

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676248	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Founders Plaza Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 721 S Hwy 78 Wylie, TX 75098	
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)		
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49092</p> <p>Based on interviews, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (Resident #1) of 4 residents reviewed for quality of care.</p> <p>On [DATE] RN A failed to monitor Resident #1 but documented doing vitals during a timeframe which she had become deceased .</p> <p>On [DATE] RN A insisted to Police Officer C Resident #1 was alive when he checked on her at 6:30 AM. RN A documented the vitals for Resident #1 at 7:04 AM. CMA (Certified Medication Aide) B found Resident #1 unresponsive at 7:00 AM during a routine morning medication pass. Police Officer C stated Resident #1 showed obvious signs that were incompatible with life at 7:44 AM and indicated she had most likely already been deceased prior to when RN A checked on her at 6:30 AM. In an interview with RN A, he later stated he did not check on Resident #1 before CMA B found her unresponsive at 7:00 AM and the vitals he uploaded were a mistake.</p> <p>This was determined to be past non-compliance immediate jeopardy from [DATE] to [DATE] due to the facility having implemented actions that corrected the non-compliance prior to the beginning of the survey.</p> <p>This failure could place residents at risk of serious injury or death.</p> <p>The findings included:</p> <p>Review of Resident #1's Face Sheet documented Resident #1 was a [AGE] year old female admitted on [DATE]. Resident #1 had a pacemaker. Resident #1 had diagnoses including atrial fibrillation (irregular heart rhythm that begins in the heart's upper chambers), hypertension (high blood pressure, motion sickness (motion caused nausea, vomiting, cold sweat, headache, dizziness, tiredness, loss of appetite, and increased salivation), acute pharyngitis (sore throat inflammation), dementia (decline in cognitive function), depressive disorder (persistent feelings of sadness or loss of interest), abdominal distension (swelling or enlargement of the abdomen), constipation (difficulty passing stools or infrequent bowel movements), muscle weakness (lack of muscle strength), asthma (inflammation of airways), gastro-esophageal reflux diseases (stomach acid flows back into the esophagus), anxiety (feeling of tension or worried thoughts), insomnia (sleep disorder that causes a difficulty in falling asleep or sleeping), dysphagia (difficulty swallowing), and gout (pain and inflammation of the joints).</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 676248
		If continuation sheet Page 1 of 7

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Resident #1's Care Plan dated [DATE] documented Resident #1 had a pacemaker.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was assessed for a Brief Interview for Mental Status (BIMS) and received a score of 14 which indicated that her cognition was intact.</p> <p>Review of Resident #1's vital signs documented by RN A, dated [DATE] at 7:04 AM revealed Resident #1 BP: ,d+[DATE], SPO2: 96%, HR: 68, Resp: 18, and Temp: 97.</p> <p>Review of Resident #1's vital signs documented by RN H, dated [DATE] at 1:35 AM revealed Resident #1 BP: ,d+[DATE], SPO2: 98%, HR: 68, Resp: 18, and Temp: 97.</p> <p>Review of Resident #1's progress notes written by RN A, dated [DATE] at 10:30 AM documented Around 7 am The floor Med tech informed this nurse the patient is unresponsive .This nurse and the other nurses rush to the patient room and patient observed lying on the bed unresponsive and code blue initiated. pulse was not detective CPR started and then pulse detected by the machine reading varies from ,d+[DATE] .The emergency personnel arrived and took over .MD,Family, notified change of condition .The emergency personnel informed this nurse they could not get rhythm and told this nurse to inform the family that she expired . and was pronounced dead by paramedics at 9:33am and they going to call the medical examiner . this nurse notified the family and the MD and the ADON.</p> <p>Review of the Medical Examiner Report notes dated [DATE] documented the synopsis was a facility hospice death. There was no trauma. Resident #1 had diagnoses of A-FIB, pacemaker, obesity, GI, pressure ulcers, bladder issues, asthma, hypertension, heart disease, intestinal obstruction, and failure to thrive. Police Officer C stated a caretaker reported he took vitals on the decedent at 0630 hours. A MedTech found the decedent unresponsive at 0700 hours. CPR was started and FD was contacted. The FD reported the decedent was in full rigor (postmortem stiffening of the muscles that occurs after death, typically starting 2 to 6 hours after death and peaking around 12 hours postmortem) at 0740 hours. Police Officer C confirmed rigor was present in the jaw, neck, and arms. The PD was satisfied there was no foul play or trauma. Case was released to Police Officer C.