STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER: Focused Care at Pasadena		STREET ADDRESS, CITY, STATE, ZIP CODE: 3434 Watters Rd Pasadena, TX 77504	

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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** 46561 Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (CR#1) of five residents reviewed for quality of care. The facility failed to immediately assess and treat CR #1 and contact the doctor from [DATE]- [DATE] after CR#1 experienced ongoing vomiting and distress. CR#1 was transported to the hospital on [DATE] at 11am. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 4:31 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for delay in needed treatment and care. Findings included: Record review of CR#1's face sheet dated [DATE] reflected he was an [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), dysphagia (difficulty swallowing) Type II Diabetes, and hypertension (high blood pressure). He was coded to DNR. Record review of CR #1's care plan last updated [DATE] reflected he had an ADL self-care performance deficit accompanied with impaired balance and limited mobility. CR#1 also had the potential for complications related to the diagnosis of hypertension. Interventions initiated [DATE] stated to monitor/document/report any s/s of headaches, confusion, disorientation, difficulty breathing, and nauseas and vomiting. Record review of CR #1 doctors' orders from [DATE]- [DATE] reflected that there was no documentation (orders) that CR #1 received medication for acid reflux, vomiting, or pain. (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the shift-to-shift report on [DATE]- [DATE] documented by the night nurse LPN A reflected that each resident had either a handwritten update regarding their condition from that shift or the words ok next to their nane. CR #1 did not have any documentation next to his name. Record review of the progress notes for CR #1 reflected on [DATE] and [DATE], no progress notes were documented. Record review of the progress note for CR #1 dated [DATE] at 10:29 am reflected RN A documented that she noticed pain while changing him. Vitals were BP ,d+[DATE], Heart rate was 127. Per the aid (name undisclosed), resident was vomiting for 2 days, and roommate stated that CR #1 was up all-night moaning. He was given Tylenol and midodrine, but resident vomited up the medicine. Dr. was called and resident was instructed to send resident to hospital due to acidosis. Record review of the hospital record for CR #1 dated [DATE] at 12:03 pm reflected that CR #1 was admitted in a wheelchair due to shortness of breath, weakness, tachycardia (a heart rate that exceeded the normal resting rate), and he was not able to verbalize complaints. His pain intensity was measured as an 8 on a scale of 1- 10 and the chief complaint noted was respiratory. CR #1 also had a blood pressure reading of , d+[DATE]. The final record of his expiration have not yet been received. In an interview on [DATE] at 12:41 pm with the Roommate of CR #1, he stated that if he was the aid, he would have sent CR#1 to the hospital that night. He expressed that during the night of [DATE], CR#1 was getting over heated and the aids kept checking on him. He couldn't say what was wrong with him, but he made a lot of noise throughout the night and the in-room ac unit was set to 69 degrees. CR#1 was sent to the hospital the next day ([DATE]) but Roommate stated that he would not have kept him at the facility under his conditions and sent him out sooner. He did not speak with he aids or the nurse regarding his roommate. In an interview on [DATE] at 3:11 pm, RN A stated that she was off on [DATE] and [DATE]. When she returned on [DATE] and was told by CNA A that CR#1 was throwing up and had been throwing up for the past 2 days. Upon rounds, CR #1 was nauseous and vomiting. RN A asked CR#1 what was wrong, and he stated, I don't know, but I know something isn't right. Resident was sweaty and after the assessment she contacted Dr. and informed him his heart rate was high, but BP was low. Dr. agreed to send him to the hospital and came by the facility before he left with the EMT to assess him. LPN A, who worked the night shift did not inform RN A of any changes in CR #1's condition. In an interview on [DATE] at 3:29 pm, CNA A stated that she worked on [DATE] from 6am-10pm. CR #1 started to vomit around 6:30 pm and his vomit was a dark brown that resembled hot chocolate. Around 7pm, she relayed his condition to LPN A, who stated that he would check on the CR#1 but she was unsure if he did. During her 2nd round around 9pm, CR #1 had vomited on the floor and all over his sheets. LPN A told CNA A that he would give him something for acid reflux. CNA A returned to work with CR#1 on [DATE] at 6am. When she changed him, she heard gurgling noises, he was not speaking, she and verbally reported it to RN A at 8am. RN A did not come to immediately check on the CR #! and she sent RN A a text at 9:14am saying CR #1was grunting and needed to be looked at. CNA A stated at 9:30am, RN A came to check on the CR#1 and gave him a covid test. CNA A stated CR#1 was taken by EMT around 11am. (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 3:43 pm with CNA B, who stated she worked on [DATE] from 10pm-6am. When she saw CR #1 at 10pm, he complained of being hot and she adjusted his AC to 69 and turned the AC on in the hallway. CNA B informed LPN A and LPN A stated that would give CR #1 something. However, CR #1 continued to tell CNA B that something was not right, and he rang the call light so much that night that it made it hard for her to tend to other residents. She said she did not know if LPN A contacted the doctor, but she tried to hint that he should. She informed LPN A of CR #1's status at 10:30pm and at 2am. In an interview on [DATE] at 3:56 pm with Dr. Z, who explained that when he saw CR #1 on [DATE], he was fine. Resident was normally verbal, and he could express his likes, dislikes, and pain. Once RN A told him that CR #1 was not well, he immediately went to the facility, entering before the EMT, and assessed the resident. Upon assessment, CR #1 was not responsive, hypotensive, and septic. When he went to the hospital, Dr. Z was also CR#1's treatment doctor at the hospital. The CP scan reflected that he had bilateral aspiration (could have choked on saliva laying down) and cause of death was aspiration pneumonia on [DATE]. The first time he was contacted regarding CR#1's symptoms was [DATE]. Dr. Z expressed that if he had been informed that CR#1 was vomiting and had diarrhea on [DATE], he would not have sent him to the hospital, but ran labs and prescribed him something for his symptoms. He stated that he was prompted to send the resident out because of his abnormal vitals, altered mental status, and low blood pressure. In an interview on [DATE] at 4:28 pm, the DON who stated that if a resident had a change in condition, they were supposed to assess the patient and get with the doctor. A change in condition was described as anything that deviated from the patient's baseline. She stated that CR#1 was a very pleasant man, and he was able to verbalize when something was wrong with him. She was not informed that CR #1 was ill until [DATE]. RN A told her the morning of [DATE] and when she went to check on CR#1, he was weak, nausea, his eyes were closed, and kept trying to clear his throat. Dr. Z was contacted, and CR#1 was sent out that morning. Through investigation, DON learned that CNA A had noticed that CR#1 had vomited, and she cleaned him up each time. CNA A also stated that she informed LPN A. DON preformed an in-service with CNA A and followed up with LPN A, who denied any knowledge of CR#1 being sick. CNA A was told