STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. Building B. Wing	03/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr Houston, TX 77070

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 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** 47277 Based on interviews, and record review, the facility failed to ensure residents were receiving person-centered Quality of Care for 1 residents (CR#1) of 8 residents reviewed. The facility failed to ensure CR #1 was properly transferred from the floor to the bed when displaying signs/symptoms of a fracture (pain, deformity, etc). CR #1 sustained a hip fracture. The facility failed to acknowledge CR#1's verbal complaint of pain by picking her up off the floor possibly causing more harm. The facility failed to follow physician orders and administer CR #1's pain medication (PRN). This failure could affect residents currently residing in the facility resulting in not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition. An Immediate Jeopardy (IJ) was identified on [DATE] at 4:34 p.m. While the IJ was removed on [DATE] at 7:22pm, 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 identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of physical harm, emotional distress, mental anguish, and death. Findings Include: Record review of CR#1's face sheet dated [DATE] reflected an [AGE] year-old female, with an original admitted [DATE]. Her diagnosis included: Cerebral Infarction of the right middle cerebral artery (stroke), hypertension (high blood pressure) and gastro-esophageal (digestive disorder). Record review of CR#1's Quarterly MDS dated [DATE], revealed the following: CR#1's BIMS score of 06 (severe cognitive impairment), CR#1's Functional Limitation in Range of Motion indicates an impaired Upper and Lower Extremities, uses motorized wheelchair, is dependent on staff for all of her ADL needs, including, rolling to left and right; has had no fall history. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of CR#1's orders dated [DATE] revealed, CR#1 was prescribed Aspirin 81 Oral Tablet chewable, Give 1 by mouth one time a day for blood clot prevention. Start date [DATE]; Change NEB MASK/TBING Every Sunday every night shift every Sun. Order date [DATE]; Atorvastatin Calcium 40 MG Tablet, give 1 tablet at bedtime for cholesterol, Start date [DATE]; Apixaban (blood thinner) dated [DATE]; Carvedilol 6.25 MG for htn Hold for SBP less than 120 or HR less than 60. Start Date [DATE] at 9:00pm; Blue-Emu Maximum Pain Relief External Cream 10% (Trolamine Salicylate (used for temporary relief of minor pain associated with arthritis)) apply to hips/knees topically every shift for pain. Order date [DATE] at 8:11am. Record review of CR #1's care plan dated [DATE], revealed the following care areas: Focus: [CR #1] has alteration in musculoskeletal status r/t CVA (stroke) with left sided Hemiplegia (paralysis). Dated initiated, created and revision on [DATE]. Interventions: [CR #1] needs to change position. Alternated periods of rest with activity out of bed in order to prevent respiratory complications, dependent edema, flexion (bending) deformity and skin pressure areas. Dated initiated and created on [DATE]. Interventions: [CR #1] Monitor/ document for risk of falls. Educate resident, family/caregivers on safety measures that need to be taken in order to reduce risk of falls. Date initiated and created on [DATE]; [DATE]; monitor/document to MD PRN s/sx or complications related to arthritis. Focus: [CR #1] I have had a Cerebral Vascular Accident (stroke). Dated initiated, created and revision on [DATE]. Goal: [CR #1] Will be free from s/sx of complications of CVA (stroke) (DVT, Contractures (permanent or temporary tightening of soft tissues, muscles, tendons, ligaments, or skin that restricts normal movement), aspirations pneumonia (lung infection), dehydration (body loses more fluid than it takes in)). Dated initiated, created and target on [DATE]. Interventions: [CR #1] Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat. Dated initiated, created on [DATE]. Focus: [CR #1] I receive routine Anticoagulant therapy r/t hx of CVA (stroke). Dated initiated and created on[DATE]. Goal: [CR #1] Will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Dated initiated and created on[DATE]. Target Date: [DATE]. Interventions: [CR#1] Labs as ordered. Report abnormal lab results to the MD. Dated initiated and created on[DATE]; Monitor/document/report to MD PRN s/sx of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, bleeding, blurred vision, SOB, Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Dated initiated and created on[DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Focus: [CR #1] Has potential impairment to skin integrity r/t decreased mobility and poor oral intake. Dated initiated and revision on [DATE]. Goal: [CR #1] Will be free from injury through the review date. Dated initiated and created on [DATE]. Target date: [DATE]. Interventions: [CR#1] Assist with and encourage turning and repositioning. Focus: [CR #1] I have an ADL Self Care Performance Deficit r/t weakness, CVA, impaired mobility. Dated initiated and created on [DATE]. Goal: [CR#1] Will safely perform Bed Mobility, Transfers, Eating, dressing, Grooming. Toilet Use and Personal Hygiene with modified independence through the review date. Dated initiated and created on [DATE]. Revision [DATE]. Target Date: [DATE]. Interventions: [CR#1] Converse with resident while providing care Dated initiated and created on [DATE]. Revision [DATE]. Target Date: [DATE]; Mobility bars for turning and repositioning Dated initiated and created on [DATE]; Toilet Use (toilet transfer, toilet hygiene): Requires staff participation to use toilet. Date initiated and created on [DATE]. Revision [DATE]. Focus: [CR #1] I am at risk for falls r/t left sided hemiplegia from CVA (stroke), impaired mobility (a limitation in a person's ability to move around easily and independently. Dated initiated and created on [DATE]. Revision [DATE]. Goal: [CR#1] Will not sustain serious injury through the review date. Dated initiated and created on [DATE]. Target Date: [DATE]. Interventions: [CR#1] Bed in lowest position as resident will allow. Dated initiated and created on [DATE]. Revision on [DATE]. Record review of the facility's video dated [DATE], revealed the following: 6:26am Resident #2 is seen coming out of the room and walking down the hall. 6:27am Resident #2 is at the nurses' station where LVN A was sitting at the nurses' station along with CNA C who was at the desk and CNA B who was standing at the desk. Resident #2 appeared to have made a statement then leaves nursing desk at 6:28am. At this time, CNA B paused before joining Resident #2, then both began walking down the hall. 6:28am Resident#2 and CNA B walked into CR#1's room. You can see CNA D, who was carrying a trash bag, walking past CR#1's room, then being alerted by CNA B. CNA D continued to another room and placed the trash bag, then proceeded to nurses' station and notified LVN A and CNA C, which is when all 3 proceeded down the hall at 6:28am. 6:30am WCN entered CR#1's room. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6:31am CNA C was observed casually walking to the nursing station, then making the 911 call. 6:31 am CNA B and CNA D exited CR#1's room, which left Resident #2 and CR#1 in the room alone. 