</p> <p>Record review of a facility statement from RN A documented he was alerted to Resident #1's by CMA B who stated the patient was unresponsive. When RN A arrived, LPN F was already there. He checked the patient's pulse; they did not get a pulse. He stated he started CPR on Resident #1. RN A documented the incident in his progress notes. When Administrator G questioned RN A about the vitals, he stated he did not do vitals on the resident prior and only when he went into the room for CPR.</p> <p>Record review of a facility statement from LVN Q documented she was at the nurse's station when she saw LPN F running down the 300 Hall with the crash cart. She immediately followed to assist. Upon entering Resident #1's room, she checked the patient's pulse but was unable to detect one. She noted the patient appeared stiff and was cool to the touch. CPR was initiated by RN A. EMS arrived shortly after.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 11:20 AM, CMA B stated she started work at 6:00 AM. She was going room to room passing medicine until she got to Resident #1's room. She stated when she entered, she said Good Morning but there was no response. She stated normally she responds. She stated the door was already open, but the lights were still off. She stated she said Good Morning three times total. She turned on the lights and saw Resident #1 lying on her side on the bed. She stated she knew something was wrong immediately and began to shiver. She rushed to get LPN F. She stated they ran back to the room together and began listening to Resident #1's heart. They put her hand on her head to feel her temperature, supplied oxygen, and started CPR. CNA O was working the hall and was told to go inform RN A of the situation. The paramedics arrived after 6 or 7 minutes of notifying them. RN A arrived at the room and started checking the pulse for Resident #1 and taking her vitals. CMA B stated she never observed RN A checking on Resident #1. She stated she was able to tell something was wrong immediately and if RN A had checked on Resident #1, he should have also been able to tell something was wrong when he entered her room. She stated she did not remember for sure what Resident #1's skin temperature felt like to the touch. She stated the facility performed in-services on the same day. The in-service was about making sure the staff checked on the residents and documented correctly. She stated ADON D was the one who performed the in-service.</p> <p>In an interview on [DATE] at 11:41 AM, LVN P stated they immediately responded when CMA B found Resident #1 unresponsive. They stated RN A, CMA B, and LPN F were all assisting. They stated they heard CMA B and immediately brought the crash cart (emergency medical cart) to the room. LVN P was responsible for checking to see if Resident #1 had an advanced directive or not. Resident #1 was full code (patient wished to receive all available medical interventions). Resident #1 was laying on her right side facing towards the door. RN A delegated LVN P to call 911. It took EMS ,d+[DATE] minutes to arrive. Resident #1 was unresponsive. She was not responding to anything. LVN P stated they could not detect a pulse and Resident #1 was not responding to anything verbal. They stated Resident #1 was a little cold to the touch. Resident #1 was stiff. It took 3 people to roll her over. LVN P, RN A, and LPN F began CPR. Once the paramedics arrived, they took over. The facility performed in-services on the same day. The risk of not checking on a resident would be not being able to give a thorough assessment of the resident at that time that you are supposed to be checking on them.</p> <p>In an interview on [DATE] at 12:00 PM, CNA O stated they were working the hall that morning. The situation with Resident #1 happened at the beginning of her shift. She stated she noticed CMA B going into Resident #1's room and heard her immediately call for help. She stated she ran over towards her and that's when they found Resident #1 unresponsive. She stated she assisted LPN F with repositioning Resident #1 while CMA B went to get help. As soon as the crash cart arrived with LVN P they began giving CPR to Resident #1. RN A had also arrived to assist with checking vitals. CNA O stated they did not remember seeing RN A going into Resident #1's room before the start of the incident. She stated she did not remember seeing him go into anyone else's room either. She stated she did see one call light that was on at 6:30 AM for a different resident so she went into that resident's room. If RN A had gone to check on residents on the hall while CNA O was in that resident's room, then she wouldn't know. She stated the facility performed in-services for abuse/neglect and documentation.