STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676230	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copperfield Healthcare and Rehabilitation	7107 Queenston Blvd Houston, TX 77095

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Number of residents sampled: Number of residents cited: (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Based on observation, interview, and record review, the facility failed to immediately inform the resident, consult with the resident's physician, and notify, consistent with his or her authority, the resident representative when there was a significant change in the resident's physical, mental, or psychosocial status and a need to alter treatment significantly for 1 of 8 residents (CR #1) reviewed for notification of changes. The facility failed to notify CR #1's physician when the resident's family member reported slurred speech and altered mental status on 08/24/25. On 08/25/25 CR #1 was transferred to the hospital where he was diagnosed with acute ischemic infarct (a type of stroke where blood flow to a part of the brain is interrupted, causing brain tissue to die). After the stroke CR #1 suffered from a significant ADL decline that left him unable to walk An Immediate Jeopardy was identified on 09/10/25. The IJ template was provided to the facility on [DATE] at 1:06 PM. While the immediacy was removed on 09/14/25 at 02:04 PM, the facility remained out of compliance at a severity level of no actual harm, with a potential for more than minimal harm that was not an immediate jeopardy, and at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. This failure could place residents at risk of delayed identification and treatment of undiagnosed illnesses, hospitalization, pain, suffering, and death. Findings included: Record review of CR #1's Face Sheet, dated 09/09/25, revealed, a [AGE] year-old male, admitted on [DATE], diagnoses including metabolic encephalopathy (change in the brain that can cause confusion and memory loss), difficulty walking, high blood pressure, and elevated liver enzymes. CR #1 discharged to the hospital on [DATE]. Record review of CR #1's admission MDS, dated [DATE]. revealed moderately impaired cognition as indicated by a BIMS score of 11 out of 15, no acute onset mental status change, no behaviors, no upper or lower body impairment and the use of a crane/crutch. Record review of CR #1's undated Care Plan revealed, Focus- Had an alteration in neurological status r/t Metabolic encephalopathy; Goal: Monitor for Confusion, Memory Problems, Drowsiness and Lethargy, Muscle Weakness and Fatigue, Breathing Difficulties. Record review of CR #1's PT Progress Note dated, 08/22/25 at 08:56 AM, revealed CR #1 could walk 150 feet with only supervision or touching assistance and his Mobility Function Score was 10 out of 12 with 12 being the highest function- Lying to sitting on side of the bed: Setup or clean-up assistance.- Chair/bed to chair transfer: supervision or touching assistance.- Ambulation - Walking 150 feet with supervision or touching assistance.- Mobility Function Score (ranges from 0-12; 12 being the highest function) = 10. Record review of the facility's 24 Hour Report log ,dated 08/24/25, revealed no documentation of any changes to CR #1. Record review of CR #1's NP Progress Note, dated 08/25/25, revealed, History: visit type- family concern; LVN J notified this FNP patient family is concerned and reporting he is having AMS, decreased cognition and follow up visit completed. ROS: Musculoskeletal: Muscle Weakness. Neurological: AAOx3, sensation normal to touch. Negative tongue deviation. Face is symmetrical. Motor strength strong and equal in BUE and BLL. ASSESSMENT & PLAN: AMS/Cognitive Decline-acute illness that poses a threat to bodily function-Ordered STAT CBC, BMP, and UA with C&S if indicated. Called [Family Member #1] and notified her of my evaluation and orders given. She requested (Resident #1) be sent to ED for eval and this done per her request. Record review of CR #1's Change in Condition Evaluation, dated 08/25/25, signed by LVN J, revealed the change was effective on 08/25/25 at 01:00 PM and CR #1 experienced decreased cognition. Nurse observed decreased cognition and slower speech from CR #1, increased confusion and needed more assistance with ADLS and dressing. The NP was notified on 08/25/25 at 12:57 PM and orders were given for STAT CBC with differential, BMP and UA with CS. CR #1 experienced a personality change, he was not cooperating as usual and no neurological changes were observed. Record review of CR #1's SNF/NF to Hospital Transfer Form dated 08/25/25 revealed CR #1 was sent to the hospital from the facility on 08/25/25 at 05:35 PM. Record review of CR #1's Progress Notes revealed there were no documented notes on 08/24/25. Record review of CR #1's Progress Note, dated 08/25/25 at 06:06 PM, signed by LVN J revealed the Nurse received verbal order to send patient to hospital non emergent to evaluate slurred speech and decreased cognition Family Member #1. Nurse called EMS for transport. Nurse called. Report given to EMS staff. Patient was being picked up at this time. Family Member #1 was notified of patient departure. Record review of CR #1's Hospital Records, dated 08/25/25 to 09/02/25, revealed CR #1 arrived at the hospital on [DATE] at 06:58 PM and discharged on 09/02/25 at 08:24 PM to an in-patient rehab facility. Record review of CR #1's Hospital Records MRI of the Brain, dated 08/25/25, revealed Acute non-hemorrhagic infarcts (acute ischemic stroke). Record review of CR #1's Hospital