6:32 WCN goes back into the room after getting supplies. 6:33 CNA C called DON. 6:38am CNA places Resident #2 in wheelchair and removes her from room. 6:39 CNA B leaves room. 6:41pm EMS arrives to the facility and enters building at 6:42am 6:44am enters CR#1's room. 6:51am EMS exits the facility with CR#1, At 6:52am outside of the facility, EMS covers CR#1 with a sheet. During the video, it was observed that all the staff left CR#1's room, while Resident #2 was still in the room with CR#1. Record Review of nursing notes written by WCN dated [DATE] at 8:27am, revealed, Resident observed lying on the floor feet facing foot bed, vitals taken, pain assessment made, head to toe assessment performed. Resident vitals ,d+[DATE] P-76 C/O pain from hip. PRN aspirin administered, resident noted with cut by right eye, EMS services immediately contacted, skin tear on left arm. Resident was not aware of how they ended up on the floor, seen by wound care physician, wounds cleansed, with wound cleanser, cut medicated with collagen powder, ST addressed with xeroform and dry dressing. RP notified; Dr. notified. Record Review of the EMS run report revealed, EMS arrived at the facility on [DATE] at 6:37am. Facility reported resident fell off bed. Patient presents with laceration above right eyebrow and swelling to right cheekbone and has a bloody nose. Patient is laying on nursing home bed with no sheets. Nursing home staff must have picked her up to the floor and placed her on bed with no sheets. There was blood all over the floor around the bed. Nursing home staff stated that patient is always altered that is her normal baseline state of mind. Patient presents with right hip in an abnormal position. Nursing home facility states that that is normal for her. Patient is complaining of right hip pain. PT (Patient) denies neck or back pain. Patient transported to trauma hospital as a precaution due to unknown patient hip history. Pt presents in an altered state. Nurse stated altered is baseline. Vitals assessed and recorded. Patient found to be at 88% at room air. Patient placed on nasal cannula at 3 liters and O2 sat improved to 95%. EKG show sinus rhythm. 18 Gage IV established in patients' right forearm. Patient transported to trauma facility. Pt history of blood thinners. Record review of the Local Hospital Trauma notes dated [DATE] at 7:47am, revealed the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Secondary Impressions: Accidental fall, Closed head injury, Frail elderly, intraventricular hemorrhage (serious brain bleed that occurs when blood enters the brain's ventricles), Nursing home resident, Right femoral fracture (also known as a broken bone), Sepsis (infection in the blood), TBI (traumatic brain injury) (brain damage), Transient hypotension 9 (temporary drop in blood pressure), Traumatic subarachnoid hemorrhage (bleeding in the space between the brain and thin membrane): *Resident was brought in by EMS from a nursing home bed for the evaluation of a closed head injury. On examination, the patient is frail, pale, thin malnourished, appearing chronically ill. Contracted left upper extremity. Contracted right lower extremity with the right lower extremely severely exaggerated internal rotation and shortening. Neurovascular intact in all extremities. Neurologically appears to be at baseline. She is screaming articulated normal speech. Localizing pain. Moving all extreme appropriately. She has a traumatic abrasion/laceration to the right supraorbital region (above the eye). Mild ecchymosis (bruise) to the right periorbital region(area around the eye socket). *Radiology of XR Pelvis area revealed, comminuted, minimally displaced right femur intertrochanteric fracture (a break in the bone (femur) just below the hip joint, between the greater and lesser trochanters (an attachment points for muscles) with varus angulation (deformity where the distal segment of a bone is angled inward, toward the midline of the body). *Head CT (imaging): Diffuse subarachnoid (a bleeding that occurs in the space between the brain and the thin membranes that cover it). *Blood tests showed WBC 22.7 (high) and Sepsis. Record Review of Facility's last vitals taken for CR#1: [DATE] Pain taken at 3:07am 0 value [DATE] Blood Pressure taken at 8:19pm ,d+[DATE] [DATE] Pulse taken at 8:19pm 66 bpm [DATE] Wts (Weights) taken at 3:51pm 91.2 Lbs [DATE] O2 stats taken at 9:23pm 95.0% [DATE] Temp taken at 3:10pm Record Review of Pain Management Review dated [DATE] at 6:57am, revealed change in condition, and the Pain Interview indicated the CR#1 was able to be interviewed, she was not hurting, has not had pain in the last 5 days, and there were no possible indicators for pain. Record Review of Fall Risk Evaluation completed by LVN A on [DATE] at 6:53am revealed, CR#1 stated was disoriented x 1, has history of falls in the past 3 months, no noted drop in blood pressure, and CR#1 has No Present predisposing conditions of Hypotension, Vertigo, CVA, Parkinson's Disease, Loss of Limb(s), seizures, arthritis, osteoporosis, fractures, Multiple Sclerosis, Wandering. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a interview on [DATE] at 2:50pm with Admin - as the video played it showed all staff leave out of CR#1. The Admin stated staff should not have left the two residents (CR#1 and Resident #2) in the room by themselves. He stated only one staff was good enough to get a nurse. He stated it took 3 minutes from the time CR#1 was found and staff calling 911. He stated he did not know if 3 minutes was an appropriate time to call 911. During a interview on [DATE] at 12:05 with RP#2 who stated CR#1 is a roommate to Resident#2. He stated he visits often, either daily or every other day. RP#2 stated when visiting he stayed around 2 hours. He stated that he has observed CR#1 just lying in the same position during the time he was visiting. He stated CR#1 appeared to be bedbound and didn't move at all. RP#2 stated she didn't talk. During a interview on [DATE] at 12:40pm with CNA A stated she is familiar with CR#1 and she can hardly move because she is bedridden. CNA stated on [DATE] around 6:30am she observed EMS coming to CR#1's room. She stated CR#1 was not assigned to her. During a interview on [DATE] at 12:49pm with CNA B stated she was at the nursing desk around 6:10am when CR#1's roommate, Resident #2, walked up and said her roommate was on the floor. She stated she followed Resident #2 to the room and observed CR#1 on the floor between in a perpendicular position. She stated CR#1 was face down and bleeding in head area. She stated she couldn't recall seeing a fall mat by CR#1's bed. During a telephone Interview on [DATE] at 1:55pm with RP#1 stated he received a call from the facility around 6:30am from an unknown person indicating CR#1 had fallen in her room and staff would keep an eye on her. He stated there was no urgency from the staff member. RP#1 stated at 8:00am (1.5 hours later) he received another call from the facility stating 911 had been called and CR#1 had been taken to hospital just for observation. RP#1 stated minutes after receiving the call from the facility, he received a call from the hospital informing him that CR#1 was unconscious, suffering from a brain bleed and multiple hip fractures; and instructed