that in the future, she should wait until the nurse came to view the vomit before she cleaned it up and all aids were informed to reach out to the DON if they tell a nurse about a sick resident, and they do not follow up. DON also verbally reeducated RN A on the facilities change in condition policy and she disclosed that RN A shift started at 6am, but she arrived at the facility late that day and did not start her rounds until 9 am. LPN A was interviewed but he was not reeducated. DON expressed that she did not reeducate LPN A because she had worked with him at a different facility and felt that he was a very competent nurse, and she believed his statement because the other staff have been messy. DON stated that the harm in not communicating when a resident changed from baseline could be hospitalization . (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 5:04 pm, LPN A stated that he started working at the facility during the month of August and worked on [DATE] and [DATE] from 6pm-6am. He explained that nurses were to round as much as possible and he remembered entering the room for CR#1 on [DATE], but he did not wake him because he was asleep. He denied that CNA A or CNA B informed him that CR #1 was vomiting and he did not administer any medication to him outside of what was prescribed. LPN A stated that if he knew there was a change in condition with CR#1, he would have checked what type of medications he was already prescribed and let the on-call doctor know. The type of assessment would have depended on the condition of the resident, but in the case of CR#1, he would have checked vitals, examined the vomit and its frequency, then followed up with the doctor. He could not remember if he did rounds with RN A on the morning of [DATE]. In an interview on [DATE] at 5:25 pm, Admin stated that her first-time hearing of the incident with CR#1 was during the morning of [DATE]. RN A told her that she was informed by the aid that CR#1 had been vomiting for several days and Dr. Z was called in before he went to the hospital. She stated that CNA A was educated in their stop and watch documentation system in the resident portal. Admin also stated that she felt that if RN A had arrived to work at 6am and did rounds immediately once she arrived, she might have been able to check on him sooner. Admin got the text later that day that CR#1 had expired. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:31 pm. The Admin and DON were notified. The Admin was provided with the IJ template on [DATE] at 4:31 pm. The following Plan of Removal submitted by the facility was accepted on [DATE] at 7:25 am: Immediate Jeopardy Facility X: On [DATE], an incident survey was initiated at Facility X. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The facility failed to immediately assess and treat CR#1 and contact the doctor from [DATE] - [DATE] after CR#1 experienced ongoing vomiting and distress. CR#1 was transported to the hospital on [DATE] at 11am. Immediate Action: o The Executive Director/Director of Clinical Operations will be educated by the Regional Directors on [DATE] to Rounding and Monitoring of residents on change of condition and timely Notification of physician and responsible party. o The DCO/Designee will conduct 1:1 in-service with LPN A to include Resident Change in condition, Shift-to-Shift reporting & Documenting changes in condition, Clinical documentation/Charting, timely notification of the physician and responsible party on change of condition to be completed on [DATE]. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o The Director of Clinical Operations initiated education on [DATE] to charge nurses on: Resident Change in condition, Shift-to-Shift reporting & Documenting changes in condition, Clinical documentation/Charting, timely notification of the physician and responsible party on change of condition to be completed on [DATE]. Staff will not be allowed to provide direct resident care until training has been completed. o The DCO/Designee initiated education on [DATE] to Certified Nursing Assistants on notifying charge nurses on change of condition and documenting on Stop & Watch in PCC to be completed on [DATE]. Staff will not be allowed to provide direct resident care until training has been completed. o The clinical team (DCO, ADCO , and designated nursing staff) initiated chart audits on all residents with a change in condition on [DATE]. Resident assessments were completed on [DATE] and no new changes in condition identified. Facilities Plan to ensure compliance quickly: o The clinical team (DCO, ADCO, and designated nursing staff) initiated chart audits on all residents with a change in condition to ensure timely notification of physician and responsible party was completed. o The DCO/Designee with review 24-hour report daily to ensure that timely notification of the physician and responsible was completed, starting [DATE]. o The Medical Director was notified of the Immediate Jeopardy on [DATE]. o The current policies reviewed with the Medical Director on [DATE] on Resident Assessment, Shift-to-Shift reporting & Documenting changes on the 24-hour report, Clinical documentation/Charting, change in condition, notifying the physician, Stop & Watch, with no changes to the current policy. This practice will be reviewed monthly with the QA committee to ensure compliance in place. o Daily rounds will be conducted by Nurse management to communicate any changes of condition and timely notification of the physician and RP will occur starting [DATE]. Monitoring Day 1: Sunday [DATE]th, 2024 Review of the plan of correction included 1:1 education for CNA B and LPN A, an audit for all residents with changes in conditions, in services for all charge nurses on facility policy, and in-service to all CNA 's regarding how to report and document any changes. -POC was accepted. Nurses were interviewed on: -When should you notify the physician? Like what things are noticeable? -What is described as a significant change or a change in condition? -When should you notify the doctor when there is a change in condition? (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-How often do you monitor them? And what do you do if you cannot reach the doctor? -Where do you document any changes? How do you left the nurse on the next shift know what occurred on your shift? How do you exchange information? In an interview on [DATE] at 4:40 pm, LVN A stated today was her first day. She explained Nurses should notify the physician immediately after changes in the resident's condition. They would notify the ADON when there was a change in condition in their breathing, change in respiratory, altered mental status. Other examples would be if the patient had an adverse reaction to medication or antibiotics and she also said if they had poor intake or output different from baseline, nausea, and vomiting. Once the doctor was notified, she would check on them every ,d+[DATE] minutes. If there were any thing that could be linked to respiratory issues, she would stay with the resident. If there was an emergency, we could use her nursing judgment to notify the doctor. Once that resident was sent out, she would then notify the physician. She stated you could document the resident's change in condition on the SBAR in the resident's assessment section. She would inform the nurse coming after her with the 24-hour report, chart on progress notes, and verbally let the nurse know with a handoff report. In an interview on [DATE] at 4:46 pm, CNA C stated that she had worked at the facility for ,d+[DATE] years and was PRN. She stated aids should notify the nurse immediately if there was a change in condition and they would document it as well. She would document the change in condition