STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676204	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to immediately consult with the resident's physician when there was a significant change in the resident's condition or need to alter treatment significantly for 1 of 5 residents (CR#1) reviewed for physician notification. The facility failed to properly identify and intervene in CR#1's acute change in condition related to his diabetes mellitus and congestive heart failure. The facility failed to notify physician after CR#1's vitals were declining, which lead to CR#1's hospitalization with vital organ impairment or failure. An Immediate Jeopardy (IJ) was identified on 05/07/2025 at 5:30 p.m. While the IJ was removed on 05/08/2025 at 10:50pm the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could affect residents by placing them at risk of delayed treatment that has the propensity to lead to death. Findings Included: Record review of CR#1's undated face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] from the local hospital with diagnoses of coronary artery disease (reduction of blood flow to heart muscle), heart failure (the heart fails to pump enough blood to meet the body needs), hypertension (high blood pressure), diabetes mellitus (blood sugar is too high), Hyperlipidemia (too much fat in the blood), arthritis (swelling and tenderness in the joints), diverticulosis (inflammation of the colon), and other fractures. CR#1 discharged to the hospital on 5/3/2025. The discharge instructions listed primary diagnosis, reason for hospitalization, procedures and tests performed while in the hospital, taking medications and follow information regarding heart failure. Record review of CR#1's Quarterly MDS dated [DATE] revealed CR#1 has a BIMS score of 12 (means resident cognition is intact). (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's orders dated 5/1/2025-5/31/2025 revealed blood sugar checks two times a day for DIABETES; Midodrine HCl Oral Tablet 5 MG-give 1 tablet by mouth every 8 hours PRN (as needed) as needed for hypotension. Hold for SBR (blood Pressure) less than 90 (no date); Sodium Polystyrene Sulfonate Suspension 15GM/60ML-Give 15 gram by mouth one time only for Hyperkalemia (elevated potassium in the blood) until 5/3/2025 11:59p.m; Cozaar Tablet 100 MG (Losartan Potassium) give 1 tablet by mouth one time a day for hypertension. Hold for ABP <100 or DBP <60. Start date 4/23/2025 9:00am; Farxiga (diabetes) Oral tablet 5 mg (Dapagliflozin Propanediaol) Give 1 tablet by mouth one time a day for DM-start date 4/23/25 9:00am. Hold from 5/3/2025 to 5/5/2025 4:41pm; Prabastatin Sodium Oral Tablet 10 MG (Pravastatin Sodium) Give 1 tablet by mouth one time a day for Hyperlipidemia (for high cholesterol levels). Start date 4/23/2025 9:00am; Carvedilol Oral tablet 25 MG give one tablet by mouth two times a day for HTN (hypertension) hold for SBP <110 or HR <60. Start date 4/23/2025; Eliquis Oral tablet 5 MG (Apixaban) (blood thinner) give 1 tablet by mouth two times a day for Anticoagulant. Start date 4/23/2025 9:00am; Gilmepride (treats high blood pressure) Oral tablet 4 MG give 1 tablet by mouth two times a day for DM. Start date 4/23/2025 9:00am-Hold date 5/3/2025-5-5-2025. Record review of CR #1's care plan dated 4/22/2025, revealed the following care areas: Focus: [CR #1] I am at risk for frequent infections, pressure/venous/stasis ulcers, vision impairment, hyper/hypoglycemia, renal failure, cognitive/physical impairment/skin desensitized to pain or pressure related to diabetes melillitus. Date initiated and revision on 5/5/2025. Interventions: [CR #1] I will have no complications related to diabetes through the review date. Date initiated and revision on 5/5/2025. Target date on 5/1/2025. Interventions: [CR #1] Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of hyperglycemia (difficulty waking up); increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdomen pain), Kassmaul (rapid) breathing, acetone breath (smells fruity), stupor (stated of reduced consciousness or responsiveness, where a person is almost unconscious but can be aroused by vigorous stimulation), coma (deep unconsciousness)-date initiated 5/5/2025; Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of hypoglycemia: Sweating, Tremor, increased heart rate (Tachycardia), pallor (Paleness), nervousness, confusion, slurred speech, lack of coordination, staggering gait (unsteady). Date initiated 5/5/2025. Focus: [CR #1] Potential for complications, s/sx related to diagnosis of hypertension. Receives anti hypertension and is at risk for side effects. Dated initiated 5/5/2025. Goal: [CR #1] My B/P (blood pressure) will stay within their normal limits, will not have s/s of hyper/hypo tension throughout the review date. Date initiated 5/5/2025. Target date 5/1/2025. Interventions: [CR #1] Administer anti-hypertensive medications as ordered. Monitor B/P and for side effects such as orthostatic hypotension (low blood pressure) and increased heart rate (Tachycardia), increased edema (swelling), headache, chest pain, and report abnormalities to physician. Dated initiated 5/5/2025; Monitor/Document/Report PRN any s/s of malignant hypertension (blood pressure rises rapidly): Headache, visual problems, confusion, disorientation, lethargy (usually tired, sluggish, and lacking energy), nausea (feeling sick in the stomach) and vomiting, irritability, seizure activity, and difficulty breathing (Dyspnea). Date initiated 5/5/2025. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of facility's last vitals taken for CR#1's Blood Pressure 5/2/2025 at 10:18am - 98/56 5/2/2025 at 7:58pm - 80/47 5/3/2025 at 7:05am - 82/47 5/3/2025 at 2:37pm - 81/43 5/3/2025 at 4:58pm - 99/51 Record Review of facility's last vitals taken for CR#1's 02 Stats 5/2/2025 10:18am 90.0% Room Air 5/2/2025 7:59pm 92.0% Room Air 5/3/2025 7:05am 93.0% Room Air 5/3/2025 4:58pm 82.0% Room Air Record Review of facility's last vitals taken for CR#1's Blood Sugar vitals 5/3/2025 2:37pm 64.0mg (manual) 5/3/2025 3:40pm 94.0mg (manual) Record Review of skilled charting for CR#1 dated 5/2/2025 at 7:33pm by LVN A, revealed the following: vital signs taken on 5/2/2025 at 10:18am were: Temperature 97.5 taken forehead (non-contact), pulse 77(bpm), Respiration 18.0(breaths/min), Blood pressure 98/56, O2 stats 92.0% (room air). Section D: Mood and Behavior: 1b: Notable changes in mood and behavior: Resident sleeping a lot more than usual. Record Review of skilled charting for CR#1 dated 5/2/2025 at 7:56pm by LVN A revealed the following: vital signs taken on 5/2/2025 at 7:59pm were: Temperature 96.8 taken forehead (non-contact), pulse 68(bpm), Respiration 20.0(breaths/min), Blood pressure 80/47, O2 stats 92.0% (room air). Section D: Mood and Behavior: 1b: Notable changes in mood and behavior: Resident sleeping a lot more than usual. Record Review of nursing notes for CR#1 dated 5/2/2025 revealed, there were no nursing notes for this date. Record Review of nursing notes for CR#1 dated 5/3/2025 at 9:16am, revealed, Change in Condition reported on the CIC Evaluation are/were: Other change in condition Tired, Weak, Confused, or Drowsy. At the time of evaluation resident/patient vital signs, weight and blood sugar were: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Blood Pressure: 82/47 - 5/3/2025 07:05 Position: Lying r/arm -Pulse: P 68 - 5/3/2025 07:05 Pulse Type: Regular -RR: R 18.0 - 5/3/2025 07:05 -Temp: T 97.3 - 5/3/2025 07:05 Route: Forehead (Non-Contact) -Weight: W 280.0 lb - 4/29/2025 14:38 (2:38pm) Scale: Mechanical Lift -Pulse Oximetry: O2 93.0% - 5/3/2025 07:05 Method: Room Air -Blood Glucose: Record Review of nursing notes for CR#1 dated 5/3/2025 at 7:20pm, revealed, Note Text: Resident lethargic this am, blood pressure low, notified vanguard received new orders: N/O: Midodrine HCl Oral Tablet 5 MG (Midodrine HCl). Record Review of Local Hospital admission dated 5.3.2025 revealed, CR#1 presented to the ED yesterday via EMS from the facility with fatigue (extreme tiredness), lethargy (lack of energy and enthusiasm), and altered mental status (a deviation form norm). EMS found CR#1 to be hypotensive (low blood pressure) (87/58), hypoglycemic (drop in blood sugar) with blood glucose (body primary source of energy) of 35 and hyperkalemic (causes kidney disease) with a potassium level of (6) six. CR#1 received D50 (intravenous), Kayexalate (treat high levels of potassium in the blood), and midodrine (treats low blood pressure) enroute to the ED. Workup (thorough diagnostic evaluation to determine the cause of symptoms or health condition) in the ED found CR#1 to be acute hypoxic (decrease in oxygen levels in the blood) and hypercapnic respiratory failure (respiratory system cannot remove carbon dioxide from the body), septic shock (a life threatening condition that occurs with body response to a severe infection causes low blood pressure and multiple organ dysfunction), acute renal failure (Kidney failure), and persistent hyperglycemia (high blood sugar levels consistently exceeding target range). CR#1 was placed on BIPAP and initiated on a D10 infusion (IV) to maintain glucose. CR#1 was fluid resuscitated per sepsis guidelines and initiated on vasopressors (medications to cause blood vessels to constrict) to maintain adequate blood pressure. CR#1 transferred to ICU for management. Foley placed in CR#1with 1200cc returned immediately after placement. The local hospital's disposition: CR#1 to remain in ICU: CR#1 at high risk for complications CR#1 is critically ill with vital organ impairment or failure. There is a high probability of imminent or life-threatening deterioration in the patient's condition Patient is unable or incompetent to participate in giving a history and/or making decisions and discussion is necessary for determining treatment decisions. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 5/6/2025 at 2:03 p.m., FM A said she is a relative of CR#1 and wanted to reiterate what was in her complaint. She stated CR#1 did not have pneumonia or sepsis before arriving to the facility 11 days ago. She stated his blood pressure has been extremely low. She stated CR#1 is in the local hospital. Stated the nursing staff did nothing to help CR#1 while in the facility. She stated if the nursing staff had checked his blood sugar like he told them they did in the hospital, they would have known that he was going into a diabetic coma. In an interview and observation on 5/6/2025 at 2:30 p.m. (at the hospital), CR#1 said he was in the facility for 11 days for rehab after having back surgery. CR#1 said after 3 days he began asking questions of the nurse regarding his glucose and checking his blood sugar levels because he was starting to feel very tired and couldn't stay awake. He said the nurse would only tell him she will be right back she had to check his orders. The nurse never returned. He said he asked this question on multiple shifts and multiple times and received the same answer. He said he started feeling lethargic and couldn't stay awake. He said he was so sleepy he went a day or two without eating. CR#1 said there was a LVN who had returned from vacation this past Saturday who listened to him, and his concerns, and she ordered labs. No other nurse did. In an Interview 5/6/2025 at 2:50pm at the hospital with FM B and FM C they stated last Thursday (5/1/2025) they tried calling resident and didn't get an answer. Both stated they called the front desk and were told he was asleep. They received the same response on Friday (5/2/2025). However, when they called Saturday (5/3/2025) and CR#1's phone went to his voicemail they had concerns and therefore called the facility. At this time FM A told FM B and FM C she didn't like what she was seeing and that she couldn't wake CR#1 after several tries. FM B said she demanded that FM D tell the facility to call 911 immediately. In a Telephone Interview 5/6/2025 at 5:30pm FM D stated this past Thursday (5/1/2025) morning CR#1 appeared unusually sleepy. She stated the nurse told her that she had given CR#1 pain medications which was why he was sleepy. FM D stated on Saturday (5/3/2025) she received a call from facility and said CR#1 was sleeping and lethargic and nurse stated she called doctor. FM D stated when she arrived at the facility Saturday (5/3/2025) the nurse had just taken his blood sugar and at that time it was 65. The nurse left the room to get some orange juice. However, while the nurse was away getting juice, FM D stated she observed the food tray with tea, and she put two packets of sugar and gave it to CR#1 herself. She stated a few moments later, the nurse returned with orange juice and sugar and gave it to resident. Stated after 30 minutes nurse re-took sugar levels and it was 93. She stated the nurse took labs. Nurse returned with lab results and said he had critical potassium levels and creatine were elevated as well. She stated the nurse said she called the doctor. However, FM D and other family members requested CR#1 go to hospital via 911. Stated the nurse returned with critical labs and stated the doctor had ordered Kayexalate (treats high blood potassium) and IV fluids; however, the nurse told her she had to get someone to come and start the IV because it was out of her range as a nurse. During this time the family continued to request CR#1 be sent out to hospital. She stated nursing staff never checked his blood sugar prior to this episode even though CR#1 and the family told the nursing staff that the hospital checked 3 times daily. She stated CR#1 asked about his blood sugar being checked and he was told by one of the nurses that the hospital told her (nurse) that he was no longer diabetic so there was no need to check his blood sugar. FM D stated CR#1 was very congested during her visit on Saturday 5/3/2025 and she told the nurse she could hear wheezing when CR#1 coughed. She stated the nurse checked CR#1's blood sugar after the family requested on Saturday, 5/3/2025. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 5/6/2025 at 6:21p.m., with MA B stated she was familiar with CR#1. She stated CR#1's family members were always in the room. She stated blood sugars were to be taken before and after meals. She stated even if it was not in the orders, typically you do it for persons who were diabetic. She stated the nurse was responsible for taking the blood sugar. She stated checking the blood sugar was on the MAR. She stated the nurse will make the notation on MAR and if she hasn't noted she would find the nurse prior to giving medication. She stated she did not make any efforts to find the nurse and inquire about the blood sugar being taken. She stated she must of gotten busy. In an interview on 5/6/2025 at 6:46 p.m., LVN A stated she was familiar with CR#1. She returned to work on Monday 4/28/25 from vacation and worked with CR#1 for the first time then. She stated she worked with CR#1 on that Tuesday (4/29/2025) and again on Saturday 5/3/2025 She stated while she was working on 5/3/2025 and during her rounds she noticed CR#1 didn't look well as his face was pale looking. She stated she took his blood pressure, and it was low (82/47). She telephoned the doctor answering service and left a message. LVN A stated she honestly did not know he was diabetic until Saturday 5/3/2025. Nurse stated upon admission the medication list delivered from the hospital was sent to the doctor. The doctor was supposed to okay the orders. She stated the NP made rounds on 4/29/2025 at which time she told her that resident had serious back surgery and Tylenol was not strong enough for him. She stated the NP gave resident a prescription for an additional pain medication. LVN A stated if she had done the admission and noted the type of medication resident was taking she would have informed nursing staff that he needed blood sugar taken prior to meals and sometimes afterwards. In an interview on 5/6/2025 at 7:30 p.m., the IDON stated he spoke with the CR#1 on Friday 5/2/2025. He stated CR#1 was talking and stated he didn't feel well; however, IDON contributed it to the back issues. He stated he listened to CR#1's chest and lungs and did not get anything alarming. He stated the facility did a chest x-ray but when the results returned CR#1 had already gone to the hospital. The IDON stated the admitting nurse (facility) was responsible for submitting any resident information upon admittance to the doctor. When asked if a diabetic patient should have a glucose test before meals, he stated they could. He stated it was a nursing judgement to draw blood for glucose labs. The IDON was asked how long it takes to develop pneumonia and sepsis and he stated the resident may have come to the facility from the hospital with that diagnosis. He was asked what should have been done when resident blood pressure taken was low and he stated that the resident's medical condition will sometimes have a low blood pressure; however, it should have been documented and possibly noted as a change of condition. The IDON stated on 5/3/2025 the nurse completed a change of condition; gave resident some orange juice and it appeared his blood glucose was increasing. He initially stated he was contacted and wanted the nurse to call 911, then he was reminded that according to the nursing notes the family requested 911. In a follow-up interview on 5/7/2025 at 9:10 p.m., with IDON - He stated the blood pressure readings on 5.2. 2025 were out of range and not normal. He stated he was not aware the resident was having issues on this date (5/2/2025). He stated the blood pressure on 5/2/2025 represented someone who is hypotensive. He stated the nurses should have called the doctor. He stated the nurses erred for not contacting the doctor for the decrease in blood pressure. He stated the expectation was to re-check the blood pressure every 15-30 minutes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a follow-up telephone interview on 5/7/2025 at 11:14am with LVN A she stated a COC is anything going on with patient and out of the ordinary. Protocol is to notify doctor and get new orders. She stated CR#1's blood pressure was low after taking it 4 times 5.3.2025. CR#1's family member told her she noticed a cough and phlegm (thick mucus) afterwards. LVN A stated she contacted the doctor who ordered CR#1 to have a chest x-ray, but he didn't get it cause resident went out to hospital. LVN A stated she would not have considered a change of condition on 5.2.2025 because he was talking to her. However, he was sleeping a lot, but easily aroused. LVN A stated this is why she did not call the doctor. In an Interview on 5/7/2025 at 11:26am with CMA A is familiar with CR#1. She stated CR#1 told her that he was nausea and felt like he wanted to throw up and refused his medication on 5/2/2025. She stated he looked normal and was talking to her as usual. CMA A stated she notified LVN A who was his charge nurse. She stated throughout the day, CMA A received a phone call at the nurses' station on Friday 5/2/2025 from CR#1's family members who was concerned he was not answering his cell phone. CMA A stated she went back to CR#1's room to get him to answer his cell phone. CR#1 told her that he heard the phone and that he was just sleeping. In an Interview on 5/7/2025 at 12:55pm the NP stated she believed she examined the CR#1. She consider a change of condition for resident mental status, shortness of breath, chest pain, changes in vital signs. Staff should notify the doctor immediately. She stated staff had her private number as well and if the resident vitals being in the 80's or 90's she should have been called. She expected the nursing staff to use their own judgement. She stated due to the blood pressure levels; resident should have been placed on repeat 5 to 15 minutes. She stated she expected the nurse to take the blood sugar. She stated the protocol at this facility was to use nursing judgement, which should have been to check blood sugar. In an Interview on 5/7/2025 at 1:17pm with RN A defined a resident's Change in condition as a deviation from what was normal for the resident. She stated Notifying a physician depends on the resident and what is out of the ordinary. RN A stated A drop in blood pressure was a change of condition and using her nursing intervention, she'd do a sternum rub until resident responds, contact doctor, increase hydration, and check his cognition. RN A stated the 80/47 blood pressure was a change of condition. She stated she documented in her own notes but not in her notes. She stated she did not contact the doctor and she should have contacted the doctor. RN a stated she spoke with CR#1 and he was in good spirits. RN A stated she kept up with him (vitals) in her own records but did not document in the nursing notes. RN A stated resident's blood sugar was 68 at 9pm on 5/2/2025. She stated on 5/3/2025 at 4:00am blood pressure was 110/66. She stated she should have notified the doctor and documented a change in condition. Record Review of Facility's Change in a Resident's Condition or Status policy dated May 2017 revealed the following: 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): d. significant change in the resident's physical/emotional/mental condition. 2. A significant change of condition is a major decline or improvement in the resident's status that: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses, Certified Nurse Aide) on Point of Care Document-STOPWATCH. The in-service reads: Certified Nurse Aides must notify Charge Nurse of Change in Condition of Residents verbally and must document change in condition on resident Electronic Medical Records under Alerts to ensure timely follow-up of resident condition. Notifications of changes in condition will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. The staff will not be allowed to provide resident care until training is completed. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on physician notification of change in condition. The in-service reads: Resident noted with a change in condition is to be assessed by nurse and Md must be notified timely. Residents must continue to assess if the physician is unable to be reached within 2 hours by repeating the call and involve the medical director. If a resident condition appears emergent send to ER. The Charge nurses will notify MD of notifications, and the Charge Nurses will insure timely staff interventions if residents conditions are emergent. Will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. The staff will not be allowed to provide resident care until training is completed. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on physician notification of change in condition. The in-service reads: Resident noted with a change in condition reflecting BP out of normal range must notify physician for further guidance for resident care. Will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses, Therapy, Certified Nurse Aide) on Signs and symptoms of Hypoglycemia The in-service reads: TO ALL LICENSED NURSES- THIS IS IMPORTANT Abnormal low blood glucose below 70 mg/dl for a person with diabetes, and below 50 mg/dl for a person without diabetes is hypoglycemia and can be a direct effect from a medication or disease process. ASSESSMENT includes the following symptoms: Perspiring or sweating; weakness, dizziness or faintness, blurred or impaired vision, numbness to tongue or lips, headache, unconsciousness, seizures, coma. TREATMENT: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	j. Administer 1 tube of glucose gel (15-20 gms) orally (available in E-kit) k. Recheck glucose level in 15 minutes. l. If glucose is still <70 mg/dl administer an additional tube of oral glucose gel. m. Recheck glucose in 15 minutes. n. If a regular meal is not available within ½ hour of episode, give snack/food items o. If blood glucose levels decreases despite oral glucose administer glycogen (syringes available in E-kit.) p. Recheck blood glucose in 30 minutes and notify MD. q. If no response or resident is unconscious call 911 for emergency transport and obtain/document vital signs per vital sign instructional in-service. r. IF RESIDENT CAN'T SWALLOW give glycogen immediately and recheck glucose level in 30 minutes. Call MD anytime. Glycogen injections are given. IF NO RESPONSE TO GLYCOGON OR PATIENT BECOMES UNCONSCIOUS CALL 911 AND NOTIFY MD. YOU DO NOT HAVE TO WAIT FOR MD ORDERS TO SEND TO HOSPITAL THIS IS A LIFE-THREATENING EMERGENCY THAT REQUIRES IMMEDIATE EMERGENCY INTERVENTIONS. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Residents displaying signs of hypoglycemia blood glucose below 70mg/dl for persons with diabetes, and below 50mg/dl for a person without diabetes must contact physician. MD will be notified by Charge nurse and will notify him timely. Will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Staffing Nurse, Treatment Nurse, MDS Nurse) on daily monitoring of clinical records for Change in Condition. The in-service reads: Daily review of skilled charting, diagnostic test results, vitals during morning meeting to ensure areas not within normal ranges are addressed timely. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on 5/8/2025. Director of Nursing completed audit on 5/7/2025 of residents with DX of Diabetes to ensure sliding scale orders are in place and parameter for contacting the physician. There are no indications of non-compliance from the audit. Completed 5/7/2025 Director of Nursing completed audit on 5/7/2025 of residents with Blood pressure medication to ensure parameter for holding and contacting the physician are in place. There are no indications of non-compliance from the audit. Completed 5/7/2025 Director of Nursing completed audit on 5/7/2025 of residents with Change of Condition to ensure physician notification was completed and timely interventions put in place. There are no indications of non-compliance from the audit. Completed 5/7/2025 The Medical Director has been notified on 5/7/2025 of immediate jeopardy and reviewed the current change in condition p[TRUNCATED]

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plans for one (Resident #1) of seven residents reviewed for comprehensive care plans in that: The facility failed to notify the PCP according to the resident care plan and physician orders when Resident #1's blood sugar level was over 401 after a blood sugar level check on 6/9/2025. This failure could place the residents at risk of harm, injuries, and delayed treatment. Findings included: Record review of Resident #1's face sheet, dated 6/11/2025, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #1 diagnosis was Diabetes mellitus (high blood sugar levels). Record review of Resident #1's quarterly MDS dated [DATE] revealed he had a BIMS score of 9 (moderately cognitive impairment). Section I- Active Diagnoses included diabetes mellitus. Section N - Medications received insulin injections. Record review of Resident #1's care plan, revised on 6/11/2025, revealed the following in part: Focus: The resident [Resident #] has hyperglycemia (condition related to high sugar in the blood) r/t diabetes. Goal: The resident [Resident #1] will be free from any s/sx of hyperglycemia through the review date. Interventions: Monitor/document/report PRN for s/sx of hyperglycemia . Record review of Resident #1's Order Summary Report dated 6/11/2023 revealed the following in part: Order date 6/23/2022. Start date 6/24/2022. Insulin Lispro (1 unit dial) 100 unit/ML Solution pen-injector- Inject as per sliding scale if: 61 - 150 = 0 151 - 200 = 3 201 - 250 = 5 251 - 300 = 8 301 - 350 = 10 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	351 - 400 = 12 401 - 450 = 15 CALL MD, subcutaneously before meals for diabetes Record review of Resident #1's blood sugar vital log dated 6/11/2025 revealed on 6/9/2025 at 15:05 (3:05 p. m.) his blood sugar level was 403.0 mg/dL and recorded by LVN A. Record review of Resident #1's MAR dated 6/11/2025 revealed the follow: Insulin Lispro (1 unit Dial) 100 Unit/ML Solution pen injector. Inject as per sliding scale: 61 - 150 = 0 151 - 200 = 3 201 - 250 = 5 251 - 300 = 8 301 - 350 = 10 351 - 400 = 12 401 - 450 = 15 CALL MD, subcutaneously before meals for diabetes. Resident #1's MAR further revealed on 6/9/2025 at the scheduled time of 1800 hours (4:00 p.m.) revealed Resident #1 was administered 15 units of insulin subcutaneously by LVN A and the blood sugar level documented was 403. Record review of Resident #1's nursing notes dated 5/12/2025 - 6/11/2025 revealed not a nursing documentation related to Resident #1's PCP being notified of his elevated blood sugar level on 6/9/2025. Record review of the 24-hour report binder (100 hall binder for Resident #1) revealed there was not a documented nursing note related to Resident #1's PCP was notified about his elevated blood sugar level on 6/9/2025. Interview and observation on 6/11/2025 at 3:35 p.m., the DON said she was not aware of Resident #1's elevated blood sugar level on 6/9/2025. She reviewed Resident #1's parameters for insulin on his order and the MAR from 6/9/2025. The DON said the PCP should have been notified immediately along with herself. The DON said LVN A should have follow instruction given by the PCP. The DON said the resident was at risk of fatigue, lethargy, or diabetic coma. She said she was responsible for monitoring elevated vitals and reviewed them in the daily meetings. She said nurses had been trained to follow physician orders. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/11/2025 at 3:48 p.m. with LVN A said she did not notify Resident #1's PCP on 6/9/2025 after Resident #1's blood sugar level was elevated to 403. She said, I am a new nurse and did not read the order fully. She said she had worked at the facility for two weeks. She said she was trained on medication administration by the facility. She said the resident was at risk for declining into a diabetic coma. Interview on 6/11/2025 at 4:20 p.m. with Resident #1's PCP said he was not notified on 6/9/2025 of Resident #1's elevated blood sugar level of 403. He said if he was notified, he would have advised the nursing staff to monitor the resident for signs and symptoms of diabetes, check the blood sugar level again and if it increased, he would have possibly increased the insulin dosage. He said the resident was at risk of becoming lethargic, thirst, and various side effects of elevated blood sugar levels. Interview on 6/11/2025 at 4:35 p.m., Resident #1 said he did not remember if he was told by LVN A that his blood sugar level was 403 and she needed to notify the doctor. He said he had not felt different in the last 2 days. Record review (after surveyor intervention) of Resident #1's nursing notes (by ADON) dated 6/11/2025 revealed the following: Follow up to blood sugar of 403 on 6/9/25 no new orders where given will continue monitor for any further episodes. Record Review of Facility's Change in a Resident's Condition or Status policy (revised) May 2017 revealed the following: Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status . 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): . i. specific instruction to notify the Physician of changes in the resident's condition.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure CR#1 received treatment and care in accordance with professional standards of practice for 1 of 5 residents (CR#1) reviewed for quality of care. The facility failed to properly identify and intervene in CR#1's acute change in condition related to his diabetes mellitus and congestive heart failure. The facility initially became aware of CR#1's declining vitals on 5/2/25 at 10:18am based on the timeline of vitals listed in nursing notes. 911 was not called until 5/3/25 at 5:30pm, which was more than 24 hours later. An Immediate Jeopardy (IJ) was identified on 05/07/2025 at 5:30 p.m. While the IJ was removed on 05/08/2025 at 10:50pm, the facility remained out of compliance at the severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk for possible serious injuries, harm and death to residents who require supervision. Findings Include: Record review of CR#1's undated face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] from the local hospital with diagnoses of coronary artery disease (reduction of blood flow to heart muscle), heart failure (the heart fails to pump enough blood to meet the body needs), hypertension (high blood pressure), diabetes mellitus (blood sugar is too high), Hyperlipidemia (too much fat in the blood), arthritis (swelling and tenderness in the joints), diverticulosis (inflammation of the colon), and other fractures. CR#1 discharged to the hospital on 5/3/2025. The discharge instructions listed primary diagnosis, reason for hospitalization, procedures and tests performed while in the hospital, taking medications and follow information regarding heart failure. Record review of CR#1's Quarterly MDS dated [DATE] revealed CR#1 has a BIMS score of 12 (means resident cognition is intact). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's orders dated 5/1/2025-5/31/2025 revealed blood sugar checks two times a day for DIABETES; Midodrine HCl Oral Tablet 5 MG-give 1 tablet by mouth every 8 hours PRN (as needed) as needed for hypotension. Hold for SBR (blood Pressure) less than 90 (no date); Sodium Polystyrene Sulfonate Suspension 15GM/60ML-Give 15 gram by mouth one time only for Hyperkalemia (elevated potassium in the blood) until 5/3/2025 11:59p.m; Cozaar Tablet 100 MG (Losartan Potassium) give 1 tablet by mouth one time a day for hypertension. Hold for ABP <100 or DBP <60. Start date 4/23/2025 9:00am; Farxiga (diabetes) Oral tablet 5 mg (Dapagliflozin Propanediaol) Give 1 tablet by mouth one time a day for DM-start date 4/23/25 9:00am. Hold from 5/3/2025 to 5/5/2025 4:41pm; Prabastatin Sodium Oral Tablet 10 MG (Pravastatin Sodium) Give 1 tablet by mouth one time a day for Hyperlipidemia (for high cholesterol levels). Start date 4/23/2025 9:00am; Carvedilol Oral tablet 25 MG give one tablet by mouth two times a day for HTN (hypertension) hold for SBP <110 or HR <60. Start date 4/23/2025; Eliquis Oral tablet 5 MG (Apixaban) (blood thinner) give 1 tablet by mouth two times a day for Anticoagulant. Start date 4/23/2025 9:00am; Gilmepride (treats high blood pressure) Oral tablet 4 MG give 1 tablet by mouth two times a day for DM. Start date 4/23/2025 9:00am-Hold date 5/3/2025-5-5-2025. Record review of CR #1's care plan dated 4/22/2025, revealed the following care areas: Focus: [CR #1] I am at risk for frequent infections, pressure/venous/stasis ulcers, vision impairment, hyper/hypoglycemia, renal failure, cognitive/physical impairment/skin desensitized to pain or pressure related to diabetes melillitus. Date initiated and revision on 5/5/2025. Interventions: [CR #1] I will have no complications related to diabetes through the review date. Date initiated and revision on 5/5/2025. Target date on 5/1/2025. Interventions: [CR #1] Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of hyperglycemia (difficulty waking up); increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abd (abdomen pain), Kassmaul (rapid) breathing, acetone breath (smells fruity), stupor (stated of reduced consciousness or responsiveness, where a person is almost unconscious but can be aroused by vigorous stimulation), coma (deep unconsciousness)-date initiated 5/5/2025; Monitor/document/report PRN (as needed) any s/sx (signs or symptoms) of hypoglycemia: Sweating, Tremor, increased heart rate (Tachycardia), pallor (Paleness), nervousness, confusion, slurred speech, lack of coordination, staggering gait (unsteady). Date initiated 5/5/2025. Focus: [CR #1] Potential for complications, s/sx related to diagnosis of hypertension. Receives anti hypertension and is at risk for side effects. Dated initiated 5/5/2025. Goal: [CR #1] My B/P (blood pressure) will stay within their normal limits, will not have s/s of hyper/hypo tension throughout the review date. Date initiated 5/5/2025. Target date 5/1/2025. Interventions: [CR #1] Administer anti-hypertensive medications as ordered. Monitor B/P and for side effects such as orthostatic hypotension (low blood pressure) and increased heart rate (Tachycardia), increased edema (swelling), headache, chest pain, and report abnormalities to physician. Dated initiated 5/5/2025; Monitor/Document/Report PRN any s/s of malignant hypertension (blood pressure rises rapidly): Headache, visual problems, confusion, disorientation, lethargy (usually tired, sluggish, and lacking energy), nausea (feeling sick in the stomach) and vomiting, irritability, seizure activity, and difficulty breathing (Dyspnea). Date initiated 5/5/2025. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record Review of facility's last vitals taken for CR#1's Blood Pressure revealed: 5/2/2025 at 10:18am - 98/56 5/2/2025 at 7:58pm - 80/47 5/3/2025 at 7:05am - 82/47 5/3/2025 at 2:37pm - 81/43 5/3/2025 at 4:58pm - 99/51 Record Review of facility's last vitals taken for CR#1's 02 Stats revealed: 5/2/2025 10:18am 90.0% Room Air 5/2/2025 7:59pm 92.0% Room Air 5/3/2025 7:05am 93.0% Room Air 5/3/2025 4:58pm 82.0% Room Air Record Review of facility's last vitals taken for CR#1's Blood Sugar vitals revealed: 5/3/2025 2:37pm 64.0mg (manual) 5/3/2025 3:40pm 94.0mg (manual) Record Review of skilled charting for CR#1 dated 5/2/2025 at 7:33pm by LVN A, revealed the following: vital signs taken on 5/2/2025 at 10:18am were: Temperature 97.5 taken forehead (non-contact), pulse 77(bpm), Respiration 18.0(breaths/min), Blood pressure 98/56, O2 stats 92.0% (room air). Section D: Mood and Behavior: 1b: Notable changes in mood and behavior: Resident sleeping a lot more than usual. Record Review of skilled charting for CR#1 dated 5/2/2025 at 7:56pm by LVN A revealed the following: vital signs taken on 5/2/2025 at 7:59pm were: Temperature 96.8 taken forehead (non-contact), pulse 68(bpm), Respiration 20.0(breaths/min), Blood pressure 80/47, O2 stats 92.0% (room air). Section D: Mood and Behavior: 1b: Notable changes in mood and behavior: Resident sleeping a lot more than usual. Record Review of nursing notes for CR#1 dated 5/2/2025 revealed, there were no nursing notes for this date. Record Review of nursing notes for CR#1 dated 5/3/2025 at 9:16am, revealed, Change in Condition reported on the CIC Evaluation are/were: Other change in condition Tired, Weak, Confused, or Drowsy. At the time of evaluation resident/patient vital signs, weight and blood sugar were: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Blood Pressure: 82/47 - 5/3/2025 07:05 Position: Lying r/arm -Pulse: P 68 - 5/3/2025 07:05 Pulse Type: Regular -RR: R 18.0 - 5/3/2025 07:05 -Temp: T 97.3 - 5/3/2025 07:05 Route: Forehead (Non-Contact) -Weight: W 280.0 lb - 4/29/2025 14:38 (2:38pm) Scale: Mechanical Lift -Pulse Oximetry: O2 93.0% - 5/3/2025 07:05 Method: Room Air -Blood Glucose: Record Review of nursing notes for CR#1 dated 5/3/2025 at 7:20pm, revealed, Note Text: Resident lethargic this am, blood pressure low, notified vanguard received new orders: N/O: Midodrine HCl Oral Tablet 5 MG (Midodrine HCl). Record Review of Local Hospital admission dated 5.3.2025 revealed, CR#1 presented to the ED yesterday via EMS from the facility with fatigue (extreme tiredness), lethargy (lack of energy and enthusiasm), and altered mental status (a deviation form norm). EMS found CR#1 to be hypotensive (low blood pressure) (87/58), hypoglycemic (drop in blood sugar) with blood glucose (body primary source of energy) of 35 and hyperkalemic (causes kidney disease) with a potassium level of (6) six. CR#1 received D50 (intravenous), Kayexalate (treat high levels of potassium in the blood), and midodrine (treats low blood pressure) enroute to the ED. Workup (thorough diagnostic evaluation to determine the cause of symptoms or health condition) in the ED found CR#1 to be acute hypoxic (decrease in oxygen levels in the blood) and hypercapnic respiratory failure (respiratory system cannot remove carbon dioxide from the body), septic shock (a life threatening condition that occurs with body response to a severe infection causes low blood pressure and multiple organ dysfunction), acute renal failure (Kidney failure), and persistent hyperglycemia (high blood sugar levels consistently exceeding target range). CR#1 was placed on BIPAP and initiated on a D10 infusion (IV) to maintain glucose. CR#1 was fluid resuscitated per sepsis guidelines and initiated on vasopressors (medications to cause blood vessels to constrict) to maintain adequate blood pressure. CR#1 transferred to ICU for management. Foley placed in CR#1with 1200cc returned immediately after placement. The local hospital's disposition: CR#1 to remain in ICU. CR#1 at high risk for complications CR#1 is critically ill with vital organ impairment or failure. There is a high probability of imminent or life-threatening deterioration in the patient's condition. Patient is unable or incompetent to participate in giving a history and/or making decisions and discussion is necessary for determining treatment decisions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 5/6/2025 at 2:03 p.m., FM A stated CR#1 did not have pneumonia or sepsis before arriving to the facility 11 days ago. She stated his blood pressure has been extremely low. She stated CR#1 was in the local hospital. She stated the nursing staff did nothing to help CR#1 while in the facility. She stated if the nursing staff had checked his blood sugar like he told them they did in the hospital, they would have known that he was going into a diabetic coma. In an interview and observation on 5/6/2025 at 2:30 p.m. (at the hospital), CR#1 said he was in the facility for 11 days for rehab after having back surgery. CR#1 said after 3 days he began asking questions of the nurse regarding his glucose and checking his blood sugar levels because he was starting to feel very tired and couldn't stay awake. He said the nurse would only tell him she will be right back she had to check his orders. The nurse never returned. He said he asked this question on multiple shifts and multiple times and received the same answer. He said he started feeling lethargic and couldn't stay awake. He said he was so sleepy he went a day or two without eating. CR#1 said there was a LVN who had returned from vacation this past Saturday who listened to him, and his concerns, and she ordered labs. No other nurse did. In an Interview 5/6/2025 at 2:50pm at the hospital with FM B and FM C they stated last Thursday (5/1/2025) they tried calling resident and didn't get an answer. Both stated they called the front desk and were told he was asleep. They received the same response on Friday (5/2/2025). However, when they called Saturday (5/3/2025) and CR#1's phone went to his voicemail they had concerns and therefore called the facility. At this time FM A told FM B and FM C she didn't like what she was seeing and that she couldn't wake CR#1 after several tries. FM B said she demanded that FM D tell the facility to call 911 immediately. In a Telephone Interview 5/6/2025 at 5:30pm FM D stated this past Thursday (5/1/2025) morning CR#1 appeared unusually sleepy. She stated the nurse told her that she had given CR#1 pain medications which was why he was sleepy. FM D stated on Saturday (5/3/2025) she received a call from facility and said CR#1 was sleeping and lethargic and nurse stated she called doctor. FM D stated when she arrived at the facility Saturday (5/3/2025) the nurse had just taken his blood sugar and at that time it was 65. The nurse left the room to get some orange juice. However, while the nurse was away getting juice, FM D stated she observed the food tray with tea, and she put two packets of sugar and gave it to CR#1 herself. She stated a few moments later, the nurse returned with orange juice and sugar and gave it to resident. Stated after 30 minutes nurse re-took sugar levels and it was 93. She stated the nurse took labs. Nurse returned with lab results and said he had critical potassium levels and creatine were elevated as well. She stated the nurse said she called the doctor. However, FM D and other family members requested CR#1 go to hospital via 911. Stated the nurse returned with critical labs and stated the doctor had ordered Kayexalate (treats high blood potassium) and IV fluids; however, the nurse told her she had to get someone to come and start the IV because it was out of her range as a nurse. During this time the family continued to request CR#1 be sent out to hospital. She stated nursing staff never checked his blood sugar prior to this episode even though CR#1 and the family told the nursing staff that the hospital checked 3 times daily. She stated CR#1 asked about his blood sugar being checked and he was told by one of the nurses that the hospital told her (nurse) that he was no longer diabetic so there was no need to check his blood sugar. FM D stated CR#1 was very congested during her visit on Saturday 5/3/2025 and she told the nurse she could hear wheezing when CR#1 coughed. She stated the nurse checked CR#1's blood sugar after the family requested on Saturday, 5/3/2025. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Focused Care at Cedar Bayou	2000 W Baker Road Baytown, TX 77521