him to hurry to the ER room. RP#1 stated he called the facility and spoke with ADON A who told him that he received a call around 5:00am this morning and that staff found CR#1 on the floor while they were doing their rounds. ADON A told RP#1 he didn't know much, but when he got to the facility, he would find out more and give him a call with an update. RP#1 stated according to the hospital CR#1 arrived at the hospital at 7:37am and was admitted 9:00am. He stated he spoke with the trauma doctor who told him due to the extent of resident injuries she would need to contact Hospice. RP#1 stated CR#1 died from her injuries around 5:00pm. RP#1 stated CR#1 is completely immobile and not able to move herself. He stated CR#1 leans on her left side; however, he found it to be odd that the injury is on the right side of the body. During a interview on [DATE] at 2:45pm ADON - stated he received a call around 6:13am from CNA C who informed him CR#1 was found on the floor. ADON stated he spoke with RP#1 but couldn't remember all of the details of the conversation. He stated he told RP#1 that he was still trying to find out details of CR#1's fall. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a interview on [DATE] at 2:50pm with WCN who stated he was summoned to CR#1's room a little after 6:00am by CNA C who informed him that CR#1 was on the floor face down bleeding. WCN stated upon his arrival to the room, he observed CR#1 in a vertical (perpendicular) position and positioned in between the two beds. WCN further described the position CR#1 face down on the floor bleeding, her head was toward her bed and her feet was toward Resident#2's bed. WCN stated LVN A was conducting a head-to-toe assessment. During the assessment, WCN heard CR#1 complain her hip was hurting and there was no pain in her head. WCN stated after LVN A completed the assessment, he and LVN A picked CR#1 up and put her in the bed. WCR stated CR#1 sustained a 1cm gash above her, he believes, right eye. WCN stated after CR#1 continued to be complained about her hip he directed CNA C to call 911. During a interview on [DATE] at 3:51pm with CNA C stated she began work at 6:13am. She stated she was seated at the nursing desk when Resident#2 arrived at the desk and informed nurses CR#1 had fallen. She stated CNA B walked with Resident#2 back to her room. CNA B returned to nursing station and reported CR#1 was on the floor bleeding and it was fresh blood. CNA C stated when she arrived at the room, she observed CR#1 on the floor face down between the two beds. Stated CNA B went and got WCN. When the WCN arrived, he told her to call 911. During a interview on [DATE] at 4:05pm with LVN A, she stated CNA B returned to the nursing desk and said CR#1 was on the floor and bleeding. She stated when she arrived at CR#1's room she observed CR#1 on floor, face down, and bleeding from her face. LVN A stated she did not assist in putting resident in the bed. She stated she noted there was a laceration above CR#1 eye area where she was bleeding. Stated at no time had the roommate come to the desk. Stated WCN did vitals and cleaned up resident face before leaving. Stated she arrived in the room and told WCN, CR#1 needed to go to the hospital she hit her head. This was after 6am. Stated CNA C called 911. She worked 300 Hall. LVN A stated CR#1 was stated she needed creme for her hip. During a telephone interview on [DATE] at 5:06pm with CNA D stated she was not assigned the 100 hall and CR#1 was not on her list. She stated she heard CR#1 had fallen. During a follow Up Interview on [DATE] at 10:00pm with CNA A, she was asked to clarify the earlier interview. CNA A stated she was assigned to 100 hall but was 30 minutes late. She stated she arrived at 6:30am. CNA A stated when she got on the 100 hall, she was informed by another CNA that CR#1 had fallen. She stated she went in the room and the WCN was cleaning blood off CR#1's face, while she was lying on her bed. CNA A stated WCN directed her to get additional towels and blankets so that he could clean the blood off the floor as he was stepping in it. CNA A stated about 10 minutes later (6:40am) EMS arrived at CR#1's door. During a telephone interview on [DATE] at 10:15pm with CNA E, she stated she worked the 100 hall and was responsible for CR#1. She stated she worked on ([DATE]) Tuesday night (10:00pm -6:00am). CNA E stated she made her last round between 4:30am-4:45am. She stated CR#1 was in her bed. CNA E stated its really odd that CR#1 fell out of bed, since the resident is bedbound and rarely moves. CNA E stated she clocked out at 6:15am and there were no issues with the resident. During an Interview on [DATE] at 4:00pm with DON, she stated the protocol for unwitnessed fall with injury was staff should alert nurse, complete patient assessment, stay with patient, depending on nursing assessment patient can go out to hospital and MD, family notified. The DON stated staff should not move a resident with a head injury; unless the resident is in a position where additional harm may exist, then the nurses are to use their judgement. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2.Head to toe guidelines were reviewed by Medical Director, DON, and ED with no changes made [DATE] parentheses (see attached) 3.Education initiated with all licensed nurses on head-to-toe assessments, when to complete an assessment and calling 911 on [DATE] by DON, ADON, Clinical Resources and Cluster Nursing Leadership completion date [DATE] 4.All licensed nurses will complete competency on head-to-toe assessments started on [DATE]. Completion day [DATE] 5.This training and competencies will be completed in person with all staff prior to the start of their shift a member of management will be at the facility at each change of shift to ensure all staff complete training prior to going to work on the floor staff will not be allowed to work unless they have completed the training and competency checks. This training will also be included in the new hire orientation and will be included for any PRN staff prior to starting work on the floor. These staff will not be allowed to work unless they have received their training and knowledge check. 6.And ad hoc meeting regarding items in the IJ template will be completed on [DATE]. Attendees will include the Medical Director, Clinical Resource, Administrator, DON, ADON, Clinical Resources and will include the plan of removal items and intervention. Surveyor confirmed the facility implemented their plan of removal and monitoring began on [DATE]. During a telephone interview[DATE] 11:42pm with LVN B stated she had training before her shift started. Stated the training was on abuse and neglect, reporting incidents. She stated the Admin and ADON took employees to office, where the employees were given a posttest then training. She stated abuse can be identified by bruises on a resident, or when resident says don't hurt me when providing care, the resident is jumpy and acting in an unusual behavior like scared. LVN B stated the assessment training was about falls, etc , which when a resident has a witnessed or unwitnessed fall, a full body assessment should be completed immediately. Any incident of finding resident do not move call 911. Stated if any resident is bleeding from head, I call 911 immediately. LVN stated nursing