for a resident using the stop and watch. He defined a change in condition as anything new from a resident's baseline. In an interview on [DATE] at 3:29pm with DON and CSD, both were informed that CNA M denied being trained, and they both said that CNA M had been trained and they would pull CNA M from the floor to provide additional training. In an interview on [DATE] at 3:32pm with LVN O, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's baseline. She said that a notification to physician, family, and facility management should be made when there was a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that anyone that was not a RN or LVN were trained to report a change in condition to a nurse immediately and they can document the change on stop and watch a form similar to SBAR. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:33pm with CNA P, she said that she was trained prior to shift on topic, Change in Condition. She defined a change in condition as anything from a resident's normal baseline. She said that she was trained that she had to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form or complete the documentation in the EMR for the resident under stop and watch. In an interview on [DATE] at 4:35pm with Dietary Manager, she said that she was trained prior to shift on topic, Change in Condition. She said that all staff in dietary had been trained prior to shift. She defined a change in condition as anything from a resident's baseline. She said that she was trained that she had to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form and give it to a nurse. In an interview on [DATE] at 4:39pm with RN D, she was not knowledgeable on the topic of change in condition. In an interview on [DATE] at 4:55pm with Cook, she said that she had been trained on abuse and neglect at the start of her shift and there was another topic put she could not recall the name or details of the training. In an interview on [DATE] at 5:00pm with DON, RVP, and CSD, they were made aware that Cook and RN D was not knowledgeable of training on change in condition, and they both said that she would be pulled and retained. In an interview on [DATE] at 5:37am with RN Q, he said that he had been trained [DATE] on change in condition. He defined a change in condition as anything out of the baseline. He said that a notification to physician, family, and facility management should be made when there is a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. He said that all other staff were trained to report a change immediately to RN or LVN, and document on stop and watch. In an interview on [DATE] at 5:43am with RN R, she said that she had been trained [DATE] on change in condition. She defined a change in condition as anything out of the baseline. She said that a notification to physician, family, and facility management should be made when there was a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that all other staff were trained to report a change immediately to RN or LVN, and document on stop and watch. In an interview on [DATE] at 5:46am with CNA S, she could not provide information on training on topic of change in condition. In an interview on [DATE] at 6:01am with CNA T, she said that she was trained prior to shift on topic, Change in Condition on [DATE]. She defined a change in condition as anything from a resident's normal condition that was new. She said that she was trained that she had to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form or complete the documentation in the EMR for the resident under stop and watch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675991	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER: Park Manor of Humble		STREET ADDRESS, CITY, STATE, ZIP CODE: 19424 McKay Dr Humble, TX 77338	

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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 - Few	In an interview on [DATE] at 6:08am with CNA U, she said that she was trained prior to shift on [DATE]. She could not remember name of the training, but she was trained to report changes in the residents health or behavior to a nurse immediately. She said that she can document the change in the EMR or by form that are located at the nurse's station. In an interview on [DATE] at 6:13am with CNA M, she said that she was trained on [DATE] on topic, Change in Condition. She defined a change in condition was any new symptom that a resident did not have before, that could be with health or behavior. She said that she was trained that she had to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form or complete the documentation in the EMR for the resident under stop and watch. In an interview on [DATE] at 6:18am with CNA V she said that she was trained on [DATE] on topic, Change in Condition. She defined a change in condition was any unusual or not the normal for a resident's health or behavior. She said that she was trained that she had to report a change in condition to a nurse immediately. She said that she can document the change on a stop in watch form or complete the documentation in the EMR for the resident under stop and watch. In