in her tablet and tell the nurse verbally. She explained that there was a certain section in the Kardex (resident charting for CNA's) that she would find the stop and watch alert. Staff could add specifically what was wrong with the resident if it was not listed. They would also notify the ADON or another nurse but mainly someone in nursing. In an interview on [DATE] at 4:50 pm, CNA D stated she had been working at the facility for one month and she worked the 2pm- 10pm shift She stated aids should notify the nurse as soon as a change in condition was noticed or immediately. A change in condition could be any behavior that was abnormal for that individual. They would document it in the POC under the new alert stop and watch tab. She stated she was comfortable going in the POC using the stop and watch. Staff would also let the coworkers who are relieving her know and if the situation was not handled, we could also notify the DON. In an interview on [DATE] at 4:54 pm, LVN B stated that he had been working at the facility for ,d+[DATE] weeks and he worked the 6am-6pm shift. He described that a change of condition could be anything outside of the normal like injuries, shortness of breath, and anything outside of their baseline, which could be something as small as a scrape. Nurses have two ways to document which is using the daily 24-hour report. They also have documentation in PCC so it was passed agency wide. There was a change in condition assessment in PCC and he would also add a progress note for nursing. The doctor should be notified as soon as possible, and he would also notify the DON. If there was an emergency, he would call 911, even if the doctor could not be reached. If there was a change in condition, he would try to check on them every , d+[DATE] minutes or try to have someone stay with them. If they could not reach the doctor, then staff could call the medical group the facility works with. (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 5:03 pm, MA A stated he had worked at the facility since October of 2023 and worked the 7am-7pm shift. He stated that aids notified the nurse if there was change in condition whenever they notice it or immediately. A change in condition could be swelling in the feet, nausea, vomiting, not eating, restlessness, coughing, or congestion. Aids could also notify the nurse, DON, or Administrator. They documented the change in condition by clicking on the new alert in the POC and they could add a new alert in the stop and watch. He stated he was comfortable with using the stop and watch. In an interview on [DATE] at 4:46 pm, MA B stated that she had worked at the facility for 1 week and she worked the 7am- 7pm shift. She explained that a change in condition could be anything such as no stool, diarrhea, change in skin color, quiet but now talking louder, slurring speech, or someone who normally talks but was now quiet. The nurse should be notified as soon as a change in condition was noticed. Aids documented the change in condition in the POC. They would go into the new alert section and place what is going on there. She stated she was comfortable with documenting in the new alert section. Aids could also notify the ADON or DON if the change in condition was not addressed by a nurse. In an interview on [DATE] at 5:10 pm, CNA E stated she had worked at the facility for 1 year and worked the 2pm- 10pm shift. She stated a change in condition could be when a resident skin color changes, they were feeling sick, or face drooping. If they were nonverbal, she would try and figure out what was wrong and then she would let the nurse know. The nurse should be informed immediately of any changes. These changes in condition would be documented in the stop and watch in the POC. Aids could go into the new alert and put it in there and she was comfortable with documenting it there. If there was a change in condition and the nurse could not get to that resident, she would also notify the ADON. In an interview on [DATE] at 5:15 pm, RN B stated that he had worked at the facility for over a year, and he worked the 6am- 6pm shift. He stated a change in condition could be classified as anything abnormal, diarrhea that was ongoing, constipation for more than 3 days, change in appetite, or behaviors. Nurses would notify the doctor immediately after the assessment. If they contacted the doctor and they did not answer within 2 hours, nurse could utilize their online service doctors for assistance. If a resident was having an emergency like active bleeding, they would not wait for the doctor, but they would call 911. If there was a change in condition, they checked on the resident based off the policy like every ,d+[DATE] minutes. Nurse would document the change in the SBAR and also do a note in the PCC. The nurse that comes in after him would do a verbal communication with the next nurse on what happened, any new orders, and what procedures so that they could know what was happening. They also have a shift to shift 24-hour report. In an interview on [DATE] at 5:21 pm, CNA F stated she had worked at the facility for 6 months and worked the 2pm- 10pm shift. She stated that a change in condition could be anything you could see like bruising, swelling, blood, and changes in diet. Aids should notify the nurse immediately, if they could not come right away, they could let the other nurse know as well as the DON's. They could update changes in the POC in the new alerts and on the first page, they could click on specific ones. She explained that they could also add custom symptoms on the stop and watch, but they still have to make sure they informed the nurses. (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 5:53 pm, LVN C stated that she had worked at the facility for 4 months and worked from 8am-5pm. She described a change in condition could be different from baseline, like changes in vitals, labored breathing, bowel changes such as not voiding, sweaty, and also change in the alert and orientation. The doctor should be notified immediately whenever the change was noticed. They always get vital signs and give them to the physician to see what interventions should be given. Nurses have to make sure all orders were placed in PCC. She would also document the change in condition assessment in PCC, which asked what were the symptoms and who was notified. They always notified the DON, ADON, PCP, and responsible party. She stated she didnt have anyone to relieve her because she was the treatment nurse, but she would always add a PRN order for nurses to follow up with. Nurses have access to the wound care cart and order in PCC. She said she would get together with floor nurses to discuss skin assessments so the nurse could add it to 24-hour report. If they were to catch something she didn't, she would go and assess as soon as notified. If there was a change in condition, depending on the situation, she would check on them as often as needed, especially for things like oxygen and blood sugar. LVN C stated they were also able to use their nursing judgement and call 911 if the doctor was not responsive and the level of care they needed was outside of what they could do at the facility. In an interview on [DATE] at 6:03 pm, LVN D stated she had been working at the facility for 2 years and worked the 6pm-6am shift. She stated a change in condition could be anything that was abnormal with the patient. Examples would be someone coughing, rashes, scratchy throat, anything that would not be the resident's normal demeanor. The doctor should be contacted after the assessment. If she checked the orders and they have a standing order, she would follow those. If the manner was persistent manner or they didn't have orders, she would call the doctor. If the