staff should never leave resident by themselves always have someone with resident. The head-to-toe assessment consists of checking entire body, vital signs, check body for any injuries, if able, move patient limbs ROM. All nursing staff is required to document in PCC (nursing notes) and complete an incident report. She stated she worked the morning that the situation occurred with CR#1 but did not assist anyone in putting resident in the bed. During a telephone interview [DATE] 11:59pm with LVN A - Stated she received training on full body assessments. Call 911 tell them that it is an emergency. Abuse coordinator is the Administration. LVN A stated the ADON gave a pretest on falls and abuse. They were true false questions on falls and abuse. Stated a resident with a fall and obvious head injuries complete assessments, take vitals, call MD and EMS services if need to be sent out. Stated it's important to document on an incident report and transferred to the nurses' notes in PCC. LVN A stated and another lady got her off the floor. One leg was bent under the other. Stated her leg was folded. Not sure if it was a fixed position. Believes it was a left leg under the right folded at a 45-degree angle. A resident should never be left alone, and someone should be with the resident at all times because anything can happen. LVNA stated she believe the CNA that assisted WCN was CNA D. (continued on next page)

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	676251	A. Building B. Wing	03/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr Houston, TX 77070

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview[DATE] at 12:20am with CNA E stated she had in service ,d+[DATE] times this week. CNA E stated she had a training on abuse and neglect. Completed a quiz a true or false test. Stated if she comes up on a resident that has fallen, she will summon her nurse, ensure resident is secured if alone, and call out loud from hallway to get a nurse. She stated there should always be an urgency. Stated if a resident was on ground you don't touch until a nurse is available to assess them then follow their directions. Stated an example of abuse was refusing to clean patient, using resident personal property for own personal gain, and physical abuse. She stated she did not assist resident in bed. She did not know CR#1 had fallen. During a telephone interview on [DATE] at 12:35am with CNA I stated she was on vacation the last (two) 2 weeks and returned last night. Stated she had in-service training on abuse, reporting, posttest. Abuse is verbally badgering a resident; an example of exploitation is personal gain for something that belongs to a resident. If you see resident on floor, do not touch, go, and get nurse, stated after the nurse completes her assessment the nurse will instruct you on whether the resident can be moved. You must follow instructions given by the nurse. Was not at the facility when CR#1 fell . If there is a fall or other unusual activities it should be reporter to nursing staff and followed up by an incident report. During an Interview on [DATE] at 6:15am with CNA D stated she has been in serviced on abuse and 911 calls. She stated she learned that to call 911 you have to say it's an emergency. CNA D stated she would call 911 if nurse tells her to call, she will call. CNA D stated the types of abuse are physical, can't hit residents. If an employee put their hands on a resident, it should be reported to nurse or the DON and ADON and Admin. Admin was the Abuse Coordinator. CNA D stated some of the s/s of resident abuse are observed by bruises or suspicious injuries on the resident's body. CNA D stated she just helped the WCN pick CR#1 up off the floor, she was doing patient care on another resident. She stated CNA B came and got her and said CR#1 was on the floor. CNA D was leaving room [ROOM NUMBER] and then went to resident room and CR#1 was on the floor. CNA D said CR#1's head was at the headboard and her feet were at the floorboard and CR#1 was laying on her side right side, but head was on the floor. CNA D stated she was shaken up because she had never seen CR#1 move. She stated the staff in the room when she arrived was WCN, CNA B, and CNA C. CNA D stated she thought WCN did an assessment on CR#1, but wasn't because she walked out of the room. WCN had CR#1 from the shoulders and CNA D had her legs. Before picking her up he checked temp, blood pressure and asked her what day it was. She picked her up and then walked out, she couldn't see her like that. CR#1 said she needed cream for her right hip, but she says that every day. CNA D noticed that her hip looked like it was out of place, after she got her in the bed, she said it looked like something was wrong with her hip. Her leg was just limp. She told WCN that and he had CNA C call 911. It was the WCN's idea to pick her up off the ground. She said she didn't realize the hip looked like that until they got her in the bed. She said she didn't think she could have injured her she had her ankles. WCN's arms were under CR#1's arm pit cradled, and CNA D had her ankles. The bed was low. CR#1 did not have a scoop mattress. During an Interview on [DATE] at 6:34 am CNA F stated she was in-serviced on abuse, elopement, and so many others before she started her shift. She stated the types of abuse on residents are physical, mental, financial, and sexual abuse. CNA F stated the Admin is the Abuse Coordinator. CNA F stated she would intervene if she was witnessing abuse and would report immediately. She stated one sign of abuse is when a resident has been physically abused and their behavior changes. CNA F stated s/s of abuse is residents being jumpy, saying don't hurt me, suspicious injuries, bruises. She stated when told to call 911 you must tell them it's an emergency. With unwitnessed or witnessed falls, the nurses perform head to toe assessments. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an Interview on [DATE] at 6:38 am CNA C stated she was in serviced on abuse, neglect, exploitation and for calling 911. She stated when calling 911 you are supposed to tell dispatcher it's an emergency. CNA C stated examples of abuse are financial, isolation, physical, mental and sexual. She stated when a resident is scared of someone, or they may tell you they have been abused. CNA C stated she would report to Admin immediately. She stated the Admin's telephone number is everywhere around the building so if he's not at the facility you can still contact him. She stated if two residents are engaged in an altercation, she would separate them. CNA C stated she called 911 when CR#1 fell . She stated 911 asked her, what's your emergency, medical or fire? CNA C stated, medical. She stated then 911 asked, what's the emergency, which was when CNA C stated, we have a patient laying on the floor. She stated the 911 operator asked [TRUNCATED]