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment describing services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 3 of 12 residents (Residents #12, Residents #80 and Resident #84) reviewed for comprehensive care plans. - The facility failed to care plan Resident #80's incontinence care due to a neurogenic bladder disorder.-The facility failed to care plan Resident #12 for an intravenous mid-line.-The facility failed to care plan Resident #84 for mobility bars on her bed.This failure could place residents at risk of not having their individual, medical, functional, and psychosocial needs identified and cause a physical, mental or psychosocial decline in health. Resident #80Record review of Resident #80's face sheet, dated 09/11/2025, reflected a [AGE] year-old female admitted on [DATE] with diagnoses including stroke due to a blood clot, paralysis following stroke affecting left non-dominant side, dementia (loss of cognitive functioning like thinking, reasoning and memory and potential loss of emotional control and personality)., neuromuscular dysfunction of bladder (neurogenic bladder being a condition where an injury or disease leads to residents having urinary incontinence, loss of sensation of a full bladder, among other symptoms) and need for assistance with personal care.Record review of Resident #80's Quarterly MDS, dated [DATE], reflected a BIMS score of 03, indicating severe cognitive impairment. Resident #80 was totally dependent on staff for ADLs including eating, oral and personal hygiene and toileting. Resident #80 was totally dependent on staff to transfer from a bed to a chair and to get on and off a toilet. Record review of Resident #80's care plan reflected she was care-planned for having bowel and bladder incontinence related to stroke, impaired mobility and having a neurogenic bladder with a created date of 09/11/2025, with interventions including being checked as required for incontinence and care by staff and nurses monitoring skin at least weekly and reporting any changes to the doctor and POA. A later care plan dated 09/12/2025 reflected a focus area of Resident #80 being at risk for urinary retention related to a diagnosis of neurogenic bladder with interventions including monitoring and documenting for signs or symptoms of UTI and for therapy to evaluate and treat for pelvic floor exercise.Record review of Resident #80's skin assessments for August and September 2025reflected she had no skin issues documented. Record review of Resident #80's progress notes, MDS B documented on 9/11/2025 at 5:00pm that she notified Resident #80's physician assistant of her diagnosis for neurogenic bladder and order received for OT to evaluate and treat for pelvic floor exercise. MDS B documented that she notified the rehab ilitation department and left a message to Resident #80's RP. Observation and attempted interview with Resident #80 on 09/11/2025 at 11:00am, Resident #80 was in her chair outside her room with non-skid socks on and pillows propped under both legs. Resident #80 appeared in a pleasant mood and in no apparent discomfort or distress. Resident #80's face and hands had no signs of symptoms of dehydration or concerns. Resident #80 did not respond to questions and did not make eye contact.Interview with OT F on 09/13/2025 at 9:45am, she said she did not work with Resident #80. For residents with neurogenic bladder, OT F would look at frequency of voiding like the resident's schedule. OT F would monitor residents when they saw them in the hallways. OT F said therapy staff would educate nursing to monitor residents in the dining room. OT F said therapy did not have the certification to do bladder training for residents. OT F said the importance of monitoring was to ensure residents kept skin integrity and for excessive moisture. Interview on 09/14/2025 at 10:45am with MDS A and MDS B, they said they were not employed at the time that Resident #80 was admitted . They said during record review in the last few days, they found she had a neurogenic bladder due to stroke. The facility began Resident #80 on pelvic floor exercises. MDS B said resident #80 also did not have incontinent in her care plan and that was an oversight. MDS A said care plans were to make sure interventions were in place for residents and that MDS nurses were responsible for ensuring resident's conditions were care-planned. Interview on 9/14/2025 at 10:59am, the DON said the interdisciplinary team (a team consisting of therapy, nursing, social work and other department representatives working together to provide care to residents) was responsible for diagnoses, like during admission and the team included MDS, ADONs, and DON among other departments . The purpose of the care plan was to put in place interventions for residents' condition. The DON said things the facility would also put tasks in POC for staff to see interventions, telling nurses on