doctor was contacted and it had been a while since we got a response, she would let the DON know so she could contact the doctor. If that does not work, then they could call the medical director. She stated she would check on a resident at least every hour with a change in condition. Change in conditions were documented in the form in the computer. They would also do a progress note. She would let the next nurse know about what happened on her last shift by doing rounds with the new nurse and giving them the 24-hours report. If they reported something to her that happened to their shift, she would still follow up every hour. In an interview on [DATE] at 6:17 pm, WCN stated that he had been working at the facility for 2 weeks and worked the 6pm- 6am shift. He explained that a change in condition could be anything that was out of their normal stasis. This could be skin tears, wounds, coughing, loss of appetite, anything that is outside of normal. These changes would be documented in the progress notes, and we would do an incident report and also a SBAR. The progress notes would be the main note that would stick out. The doctor would be notified after the vitals and pain scales so the doctor could make a precise assessment for proper patient care. He would notify the doctor, ADON, DON, and the family so they were not the last to know. If a resident had an emergency, we could send them out via 911 because we have to use critical thinking or be proactive, so we won't have a dead person. Nurses exchanged information by using the 24-hour report, and they also walked room to room with the previous nurse. Nurses will both have a 24-hour report and take notes based off the initial notes. He stated they have to know everything that was going on, even the little things. Monitoring Day 2: Monday [DATE]th, 2024 (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 1:51 pm, CNA G stated she had worked at the facility for ,d+[DATE] years and worked the 6am- 2pm. She stated a change in behavior could be everything, if they were throwing up and having diarrhea, not eating, or declining. They reported by letting the nurses know, then going into the POC to the new alerts to add what was going on with the resident. She stated she was comfortable with using the POC to make repots. If the nurse was not available, she would tell the ADON to let them know what was going on. In an interview on [DATE] at 1:57 pm, CNA H stated she had worked at the facility for 1 year and a half and worked the 6am- 2pm shift. She stated a change could range from someone getting aggressive, wandering, crying, or stopping eating. Anything that came off of their daily routine. If they have a change, she verbally told the nurse and she also put it in the POC. If she came back the next day and something wasn't done, she would tell the ADON or DON. In the POC, she would go to patient charting and click on new alert and stop and watch. It allowed them to put in what was the different reason for their change. They could also create a custom alert. She stated she was comfortable with creating customs alerts and the stop and watch. In an interview on [DATE] at 2:01 pm, RN C stated she had worked at the facility for ,d+[DATE] months and worked the 6am- 6pm shift. She stated that a change of confirm is any behavior that was different from the patient's baseline. This could be disorientation and confusion, abdominal pain, and diarrhea. She would have to do my assessment and check vital signs. She would check the medication to see if they have medication prescribed for that ailment then notify the doctor and family. If the doctors gave her an order, she would follow up on their recommendations. The DON would also be notified. The change was documented in the SBAR in the POC, and she would also create a progress note. If they reached out to the doctor and they did not respond right away, she would call 911 to send the resident out and let the DON know. Then she would follow back up with the doctor to let them know what was done. When a resident had a change in condition, they should be checked on frequently. In an interview on [DATE] at 2:10 pm, RN D stated she had worked at the facility for 1 year and worked the 6am- 6pm shift. She stated that a change in condition is anything that was not from the baseline, like commuting, diarrhea, anything that was not normal for them. When they have a change, they did their assessment and did a change of condition assessment form. Nurses were to notify the MD, RP, and the DON. If the doctor took a while to respond, she would let the DON know and they would reach out through a different route. In the event of a medical emergency, she would use her nursing judgement and send the patient out and document. The change of condition was documented in the form under assessment, she would do a progress note, and an incident report. If there was a change, they would check on the resident every 15 minutes, then every hour. Then she would check every hour. In an interview on [DATE] at 2:16 pm, ADON stated she had worked at the facility for 1 year and a half and worked from 8am- 5pm. She stated RN A was supposed to come in on [DATE] today but she did not but she was scheduled to come tomorrow. The DON was on PTO, but she was on schedule to work ,d+[DATE] and , d+[DATE]. She stated she was out the week of ,d+[DATE] to,d+[DATE] but she said she nor the DON were notified of any changes in condition. She said if the DON had known, she knew she would have taken care of it herself. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Pasadena	3434 Watters Rd Pasadena, TX 77504

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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 8:49 pm, LPN A stated that a change in condition could be when the resident that was not their normal self. Their blood pressure could be high, abnormal vomiting, or skin teas. If there was a change, they check the vitals, and examine what could have caused the change. They could also call the doctor to see if there was an order and they would follow it. This could be a lab or a diagnosis. He would also call the family and notify the DON. The documentation was the change in condition assessment, and he would do a progress report. If there was a change in condition the resident, he would monitor them every 15-30 minutes, and if a medical emergency, he would call 911 even if the doctor had not responded. He stated he would fully document the changes on the reports. They exchanged information with the next shift nurse by using the 24-hour report and doing rounds. ADON and the investigator reviewed the staff roster with the in-service sing in sheet and pointed out that there were 4 staff members left to in-service. She stated that 2 staff were on PTO and would not be back that week, 2 staff were on nurse who worked PRN. She said she had reached out to them, but they did not answer. She stated she would reach out to them again to attempt to relay the information by phone. She sent a text message to the investigator at 7:28 pm informing that she was able to reach but PRN nurses successfully. Monitoring Day 3: Tuesday [DATE]th, 2024 -Reviewed the in-service list for CNA's and Nurse and all staff had been successfully in serviced. QAPI Charts were reviewed and all documents were completed. All residents were reviewed for recent changes in condition and no changes were identified. 24-hour reports were monitored and updates were completed per shift and notification was noted to the Dr. as needed. An Immediate Jeopardy (IJ) was identified on [DATE]. An IJ Template was provided to the facility on [DATE] at 4:31 pm. While the Immediate Jeopardy was removed on [DATE] at 1:52 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.