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on interviews, and record review, the facility failed to ensure residents were free from Accident Hazards and Supervision for 1 resident (CR#1) of 8 residents reviewed for Accident Hazards and Supervision. The facility failed to ensure each CR #1 was transferred properly after she was found face down on the floor, sustaining multiple injuries, including laceration above the eye, closed head injury and broken femur. The facility failed to acknowledge CR#1's verbal complaint of pain by picking her up off the floor possibly causing more harm. An Immediate Jeopardy (IJ) was identified on 03/27/2025 at 4:34 p.m. While the IJ was removed on 03/29/2025 at 3:30pm, 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 identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures placed residents at risk of physical harm. Findings Include: Record review of CR#1's face sheet dated 11/8/2023 reflected an [AGE] year-old female, with an original admitted [DATE]. Her diagnosis included: Cerebral Infarction of the right middle cerebral artery (stroke), hypertension (high blood pressure) and gastro-esophageal (digestive disorder). Record review of CR#1's Quarterly MDS dated [DATE], revealed the following: CR#1's BIMS score of 06 (severe cognitive impairment), CR#1's Functional Limitation in Range of Motion indicates an impaired Upper and Lower Extremities, uses motorized wheelchair, is dependent on staff for all of her ADL needs, including, rolling to left and right; has had no fall history. Record review of CR#1's orders dated 11/8/2023 revealed, CR#1 was prescribed Aspirin 81 Oral Tablet chewable, Give 1 by mouth one time a day for blood clot prevention. Start date 11/9/2023; Change NEB MASK/TBING Every Sunday every night shift every Sun. Order date 5/20/2024; Atorvastatin Calcium 40 MG Tablet, give 1 tablet at bedtime for cholesterol, Start date 11/9/2023; Apixaban (blood thinner) dated 11/8/2023; Carvedilol 6.25 MG for htn Hold for SBP less than 120 or HR less than 60. Start Date 6/28/2024 at 9:00pm; Blue-Emu Maximum Pain Relief External Cream 10% (Trolamine Salicylate (used for temporary relief of minor pain associated with arthritis)) apply to hips/knees topically every shift for pain. Order date 2/19/2025 at 8:11am. Record review of CR #1's care plan dated 11/8/2023, revealed the following care areas: Focus: [CR #1] has alteration in musculoskeletal status r/t CVA (stroke) with left sided Hemiplegia (paralysis). Dated initiated, created and revision on 12/12/2023. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interventions: [CR #1] needs to change position. Alternated periods of rest with activity out of bed in order to prevent respiratory complications, dependent edema, flexion (bending) deformity and skin pressure areas. Dated initiated and created on 12/12/2023. Interventions: [CR #1] Monitor/ document for risk of falls. Educate resident, family/caregivers on safety measures that need to be taken in order to reduce risk of falls. Date initiated and created on 12/12/2023; 12/12/2023; monitor/document to MD PRN s/sx or complications related to arthritis. Focus: [CR #1] I have had a Cerebral Vascular Accident (stroke). Dated initiated, created and revision on 12/12/2023. Goal: [CR #1] Will be free from s/sx of complications of CVA (stroke) (DVT, Contractures (permanent or temporary tightening of soft tissues, muscles, tendons, ligaments, or skin that restricts normal movement), aspirations pneumonia (lung infection), dehydration (body loses more fluid than it takes in)). Dated initiated, created and target on 12/12/2023. Interventions: [CR #1] Monitor/document mobility status. If resident is presenting with problems or paralysis, obtain order for Physical therapy and Occupational therapy to evaluate and treat. Dated initiated, created on 12/12/2023. Focus: [CR #1] I receive routine Anticoagulant therapy r/t hx of CVA (stroke). Dated initiated and created on12/12/2023. Goal: [CR #1] Will be free from discomfort or adverse reactions related to anticoagulant use through the review date. Dated initiated and created on12/12/2023. Target Date: 1/6/2025. Interventions: [CR#1] Labs as ordered. Report abnormal lab results to the MD. Dated initiated and created on12/12/2023; Monitor/document/report to MD PRN s/sx of anticoagulant complications: blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, bleeding, blurred vision, SOB, Loss of appetite, sudden changes in mental status, significant or sudden changes in v/s. Dated initiated and created on12/12/2023. Focus: [CR #1] Has potential impairment to skin integrity r/t decreased mobility and poor oral intake. Dated initiated and revision on 5/11/2024. Goal: [CR #1] Will be free from injury through the review date. Dated initiated and created on 5/11/2024. Target date: 1/6/2025. Interventions: [CR#1] Assist with and encourage turning and repositioning. Focus: [CR #1] I have an ADL Self Care Performance Deficit r/t weakness, CVA, impaired mobility. Dated initiated and created on 11/9/2023. Goal: [CR#1] Will safely perform Bed Mobility, Transfers, Eating, dressing, Grooming. Toilet Use and Personal Hygiene with modified independence through the review date. Dated initiated and created on 11/9/2023. Revision 11/10/2023. Target Date: 1/6/2025. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interventions: [CR#1] Converse with resident while providing care Dated initiated and created on 11/9/2023. Revision 11/10/2023. Target Date: 1/6/2025; Mobility bars for turning and repositioning Dated initiated and created on 1/27/2025; Toilet Use (toilet transfer, toilet hygiene): Requires staff participation to use toilet. Date initiated and created on 11/10/2023. Revision 11/10/2023. Focus: [CR #1] I am at risk for falls r/t left sided hemiplegia from CVA (stroke), impaired mobility (a limitation in a person's ability to move around easily and independently. Dated initiated and created on 11/9/2023. Revision 2/20/2024. Goal: [CR#1] Will not sustain serious injury through the review date. Dated initiated and created on 11/9/2023. Target Date: 1/6/2025. Interventions: [CR#1] Bed in lowest position as resident will allow. Dated initiated and created on 11/9/2023. Revision on 4/21/2024. Record review of the Local Hospital Trauma notes dated 3/4/25 at 7:47am, revealed the following: *Secondary Impressions: Accidental fall, Closed head injury, Frail elderly, intraventricular hemorrhage (serious brain bleed that occurs when blood enters the brain's ventricles), Nursing home resident, Right femoral fracture (also known as a broken bone), Sepsis (infection in the blood), TBI (traumatic brain injury) (brain damage), Transient hypotension 9 (temporary drop in blood pressure), Traumatic subarachnoid hemorrhage (bleeding in the space between the brain and thin membrane): *Resident was brought in by EMS from a nursing home bed for the evaluation of a closed head injury. On examination, the patient is frail, pale, thin malnourished, appearing chronically ill. Contracted left upper extremity. Contracted right lower extremity with the right lower extremely severely exaggerated internal rotation and shortening. Neurovascular intact in all extremities. Neurologically appears to be at baseline. She is screaming articulated normal speech. Localizing pain. Moving all extreme appropriately. She has a traumatic abrasion/laceration to the right supraorbital region (above the eye). Mild ecchymosis (bruise) to the right periorbital region (area around the eye socket). *Radiology of XR Pelvis area revealed, comminuted, minimally displaced right femur intertrochanteric fracture (a break in the bone (femur) just below the hip joint, between the greater and lesser trochanters (an attachment points for muscles) with