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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, interview and record review the facility failed to ensure, based on the comprehensive assessment of a resident, residents received treatment and care and services in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 of 8 residents (CR #1) reviewed for quality of care. - The facility failed to act on 08/24/25 when CR #1's family member notified the nurse of slurred speech and altered mental status that indicated a stroke until 08/25/25. - On 08/25/25 CR #1 was transferred to the hospital where he was diagnosed with acute ischemic infarct (a type of stroke where blood flow to a part of the brain is interrupted, causing brain tissue to die). After the stroke CR #1 suffered from a significant ADL decline going from walking 150 feet with supervision to being unable to walk more than 3 steps with substantial/maximum assistance. An Immediate Jeopardy was identified on 09/10/25. The IJ template was provided to the Administrator and DON on 09/10/25 at 1:06 PM. While the immediacy was removed on 09/14/25 at 02:04 PM, the facility remained out of compliance at a severity level of no actual harm, with a potential for more than minimal harm that was not an immediate jeopardy, and at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems. Failure outside of the IJ - The facility failed to obtain a physician order to discontinue Resident #12's mid-line that had been inserted on 08/05/25. The resident completed her IV antibiotic therapy on 08/28/25. The facility did not obtain an order to discontinue resident mid-line until 09/10/25. These failures could place residents at risk of delayed identification and treatment of undiagnosed illnesses, hospitalization, pain, suffering, and death. Findings included Record review of CR #1's Face Sheet, dated 09/09/25, revealed, a [AGE] year-old male, admitted on [DATE], diagnoses including metabolic encephalopathy (change in the brain that can cause confusion and memory loss), difficulty walking, high blood pressure, and elevated liver enzymes. CR #1 discharged to the hospital on [DATE]. Record review of CR #1's admission MDS, dated [DATE]. revealed moderately impaired cognition as indicated by a BIMS score of 11 out of 15, no acute onset mental status change, no behaviors, no upper or lower body impairment and the use of a crane/crutch. Record review of CR #1's undated Care Plan revealed, Focus- Had an alteration in neurological status r/t Metabolic encephalopathy; Goal: Monitor for Confusion, Memory Problems, Drowsiness and Lethargy, Muscle Weakness and Fatigue, Breathing Difficulties. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of CR #1's PT Progress Note dated, 08/22/25 at 08:56 AM, revealed CR #1 could walk 150 feet with only supervision or touching assistance and his Mobility Function Score was 10 out of 12 with 12 being the highest function). - Lying to sitting on side of the bed: Setup or clean-up assistance. - Chair/bed to chair transfer: supervision or touching assistance. - Ambulation - Walking 150 feet with supervision or touching assistance. - Mobility Function Score (ranges from 0-12; 12 being the highest function) = 10. Record review of the facility 300 Hall 24 Hour Report log revealed: - On 08/24/25 there was nothing documented regarding CR #1. - On 08/25/25 CR #1 experienced a change in condition: decreased cognition and STAT orders for CBS, BMP, UA with CS were entered. On 08/26/25 CR #1 was transferred to the hospital on [DATE] for AMS. Record review of CR #1's NP Progress Note, dated 08/25/25, revealed, History: visit type- family concern; LVN J notified this FNP patient family is concerned and reporting he is having AMS, decreased cognition and follow up visit completed. ROS: Musculoskeletal: Muscle Weakness. Neurological: AAOx3, sensation normal to touch. Negative tongue deviation. Face is symmetrical. Motor strength strong and equal in BUE and BLL. ASSESSMENT & PLAN: AMS/Cognitive Decline-acute illness that poses a threat to bodily function-Ordered STAT CBC, BMP, and UA with C&S if indicated. Called [Family Member #1] and notified her of my evaluation and orders given. She requested (Resident #1) be sent to ED for eval and this done per her request. Record review of CR #1's Change in Condition Evaluation dated 08/25/25 signed by LVN J revealed, the change was effective on 08/25/25 at 01:00 PM and CR #1 experienced decreased cognition. Nurse observed decreased cognition and slower speech from CR #1, increased confusion and needed more assistance with ADLS and dressing. The NP was notified on 08/25/25 at 12:57 PM and orders were given for STAT CBC with differential, BMP