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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** 46561 Based on interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (CR#1) of five residents reviewed for quality of care. The facility failed to immediately assess and treat CR #1 and contact the doctor from [DATE]- [DATE] after CR#1 experienced ongoing vomiting and distress. CR#1 was transported to the hospital on [DATE] at 11am. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 4:31 PM. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk for delay in needed treatment and care. Findings included: Record review of CR#1's face sheet dated [DATE] reflected he was an [AGE] year-old male that was admitted to the facility on [DATE] with diagnoses of rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), dysphagia (difficulty swallowing) Type II Diabetes, and hypertension (high blood pressure). He was coded to DNR. Record review of CR #1's care plan last updated [DATE] reflected he had an ADL self-care performance deficit accompanied with impaired balance and limited mobility. CR#1 also had the potential for complications related to the diagnosis of hypertension. Interventions initiated [DATE] stated to monitor/document/report any s/s of headaches, confusion, disorientation, difficulty breathing, and nauseas and vomiting. Record review of CR #1 doctors' orders from [DATE]- [DATE] reflected that there was no documentation (orders) that CR #1 received medication for acid reflux, vomiting, or pain. Record review of the shift-to-shift report on [DATE]- [DATE] documented by the night nurse LPN A reflected that each resident had either a handwritten update regarding their condition from that shift or the words ok next to their nane. CR #1 did not have any documentation next to his name. Record review of the progress notes for CR #1 reflected on [DATE] and [DATE], no progress notes were documented. Record review of the progress note for CR #1 dated [DATE] at 10:29 am reflected RN A documented that she noticed pain while changing him. Vitals were BP ,d+[DATE], Heart rate was 127. Per the aid (name undisclosed), resident was vomiting for 2 days, and roommate stated that CR #1 was up all-night moaning. He was given Tylenol and midodrine, but resident vomited up the medicine. Dr. was called and resident was instructed to send resident to hospital due to acidosis. (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 the hospital record for CR #1 dated [DATE] at 12:03 pm reflected that CR #1 was admitted in a wheelchair due to shortness of breath, weakness, tachycardia (a heart rate that exceeded the normal resting rate), and he was not able to verbalize complaints. His pain intensity was measured as an 8 on a scale of 1- 10 and the chief complaint noted was respiratory. CR #1 also had a blood pressure reading of , d+[DATE]. The final record of his expiration have not yet been received. In an interview on [DATE] at 12:41 pm with the Roommate of CR #1, he stated that if he was the aid, he would have sent CR#1 to the hospital that night. He expressed that during the night of [DATE], CR#1 was getting over heated and the aids kept checking on him. He couldn't say what was wrong with him, but he made a lot of noise throughout the night and the in-room ac unit was set to 69 degrees. CR#1 was sent to the hospital the next day ([DATE]) but Roommate stated that he would not have kept him at the facility under his conditions and sent him out sooner. He did not speak with he aids or the nurse regarding his roommate. In an interview on [DATE] at 3:11 pm, RN A stated that she was off on [DATE] and [DATE]. When she returned on [DATE] and was told by CNA A that CR#1 was throwing up and had been throwing up for the past 2 days. Upon rounds, CR #1 was nauseous and vomiting. RN A asked CR#1 what was wrong, and he stated, I don't know, but I know something isn't right. Resident was sweaty and after the assessment she contacted Dr. and informed him his heart rate was high, but BP was low. Dr. agreed to send him to the hospital and came by the facility before he left with the EMT to assess him. LPN A, who worked the night shift did not inform RN A of any changes in CR #1's condition. In an interview on [DATE] at 3:29 pm, CNA A stated that she worked on [DATE] from 6am-10pm. CR #1 started to vomit around 6:30 pm and his vomit was a dark brown that resembled hot chocolate. Around 7pm, she relayed his condition to LPN A, who stated that he would check on the CR#1 but she was unsure if he did. During her 2nd round around 9pm, CR #1 had vomited on the floor and all over his sheets. LPN A told CNA A that he would give him something for acid reflux. CNA A returned to work with CR#1 on [DATE] at 6am. When she changed him, she heard gurgling noises, he was not speaking, she and verbally reported it to RN A at 8am. RN A did not come to immediately check on the CR #! and she sent RN A a text at 9:14am saying CR #1was grunting and needed to be looked at. CNA A stated at 9:30am, RN A came to check on the CR#1 and gave him a covid test. CNA A stated CR#1 was taken by EMT around 11am. In an interview on [DATE] at 3:43 pm with CNA B, who stated she worked on [DATE] from 10pm-6am. When she saw CR #1 at 10pm, he complained of being hot and she adjusted his AC to 69 and turned the AC on in the hallway. CNA B informed LPN A and LPN A stated that would give CR #1 something. However, CR #1 continued to tell CNA B that something was not right, and he rang the call light so much that night that it made it hard for her to tend to other residents. She said she did not know if LPN A contacted the doctor, but she tried to hint that he should. She informed LPN A of CR #1's status at 10:30pm and at 2am. (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 3:56 pm with Dr. Z, who explained that when he saw CR #1 on [DATE], he was fine. Resident was normally verbal, and he could express his likes, dislikes, and pain. Once RN A told him that CR #1 was not well, he immediately went to the facility, entering before the EMT, and assessed the resident. Upon assessment, CR #1 was not responsive, hypotensive, and septic. When he went to the hospital, Dr. Z was also CR#1's treatment doctor at the hospital. The CP scan reflected that he had bilateral aspiration (could have choked on saliva laying down) and cause of death was aspiration pneumonia on [DATE]. The first time he was contacted regarding CR#1's symptoms was [DATE]. Dr. Z expressed that if he had been informed that CR#1 was vomiting and had diarrhea on [DATE], he would not have sent him to the hospital, but ran labs and prescribed him something for his symptoms. He stated that he was prompted to send the resident out because of his abnormal vitals, altered mental status, and low blood pressure. In an interview on [DATE] at 4:28 pm, the DON who stated that if a resident had a change in condition, they were supposed to assess the patient and get with the doctor. A change in condition was described as anything that deviated from the patient's baseline. She stated that CR#1 was a very pleasant man, and he was able to verbalize when something was wrong with him. She was not informed that CR #1 was ill until [DATE]. RN A told her the morning of [DATE] and when she went to check on CR#1, he was weak, nausea, his eyes were closed, and kept trying to clear his throat. Dr. Z was contacted, and CR#1 was sent out that morning. Through investigation, DON learned that CNA A had noticed that CR#1 had vomited, and she cleaned him up each time. CNA A also stated that she informed LPN A. DON preformed an in-service with CNA A and followed up with LPN A, who denied any knowledge of CR#1 being sick. CNA A was told that in the future, she should wait until the nurse came to view the vomit before