STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676094	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Orange	4201 Fm 105 Orange, TX 77630

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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors for 1 of 4 (Resident #1) residents reviewed for medication errors. 1. The facility failed to administer Resident #1 the appropriate dose of morphine. Resident #1 was administered 1ml (20mg) of morphine every 3 minutes from 11:15 a.m. to 11:39 a.m. (180mg) instead of 1ml (20mg) every 30 minutes. 2. The facility failed to ensure Resident #1's morphine order was properly transcribed. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on [DATE] and ended on [DATE]. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk for harm or death relating to being administered too much medication. Finding Include: 1. Record review of Resident #1's face sheet dated [DATE] indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (progressive disease that destroys memory and other important mental functions), chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), epilepsy (brain condition that causes reoccurring seizures), diabetes with neuropathy (nerve damage that occurs as a complication of diabetes), paranoid schizophrenia (intense paranoia and delusional thinking), legally blind (severely impaired vision), and pain. Record review of Resident #1's physician orders dated [DATE] through [DATE] indicated she had an order morphine sulfate (concentrate) oral solution 100mg/5ml give 1ml by mouth every 2 hours as needed starting [DATE]. Record review of Resident #1's quarterly MDS dated [DATE] indicated she usually understood others and was usually understood by others. The MDS indicated she had a BIMS of 7 (severely impaired cognitively). The MDS indicated she required total dependence with self-care, bed mobility, transfers, and dressing. The MDS indicated she received scheduled pain medication regimen, and she is taking high-risk drug of opioid. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's care plan last revised [DATE] indicted she was at risk for experiencing discomfort or pain with interventions including administer medication to relieve pain as ordered and discuss with the physician and review medications as indicated to ensure she was on the least amount of medication at the lowest dose to treat her pain. Record review of Resident #1's MAR dated [DATE] indicated Resident #1 had been administered 1ml (20mg) of morphine on [DATE] at 10:30 a.m. and 2:00 p.m. by LVN A. Record review of Resident #1's morphine sulfate prescription label dated [DATE] indicated morphine sulfate 100mg/5ml give 1ml by mouth or under tongue every 30 minutes as needed until comfortable and then every 2 hours for pain or shortness of breath. Record review of Resident #1's Nurse Progress Note dated [DATE] at 11:58 a.m. authored by LVN A indicated Resident #1's sitter approached the nurse's station with the resident's family member on the phone stating Resident #1 was in pain. Resident #1 had received routine Norco 7.5mg/325mg one tablet at 7 a.m. and prn morphine 1ml at 10:30 a.m. LVN A assessed the resident to have increased respirations and heart rate, and she was noted to be with sounds of distress, grimacing and stating she was hurting and saying Lord Help Me. LVN A contacted Hospice RN and received orders to administer morphine 1ml (20mg) every 3 minutes until the resident was at comfort level and pain subsided, then start morphine 1ml (20mg) every 2 hours routinely around the clock. The note indicated morphine 1ml every 3 minutes was initiated. Morphine was administered every 3 minutes for 9 doses with the resident's subjective and objective signs and symptoms of pain resolved after the 9th dose. Hospice RN notified of morphine on hand and status of resident needing more morphine. Record review of Resident #1's undated Narcotic Count Sheet for morphine sulfate 100mg/5ml bottle indicated the dosage was give 1ml by mouth/under tongue every 2 hours as needed for pain or shortness of breath. The Narcotic Count Sheet indicated the initial amount of morphine received was 45ml. The Narcotic Count Sheet indicated Resident #1 received 1ml of morphine on [DATE] at 10:30 a.m., 1ml of morphine on [DATE] at 11:15 a.m., 1ml of morphine on [DATE] at 11:18 a.m., 1ml of morphine on [DATE] at 11:21 a.m., 1ml of morphine on [DATE] at 11:24 a.m., 1ml of morphine on [DATE] at 11:27 a.m., 1ml of morphine on [DATE] at 11:30 a.m., 1ml of morphine on [DATE] at 11:33 a.m., 1ml of morphine on [DATE] at 11:36 a.m., 1ml of morphine on [DATE] at 11:39 a.m., 1ml of morphine on [DATE] at 12:00 p.m., and 1ml of morphine on [DATE] at 2:00 p.m. all doses administered by LVN A. (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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 3:51 p.m., LVN A said on [DATE] around 11:00 a.m. Resident #1's sitter, who was on the phone with Resident #1's family member, notified her of Resident #1 being in pain. She said Resident #1 received her dose of Norco 7.5mg/325mg earlier that morning at 7:00 a.m. and prn morphine 1ml (20mg) at 10:30 a.m. She said Resident #1, remained tensed, crying, moaning, grimacing and stating she was