and UA with CS. CR #1 experienced a personality change, he was not cooperating as usual and no neurological changes were observed. Record review of CR #1's Progress Note, dated 08/25/25 at 06:06 PM, signed by LVN J revealed the Nurse received verbal order to send patient to hospital non emergent to evaluate slurred speech and decreased cognition Family Member #1. Nurse called EMS for transport. Nurse called. Report given to EMS staff. Patient was being picked up at this time. Family Member #1 was notified of patient departure. Record review of CR #1's Hospital Records, dated 08/25/25 to 09/02/25, revealed CR #1 arrived at the hospital on [DATE] at 06:58 PM and discharged on 09/02/25 at 08:24 PM. Record review of CR #1's Hospital Records MRI of the Brain, dated 08/25/25, revealed Acute non-hemorrhagic infarcts (acute ischemic stroke). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of CR #1's Hospital Inpatient neurology consult, dated 08/26/25 at 04:04 PM, revealed Chief Complaint- patient present with slurred speech. General: Patient is alert and oriented to name, hospital with choices, not time. Speech is halting with frequent pauses for word findings sometimes unable to continue his thought. Assessment & Plan: cerebrovascular accident (medical condition caused by a loss of blood flow to the brain) due to embolism (a condition where a blood clot or other foreign material travels through the blood stream and blocks a blood vessel). MRI brain (scan of the brain) revealed acute infarcts. Record review of CR #1's Hospital Discharge summary, dated [DATE], revealed Hospital Course: This is a [AGE] year-old male with past medical history of HTN, obesity, anemia of chronic disease presented from SNF due to worsening confusion and slurred speech was noted to have acute CVA to left midbrain and left frontal lobe. Neurology was recommended to continue DAPT (treatment with 2 blood thinners) aspirin and Plavix for 21 days and then monotherapy (single treatment) with aspirin. Patient has had behavioral and mood changes which neurology has attributed to his recent stroke. He is being discharged to an Inpatient Rehab facility in good condition for further therapies. Outpatient follow-up with neurologist. Record review of CR #1's Hospital Physical Therapy Flowsheets dated 09/02/25 revealed, Transfers- substantial to maximum assistance. Distance with walker- 3 steps with substantiate/maximum assistance with 2 people with a front wheeled walker. In an interview on 09/08/25 at 03:56 PM, Family Member #1 said when she spoke to CR #1 on Sunday, 08/24/25, the resident did not seem the same. She said CR #1 had slurred speech and a change in his condition so she contacted the facility. Family Member #1 said CR #1's nurse said there was no doctor on site since it was a Sunday, but she would notify administration and the change would be discussed in the facility's morning meeting on Monday. She said she knew the facility typically had their morning meeting around 10 AM so she waited until after the meeting on Monday 08/25/25 to follow up on CR #1's change in condition. Family Member #1 said when she called on Monday, she was notified that the resident's vitals were normal and was advised to schedule CR #1 to see a neurologist (doctor who specializes in disorders of the brain, spinal cord and nerves). Family Member #1 said she spoke to the NP who said she could wait for CR #1 to see the neurologist or she could send him out to the ER. She said she requested CR #1 be sent to the hospital for further evaluation, and when admitted , the hospital said CR #1 had 2 strokes. Family Member #1 said since the strokes the resident suffered a significant decline. Prior to the strokes the resident had good memory and received PT/OT and walked 125 feet independently while tethered (attached to an object or individual) but now the resident had to be followed by the turn team and needed significant speech therapy. The resident could not swallow now, had a modified diet and was unable to even open his phone. Family Member #1 said she noticed CR #1's slurred speech on 08/24/25 in the afternoon and the resident was not sent out till over 24 hours later, on 08/25/25, which resulted in his change of condition and hospitalization from 08/25/25 to 09/02/25. In an interview on 09/09/25 at 09:05 AM, LVN J said on 08/24/25 she was notified by Family Member #1 that CR #1 experienced a change in condition that he had slurred speech and he was a little different so she said she immediately notified NP A. She said NP A assessed the resident and gave orders to send him to the Hospital for further evaluation. LVN J said NP A said he did not need to go out 911 so she requested emergency transportation (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 09/09/25 at 12:07 PM, RN H said she was no longer employed with the facility. She said on Sunday, 08/24/25, Family Member #1 reported that CR #1 was confused and unable to articulate his words. She said she assessed the resident and there was nothing wrong so she spoke to Family #1 about