an interview on [DATE] at 7:55am with DON, she was informed of CNA S inability to provide information on the training topic of change in condition. In an interview on [DATE] at 8:47am with Floor Tech, he said that he was trained on [DATE] on change in condition. He defined a change in condition as something he had not observed before with a resident's health or behavior. He said that he had to report the change to a nurse immediately and document it on the stop and watch form. In an interview on [DATE] at 8:54am with Housekeeper, she said that she was trained on [DATE] on change in condition. She defined a change in condition as anything new with a resident's health or behavior. She said that she had to report the change to a nurse immediately and document it on the stop and watch form. In a phone interview on [DATE] at 9:38am with CNA S, she said that she received one on one training on topic change in condition and stop and watch. She defined as change in condition as something new from a resident's baseline. She said that she had to report to a nurse immediately, she could fill out the stop and watch form at the nurse station, but as a CNA she should document in EMR for the resident. In a phone interview on [DATE] at 9:41am with RN D, said that she received a one-on-one training on [DATE] on change in condition. She defined a change in condition as anything out of the resident's normal behavior or medical condition. She said that a notification to physician, family, and facility management should be made when there was a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that all other staff were trained to report a change immediately to RN or LVN. In a phone interview on [DATE] at 9:46am with Cook, she said that she received one on one training on topic change in condition and stop and watch. She defined a change in condition as a resident being sick, looks sick, or change from their behavior that she had not seen before. She said that she had to report to a nurse immediately, she could fill out the stop and watch form at the nurse station. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 9:50am with MDS Nurse, she said that she completed an audit for change in conditions from [DATE] to the [DATE] for respiratory concerns and notification to the physician with concerns identified. She said that she had been trained [DATE] on change in condition. She defined a change in condition as anything out of the baseline. She said that a notification to physician, family, and facility management should be made when there is a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that all other staff were trained to report a change immediately to RN or LVN, and document on stop and watch. In an interview on [DATE] at 8:45am with LVN C, she said that she had been trained [DATE] on change in condition. She defined a change in condition as anything out of the baseline. She said that a notification to physician, family, and facility management should be made when there is a change in condition, and progress note, physician orders, and SBAR should be completed in EMR. She said that all other staff were trained to report a change immediately to RN or LVN, and document on stop and watch. In an interview on [DATE] at 10:57am with RR, she said that she was made aware of CR#1 had diarrhea by CR#1 and nurse at the facility the night of [DATE]. She said that she was told that CR#1 received medication to treat the diarrhea. She said that when she arrived at the facility the morning of [DATE] he no longer complained of diarrhea. Record review of the plan of removal was completed from [DATE] through[DATE]: -In-service training documentations were reviewed with all staff scheduled trained prior to the start of their shift, with no newly hired employees. -Respiratory assessment of all current residents for respiratory concerns completed on [DATE] by unit managers with no issues identified. -Audit on change in conditions from [DATE] to the [DATE] for respiratory concerns and notification to the physician completed by MDS on XXX[DATE] with no concerns identified. -Notification made to the Medical Director who participated in Impromptu QAPI to address change in condition completed on [DATE]. An [NAME] [TRUNCATED]

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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	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 (CR #1) out of 10 residents reviewed for quality of care in that: 1-The facility failed to obtain physician orders on [DATE] prior to treating CR#1 with loperamide to treat diarrhea. 2-The facility failed to arrange emergency transportation to local hospital when requested by RR for CR#1 when he expressed having trouble breathing on [DATE] and complained of abdominal pain with diarrhea. CR#1 was wheeled to a local hospital on [DATE] and expired while at the hospital on [DATE]. 3-The facility failed to establish if CR#1 wanted to the leave the facility to the hospital when requested by the Resident Representative (RR) when he was alert and oriented times four. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 4:20 pm. While the IJ was removed on [DATE], the facility remained out of compliance due to the facility's need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could expose residents to low quality of care, worsening of condition, hospitalization , and death. Findings included: Record review of CR#1's face sheet dated, [DATE], reflected he was a [AGE] year-old male, admitted to the facility on [DATE] as his own responsible party with diagnoses of metabolic encephalopathy (chemical imbalance in the blood affecting the brain), sepsis(infection), pneumonia (lung infection), end stage renal disease (kidney failure), pleural effusion (excess fluid affecting the lungs), dyspnea(Shortness of breath), atherosclerotic heart disease(plaque buildup in the arteries of the heart), and atrial fibrillation(irregular heartbeat). CR#1 was discharged on [DATE]. Record review of CR#1 baseline care plan dated [DATE] with no information to indicate CR#1 admitted with diarrhea. Record review of CR#1's entry MDS (Minimum Data Set) assessment dated [DATE] reflected an admitted [DATE]. The MDS assessment indicated CR#1 had a pay source of Medicare and Medicaid was pending. Record review of CR#1's undated physician order summary did not reveal orders for loperamide , used to control and relieve the symptoms of diarrhea. Record review of electronic medical records (EMR) for CR #1 did not reveal progress notes completed, or Situation, Background, Assessment, and Recommendation (SBAR) completed by LVN A regarding CR#1 change in condition after he expressed having trouble breathing or diarrhea on [DATE] to LVN A. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of electronic medical records (EMR for CR #1) did not reveal a Situation, Background, Assessment, and Recommendation (SBAR) completed by LVN B regarding CR#1 change in condition after he expressed abdominal pain on [DATE] to LVN B. Record review of CR#1's nursing progress note entered by LVN B dated [DATE] read in part Upon arrival, resident noted saying I'm in pain, I don't know what to do repeatedly. When asked for a specific location of pain, resident touched his abdomen, RR present in room. Writer palpated residents abdomen, upper quadrants hard but non distended (enlarged), lower quadrants soft, non distended. Resident states he has frequent regular bowel movements and ,d+[DATE] nurse(LVN A) stated resident had a large bowel movement(bm) on her shift. Vitals assessed and are all wnl (within normal limits), NP (Nurse Practitioner) notified and gave orders to get STAT Chest XRAYS and KUB. Writer informed residents RR of this information however she refused stating he needs to be seen in the ER immediately. Residents RR dressed resident, transferred him into his wheelchair and rolled him out of the facility. RR informed that by making this call, resident is leaving Against Medical Advice(AMA). RR begin calling staff members idiots and continued to leave the facility. DON and NP notified. Record review of CR#1 medical records from local hospital with admitted [DATE] and discharge date of [DATE] revealed in the discharge summary no diagnosis for diarrhea and no orders for loperamide was provided at discharge. Record review of CR#1 medical records from local hospital with admitted [DATE] with chief complaint of diarrhea and shortness of breath (SOB). Computed Tomography Scan(CT SCAN a diagnostic imaging procedure) completed of abdomen and pelvis with left free intraperitoneal gas suspicious for perforated hollow viscus (air under the diaphragm suggesting a hole or series of holes in the intestine or bowel) with recommendation for surgical consult. CT SCAN revealed complete collapse of left lower lobe and partial collapse of the right lower lobe. Death summary revealed family declined surgical intervention, made CR#1 do-not-resuscitate (DNR), and resident transition care to comfort measures only. Resident expired on [DATE] while at the hospital. In a phone interview on [DATE] at 9:10 am with RR, she said that CR#1 called her on [DATE] at 5:00am saying he could not breath and his stomach hurt bad, so she went to the facility. She said a nurse came into the room when she arrived at the facility, and said she contacted a doctor, he ordered a x-ray that would take 4 hours. She said she told the nurse (name unknown) she could not wait 4 hours because CR#1 could not breathe, and the nurse said that's what the doctor said to do. She said she told the nurse she was taking him to emergency room (ER). She said that she asked nurses at the facility to help put CR#1 in the car, and she was told they were not allowed to help. She called 911 to take CR#1 to the hospital, Emergency Medical Services (EMS) told her that permission was needed to come on private property, she asked a nurse to give EMS permission to come on the property, and she was told they could not give permission. She said that she had to push CR#1 in his wheelchair to the ER (located 0.6 miles from the facility). She said that while at the hospital CR#1 had a CT scan that confirmed a perforated intestine (diagnostic imaging procedure to confirm presences of a hole or series of holes in the intestine or bowel). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 10:50am with ADMIN, he said he received a called from RR on [DATE], who was upset about policy and procedure regarding leaving against medical advice (AMA) and where responsibility lies. He said CR#1 was at the facility less than 10 hours, and while admitted complained of abdominal pain. He said that stat KUB (X-ray of abdominal area for causes of abdominal pain) and other tests were ordered but RR did not want to wait. He said that RR took CR#1 from the facility AMA, could not get CR#1 in the vehicle, staff explained that once she took resident from the facility help could not be provided. He said that according to the RR she called 911, was told that permission was required to come to the facility, but he had not heard of a dispatcher needing permission to come to the facility before. In an interview on [DATE] at 12:48pm with LVN C, she said that she worked from 6:00am-2:00pm on [DATE] as the treatment nurse. She said that she was going to respond to the call light of CR#1, RR came into the hall as she approached the door, she asked if RR if she needed anything, and RR said she was taking CR#1 to the hospital. She said that she told RR to allow her to get LVN B, the nurse assigned to the hall. She said that she told LVN B that RR wanted to take CR#1 to the hospital, and she went back to her duties. She said that she overheard nursing staff (names unknown) saying that CR#1 was leaving AMA, she did not hear the details why, or if staff offered assistance with transportation. In a phone interview on [DATE] at 12:59pm with LVN B, she said that she worked on [DATE] from 6:00am-2:00pm. She said that at 7:00am RR was at the facility an alerted that CR#1 was having abdominal pain and there was no mention of CR#1 having trouble breathing. She said that she assessed CR#1, his stomach was not distended, his vitals were in normal range, CR#1 said that he had pain in abdomen, RR said she wanted CR#1 to go to the hospital, and she explained to RR that she had to call the doctor first. She said that she called NP, who ordered stat labs and x-ray. She said that she returned to the room of CR#1 who had been dressed and placed in wheelchair by RR, and RR said that she was not willing to wait on labs and she was taking CR#1 to the hospital immediately. She said that she told RR to wait on labs and then they could send CR#1 out to the hospital. She said that she called DON, while RR called 911 as she was taking CR#1 to the front entrance, and she tried to explain that CR#1 would be leaving AMA. She said that RR was still on the phone with 911 as she passed LVN C, RR spoke to LVN C, RR called them idiots, and left the facility with CR#1. She said that RR never asked her for assistance or for her to speak with anyone while on the phone with 911. She said that she did not follow RR and CR#1 outside and she was unsure if other staff followed them. She said that process if resident or family is requesting to go out to the hospital is to notify the physician for order, if physician does not give the order, the family or resident can call 911 themselves. In a phone interview on [DATE] at 1:28pm with NP, he said that he was notified CR #1 was having abdominal pain, orders given for stat x-ray and KUB, but residents family was refusing and wanted to go to the hospital. He said that if a resident or family was wanting to refuse treatment and go the hospital, he would always say send them to the hospital. He said that a resident and family have the right to refuse treatment and go to the hospital. He said that he could not see a situation where he would not give order to send resident to the hospital when requested, by resident or family as long as family has POA (Power of Attorney) and can make decision. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 2:03pm with CNA E, he said that he worked a double on [DATE] from 6:00am-2:00pm and 2:00pm 10:00pm. He said that he rounded during shift change on second shift with another CNA (name unknown), and CR#1 was observed on the floor of his room. He said that CR#1 had diarrhea. He said that a nurse (name unknown) was alerted who came to assess CR#1. He said that CR#1 said appeared to have normal breathing. He did not know what was done to treat diarrhea. He said that worked 6:00am-2:00pm on [DATE]. He said that he was running late to work, and it was approximately 7:00am when he saw CR#1 being pushed in a wheelchair by RR towards the hospital. He said that he reported what he saw to the DON when got to the facility. In a phone interview on [DATE] at 2:03pm with CNA F, she said that she worked from 3:20pm on [DATE] to 5:00am on [DATE]. She said that CR#1 complained his stomach was hurting and had diarrhea. She said that CR#1 went to the bathroom approximately four times with diarrhea. She said that the nurse (name unknown) gave CR#1 medication for his stomach, but she was unsure what the name of the medication was. She said that CR#1 did not say he was having trouble breathing. In a phone interview on [DATE] at 3:40am with LVN A, she said that she worked on [DATE] from 10:00pm until 6:00am on [DATE]. She said