hurting. She said she contacted Hospice RN and received new orders to administer morphine 1ml (20mg) every 3 minutes until the resident was comfortable and then start morphine 1 ml (20mg) every 2 hours routinely around the clock. She said she clarified and confirmed the order 2 or 3 times with Hospice RN. She said she initiated the morphine 1ml (20mg) every 3 minutes and administered a total of 9 doses over a 24-minute period to Resident #1 with pain resolved. She said she remained in Resident #1's room at her bedside and set an alarm on her cell phone to monitor her pain every 3 minutes and administered the morphine when she continued to complain of pain. She said after the 9th dose of morphine, Resident #1 was resting comfortably with no complaints of pain or signs of discomfort. She said she notified Hospice RN at around 12:00 p.m. of Resident #1's morphine supply running low, and Hospice RN told her she would deliver more morphine when she came to assess the resident. She said she administered Resident #1 morphine 1ml (20mg) again at 12:00 p.m. for complaints of pain with effectiveness. She said she administered another dose of morphine at 2:00 p.m. to follow the ordered routine dosing of morphine to be given every 2-hours. She said around 2:30 p.m., Hospice RN arrived at the facility during report, identified the morphine order was transcribed wrong. She said Resident #1 was supposed to have received morphine 1ml (20mg) every 30 minutes not every 3 minutes. She said Hospice RN notified Resident #1's RP and family of the incident and offered Narcan to reverse the effects and/or transfer to the ER for evaluation, but the RP and family denied the treatment. She said Hospice RN assessed Resident #1 with no abnormal findings and directed her and LVN D to hold all medications for 4 hours and assess the resident's vital signs every 30 minutes for 4 hours and to notify hospice with any changes. She said she notified the DON of the incident with Resident #1's morphine dosage, and she was instructed to complete a medication error incident. She said she received 1:1 training from the DON and ADON regarding if orders received did not seem correct or if she was uncomfortable with administering a medication, she needed to contact the DON for clarification before administering. She said she clarified the order with Hospice RN ,d+[DATE] times, and Hospice RN was communicating with the physician via text while on the phone with her and she administered what the physician ordered. She said LVN B was at the nurses' station when she received the orders and heard the conversation. She said she was not familiar with the hospice service company providing Resident #1's care and thought the morphine dose was a new pain management treatment plan specific to this hospice. She said she was alarmed with the dosing which was why she clarified the order with the hospice nurse , d+[DATE] times. She said she was aware of signs of overdose of morphine to include decrease respirations, decrease heart rate, drowsiness, and confusion. Record review of Resident #1's Nurse Progress Note dated [DATE] at 3:20 p.m. late entry authored by LVN A indicated Resident #1 was being fed by sitter at this time, no concerns noted, resident stable, staff will continue to monitor. Weekend Supervisor aware of events. At 1:00 p.m. family member arrived, resident reassessed and VS WNL. The resident was alert, and the family member fed the resident. Resident #1 had no verbal complaints of pain/ discomfort or non-verbal signs and symptoms of pain/discomfort. The resident was resting at this time and the nurse would continue to monitor. At 2:30 p.m., Hospice RN arrived to deliver Resident #1's Morphine, and assessed the resident indicating the vital signs were WNL. Hospice RN gave orders to hold all medications for 4 hours and assess vital signs every 30 minutes for 4 hours. Hospice RN offered Resident #1's family member to administer Resident #1 Narcan or send to the ER for accidental overdose of morphine and the family member declined. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 2:22 p.m., Hospice RN said she received a report from LVN A Resident #1 was having a pain crisis and she had already had her Norco 7.5mg/325mg around 7:00 a.m. and a dose of morphine 1ml (20mg) around 10:30 a.m. She said she contacted the hospice physician with the report and assessment and was given new orders to administer morphine 1ml (20mg) every 30 minutes until pain subsides or comfortable and then every 2 hours as needed. She said LVN A repeated back the order and instead of every 30 minutes she said every 3 minutes and she corrected LVN A and instructed the medication needed to be provided every 30 minutes not 3 minutes. She said she received a call from LVN A regarding Resident #1's morphine supply was low. She said when she arrived at the facility around 2:15 p.m. to drop of the morphine prescription and assess Resident #1, during conversation and narcotic count, she discovered Resident #1 was administered morphine 1ml (20mg) every 3 minutes starting at 11:15 a.m. through 11:39 a.m. totaling 9 doses (180mg) in 24 minutes and additional morphine 1ml (20mg) given and 12:00 p.m. and 2:00 p.m. She said when she learned of the