getting a consultation because his symptoms were most likely early dementia. RN H said CR #1 had paused thinking but he did not have slurred speech, he could not articulate his words and when he spoke you had to give him time. She said she told Family Member #1 she could request a psych consultation for Monday. RN H said she did not document Family Member #1's complaint or her assessment of CR #1, she did not send out any notifications and she did not communicate the events to the night shift nurse. In an interview on 09/09/25 at 12:37 PM, NP A said symptoms of stroke included slurred speech and altered mental status. She said the facility's stroke protocol was to notify the provider immediately of any symptoms of a stroke. She said If she was in the facility at the time of the notification she would see the resident immediately if she was not in the facility she would rely on the nurses assessment and description of symptoms. She said on 08/25/25 she was notified of CR #1's family members concerns that the resident had altered mental status and slower cognition. NP A said when she assessed CR #1 he was tired and fatigued but he did not have slurred speech, and he had normal neurological response. She said Family Member #1 was concerned CR #1 had a stroke so she told them the only way to absolutely rule out a stroke was with imaging, so Family Member #1 requested CR #1 be sent to the hospital for further evaluation. NP A said she was not aware CR #1's symptoms were reported on Sunday, 08/24/25. She said she was the on call provider on the weekends (Sunday, 08/24/25) and no notification was sent to her or her supervising physician prior to 08/25/25. NP A said she expected to be notified of any resident changes reported or identified and delayed notification of a resident's change in condition could result in delayed identification and treatment of conditions. She said delayed identification/treatment of a stroke could result in worsening symptoms like slurred speech, one sided weakness, decreased strength and decreased speech. NP A said, I will be honest, I don't think it was a stroke. In an interview on 09/09/25 at 01:00 PM the DON said when a resident had a change of condition or a family member expressed concerns of a change of condition the resident should be immediately assessed, notification should be sent out to the: provider, staff and then the resident's representative; and the information documented in the resident's chart as a change in condition. She said it didn't matter if the event occurred over the weekend or on the weekday, the resident should be assessed with the information documented and notifications sent out to the provider and the family. She said signs and symptoms of a stroke included drooling, general fatigue, slurred speech, changes in speech, and sometimes the resident could not speak. The DON said if a resident displayed symptoms of a stroke staff should immediately assess the resident, document it as a change of condition send notification to the NP and send the resident to the hospital via 911. She said a delay in identification and intervention on a stroke could result in worsening symptoms and the resident suffering multiple strokes. The DON said she only found out about the delayed notification of CR #1's family concerns about stroke after she returned from leave in September. She said RN H failed to report the concerns on 08/24/25 and LVN J caught it on Monday, 08/25/25 and too her knowledge no information was communicated to the provider or facility administration about CR#1's slurred speech or altered mental status from Sunday to Monday. She said the 5 hour wait until CR #1 was transferred to the hospital was unacceptable. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of the facility policy titled Charting and Documentation, dated 05/2007 revealed, 1. A charting entry should be made every shift when a resident status reflects unstable condition. The following are examples of conditions which will require documentation every shift: 2- unstable physical conditions which require every shift monitoring of . any other nursing observations that are indicated. 7. Responsible party of family contacts in person or per telephone. Record review of the facility policy titled 24 Hour Report Summary, dated 05/2007 revealed, policy: it is the policy of this facility to use a 24-hour report summary as a communication tool in the ongoing resident evaluation process. Purpose: The 24-hour report summary is used to track individual resident events , conditions, or symptoms over a period of one month. The information is logged from the daily 24-hour report and is a significant tool in the ongoing resident evaluation process. It provides a comprehensive picture of the resident and is more likely to identify changes in status than a one time snapshot obtained through a formal assessment. 