she cleaned it up and all aids were informed to reach out to the DON if they tell a nurse about a sick resident, and they do not follow up. DON also verbally reeducated RN A on the facilities change in condition policy and she disclosed that RN A shift started at 6am, but she arrived at the facility late that day and did not start her rounds until 9 am. LPN A was interviewed but he was not reeducated. DON expressed that she did not reeducate LPN A because she had worked with him at a different facility and felt that he was a very competent nurse, and she believed his statement because the other staff have been messy. DON stated that the harm in not communicating when a resident changed from baseline could be hospitalization . In an interview on [DATE] at 5:04 pm, LPN A stated that he started working at the facility during the month of August and worked on [DATE] and [DATE] from 6pm-6am. He explained that nurses were to round as much as possible and he remembered entering the room for CR#1 on [DATE], but he did not wake him because he was asleep. He denied that CNA A or CNA B informed him that CR #1 was vomiting and he did not administer any medication to him outside of what was prescribed. LPN A stated that if he knew there was a change in condition with CR#1, he would have checked what type of medications he was already prescribed and let the on-call doctor know. The type of assessment would have depended on the condition of the resident, but in the case of CR#1, he would have checked vitals, examined the vomit and its frequency, then followed up with the doctor. He could not remember if he did rounds with RN A on the morning of [DATE]. (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 5:25 pm, Admin stated that her first-time hearing of the incident with CR#1 was during the morning of [DATE]. RN A told her that she was informed by the aid that CR#1 had been vomiting for several days and Dr. Z was called in before he went to the hospital. She stated that CNA A was educated in their stop and watch documentation system in the resident portal. Admin also stated that she felt that if RN A had arrived to work at 6am and did rounds immediately once she arrived, she might have been able to check on him sooner. Admin got the text later that day that CR#1 had expired. This was determined to be an Immediate Jeopardy (IJ) on [DATE] at 4:31 pm. The Admin and DON were notified. The Admin was provided with the IJ template on [DATE] at 4:31 pm. The following Plan of Removal submitted by the facility was accepted on [DATE] at 7:25 am: Immediate Jeopardy Facility X: On [DATE], an incident survey was initiated at Facility X. On [DATE] the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate jeopardy to resident health and safety. The facility failed to immediately assess and treat CR#1 and contact the doctor from [DATE] - [DATE] after CR#1 experienced ongoing vomiting and distress. CR#1 was transported to the hospital on [DATE] at 11am. Immediate Action: o The Executive Director/Director of Clinical Operations will be educated by the Regional Directors on [DATE] to Rounding and Monitoring of residents on change of condition and timely Notification of physician and responsible party. o The DCO/Designee will conduct 1:1 in-service with LPN A to include Resident Change in condition, Shift-to-Shift reporting & Documenting changes in condition, Clinical documentation/Charting, timely notification of the physician and responsible party on change of condition to be completed on [DATE]. o The Director of Clinical Operations initiated education on [DATE] to charge nurses on: Resident Change in condition, Shift-to-Shift reporting & Documenting changes in condition, Clinical documentation/Charting, timely notification of the physician and responsible party on change of condition to be completed on [DATE]. Staff will not be allowed to provide direct resident care until training has been completed. o The DCO/Designee initiated education on [DATE] to Certified Nursing Assistants on notifying charge nurses on change of condition and documenting on Stop & Watch in PCC to be completed on [DATE]. Staff will not be allowed to provide direct resident care until training has been completed. o The clinical team (DCO, ADCO , and designated nursing staff) initiated chart audits on all residents with a change in condition on [DATE]. Resident assessments were completed on [DATE] and no new changes in condition identified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facilities Plan to ensure compliance quickly: o The clinical team (DCO, ADCO, and designated nursing staff) initiated chart audits on all residents with a change in condition to ensure timely notification of physician and responsible party was completed. o The DCO/Designee with review 24-hour report daily to ensure that timely notification of the physician and responsible was completed, starting [DATE]. o The Medical Director was notified of the Immediate Jeopardy on [DATE]. o The current policies reviewed with the Medical Director on [DATE] on Resident Assessment, Shift-to-Shift reporting & Documenting changes on the 24-hour report, Clinical documentation/Charting, change in condition, notifying the physician, Stop & Watch, with no changes to the current policy. This practice will be reviewed monthly with the QA committee to ensure compliance in place. o Daily rounds will be conducted by Nurse management to communicate any changes of condition and timely notification of the physician and RP will occur starting [DATE]. Monitoring Day 1: Sunday [DATE]th, 2024 Review of the plan of correction included 1:1 education for CNA B and LPN A, an audit for all residents with changes in conditions, in services for all charge nurses on facility policy, and in-service to all CNA 's regarding how to report and document any changes. -POC was accepted. Nurses were interviewed on: -When should you notify the physician? Like what things are noticeable? -What is described as a significant change or a change in condition? -When should you notify the doctor when there is a change in condition? -How often do you monitor them? And what do you do if you cannot reach the doctor? -Where do you document any changes? How do you left the nurse on the next shift know what occurred on your shift? How do you exchange information? (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 4:40 pm, LVN A stated today was her first day. She explained Nurses should notify the physician immediately after changes in the resident's condition. They would notify the ADON when there was a change in condition in their breathing, change in respiratory, altered mental status. Other examples would be if the patient had an adverse reaction to medication or antibiotics and she also said if they had poor intake or output different from baseline, nausea, and vomiting. Once the doctor was notified, she would check on them every ,d+[DATE] minutes. If there were any thing that could be linked to respiratory issues, she would stay with the resident. If there was an emergency, we could use her nursing judgment to notify the doctor. Once that resident was sent out, she would then notify the physician. She stated you could document the resident's change in condition on the SBAR in the resident's assessment section. She would inform the nurse coming after her with the 24-hour report, chart on progress notes, and verbally let the nurse know with a handoff report. In an interview on [DATE] at 4:46 pm, CNA C stated that she had worked at the facility for ,d+[DATE] years and was PRN. She stated aids should notify the nurse immediately if there was a change in condition and they would document it as well. She would document the change in condition in her tablet and tell the nurse verbally. She explained that