</p> <p>In an interview on [DATE] at 12:15 PM, LVN Q stated that there is a risk of missing the required resident check timings if you are not checking on a resident when you are supposed to. If the timings are incorrect then there is a risk that a resident could be crashing. That would not be right for the resident because had they been checked on like they were supposed to be then maybe something could have been noticed to prevent the resident from injury, accident, or worse.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 2:41 PM, RN H stated she was the overnight nurse that worked the hall before RN A. She stated during her shift there were no condition changes. She stated she performed her resident check rounds in the beginning of her shift. She stated around 1 AM, Resident #1 was asking to have the AC cooled down. She performed vitals for Resident #1 at 1:30 AM and she was stable at that time. She stated at that time Resident #1 was okay. She stated she performed another round at 4 AM. Resident #1 was observed laying down in her bed. She stated she performed a quick round because Resident #1 did not have to take medications overnight. She stated she briefly looked inside the room and asked if Resident #1 was okay but there was no response. She didn't want to disturb Resident #1's sleep because she wasn't saying anything. She was laying on her side with her face towards the window. When asked if she checked to see if Resident #1 was breathing, she stated she only went into the room to perform a quick round because she didn't want to disturb Resident #1.</p> <p>In a telephone interview on [DATE] at 12:30 PM, Physician E stated he was informed of the change in condition and was also told by the facility, RN A had got lazy with his charting. He stated he was told RN A documented he had checked on Resident #1 instead of actually checking on Resident #1 and put vitals that were not accurate but once someone else checked on her they realized she was deceased. He stated the EMS said she most likely passed away prior to any of the checks that were documented. He stated this resident was a high risk for cardiac arrest because she had a pacemaker but it was still a surprise and out of the ordinary. He did not think whether RN A checked on Resident #1 or not would have changed the outcome for Resident #1. He stated the risk of injury was high to all residents if the facility was not checking on residents and falsely documenting. He stated if this occurred to a resident who had been in better health then it definitely could have changed the resident's outcome and been preventable.</p> <p>In a telephone interview on [DATE] at 12:51 PM, RN A stated he came to work around 6:05 AM. He stated when he came to work, he usually did rounds on his halls. He stated he did not remember if he checked on Resident #1 or not during that time. He stated he was alerted of Resident #1 not responding by CMA B and rushed to her room. He stated he checked Resident #1's pulse but could not detect it. He stated she was sleeping with her face towards the door. He stated the nurses called a code blue, and everyone began rushing into the room to assist. He stated it took ,d+[DATE] minutes for EMS services to arrive. He stated he went to check on Resident #1 after taking over from the night shift nurse (RN H) around 7:00 AM. He stated he was told the resident was unresponsive around 7 AM to 7:30 AM. He stated Resident #1 was not stiff but she was a little cold to the touch. He stated he attempted to take her pulse with her finger, and it gave a pulse. He stated his documentation and vital checks were wrong. He stated he thought the pulse was around ,d+[DATE] He stated he did detect a pulse and the resident did have oxygen at that time. He stated the documentation that he put in the vitals could have been for another resident, he wasn't sure. He stated he always checked on his residents every morning but in this scenario he didn't have time to check on her yet. He stated he didn't know what the risk would be of not checking on the resident. He stated she was independent and was someone that would let you know if she needed something.