2- Instructions for completion: Name of the resident in room number. Date. Unit. The following information should be included on the 24-hour report but not limited to: Change in condition. Record review of the facility policy titled Change in Condition, dated 06/2019 revealed, 1. If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to): Change or a trending change in vital signs; Change in ability or decline in physical function; Change in mental status. 2. The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions. 3. The resident will then be placed on the 24-Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions. An attempt to identify the cause for decline, when it occurs, needed assist and resident behavior / acceptance of increased need of assistance will be monitored. 4. The nurse will communicate the change to the Resident and/or Responsible Party and to other departments as appropriate. Updated communications will be available during morning report. 5. There will be certain circumstances where immediate attention will be warranted, and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his / her clinical judgment and shall contact the physician based on the urgency of the situation. The Medical Director shall be notified in the event that the Attending Physician or on-call Physician cannot be reached. The resident / resident representative will be notified of the change of condition and any changes in the resident's medical or nursing care. 6. Each department notified will perform their own evaluation and assessment to determine if the change requires further intervention and implement actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR). This was determined to be an Immediate Jeopardy (IJ) on 09/10/25. The Administrator and DON were notified. The Administrator was provide with the IJ template on 09/10/25 at 1:06 PM. The following Plan of Removal submitted by the facility was accepted on 09/11/25 at 10:50 AM. Plan of removal for F684: 09/10/2025 (continued on next page)

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	676230	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	CR#1 experienced a delay of over 24 hours in identification and treatment after he displayed signs and symptoms of stroke including slurred speech, slow speech, altered mental status, and fatigue. Upon admission to the hospital, CR#1 was diagnosed with an acute ischemic infarct due to a suspected embolism. 1. The Medical Director was notified of the IJs by the Executive Director on 09/10/2025 at 1:38 pm. 2. The attending nurse practitioner was notified of the IJs by the Executive Director on 09/10/2025 at 1:52 pm. 3. CR#1 was discharged to the hospital on [DATE] and did not return to the facility after that. He was discharged to inpatient rehab from the hospital. The RN who worked 8/24/2025 received a disciplinary action and is no longer employed with the facility. The nurse that worked 8/25/2025 day shift will be provided with 1-on-1 education and training by 09/11/2025 regarding timely transportation of residents to the hospital after orders are received from the MD/ NP. 4. An audit was completed by the DON/designee on 09/10/2025 for all residents with a history of stroke. A head-to-toe assessment was conducted on these residents by the DON/designee, ADON, MOS, Clinical Resource Nurse, and Nurse Managers to ensure no active signs or symptoms of stroke are present. No residents with active signs/ symptoms of stroke were identified. 5. Education initiated on 09/10/2025 by DON/ designee on licensed nurses that included- A. Stroke/ TIA protocol including identification of signs and symptoms B. Change of condition which includes timely notification to MD/NP, DON, and RP. C. Communication- between nursing (24-hour report) and between nursing staff and provider D. Documentation and charting which includes notification to nurse management, MD/ NP, and RP. E. Head to toe assessment with competency checks all licensed nurses. F. Emergency and non-emergency transfers and notification to MD/NP if there is a delay in transport arrival. G. Resident/ family concerns regarding COC which includes notification to the MD/ NP of the concerns reported and assessment findings. Target completion date: 09/11/2025 6. Education initiated on 09/10/2025 by DON/ designee on all staff that included- A. Stroke/ TIA protocol including identification of signs and symptoms. B. Change of condition C. Resident/family concerns regarding COC Target completion date: 09/11/2025 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	7. Nurses are responsible for notifying the DON/ designee upon identification of a change of condition. DON/ designee will review the 24-hour report daily for change of condition with timely notification of MD/ NP. 8. Care plans will be updated for all residents with a history of stroke to include personalized/ individualized interventions/ prevention-this will be completed by MDS coordinator/ designee to be completed 9/10/2025. 9. The DON/designee will administer post-training tests to all staff regarding the stroke protocol. Testing began on 09/10/2025 and will be completed by 09/11/2025. 