varus angulation (deformity where the distal segment of a bone is angled inward, toward the midline of the body). *Head CT (imaging): Diffuse subarachnoid (a bleeding that occurs in the space between the brain and the thin membranes that cover it). *Blood tests showed WBC 22.7 (high) and Sepsis. Record Review of Facility's last vitals taken for CR#1: 3/4/2025 Pain taken at 3:07am 0 value 3/3/2025 Blood Pressure taken at 8:19pm 127/69 3/3/2025 Pulse taken at 8:19pm 66 bpm (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2/7/2025 Wts (Weights) taken at 3:51pm 91.2 Lbs 12/2/2024 O2 stats taken at 9:23pm 95.0% 11/12/2024 Temp taken at 3:10pm Record Review of Fall Risk Evaluation completed by LVN A on 3/4/2025 at 6:53am revealed, CR#1 stated was disoriented x 1, has history of falls in the past 3 months, no noted drop in blood pressure, and CR#1 has No Present predisposing conditions of Hypotension, Vertigo, CVA, Parkinson's Disease, Loss of Limb(s), seizures, arthritis, osteoporosis, fractures, Multiple Sclerosis, Wandering. Record Review of Facility's policy dated 05/2007 revealed, a transfer is the safe movement of a resident from one surface to another. FLOOR TO BED 1. Two-person lift a. Preparation 1. Ensure the bed is at a comfortable height and the area is free of obstacles. b. Positioning 1. One person kneels on the side of the resident 2. One person kneels on the opposite side of the resident 3. Support the head, torso, and hips. c. Lifting 1. Both people gently lift the resident off the floor keeping their back straight and using their legs for power. d. Transfer 1. Move the resident to the bed ensuring a smooth and controlled transfer. During an Interview on 3/5/2025 at 2:50pm with WCN stated he heard CR#1 complain her hip was hurting and there was no pain in her head. WCN stated after A completed the assessment, and he ruled out any head injury, he felt it was okay to move resident to the bed. He stated he and LVN A picked CR#1 up and put her in the bed. WCR stated CR#1 sustained a 1cm gash above her, he believes, right eye. WCN stated after CR#1 continued to be complained about her hip he directed CNA C to call 911. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an Interview on 3/6/2025 at 4:00pm with DON, she stated the protocol for unwitnessed fall with injury was staff should alert nurse, complete patient assessment, stay with patient, depending on nursing assessment patient can go out to hospital and MD, family notified. The DON stated staff should not move a resident with a head injury; unless the resident is in a position where additional harm may exist, then the nurses are to use their judgement. The DON stated CR#1 should have been moved to determine what could be done in house until EMS arrives. She further stated CR#1 should have been picked up and placed in bed based on the nursing assessment. She stated CR#1 did hit her head; however, there were no bulging and/or abnormalities to determine if she needed to stay on the floor or moved. DON stated in this case, CR#1 could be moved, after nursing assessments, because there were no abnormalities. During a Follow-up Interview on 3/7/25 3:14pm with WCN who reiterated CR#1 was face down on the floor. He stated there were no bulging or contusion, and CR#1 told him she only had pain in her hip before he moved her. WCN stated CR#1's vitals were checked. He stated CR#1 was about 96% for 02 stats. WCN stated CR#1 was not on oxygen. WCN stated he had given CR#1 aspirin for PRN (Given as needed) for her hip pain. WCN stated, CR#1 was lifted by her head and legs. When asked who assisted him in lifting CR#1, he stated, I lifted with a black girl. He stated he had upper body, and the CNA had the feet area. WCN stated CR#1 complained of hip pain, but he moved her anyway. WCN stated he should not have moved her. WCN stated he could have furthered injured resident and fractured her hip when he moved her. WCN stated he has had Unwitnessed Fall Training, which consist of reporting, vitals, documentation, neuro checks, contact family, MD, and DON. During a Telephone Interview on 3/7/25 11:59pm with LVN A -. LVN A stated another lady got CR#1 off the floor. She stated One of CR#1's legs was bent under the other. Stated her leg was folded. Not sure if it was a fixed position. Believes it was a left leg under the right folded at a 45-degree angle. LVN A stated she believe the CNA that assisted WCN was CNA D. During an Interview on 3/8/2025 at 6:15am with CNA D stated she just helped the WCN pick CR#1 up off the floor, she was doing patient care on another resident. She stated CNA B came and got her and said CR#1 was on the floor. CNA D was leaving room [ROOM NUMBER] and then went to resident room and CR#1 was on the floor. CNA D said CR#1's head was at the headboard and her feet were at the floorboard and CR#1 was laying on her side right side, but head was on the floor. CNA D stated WCN had CR#1 from the shoulders and CNA D had her legs. Before picking her up he checked temp, blood pressure and asked her what day it was. She picked her up and then walked out, she couldn't see her like that. She stated CR#1 said she needed cream for her right hip, but she says that every day. CNA D noticed that her hip looked like it was out of place, after she got her in the bed, she said it looked like something was wrong with her hip. Her leg was just limp. She told WCN that and he had CNA C call 911. It was the WCN's idea to pick her up off the ground. She said she didn't realize the hip looked like that until they got her in the bed. She said she didn't think she could have injured her she had her ankles. WCN's arms were under CR#1's arm pit cradled, and CNA D had her ankles. The bed was low. CR#1 did not have a scoop mattress. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an Interview on 3/8/2025 at 6:54am with ADON he stated no one should ever move a resident unless assessment determines no harm was done. ADON stated he does not have x-ray vision so he would ask the resident about pain and if resident says no pain, then its ok, but if the resident says they have hip pain, that resident should not be moved and staff would want call ambulance, because a stretcher would stabilize the resident. You don't want to further injure the resident. ADON stated every resident that hits the floor doesn't mean that they fractured something. He stated that what's included in an assessment, is pain level, resident alertness, bleeding, bruising, anything new scarring skin tears. All vitals, blood pressure, pulse, oxygen, blood sugars, O2 sats and temperature should be documented in the computer (PCC-Nursing Notes). ADON stated if it's not documented it's not done. During a Telephone Interview on 3/8/25 at 7:00pm with DON- stated a head-to-toe assessment was for emergency situations was to assess the resident for pain or injury, alertness, consciousness, abnormalities, broken bones, bleeding, and breathing. The DON stated she was notified of CR#1's fall at 6:31am. The DON stated the proper way to move the resident off the floor is to ensure resident and staff are not injured during the move. She stated two people must pick up a person from the floor. The DON stated staff were to make sure patient is secured from floor to bed, the upper body, lower body should be secured. The DON stated