that at the start of the shift CR#1 was observed with diarrhea, and she gave him over the counter medication, loperamide. She said that CR#1 had two more episodes of diarrhea after the medication was given, and the diarrhea had subsided by the morning of [DATE]. She said that right before shift change, CR#1 said he was having trouble breathing. She said that she observed CR#1 laying down, with breathing unlabored. She said that she checked CR#1 vitals and oxygen saturation was between , d+[DATE]. She said that she elevated the head of CR#1. She said that during shift change RR complained that the abdomen of CR#1 looked distended while she was giving report at the end of her shift. She said that three were two other nurses (names unknown) present to assess CR#1. She said that his stomach did not appear to be distended but RR wanted CR#1 to go to the hospital. She said that they tried explaining that it was not the facility protocol to send resident to the hospital without order from doctor and the doctor may request labs first. She said that another nurse in the room told RR that she could call 911. She said that RR wheeled CR#1 out of the facility. In an interview on [DATE] at 4:16pm with DON , she said that she started at the facility in January of 2024. She said that she was told that the RR of CR#1 signed him out AMA and took him to the hospital. She said that staff told her they saw RR pushing CR#1 to the hospital. She said that there were calls to the facility with concerns that two residents had eloped because they were seen walking to the hospital. She said that RR spoke to ADMIN and said that she called 911, but EMS was not dispatched because they needed permission to come on the property. She said that she did an in-service (training) after the incident because it was bad for optics and concerns for customer service after the facility received calls with concerns that two residents had eloped and were seen walking down the street. She said that a resident or family can refuse treatment and request to be sent to the hospital. She said that staff should consider if resident was able to speak for themselves when the request was made by family. She said that staff should contact the doctor because a resident cannot be discharged or transferred without an order from the doctor, or it was considered AMA. She said that if staff tell a doctor that family or resident wanted to go the hospital and the physician says to let them go that was not AMA. She said that resident and family have the right to call 911, remain inside of the facility and wait on EMS to arrive. She said that staff should speak with 911 dispatcher if requested. She said that staff are not able to assist with transferring a resident into a personal vehicle after leaving AMA because the resident and family have taken responsibility at that time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a follow up interview on [DATE] at 11:47am with LVN C, she said that she was nowhere near RR and CR#1 while RR was on the 911 call. She said that she was never asked to speak with 911 dispatcher, and he was not asked to help transfer CR#1 into the vehicle of RR so that he could be taken to the hospital. She said that she never entered the room of CR#1 and she only saw him briefly from the hallway. She said that CR#1 appeared to have normal breathing, she was not aware of CR#1 to have diarrhea or abdominal pain. She said that if a resident or family member were refusing treatment and requested resident transferred to the hospital she would explain to the family the steps she needed to take first, which included assessment of resident, followed by contacting the physician to provide information of the assessment and get order to send the resident to the hospital in the way requested by resident or family to avoid discharging AMA. She said that she has never had a physician refuse to provide the order to transfer to the hospital to avoid discharging AMA. She said if a resident or family were speaking with 911 dispatcher and to help with transfer she would speak with dispatcher if requested. She said that she had been trained that if a resident has discharged AMA, staff cannot help with transfers to get them in the car, but no other training was provided about what to do after. She said that she would help transfer to the car even though she was trained not to ensure the resident made it safely inside the car. In a phone interview on [DATE] at 12:20pm with Physician, she said that a resident or responsible party have the right to refuse treatment and request transfer to hospital, and she has never not provided an order to transfer a resident when requested. She said that if a resident discharged AMA she would expect the facility to follow their policy. She said if a resident discharged AMA and there was a concern with their safety during the discharged , she would give an order to send the resident to the hospital by 911. She said that a resident being pushed to the hospital by a relative would be considered unsafe. In a phone interview on [DATE] at 1:05pm with LVN B, she said that she worked on [DATE] from 6:00am-2:00pm. She