10. All training and competency checks will be completed in-person before staff begin their next shift. A member of the management team will be present at each shift change to ensure completion. Staff will not be allowed to work until training and competencies are completed. Training will be part of new hire orientation and mandatory for PRN staff before working on the floor. Target Completion Date: 09/11/2025. 11. An ad hoc QAPI meeting regarding items in the IJ template will be completed on 09/11/2025. Attendees will include the Medical Director, Clinical Resource, Administrator, DON, ADON, and will include the plan of removal items and interventions. 12. A summary of the IJ and corrective actions will be reviewed by the QAPI Committee: Weekly for 4 weeks or until substantial compliance is achieved. Then monthly for 90 days to ensure ongoing compliance. Monitoring of the POR In an interview on 09/13/25 at 09:20 AM, LVN J said she received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition on 09/12/25. LVN J displayed competency on the topics she received training on. In an interview on 09/13/25 at 09:23 AM, MA D said she received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition within the last 3 days. MA D displayed competency on the topics she received training on. In an interview on 09/13/25 at 09:27 AM, PTA H said she received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition on 09/11/25. PTA H displayed competency on the topics she received training on. In an interview on 09/13/25 at 09:20 AM, RN E said he received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition on 09/12/25. RN E displayed competency on the topics he received training on. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 09/13/25 at 09:27 AM, LVN K said she received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition on 09/11/25. LVN K displayed competency on the topics she received training on. In an interview on 09/13/25 at 09:27 AM, MA C said she received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition on 09/11/25. MA C displayed competency on the topics she received training on. In an interview on 09/13/25 at 09:20 AM, RN F said he received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition in the last view days. RN F displayed competency on the topics he received training on. In an interview on 09/13/25 at 01:18 AM, CNA AR said she received training on the facility stroke protocol, changes in condition, communication between nurses, documentation, head to toe assessments, emergency and non-emergency transfers and resident/family concerns regarding changes in condition within the last 3 days. CNA AR displayed competency on the topics she received training on. Record review for POR monitoring revealed: - On 09/10/25 the facility had an ad hoc QAPI meeting regarding notification of changes, quality of care and changes of condition. The DON, ADONs, Administrator and Medical Director were in attendance. - On 09/10/25 the facility in-serviced all staff on Stroke Protocol/signs and symptoms of a stroke. Residents #5, #24, #27, #120 and #126 were identified as having history of stroke without the appropriate care plan and their care plans were updated appropriately. - On 09/10/25 the facility in-serviced all staff on changes of condition, stop and watch early warning tool, documentation and notification of change. - On 09/11/25 the DON completed a 1on1 in-services with LVN J on CIC, Nursing Communication, Physician Notification, Stroke Police, Hospital Transport - On 09/10/25 the facility in-serviced all staff on documentation, change of condition and required charting. - On 09/10/25 the facility in-serviced all staff on Hospital Transport. - On 09/10/25 the facility in-serviced nurses on Nursing communication and 24-hour report/rounding. - On 09/10/25 the facility in-serviced all staff on Resident/Family concerns regarding a change in condition. - On 09/10/25 the facility completed competency assessments on stroke for both licensed and non-licensed staff. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	- On 09/10/25 the facility completed competency assessments with all licensed staff on Changes of Condition - On 09/10/25 the facility completed competency assessments on licensed and non-licensed staff for Head-to-Toe Assessments - On 09/10/25 the facility completed an audit of all changes of conditions from 07/10/25 to 09/10/25. All reported CIC had appropriately timed provider notifications. - On 09/10/25 the facility completed an audit on all residents with a stroke diagnosis: - Their Care Plans were audited- Residents #5, #24, #27, #120 and #126 were identified as having history of stroke without the appropriate care plan and their care plans were updated appropriately. - On 09/11/25 the DON completed a 1on1 in-services with LVN J on CIC, Nursing Communication, Physician Notification, Stroke Police, Hospital Transport - On 09/12/25 the facility completed an audit on the 24-hr. report for 09/11/25. - On 09/13/25 the facility completed an audit on the 24-hr. report for 09/12/25. - On 09/14/25 the facility completed an audit on the 24-hr. report for 09/13/25. An IJ was identified on 09/10/25. The IJ template was provided to the Administrator on 09/10/25 at 01:06 PM. While the IJ was removed on 09/14/25 at 02:04 PM, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain and infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections for 1of 3 staff reviewed for infection control. 