when picking up residents you are not to grab them by their clothing or ankles. She stated the lower body was described as grabbing the resident under their bottom and the other hand supporting their legs and lifting them up. The upper body was supporting their head and back. She stated sometimes during a residents' fall, getting a Hoyer lift may create more time for transporting resident off the floor. The DON stated that based on what the nurses told her during CR#1's assessment, she would not do anything differently. She stated she also spoke with the Medical Director and the doctor was also in agreement with nursing staff's actions. An Immediate Jeopardy (IJ) was identified on 03/27/2025 at 4:34 p.m. While the IJ was lowered on 03/29/2025 at 3:30pm, 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 identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. Name of facility: [Facility Name] Date: 3/6/2025 Tag: F-689 Problem: The facility failed to ensure the resident environment remain free of accident hazards as is possible and residents receive adequate supervision and assistance when being transferred. The fill of solidity fell to properly transfer CR #1 from the floor causing an injury and being hospitalized . Immediate Action: (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Medical director was notified of IJ on 3/27/2025 at 6:16 PM by Executive Director 2. What to do when a resident falls, including when and if to transfer was reviewed by Medical Director, DON, and ED with no changes made 3/27/25 (see attached) 3. Education initiated with all nursing staff by on what to do if a resident falls to include if and when to transfer on 3/27/2025 by DON, ADON, Clinical Resources and Cluster Nursing Leadership completion date 3/28/2025. 4. All falls were reviewed by clinical resource 3/28/2025, no negative outcomes were identified. (See attached) 5. All nursing staff will complete competency post on what to do if a resident falls to include when and if to transfers started on 3/27/2025. Completion date 3/28/2025 6. Education initiated on transferring a resident from the floor to the bed to all nursing staff by therapy department with all nursing staff 3/27/25. Anticipated completion date 3/28/25. 7. All Nursing staff will complete a competency (return demonstration) on transferring a resident from the floor to the bed initiated 3/27/25 Anticipated completion date 3/28/25. 8. This training and competencies will be completed in person with all staff prior to the start of their next shift. A member of management will be at the facility at each change of shift to ensure all staff completed training prior to going to work on the floor. Staff will not be allowed to work unless they have completed the training and competency checks. This training will also be included in the new hire orientation and will be included for any PRN staff prior to starting work on the floor. These will not be allowed to work unless they have received their training and knowledge check. 9. And ad hoc meeting regarding items in the IJ template will be completed on 3/28/2025. Attendees will include the Medical Director, Clinical Resource, Administrator, DON, ADON, Clinical Resources and will include the plan of removal items and interventions. 10. DON/ADON/Designee will verify staff competency with staff weekly using what to do when a resident falls to include when and if the transfer (case scenarios) 11. The summary of the IJ and corrective actions to be reviewed by QAPI committee x 4 weeks or until substantial compliance established and continuing monthly for 90 days to ensure ongoing compliance. During an interview on 3.28.25 at 4:00pm with the DOT it was revealed she has completed therapy training with the first and second shift staff, LVN, ADON, DON on the proper way to transfer a resident off the floor into the bed. She states she went over the initial policies of finding a resident on the floor, calling for a nurse, after the assessment and getting permission, the resident should be picked up by at least 2 people, The head, neck, torso, and legs should be secured. It is not advisable to pick someone up by their ankles. She stated the legs, at the mid knee area is where someone should start. Staff must bend their knees when lifting to ensure no injuries. 3.28.25 at 5:25PM POR for F689 Accepted and Monitoring began at 5:30PM (continued on next page)

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	676251	A. Building B. Wing	03/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3.28.25 at 5:30PM monitoring began interviewing facility staff employees, (ADON B; CNA's C, H, I, L,O, P, M, N; DON; LVN's C, D, E, and N; RN's B, C and D) revealed, each were interviewed and completed online continuing education training in all areas of patient care with Relias (internet training); Train the Trainer for ADON's by the pharmacist; protocol for resident unwitnessed falls and head to toe assessments, transferring resident from the floor to the bed or wheelchair properly, completing training on falls by using posttest and demonstrating the proper way of transferring resident from the floor. During a Follow-Up Interview on 3.29.25 at 3:10 PM with DON revealed in-services will be monitored by utilizing cluster partners (other facility's under same corporate office) who will come out to the facility and conduct random interviews with staff. Continuous QAPI discussions. DON stated she conducted the in-service 12 medication administration training and found that staff needed updates. She stated there were some rights added as when she started in the nursing field there were only 5 medication administration rights training. The DON stated the MAR and TAR will be monitored by running daily reports to ensure proper documentation with confirmation of new medications. The reports will be daily with or without her working at the facility. The DON stated the system she will use to verify staff competencies would be audits, random questioning, and return demonstration (having staff give examples). The DON stated the most important thing learned from these citations was documentation is a big key in success and failure, and she learned more about staff weakness and strengths. 3.29.25 at 3:30pm IJ Lowered: 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 identified as isolated due to the facility's need to evaluate the effectiveness of the corrective systems. During an interview on 3.29.25 at 4:45PM with Administrator- He stated the IJ's have taught him to look at processes and that documentation needs to be specific and completed on time. He stated more awareness is being put in place to ensure the documentation is appropriate along with ensuring in-service training is continuous in areas of resident care. The DON will view all documentation by running daily reports and confirming new medications.