said that LVN A, CR#1, or RR had not disclosed to her that CR#1 had diarrhea or trouble with his breathing. She said that both incidents are considered a change in condition. She said that notification should have been made to the physician. She said that if she had been made aware of the change in condition, she would have provided the information to NP when CR#1 expressed he had abdominal pain. She said that RR left the facility with CR#1 before she could give her the discharge AMA documents, she left before she had a chance to do anything. She said that she did not follow RR and CR#1 to the front of the building or outside of the facility. She said RR did not ask her to speak with 911 or for assistance with getting CR#1 into her vehicle. She said that she had been trained that staff could not help with transferring to a vehicle. She said that there had been no training on what step should be taken after a resident was outside of the facility during a discharge AMA. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a phone interview on [DATE] at 1:16pm with LVN A, she said that CR#1 never told her that he had trouble breathing and she denied that she had provided the information in a previous interview. She said that a resident expressing they had trouble breathing with oxygen saturation in normal range is not a change of condition and she had no need to complete to a SBAR but the information should have been documented. She said that when CR#1 had diarrhea it was a change in condition, and she did notify the physician to treat the diarrhea. She said that there should have been a progress note and SBAR completed, and if tasks were not completed it, should have been done. She said that both LVN B and LVN C were present in the room when CR#1 was assessed for abdominal pain, but she did not remember if it was LVN B or LVN C that told RR to call 911. She said RR did not ask her to speak with 911 or for assistance with getting CR#1 into her vehicle. She said that she had been trained that staff could not help with transferring to a vehicle. She said that there had been no training on what step should be taken after a resident is outside of the facility during a discharge AMA. In an interview on [DATE] at 2:03pm with RN I, she said that did not work on [DATE] but she knew that State Survey Agency (SSA) was investigating CR#1 being pushed in a wheelchair to the hospital by RR. She said that if she had been on duty the situation would not have gotten that far because she would have assessed resident, called the physician, and asked for order to send CR#1 to the hospital by 911 or scheduled transport depending on RR request. She said there has never been situation that a physician declined the order. She said that she would have done what every was necessary to prevent the family from walking to the hospital because that was not safe. She said there had been no training about what step should be taken in a situation like what happened to CR#1, only that you provide care while in facility and cannot help with transferring the resident into a vehicle once the leave the facility. She said although she had not been trained to do so, she would have followed CR#1 and RR to parking lot to ensure she was going to be able to transfer the resident safely to the vehicle. She said that if she observed the transfer to be unsafe, RR was unable to get CR#1 in the car or started walking with CR#1 she would have called 911, followed by DON, Administrator, and physician. In an interview on [DATE] at 2:28pm CSD said that he was a RN with corporate office. He was not made aware of situation with CR#1 being discharged AMA. He said that if a resident or responsible party requested to have a resident sent to the hospital the nurse should first ask to assess the resident so that notification could be made to the physician. He said that the physician may give orders for treatment prior to the order to go the hospital. He said that if the resident or responsible party are not in agreement with treatment then the nurse should call the physician and give information to physician for order of emergency or non emergency transportation to the hospital based on what resident or responsible party wanted. He said that if a physician declines to provide the order the family could be educated on calling 911 but staff should be available to assist. He said if the decision is to discharge AMA, care is still provided while inside of the facility. He said that staff are not able to help transfer a resident to vehicle because the facility can be liable if something happened during the transfer once outside of the facility. He said that staff should be contacting the DON or ADMIN when there is a discharge AMA for instructions. In an interview on [DATE] at 3:04pm with RVP, she said that she was not made aware of situation with CR#1 being discharged AMA. She said that if a resident or responsible party was requesting to be sent to the hospital, staff should notify the physician for an order to send the resident based on the request by emergency or non-emergency transport. She said that a resident or responsible party have the right to decline treatment and seek treatment at the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675991	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/14/2024