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on 5/6/2025 at 6:21p.m., with MA B stated she was familiar with CR#1. She stated CR#1's family members were always in the room. She stated blood sugars were to be taken before and after meals. She stated even if it was not in the orders, typically you do it for persons who were diabetic. She stated the nurse was responsible for taking the blood sugar. She stated checking the blood sugar was on the MAR. She stated the nurse will make the notation on MAR and if she hasn't noted she would find the nurse prior to giving medication. She stated she did not make any efforts to find the nurse and inquire about the blood sugar being taken. She stated she must of gotten busy. In an interview on 5/6/2025 at 6:46 p.m., LVN A stated she was familiar with CR#1. She returned to work on Monday 4/28/25 from vacation and worked with CR#1 for the first time then. She stated she worked with CR#1 on that Tuesday (4/29/2025) and again on Saturday 5/3/2025 She stated while she was working on 5/3/2025 and during her rounds she noticed CR#1 didn't look well as his face was pale looking. She stated she took his blood pressure, and it was low (82/47). She telephoned the doctor answering service and left a message. LVN A stated she honestly did not know he was diabetic until Saturday 5/3/2025. Nurse stated upon admission the medication list delivered from the hospital was sent to the doctor. The doctor was supposed to okay the orders. She stated the NP made rounds on 4/29/2025 at which time she told her that resident had serious back surgery and Tylenol was not strong enough for him. She stated the NP gave resident a prescription for an additional pain medication. LVN A stated if she had done the admission and noted the type of medication resident was taking she would have informed nursing staff that he needed blood sugar taken prior to meals and sometimes afterwards. In an interview on 5/6/2025 at 7:30 p.m., the IDON stated he spoke with the CR#1 on Friday 5/2/2025. He stated CR#1 was talking and stated he didn't feel well; however, IDON contributed it to the back issues. He stated he listened to CR#1's chest and lungs and did not get anything alarming. He stated the facility did a chest x-ray but when the results returned CR#1 had already went to the hospital. The IDON stated the admitting nurse (facility) was responsible for submitting any resident information upon admittance to the doctor. When asked if a diabetic patient should have a glucose test before meals, he stated they could. He stated it was a nursing judgement to draw blood for glucose labs. The IDON was asked how long it takes to develop pneumonia and sepsis and he stated the resident may have come to the facility from the hospital with that diagnosis. He was asked what should have been done when resident blood pressure taken was low and he stated that the resident's medical condition will sometimes have a low blood pressure; however, it should have been documented and possibly noted as a change of condition. The IDON stated on 5/3/2025 the nurse completed a change of condition; gave resident some orange juice and it appeared his blood glucose was increasing. He initially stated he was contacted and wanted the nurse to call 911, then he was reminded that according to the nursing notes the family requested 911. In a follow-up interview on 5/7/2025 at 9:10 p.m., the IDON stated the blood pressure readings on 5/2/2025 were out of range and not normal. He stated he was not aware the resident was having issues on this date (5/2/2025). He stated the blood pressure on 5/2/2025 represented someone who was hypotensive. He stated the nurses should have called the doctor. He stated the nurses erred for not contacting the doctor for the decrease in blood pressure. He stated the expectation was to re-check the blood pressure every 15-30 minutes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on 5/7/2025 at 9:52am with LVN B she stated she did the intake admission for the CR#1 when he arrived at the facility and CR#1 was oriented to facility. She stated she sent the discharge summary to the physician, via celo (nursing service that communicates with the doctor); which allows the doctor to review and make changes to the discharge summary from the hospital or allow all instructions to remain in accordance with the discharge summary from the hospital. She stated in CR#1's case everything remained the same and the hospital discharge summary did not indicate taking blood glucose from CR#1 before or after meals. She stated the physician will add addendums. LVN B stated she did CR#1's vitals upon admission to facility and there were no concerns. She stated CR#1 was alert and oriented times 3-4. LVN B stated in an event a resident has a change of condition you must Notify physician and place resident on monitoring. Look at medical diagnosis because a resident with blood glucose issues could be Asymptomatic (showing no symptoms), so you must look at his medical history to see if there's a history of being hypo or hyper glycemic, orders prescribed, to see if resident has diabetes, and you must check blood sugar. In a follow-up telephone interview on 5/7/2025 at 11:14am with LVN A she stated a COC was anything going on with patient and out of the ordinary. Protocol was to notify doctor and get new orders. She stated CR#1's blood pressure was low after taking it 4 times on 5/3/2025. CR#1's family member told her she noticed a cough and phlegm (thick mucus) afterwards. LVN A stated she contacted the doctor who ordered CR#1 to have a chest x-ray, but he didn't get it because resident went out to hospital. LVN A stated she would not have considered a change of condition on 5/2/2025 because he was talking to her. However, he was sleeping a lot, but easily aroused. LVN A stated this was why she did not call the doctor. In an Interview on 5/7/2025 at 11:26am with MA A was familiar with CR#1. She stated CR#1 told her that he had nausea and felt like he wanted to throw up and refused his medication on 5/2/2025. She stated he looked normal and was talking to her as usual. MA A stated she notified LVN A who was his charge nurse. She stated throughout the day, MA A received a phone call at the nurses' station on Friday 5/2/2025 from CR#1's family members who was concerned he was not answering his cell phone. MA A stated she went back to CR#1's room to get him to answer his cell phone. CR#1 told her that he heard the phone and that he was just sleeping. In an Interview on 5/7/2025 at 12:55pm the NP stated she believed she examined the CR#1. She consider a change of condition for resident mental status, shortness of breath, chest pain, changes in vital signs. Staff should notify the doctor immediately. She stated staff had her private number as well and if the resident vitals being in the 80's or 90's she should have been called. She expected the nursing staff to use their own judgement. She stated due to the blood pressure levels; resident should have been placed on repeat 5 to 15 minutes. She stated she expected the nurse to take the blood sugar. She stated the protocol at this facility was to use nursing judgement, which should have been to check blood sugar. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an Interview on 5/7/2025 at 1:17pm with RN A defined a resident's Change in condition as a deviation from what was normal for the resident. She stated Notifying a physician depends on the resident and what is out of the ordinary. RN A stated A drop in blood pressure was a change of condition and using her nursing intervention, she'd do a sternum rub until resident responds, contact doctor, increase hydration, and check his cognition. RN A stated the 80/47 blood pressure was a change of condition. She stated she documented in her own notes but not in her notes. She stated she did not contact the doctor and she should have contacted the doctor. RN a stated she spoke with CR#1 and he was in good spirits. RN A stated she kept up with him (vitals) in her own records but did not document in the nursing notes. RN A stated resident's blood sugar was 68 at 9pm on 5/2/2025. She stated on 5/3/2025 at 4:00am blood pressure was 110/66. She stated she should have notified the doctor and documented a change in condition. An Immediate Jeopardy (IJ) was identified on 05/07/2025 at which time the IJ template was provided to the IDON on 5/7/2025 at 5:30pm. The following Plan of Removal submitted by the facility was accepted on 5/8/2025 at 11:02 a.m. Allegation: The facility failed to promptly identify and intervene in CR#1's acute change in condition related to his diabetes mellitus and congestive heart failure from 5/2/2025-5/3/2025, which resulted in hospitalization. PLAN OF REMOVAL Name of facility: Date: 5.7.2025 Immediate action: On 5/6/2025 an investigation survey was initiated. On 5/7/2025 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 notification of Immediate Jeopardy states as follows: The facility failed to promptly identify and intervene in CR #1's acute change in condition related to his diabetes mellitus and congestive heart failure, from 5/2/25-5/3/25, which resulted in the family requesting he be sent to the ER on [DATE]. Resident CR#1 was discharged to the hospital on 5/3/2025 and remains in hospital at this time. 5/7/25 Charge Nurse (LVN/RN) will receive re-education and will receive disciplinary action if residents are not assessed timely and physicians notified of resident change in conditions, to include changes related to Diabetes mellitus and congestive heart failure. 5/7/25 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Director of Nursing in-serviced LVN A and RN A on 5/7/25 on timely assessing residents of change in condition, continual documentation of change in condition to include vitals for resident until resident is stable or discharged to hospital, timely notification of change in condition of a resident to physician and/or medical director. 5/7/25 Facilities Plan to ensure compliance quickly F-684 Quality of Care On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses, Certified Nurse Aide) on Point of Care Document- STOPWATCH. The in-service reads: Certified Nurse Aides must notify Charge Nurse of Change in Condition of Residents verbally and must document change in condition on resident Electronic Medical Records under Alerts to ensure timely follow-up of resident condition. Notifications of changes in condition will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. The staff will not be allowed to provide resident care until training is completed. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on physician notification of change in condition. The in-service reads: Resident noted with a change in condition is to be assessed by nurse and Md must be notified timely. Residents must continue to assess if the physician is unable to be reached within 2 hours by repeating the call and involve the medical director. If a resident condition appears emergent send to ER. The Charge nurses will notify MD of notifications, and the Charge Nurses will insure timely staff interventions if residents conditions are emergent. Will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. The staff will not be allowed to provide resident care until training is completed. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses) on physician notification of change in condition. The in-service reads: Resident noted with a change in condition reflecting BP out of normal range must notify physician for further guidance for resident care. Will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. This education will also be included in all new nurse orientations for any newly hired nurses and any Agency staff. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Certified Medication Aides, Charge Nurses, Therapy, Certified Nurse Aide) on Signs and symptoms of Hypoglycemia. The in-service reads: TO ALL LICENSED NURSES- THIS IS IMPORTANT (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	]Abnormal low blood glucose below 70 mg/dl for a person with diabetes, and below 50 mg/dl for a person without diabetes is hypoglycemia and can be a direct effect from a medication or disease process. ASSESSMENT includes the following symptoms: Perspiring or sweating; weakness, dizziness or faintness, blurred or impaired vision, numbness to tongue or lips, headache, unconsciousness, seizures, coma. TREATMENT: a. Administer 1 tube of glucose gel (15-20 gms) orally (available in E-kit) b. Recheck glucose level in 15 minutes. c. If glucose is still <70 mg/dl administer an additional tube of oral glucose gel. d. Recheck glucose in 15 minutes. e. If a regular meal is not available within ½ hour of episode, give snack/food items f. If blood glucose levels decreases despite oral glucose administer glycogen (syringes available in E-kit.) g. Recheck blood glucose in 30 minutes and notify MD. h. If no response or resident is unconscious call 911 for emergency transport and obtain/document vital signs per vital sign instructional inservice. i. IF RESIDENT CANT SWALLOW give glycogen immediately and recheck glucose level in 30 minutes. Call MD anytime Glycogen injections are given. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	IF NO RESPONSE TO GLYCOGON OR PATIENT BECOMES UNCONSCIOUS CALL 911 AND NOTIFY MD. YOU DO NOT HAVE TO WAIT FOR MD ORDERS TO SEND TO HOSPITAL THIS IS A LIFE-THREATENING EMERGENCY THAT REQUIRES IMMEDIATE EMERGENCY INTERVENTIONS. Residents displaying signs of hypoglycemia blood glucose below 70mg/dl for persons with diabetes, and below 50mg/dl for a person without diabetes must contact physician. MD will be notified by Charge nurse and will notify him timely. Will be monitored by the Assisted Director of Nursing/Designee during the daily clinical meeting and ongoing. DON will monitor this process during monthly QA. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on 5/8/2025. On 5/7/2025 Regional Nurse initiated Inservice with Nursing Staff (Assisted Director of Nursing, Director of Nursing, Staffing Nurse, Treatment Nurse, MDS Nurse) on daily monitoring of clinical records for Change in Condition. The in-service reads: Daily review of skilled charting, diagnostic test results, vitals during morning meeting to ensure areas not within normal ranges are addressed timely. All nursing staff expected to be in-serviced prior to the next shift worked. Staff will not be allowed to provide direct care until services have been completed. This education will also be included in all new nurse orientations for any newly hired nurses and Agency staff. This in-service is to be completed on 5/8/2025. Director of Nursing completed audit on 5/7/2025 of residents with DX of Diabetes to ensure sliding scale orders are in place and parameter for contacting the physician. There are