1) RN E failed to practice hand hygiene before and after assisting Resident #84' with care. 2) RN E failed to sanitize the blood pressure device after taking Resident #3's blood pressure. 3)The facility failed to label and bag all personal care items in room [ROOM NUMBER]. Resident #12 resided in room [ROOM NUMBER]. These failures placed the residents at risk for cross contamination and infections. Findings include: Record review of Resident #12's face sheet, dated 09/11/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #12 had diagnoses which included the following: chronic respiratory failure, type 2 diabetes mellitus (when the body has trouble controlling blood sugar and using it for energy), cerebral infarction (interruption of blood flow in the brain), pressure ulcer of sacral (triangular shaped bone located at the base of the spine) stage 4 (deep wound exposing the muscles, ligaments, or bones), dysphagia (difficulty swallowing), Parkinson's Disease (disorder that effects movement and sometimes cause tremors), hypertension (elevated blood pressure), cognitive communication deficit, tracheostomy (surgical opening in the windpipe to improve breathing), colostomy (surgical incision that creates an opening in the abdomen to reroute stool from the colon directly into an outside bag), and gastrostomy (surgical incision that creates an opening through the stomach wall to provide nutrition, fluids, and medications directly into the stomach). Record review of Resident #3's face sheet, dated 09/17/25, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #3 had diagnoses which included dementia, dysphagia, hypertension, and bipolar disorder (mental illness that causes unusual shifts in mood, ranging from highs to low. with one experiencing a change in their thinking, behavior, and sleep. Record review of Resident #84's face sheet, dated 09/12/25, reflected the resident was admitted to the facility on [DATE]. Resident #84 had diagnoses which included the following: hemiplegia (paralysis or weakness on one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), dysphagia (difficulty swallowing), chronic kidney disease, syncope and collapse (temporary loss of consciousness/fainting caused by sudden , brief decrease in blood flow to the brain), cognitive deficit, falls, cerebral infarction (blood flow to the brain is interrupted), hypertension (elevated blood pressure), muscle wasting and atrophy (muscle lose mass and strength).Observation on 09/09/25 at 9:40 AM of RN E at the bedside of Resident #3 revealed the RN was wearing gloves and took the resident's vital signs. When RN E was done, he removed his gloves and did not wash or sanitize his hands and left the room with the gloves in his hands walking back to the cart on the hallway. RN E laid the blood pressure machine on top of cart and did not sanitize the equipment and proceeded to work at his cart. Observation on 09/09/25 at 9:47 AM revealed RN E entered Resident #84's room and donned gloves to assist with care by assisting the resident to the wheelchair. Resident #84's brief was soiled with feces, and the resident had placed her brief on the floor. After RN E assisted Resident #84 and placed the soiled brief in trash can, RN E removed his gloves and left the room without washing his hands or sanitizing. RN E proceeded to go back to cart on the hallway and work. Observation on 09/09/25 at 10:13 AM revealed in room [ROOM NUMBER] (Resident #12's bathroom) was 2 gray wash basins on top of the commode chair. One of the wash basins were not labeled and the other had Resident #12's name on it. The wash pans were not inside of plastic bags. Interview on 09/09/25 at 10:19 AM, CNA V said she was the CNA for Resident #12. After CNA V observed the wash pans on the commode chair, she said all resident personal care items should be labeled and bagged to prevent cross contamination and infections. CNA V said she would take care of the incident right away. Interview on 09/09/25 at 3:30 PM, RN E said he received in-service on fall preventions, infection control, and hand washing to prevent cross contamination and infections. RN E said it was important to wash hands before putting on gloves and washing hands after removing gloves, before touching a resident, after assisting residents with carer, and before leaving a resident room. RN E said he was in-serviced on sanitizing resident care equipment which included blood pressure devices and blood glucose machines after using and in between usage on each resident to prevent cross contamination and the spread of infections. RN E said the reason he was not practicing infection control regarding handwashing/sanitizing hands and sanitizing resident care equipment was because he