NAME OF PROVIDER OR SUPPLIER Park Manor of Humble		STREET ADDRESS, CITY, STATE, ZIP CODE 19424 McKay Dr Humble, TX 77338	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:13pm with local emergency service staff, he said that he reviewed the 911 call placed on [DATE] between 6:43am-7:00am by RR, and RR was clearly inside of the facility. He said that he may not have all the details correct but he could provide his account of what he remembered hearing. He said that RR said that CR#1 needed to go the hospital due to stomach pain. He said that the dispatcher asked to speak to someone inside of the facility, and RR could be heard asking for someone at the facility to speak with the dispatcher, and staff could beard in the background refusing to get on the phone. He said that the dispatcher told RR that since she was still inside of the facility EMS could not be dispatched and told her she could once she was outside of the facility. He said that there were no calls from the facility or RR from outside of the facility. In an interview on [DATE] at 4:40pm with ADMIN, he said that he spoke with the local emergency service staff about the 911 call. He said that he was not concerned about the call because RR said that CR#1 was having stomach pain and not SOB, as accounted by the staff. He said that he was told that staff was in the background saying that they were handling the situation. In an interview on [DATE] at 9:40am with DON and ADMIN present. She said that any medication that was given to a resident must have a physician order prior to administering the medication. She said that the facility does have over the counter medication in stock. She said that she did not know if the facility had standing orders for over-the-counter medications, but she would find out. In an interview on [DATE] at 10:15am with Medical Director, he said that a physician order must be obtained prior to administering the medication to include over the counter medication. He said that if staff provided a medication without an order the staff would be practicing outside of their scope as a nurse. He said that the risk to a resident could be adverse reaction to the medication, may require further treatment, or being sent to the hospital. He said that a resident or responsible party have the right to decline treatment and seek treatment at the hospital. He said that staff should call the physician to provide information on why the resident or responsible party is insisting to go to the hospital and request an order in line to what the resident or responsible party is requesting. He said that when the family is at the bed side, they may see something that staff may not see. He said that he had never heard of a situation when a physician blocked a resident or responsible party from going to the hospital when they are insisting. He said that there should never be a situation where a resident is pushed to the hospital by wheelchair because staff did not obtain an order to send the resident to the hospital by emergency or non-emergency transport when requested. He said that staff should use their best judgement and call 911 to avoid the situation. Interview on [DATE] at 11:08am with DON, she said that the facility does not have standing orders for medications and all medications require an order. She said that she was unsure if they had loperamide in stock for over-the-counter medication but she would find out. In an interview on [DATE] at 11:20am with DON, she said that the facility did have the over-the-counter medication loperamide that is used to treat diarrhea, and she provided an unopened box to view. She said that she was unsure of how to view medication orders on a discharged resident, but she would find out. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 11:26am with DON while MDS Nurse was present said that there was not a progress note or SBAR completed to show that CR#1 had diarrhea. If resident had diarrhea. She said that diarrhea would be considered a change in condition if the resident had not admitted with the diagnosis. She reviewed CR#1 admission medical records and admission progress note with no information regarding diarrhea. She reviewed CR#1 physician orders with no orders provided for loperamide. She said that if CR#1 had diarrhea the physician should have been notified for orders on treatment, and medication should not have been given without an order. She said that without the order the nurse would be practicing outside of the scope of a nurse. She said that nursing staff never provided information that CR#1 was treated for diarrhea and the information was new to her. Record review on [DATE] at 12:22pm of written statement provided by local emergency service staff read in part, .On 18th of February, 2024, at 07:43:03 hrs, our dispatchers in the police department received a 911 call . On the call she states that she wanted to request an ambulance .for CR#1 because he was having some breathing issues and his