there was a certain section in the Kardex (resident charting for CNA's) that she would find the stop and watch alert. Staff could add specifically what was wrong with the resident if it was not listed. They would also notify the ADON or another nurse but mainly someone in nursing. In an interview on [DATE] at 4:50 pm, CNA D stated she had been working at the facility for one month and she worked the 2pm- 10pm shift She stated aids should notify the nurse as soon as a change in condition was noticed or immediately. A change in condition could be any behavior that was abnormal for that individual. They would document it in the POC under the new alert stop and watch tab. She stated she was comfortable going in the POC using the stop and watch. Staff would also let the coworkers who are relieving her know and if the situation was not handled, we could also notify the DON. In an interview on [DATE] at 4:54 pm, LVN B stated that he had been working at the facility for ,d+[DATE] weeks and he worked the 6am-6pm shift. He described that a change of condition could be anything outside of the normal like injuries, shortness of breath, and anything outside of their baseline, which could be something as small as a scrape. Nurses have two ways to document which is using the daily 24-hour report. They also have documentation in PCC so it was passed agency wide. There was a change in condition assessment in PCC and he would also add a progress note for nursing. The doctor should be notified as soon as possible, and he would also notify the DON. If there was an emergency, he would call 911, even if the doctor could not be reached. If there was a change in condition, he would try to check on them every , d+[DATE] minutes or try to have someone stay with them. If they could not reach the doctor, then staff could call the medical group the facility works with. In an interview on [DATE] at 5:03 pm, MA A stated he had worked at the facility since October of 2023 and worked the 7am-7pm shift. He stated that aids notified the nurse if there was change in condition whenever they notice it or immediately. A change in condition could be swelling in the feet, nausea, vomiting, not eating, restlessness, coughing, or congestion. Aids could also notify the nurse, DON, or Administrator. They documented the change in condition by clicking on the new alert in the POC and they could add a new alert in the stop and watch. He stated he was comfortable with using the stop and watch. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 4:46 pm, MA B stated that she had worked at the facility for 1 week and she worked the 7am- 7pm shift. She explained that a change in condition could be anything such as no stool, diarrhea, change in skin color, quiet but now talking louder, slurring speech, or someone who normally talks but was now quiet. The nurse should be notified as soon as a change in condition was noticed. Aids documented the change in condition in the POC. They would go into the new alert section and place what is going on there. She stated she was comfortable with documenting in the new alert section. Aids could also notify the ADON or DON if the change in condition was not addressed by a nurse. In an interview on [DATE] at 5:10 pm, CNA E stated she had worked at the facility for 1 year and worked the 2pm- 10pm shift. She stated a change in condition could be when a resident skin color changes, they were feeling sick, or face drooping. If they were nonverbal, she would try and figure out what was wrong and then she would let the nurse know. The nurse should be informed immediately of any changes. These changes in condition would be documented in the stop and watch in the POC. Aids could go into the new alert and put it in there and she was comfortable with documenting it there. If there was a change in condition and the nurse could not get to that resident, she would also notify the ADON. In an interview on [DATE] at 5:15 pm, RN B stated that he had worked at the facility for over a year, and he worked the 6am- 6pm shift. He stated a change in condition could be classified as anything abnormal, diarrhea that was ongoing, constipation for more than 3 days, change in appetite, or behaviors. Nurses would notify the doctor immediately after the assessment. If they contacted the doctor and they did not answer within 2 hours, nurse could utilize their online service doctors for assistance. If a resident was having an emergency like active bleeding, they would not wait for the doctor, but they would call 911. If there was a change in condition, they checked on the resident based off the policy like every ,d+[DATE] minutes. Nurse would document the change in the SBAR and also do a note in the PCC. The nurse that comes in after him would do a verbal communication with the next nurse on what happened, any new orders, and what procedures so that they could know what was happening. They also have a shift to shift 24-hour report. In an interview on [DATE] at 5:21 pm, CNA F stated she had worked at the facility for 6 months and worked the 2pm- 10pm shift. She stated that a change in condition could be anything you could see like bruising, swelling, blood, and changes in diet. Aids should notify the nurse immediately, if they could not come right away, they could let the other nurse know as well as the DON's. They could update changes in the POC in the new alerts and on the first page, they could click on specific ones. She explained that they could also add custom symptoms on the stop and watch, but they still have to make sure they informed the nurses. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER: Focused Care at Pasadena		STREET ADDRESS, CITY, STATE, ZIP CODE: 3434 Watters Rd Pasadena, TX 77504	

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

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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 5:53 pm, LVN C stated that she had worked at the facility for 4 months and worked from 8am-5pm. She described a change in condition could be different from baseline, like changes in vitals, labored breathing, bowel changes such as not voiding, sweaty, and also change in the alert and orientation. The doctor should be notified immediately whenever the change was noticed. They always get vital signs and give them to the physician to see what interventions should be given. Nurses have to make sure all orders were placed in PCC. She would also document the change in condition assessment in PCC, which asked what were the symptoms and who was notified. They always notified the DON, ADON, PCP, and responsible party. She stated she didnt have anyone to relieve her because she was the treatment nurse, but she would always add a PRN order for nurses to follow up with. Nurses have access to the wound care cart and order in PCC. She said she would get together with floor nurses to discuss skin assessments so the nurse could add it to 24-hour report. If they were to catch something she didn't, she would go and assess as soon as notified. If there was a change in condition, depending on the situation, she would check on them as often as needed, especially for things like oxygen and blood sugar. LVN C stated they were also able to use their nursing judgement and call 911 if the doctor was not responsive and the level of care they needed was outside of what they could do at the facility. In an interview on [DATE] at 6:03 pm, LVN D stated she had been working at the facility for 2 years and worked the 6pm-6am shift. She stated a change in condition could be anything that was abnormal with the patient. Examples would be someone coughing, rashes, scratchy throat, anything that would not be the resident's normal demeanor. The doctor should be contacted after the assessment. If she