morphine overdose, she assessed Resident #1 and contacted the hospice physician. She said the hospice physician provided options of the antidote of Narcan and/or send the resident to ER for evaluation. She said she informed Resident #1's RP of the accidental overdose and the options suggested by the hospice physician. She said the RP stated she felt Resident #1 was comfortable and did not want an antidote administered. She said the RP was informed of the potential effects if antidote not given and she verbalized understanding. She said facility staff was notified to contact hospice of any changes. She said she was contacted by LVN D around 5:00 p.m., indicating Resident #1's respirations were more labored and decreased, and family was requesting hospice to reassess the resident. She said she returned to the facility and completed an assessment on Resident #1 and reported findings of respiratory rate of 6 breaths per minute to the hospice physician. She said she rediscussed the antidote and ER evaluation options and effects if administered and RP declined. She said she provided end of life counseling with RP and family. She said she was contacted around 4:30 a.m. on [DATE] Resident #1 had no signs of life and requested RN to facility and pronounce time of death. Record review of Resident #1's hospice assessment dated [DATE] time in at 2:15 p.m. authored by Hospice RN indicated the resident's facility nurse called indicating the resident was having pain after already receiving Norco 7XXX,d+[DATE] mg two hours ago around 8:00 a.m. and a dose of morphine 1ml (scheduled every two hours) 30 minutes ago at 10:35 a.m., Hospice MD was notified, and new orders were received for morphine 1ml to be given every 30 minutes as needed for pain or shortness of breath until patient was comfortable and then every two hours. LVN A was given new orders and verbalized understanding. LVN A called back and stated Resident #1 would not have enough medication of morphine to last through the day and new orders/directions were sent to pharmacy. The morphine prescription would be picked up and delivered to the facility (by Hospice RN). Upon arriving to the facility, Resident #1's pain status and morphine doses given was verified when LVN A reported she had given 9 doses of morphine and last dose given was at 2:00 p.m. Hospice RN reviewed the resident's Morphine Narcotic Count Sheet and the times it was administered, and morphine had been given every 3 minutes and not every 30 minutes. The note indicated LVN A stated she had transcribed the order incorrectly for every 3 minutes. Resident #1 was assessed (by Hospice RN), and vital signs were taken, and Hospice MD was notified of the medication error and patient status. New orders given for the facility to hold the resident's pain medications for four hours, to obtain vital signs every 30 minutes, and to call Hospice if any changes occurred. The note indicated Hospice RN spoke with the resident's family member as well as the facility staff nurse with additions to the plan of care with verbalization of understanding. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #1's hospice assessment dated [DATE] time in at 5:00 p.m. authored by Hospice RN indicated LVN D called around 4:45 p.m. and Resident #1's family member requested for Hospice RN to return to the facility and assess Resident #1 because her respirations had changed and were more labored. Hospice nurse returned to reassess Resident #1. Family members were notified of options at the facility or send the resident to ER since this was not related to the Hospice diagnosis, but for treatment for symptoms from facility nurse giving incorrect frequencies of morphine Hospice RN discussed with Resident #1's family members regarding what happened if Narcan was administered to reverse the medication and the resident's pain could return and pain medications would still be held until patient was stable prior to resuming pain medication or send the resident to ER where they would likely give the Narcan as treatment. Hospice RN informed family members at bedside if Narcan was not given she could very well pass soon. Family member asked why Narcan would be given, and other family member responded because the morphine given was too much. Family members said she looked comfortable and would rather her be comfortable and pass rather than give her medications could cause her to be in pain again. Hospice RN gave direction for family members to contact additional immediate family because with her decreased respirations and pauses between breaths as the resident may soon pass. During an interview on [DATE] at 12:53 p.m., LVN D said she worked the ,d+[DATE] p.m. shift on [DATE] and during shift change she was made aware the Resident #1 had received an accidental overdose of morphine during the previous shift. She said Resident #1 was monitored throughout her shift and obtained vital signs every 30 minutes starting around 3:30 p.m. for 4 hours ending around 7:30 p.m. She said she did contact the hospice RN at the request of Resident #1's family because her respirations were labored and decreased at around 5:00 p.m. She said Resident #1's alertness and respiratory rate decreased throughout the shift. She said when she made her last rounds with oncoming nurse LVN C around 10 p.m. Resident #1's respiratory rate was down to 3 breaths per minute. Record review of Resident #1's Nurse Progress Note dated [DATE] at 5:05 a.m. authored by LVN C indicated nurse was called to resident room by Resident #1's sitter and no signs of life was present this nurse called hospice nurse, she arrived, assessed Resident #1, and pronounced time of death. During an interview on [DATE] at 2:18 p.m., LVN C said she worked the 10 p.m.