stomach was hurting. The dispatcher stated that, because her husband was a patient at that medical facility, the staff would have to request us to come and take him to another medical facility. The dispatcher then asked if one of the staff members could maybe speak with her, versus having to call separately requested that t . staff speak with the dispatcher and give permission for the ambulance to come and take her husband (the patient). The staff was heard on the 911 call stating that they would not speak with the 911 dispatcher she was going to take him to the hospital herself and then disconnected the call . In a phone interview on [DATE] at 12:30pm with LVN A, she said she did not notify a physician when CR#1 had diarrhea. She said that she gave CR#1 over the counter anti diarrhea medication without a physician order, she did not enter a progress or SBAR, or tell any other staff during shift change that CR#1 had been treated for diarrhea. She said that she got overwhelmed with duties and she forgot to complete the steps. She said that she meant to call the doctor after she gave the medication, she forgot, and it was stupid mistake. She said that she knew that an order was needed prior to giving any medication. She said that she had been suspended. She said that she practiced outside of her scope as a nurse, could have put CR#1 at risk, and if the physician was contacted, they may have provided different orders. Record Review of facility policy titled Administering Medications Dated Revised [DATE] revealed, in part, Policy Statement. Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 3.Medications must be administered in accordance with the orders, including any required time frame . Record Review of facility policy titled Discharging a Resident without a Physician's Approval Dated Revised [DATE] revealed, in part, .A physician's order should be obtained for all discharges, unless a resident or representative is discharging himself or herself against medical advise . Record Review of facility policy titled Transfer or Discharge, Emergency Dated Revised [DATE] revealed, in part, .Policy Statement. Emergency transfers or discharges may be necessary to protect the health and/or well-being of the resident(s). Policy Interpretation and Implementation. 4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institutions, our facility will implement the following procedures: a. notify the residents attending physician; c. prepare the resident for transfer; f. assist in obtaining transportation; and g. others as appropriate or as necessary (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of facility policy titled Transportation, Social Services Dated Revised [DATE] revealed, in part, .Policy Statement. Our facility shall help arrange transportation for residents as needed. 1. Except in emergencies, the resident or his or her representative (sponsor) shall be expected to arrange for transportation This was determined to be an Immediate Jeopardy (IJ) on [DATE]. The Administrator was notified on [DATE]. The Administrator was provided with the IJ template on [DATE] 4:17pm. The following Plan of Removal submitted by the facility was accepted on [DATE] 1:19pm. The plan of removal reflected the following: Facility Name: Plan of Removal -The facility failed to obtain physician orders on [DATE] prior to treating CR#1 with loperamide to treat diarrhea. -The facility failed to arrange emergency transportation to local hospital for CR#1 when requested by family on [DATE]. What corrective actions have been implemented for the identified residents? A. On [DATE] resident CR#1 involved in alleged deficient practice was discharged to the hospital against medical advice per R R's request and did not return to the facility. The attending physician was notified on [DATE] at 7:31 am and this was documented in the resident clinical record. B. On [DATE] at 5:00 pm Administrator notified the Medical Director, and the attending physician of alleged deficient practice. C. On [DATE] LVN A was in-serviced on Notifying the Physician Immediately of Change of Condition Occurs and Obtaining Orders from the Physician before Treating the Resident. D. On [DATE] LVN A was suspended on [DATE] pending investigation due to investigation findings. E. On [DATE] LVN B was in-serviced on Assisting Residents/RR with Arranging Emergency Transportation Upon Request. F. Clinical Services Director reviewed facility policy on [DATE] regarding notification of physician and no revisions were deemed necessary. G. Clinical Services Director reviewed facility policy on [DATE] regarding administering medications and no revisions were deemed necessary. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	H. Clinical Services Director reviewed facility policy on [DATE] regarding discharging a resident without a physician's approval and revisions were made. Summary of revision: The Administrator and Director of Nursing will be promptly notified. The Charge Nurse will assist with arranging emergency transport or regular transport as applicable upon resident or representative (sponsor) request. The Attending physician will be up [TRUNCATED]