checked the orders and they have a standing order, she would follow those. If the manner was persistent manner or they didn't have orders, she would call the doctor. If the doctor was contacted and it had been a while since we got a response, she would let the DON know so she could contact the doctor. If that does not work, then they could call the medical director. She stated she would check on a resident at least every hour with a change in condition. Change in conditions were documented in the form in the computer. They would also do a progress note. She would let the next nurse know about what happened on her last shift by doing rounds with the new nurse and giving them the 24-hours report. If they reported something to her that happened to their shift, she would still follow up every hour. In an interview on [DATE] at 6:17 pm, WCN stated that he had been working at the facility for 2 weeks and worked the 6pm- 6am shift. He explained that a change in condition could be anything that was out of their normal stasis. This could be skin tears, wounds, coughing, loss of appetite, anything that is outside of normal. These changes would be documented in the progress notes, and we would do an incident report and also a SBAR. The progress notes would be the main note that would stick out. The doctor would be notified after the vitals and pain scales so the doctor could make a precise assessment for proper patient care. He would notify the doctor, ADON, DON, and the family so they were not the last to know. If a resident had an emergency, we could send them out via 911 because we have to use critical thinking or be proactive, so we won't have a dead person. Nurses exchanged information by using the 24-hour report, and they also walked room to room with the previous nurse. Nurses will both have a 24-hour report and take notes based off the initial notes. He stated they have to know everything that was going on, even the little things. Monitoring Day 2: Monday [DATE]th, 2024 (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 1:51 pm, CNA G stated she had worked at the facility for ,d+[DATE] years and worked the 6am- 2pm. She stated a change in behavior could be everything, if they were throwing up and having diarrhea, not eating, or declining. They reported by letting the nurses know, then going into the POC to the new alerts to add what was going on with the resident. She stated she was comfortable with using the POC to make repots. If the nurse was not available, she would tell the ADON to let them know what was going on. In an interview on [DATE] at 1:57 pm, CNA H stated she had worked at the facility for 1 year and a half and worked the 6am- 2pm shift. She stated a change could range from someone getting aggressive, wandering, crying, or stopping eating. Anything that came off of their daily routine. If they have a change, she verbally told the nurse and she also put it in the POC. If she came back the next day and something wasn't done, she would tell the ADON or DON. In the POC, she would go to patient charting and click on new alert and stop and watch. It allowed them to put in what was the different reason for their change. They could also create a custom alert. She stated she was comfortable with creating customs alerts and the stop and watch. In an interview on [DATE] at 2:01 pm, RN C stated she had worked at the facility for ,d+[DATE] months and worked the 6am- 6pm shift. She stated that a change of confirm is any behavior that was different from the patient's baseline. This could be disorientation and confusion, abdominal pain, and diarrhea. She would have to do my assessment and check vital signs. She would check the medication to see if they have medication prescribed for that ailment then notify the doctor and family. If the doctors gave her an order, she would follow up on their recommendations. The DON would also be notified. The change was documented in the SBAR in the POC, and she would also create a progress note. If they reached out to the doctor and they did not respond right away, she would call 911 to send the resident out and let the DON know. Then she would follow back up with the doctor to let them know what was done. When a resident had a change in condition, they should be checked on frequently. In an interview on [DATE] at 2:10 pm, RN D stated she had worked at the facility for 1 year and worked the 6am- 6pm shift. She stated that a change in condition is anything that was not from the baseline, like commuting, diarrhea, anything that was not normal for them. When they have a change, they did their assessment and did a change of condition assessment form. Nurses were to notify the MD, RP, and the DON. If the doctor took a while to respond, she would let the DON know and they would reach out through a different route. In the event of a medical emergency, she would use her nursing judgement and send the patient out and document. The change of condition was documented in the form under assessment, she would do a progress note, and an incident report. If there was a change, they would check on the resident every 15 minutes, then every hour. Then she would check every hour. In an interview on [DATE] at 2:16 pm, ADON stated she had worked at the facility for 1 year and a half and worked from 8am- 5pm. She stated RN A was supposed to come in on [DATE] today but she did not but she was scheduled to come tomorrow. The DON was on PTO, but she was on schedule to work ,d+[DATE] and , d+[DATE]. She stated she was out the week of ,d+[DATE] to,d+[DATE] but she said she nor the DON were notified of any changes in condition. She said if the DON had known, she knew she would have taken care of it herself. (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 8:49 pm, LPN A stated that a change in condition could be when the resident that was not their normal self. Their blood pressure could be high, abnormal vomiting, or skin teas. If there was a change, they check the vitals, and examine what could have caused the change. They could also call the doctor to see if there was an order and they would follow it. This could be a lab or a diagnosis. He would also call the family and notify the DON. The documentation was the change in condition assessment, and he would do a progress report. If there was a change in condition the resident, he would monitor them every 15-30 minutes, and if a medical emergency, he would call 911 even if the doctor had not responded. He stated he would fully document the changes on the reports. They exchanged information with the next shift nurse by using the 24-hour report and doing rounds. ADON and the investigator reviewed the staff roster with the in-service sing in sheet and pointed out that there were 4 staff members left to in-service. She stated that 2 staff were on PTO and would not be back that week, 2 staff were on nurse who worked PRN. She said she had reached out to them, but they did not answer. She stated she would reach out to them again to attempt to relay the information by phone. She sent a text message to the investigator at 7:28 pm informing that she was able to reach but PRN nurses successfully. Monitoring Day 3: Tuesday [DATE]th, 2024 -Reviewed the in-service list for CNA's and Nurse and all staff had been successfully in serviced. QAPI Charts were reviewed and all documents were completed. All residents were reviewed for recent changes in condition and no changes were identified. 24-hour reports were monitored and updates were completed per shift and notification was noted to the Dr. as needed. An Immediate Jeopardy (IJ) was identified on [DATE]. An IJ Template was provided to the facility on [DATE] at 4:31 pm. While the Immediate Jeopardy was removed on [DATE] at 1:52 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.