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 12:35 PM, Assistant Director of Nurses (ADON) D revealed it was the facilities policy to check on the residents at the beginning of their shift and every 2 hours. He stated there was a concern RN A didn't document correctly. He stated the response the facility had upon finding resident was done correctly but it coincided with RN A not checking or documenting correctly. If a nurse were to go into her room in the morning and see her sleeping, then you would assume she was sleeping. She doesn't normally wake up until around 8 AM. This resident was good at using her call light and letting you know if she needed anything. He stated he expected his employees to check on the residents before they take over the shift during shift change. He stated when a nurse takes report you should do your checks. He stated at nighttime this was not a disoriented patient and there was nothing saying you specifically have to take vitals at nighttime for a resident such as this if they were sleeping. He stated for people who didn't talk you should go take their vitals but in this instance she was verbal. He stated he still expected his staff to make sure a resident was breathing and maybe say hi to see if the resident would respond. Otherwise, just let them sleep but make sure they were breathing. This was not a resident we were expecting. This was unexpected.</p> <p>In an interview on [DATE] at 3:16 PM, Police Officer C stated he was responding to a call at the facility at 7:44 AM. He stated once he arrived Resident #1 was not conscious and not breathing. He stated Resident #1 was found to be deceased with obvious signs incompatible with life. He interviewed RN A and RN A insisted Resident #1 was alive when he checked on her and took her vitals at 6:30 AM. He stated RN A later uploaded those vitals into the charting software at 7:04 AM. CMA B was passing medications and found Resident #1 was unresponsive at 7:00 AM. He shared his concern with Administrator G that he believed Resident #1 was in rigor mortis when CMA B found Resident #1 and appeared to have been deceased prior to when RN A claims they checked on her and took her vitals.</p> <p>It was determined these failures placed Resident #1 in an Immediate Jeopardy (IJ) situation on [DATE]. The facility took the following actions to correct the non-compliance on [DATE]:</p> <p>Interview on [DATE] at 11:00 AM with Administrator G revealed he believed RN A falsified the vitals for Resident #1, documenting he had checked on Resident #1 when he had not. Resident #1 was most likely already deceased before CMA B discovered her. Administrator G stated RN A was immediately suspended on the day of the accident [DATE]. He stated the facility has already completed a plan of correction, plan of removal, and were continuing to monitor. Staff have been in-serviced on Abuse and Neglect. Staff have been in-serviced on how to correctly document. Staff have been in-serviced on resident checks.</p> <p>Record review of facility In-services conducted by the ADON dated [DATE] and signed by all staff on the following:</p> <ul style="list-style-type: none"> a. Nursing Policies and Procedures b. Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property. <p>Interview on [DATE] at 12:35 PM with Assistant Director of Nursing D stated in-services have been completed for all floor staff and would continue to be conducted until every PRN staff member that has not presented to work has received the in-service at the start of their shift.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record Review of the Audit of Random Vital Signs Form revealed the facility performed random monitoring by observation and supervision thereafter by the DON and the ADON to monitor proper documentation of the residents in the facility. The document revealed the staff needed to correctly document resident vitals and pass an audit of random resident vital signs that were supported by resident testimony. The DON and the ADON would be conducting audits three times a week until every staff member continued to demonstrate proficiency and thereafter. The document included a section for dates and two random resident audits for documentation.</p> <p>Review of the Suspension Form dated [DATE] documented RN A was suspended.</p> <p>Interview on [DATE] at 11:20 AM with CMA B revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>Interview on [DATE] at 11:41 AM with LVN P revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>Interview on [DATE] at 12:00 PM with CNA O revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>Interview on [DATE] at 12:15 PM with LVN Q revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>Interview on [DATE] at 2:40 PM with RN I revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>Interview on [DATE] at 2:45 PM with CMA J revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>Interview on [DATE] at 2:50 PM with CMA K revealed they understood the policies regarding Abuse/Neglect and Nursing Policies and Procedures. They indicated they recently received in-service training on [DATE]. They stated they understood the importance of checking on residents and documenting correctly.</p> <p>(continued on next page)</p>		

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