-6 a.m. shift on [DATE] - [DATE] and during shift change she was made aware the Resident #1 had received an accidental overdose of morphine during the morning shift and she was being monitored. She said Resident #1 was not responding to verbal or tactile stimuli during her assessments and respiratory rate was at 3 -4 breathes a minute with periods of apnea. She said Resident #1's RP and family was at bedside most of the night. She said around 4:15 a.m., Resident #1's family member reported the resident was not breathing and had no signs of life. She said she went to assess Resident #1 and found no signs of life and contacted Hospice RN. She said Hospice RN arrived at the facility and pronounced Resident #1 deceased around 4:30 a.m. Record review of Resident #1's hospice assessment dated [DATE] time in at 4:38 a.m. authored by Hospice RN indicated Resident #1 expired on [DATE] at 4:38 a.m., death was pronounced by Hospice RN, after no pulse, respirations or other signs of life noted for 2 full minutes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 2:13 p.m., LVN B said she was present at the nurses' station when LVN A was receiving the morphine orders for Resident #1, but she only heard LVN A's side of the conversation and heard her verify morphine 1ml every 3minutes until pain subsided and ask for the nurse's name and prescribing MD's name. She said she did acknowledge to LVN A this order for morphine seemed to be a lot. She said she left the nurses' station during the phone call but if she was transcribing the order she would have questioned the order or contacted the weekend supervisory before administering. During an interview on [DATE] at 10:20 a.m., the Hospice Physician said Hospice RN called her on [DATE] at 11:08 a.m. reporting Resident #1 was having a pain crisis and had received Norco 7.5mg and 1ml of morphine (20mg) over the last 2 hours with no relief. She said she gave orders for Resident #1 to have Morphine 1ml (20mg) every 30 minutes until her pain subsided or comfortable and then continue Morphine 1ml (20mg) every 2 hours for pain. She said around 2:57 p.m. Hospice RN contacted her and reported facility nurse (LVN A) transcribed the order incorrectly and had administered Resident #1's morphine 1ml (20mg) every 3 minutes for 9 doses (total of 180 mg in 24 minutes) instead of every 30 minutes. She said Hospice RN reported vital signs, assessment, and last dose of morphine 1ml (20mg) was at 2:00 p.m. and resident's vital signs were stable. She ordered for Narcan to be administered or to transfer the resident to the ER for evaluation which was declined by RP. She said she ordered for facility staff to continue to monitor Resident #1 and report to hospice with any changes. She said Hospice RN notified her around 4:30 p.m. of Resident #1's respiratory rate decreasing, and she returned to the facility to complete an assessment. She said Hospice RN reported the resident's decrease in responsiveness and respiratory rate. She said she advised Hospice RN to offer the resident's family the Narcan to be administered or sending the resident to the ER for evaluation, again the RP declined. She said morphine should never be given every 3 minutes because with liquid morphine it takes ,d+[DATE] minutes to take affect which is why it was ordered every 30 minutes during a pain crisis. She said the morphine could remain in the body's system for up to 6 hours depending on the body's metabolism. She said she had never ordered morphine 1ml (20mg) every 3 minutes as it would cause respiratory distress or failure if multiple doses given which could lead to death. During an interview on [DATE] at 12:42 p.m., the Attending NP said she was not contacted regarding Resident #1's morphine accidental overdose/medication error. The Attending NP said if she had been notified of the morphine overdose, she would have ordered for an antidote like Narcan to be administered and to monitor respirations or given an order for Resident #1 to be sent to the hospital due to her being on hospice. The Attending NP said she had never heard of morphine 20mg be given every 3 minutes and a large dose administered would cause respiratory distress or failure leading to death if antidote was not administered. During an interview on [DATE] at 2:30 p.m., RN E said she was the RN supervisor during the previous weekend (time of the incident), and she was not notified of the medication discrepancy until around 2:15 p.m. when she was asked for the DON's phone number to discuss the incident with her. She said if she was made aware of the medication discrepancy, she would have contacted Hospice RN or the hospice physician for clarification because the transcribed dose was not within the standard morphine prescribing guidelines. During an interview [DATE] at 2:47 p.m., the facility contracted Pharmacist said the effects of morphine overdose was respiratory depression, confusion, disorientation, fatigue, and sleepiness. She said she had never heard of morphine 20mg be given every 3 minutes and that was a concerning high dosage. The Pharmacist said the order should have been clarified before administering. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on [DATE] at 5:00 p.m., the DON said she was not made aware of the incident with Resident #1's morphine incorrect dosage until [DATE] around 2:45 p.m. She said she contacted the consulting pharmacy, had LVN A complete medication error incident, verified hospice was aware, took statements, interviewed involved staff, and visited with Resident #1 and family. The DON said if licensed staff received an order that did not seem correct, outside of prescribing guidelines, or if they were not comfortable giving a medication, they should contact her, for further discussion and clarification from the pharmacist and the ordering or attending physician. The DON said the morphine overdose could have caused respiratory depression and death. The DON said Resident #1's RP was offered an antidote but declined. The DON said vital signs would be monitored more often or longer if an order was given by the physician. The DON said she contacted their pharmacist consultant regarding the overdose and was advised to complete a medication error incident report. She said the facility pharmacy consultant scheduled an in-person training for all licensed facility staff next week for continued training and the consultant would be providing staff a resource to have available for narcotic minimal and maximal dosage (not to exceed). The DON said she had provided training on [DATE] to licensed staff about clarification of verbal orders, completed medication pass competency checks with scheduled staff since the incident, and performed a chart audit of all residents on pain medication verifying adequate frequency/duration. The DON said she was performing medication pass review competency checkoffs on the licenses staff as they return to work and will not allow them to work if competency check not passed. The DON said she expected the licensed staff to use their professional judgement and not to provide medications they did not feel comfortable administering or to contact her prior to administering for additional clarification. Record review of the facility's Preventing and Detecting Adverse Consequences and Medication Error policy-dated [DATE] indicated, 2. When a resident receives a new medication the medication order is evaluated for the following a. the dose route of administration duration and monitoring are in agreement with the current clinical practice clinical guidelines and or manufacturers specifications for use Record review of an In-Service training report dated [DATE], with LVN A one on one training, with contents or summary of the training session included: if you receive a verbal order from MD or nurse that you do not feel comfortable following through with contact the DON immediately to discuss the orders received and MD or nurse will be contacted after discussion of order to verify or clarify order received. Record review of an In-Service training report dated [DATE], with facility charge nurses with contents or summary of training session included: if you receive a verbal order from MD or nurse that you do not feel comfortable following through with contact the DON immediately to discuss the orders received and MD or nurse will be contacted after discussion of order to verify or clarify order received, indicated 26 charge nurses signed the in-service record or received the training via phone conversation. Record review of Medication Pass Review Competency Checkoffs dated [DATE] -[DATE] indicated 8 charge nurses had completed and passed medication pass competency check off. Record review of a facility audit dated [DATE] at 9:30 a.m. indicated all residents with pain medication were reviewed for correct frequency and/duration of pain medications. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Incident logs from [DATE] through [DATE] indicated there were no other medication error incidents at the facility. During interviews on [DATE] from 11:30 a.m. - [DATE] to 5:00 p.m., 2 RNs (RN E, RN F), and 9 LVNs (LVN A, LVN B, LVN C, LVN D, LVN G, LVN H, LVN I, LVN J, and LVN K) were able to identify correct protocol for receiving verbal orders, clarifying and repeating the order back to the prescriber and if orders were not within the prescribing guidelines or if they did not feel comfortable following or administering the orders, they were to contact the DON immediately to discuss the issues and the DON would contact the MD or nurse to verify/clarify the order received. All staff were able to identify the signs and symptoms of accidental overdosing of morphine and protocols to follow. On [DATE] at 05:25 p.m., the Administrator was informed of the Immediate Jeopardy. The non-compliance was identified as past non-compliance. The Immediate Jeopardy began on [DATE] and ended on [DATE]. The facility had corrected the noncompliance before survey began.