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47277 Based on interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure accurate acquiring, receiving, dispensing, and administering of all drugs to meet the needs of each resident for CR#1 & CR#2 of 8 residents reviewed for pharmacy services. The facility failed to ensure CR #1 received his medication as ordered when WCN administered non-scheduled aspirin without an order when CR #1 had a known head injury. The facility failed to ensure CR#2 recevied his IV antibiotic medication as ordered by the physician. An Immediate Jeopardy (IJ) was identified on 03.27.25 at 4:34 p.m. While the IJ was lowered on 03.29.25 at 3:30pm, 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 identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. These failures could place residents at risk of receiving inadequate treatments or results or ingesting medications for which they were not prescribed and ineffective therapeutic outcomes by not documenting when medications were given or not given. Findings included: Record review of CR#1's face sheet dated 11/8/2023 reflected an [AGE] year-old female, with an original admitted [DATE]. Her diagnosis included: Cerebral Infarction of the right middle cerebral artery (stroke), hypertension (high blood pressure) and gastro-esophageal (digestive disorder). Record review of CR#1's Quarterly MDS dated [DATE], revealed the following: CR#1's BIMS score of 06 (severe cognitive impairment), CR#1's Functional Limitation in Range of Motion indicates an impaired Upper and Lower Extremities, uses motorized wheelchair, is dependent on staff for all of her ADL needs, including, rolling to left and right; has had no fall history. Record review of CR#1's orders dated 11/8/2023 revealed, CR#1 was prescribed Aspirin 81 Oral Tablet chewable (No order for aspirin to be used as a PRN pain medication). Give 1 by mouth one time a day for blood clot prevention. Start date 11/9/2023; Apixaban (blood thinner) dated 11/8/2023. Record Review of Medication Administration policy dated 05/2007 reveals the following: 2. Medications must be administered in accordance with the written orders of the attending physician. NOTE: If a dose seems excessive considering the resident's age and condition, or a drug order seems to be unrelated to the resident's current diagnosis or condition, the nurse should contact the physician. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. All current drugs and dosage schedules must be recorded on the resident's electronic medication administration record (MAR). 8. Unless otherwise specified by the resident's attending physician, routine medications should be administered as schedules. 10. The nurse administering the medications must initial the resident's electronic MAR, on the appropriate line and date for that specific day. Record Review of nursing notes written by WCN dated 3/4/2025 at 8:27am, revealed, Resident observed lying on the floor feet facing foot bed, vitals taken, pain assessment made, head to toe assessment performed. Resident vitals 180/90 P-76 C/O pain from hip. PRN aspirin administered, resident noted with cut by right eye, EMS services immediately contacted, skin tear on left arm. Resident was not aware of how they ended up on the floor, seen by wound care physician, wounds cleansed, with wound cleanser, cut medicated with collagen powder, ST addressed with xeroform and dry dressing. RP notified; Dr. notified. During the follow-Up Interview on 3.26.25 at 5:08pm with DON revealed she did not know CR#1 had sepsis prior to her hospitalization . She stated labs were not necessary because CR#1 never exhibited any symptoms that would be a cause for labs. DON stated because of the lack of symptoms, nursing staff did not monitor for signs or symptoms of sepsis. The DON stated labs are only ordered for someone in CR#'1's condition (CVA, Anticoagulants) when there are indicators like when there is a change of condition. DON stated when medications are administered, nursing staff must follow physician orders. She stated WCN gave CR#1 and aspirin (PRN) because it was for pain. The DON stated she spoke with the facility's medical director and CR#1's physician and was informed that CR#1's outcome would not have changed her injuries. CR#2 Record review of CR#2's undated face sheet revealed a [AGE] year-old male initially admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE] with a diagnosis of anemia (iron deficiency), hypertension (high blood pressure), Renal failure (kidneys lose the ability to filter waste), Obstructive uropathy (urinary tract disorder); Dementia (decline in cognitive abilities), seizure disorder (abnormal brain signals). Record review of CR#2's Quarterly MDS dated [DATE], revealed the following: CR#2's did not have a BIMS score, which indicates a severe cognitive impairment; CR#2 uses a wheelchair; dependent on staff for toileting, showering, and getting dressed; totally dependent on staff for sitting and lying in bed; CR#2 is always incontinent for urinary. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#2's orders dated, 2/13/2025 for Trileptal oral tablet 300 MG give 1 tablet by mouth two times a day for status epilepticus (start date 1/26/2025 at 5:00pm); Apixaban Oral Tablet by mouth two times a day for anticoagulant for 30 days (start 2/18/2025 at 8:00am); Apixaban Oral tablet 5 MG give 2 tablet by mouth two times a day of Anticoagulant for 3 days (start date-2/14/2025); change intravenous tubing with new IV bag every day shift (order date 1/26/2025 at 10:20am-D/C dated 2/26/2025 at 12:20am); Meropenem intravenous solution reconstituted 1 GM-Use 1 gram intravenously one time a day for UTI for 9 days (order date 1/24/2025 at 7:14pm); Midline care: Change Central Line/Mid line dressing Q 7 days if visible for assessment. Change dressing PRN if wet, soiled, saturated or loose every day shift every 7 days (order date 1/26/2025 at 10:20am-D/C dated 2/13/2025); Mid line flushing: Flush with 5cc 0.9% NS IV solution before and after each med administration every day shift (order date 1/26/2025-D/D dated 2/14/2025); Tombramycin Sulfate Injection Solution 80 MG/2ML_use 4 ml intravenously one time a day every Mon, Wed, Fri for give after HD SEND WITH RESIDENT TO HD. THEY CAN ADMINISTER THERE (order datre 2/13/2025 4:29pm - D/C dated 2/14/2025 at 12:53pm); Cefdnir Capsule 300 MG_Give 1 capsule by mouth two times a day for infection for 7 days (order date 2/26/2025 at 0022); Insert peripheral IV one time only for IV antibiotics until 2/14/2025 11:59pm (order date 2/14/2025 at 7:11pm). Record review of CR #2's care plan dated, revealed the following care areas: Focus: [CR#2] has renal insufficiency r/t CKD stage 5 Hemodialysis 3X/WEEK EVER MWF. Created and initiated on 8/6/2024 and revision 2/24/2025. Goal: [CR#2] will be free from infection through the review date. Date initiated and created 8/6/2024, Target date 1/21/2025. Interventions: [CR#2] Monitor and report changes in mental status: lethargy; tiredness; fatigue; tremors; seizures. Date initiated 8/6/2024. Focus: [CR#2] has a Urinary Tract Infection. Date initiated, created and revised on 1/29/2025. Goal: [CR#2] Urinary tract infection will resolve without complications by review date. Date initiated and created 1/29/2025. Target date: 1/21/2025 Interventions: [CR#2] Give antibiotic therapy as ordered, Monitor/document for side effects and effectiveness. Created 1/29/2025; Monitor/document/report to MD PRN for s/sx of UTI: Frequency, Urgency, Malaise, foul smelling urine, dysuria, Fever, nausea and vomiting, flank pain, Supra-pubic pain, Hematuria, Cloudy urine, Altered mental status, Loss of appetite, Behavioral changes. Date initiated 1/29/2025; Obtain vital signs as ordered. Focus: [CR#2] At risk for impaired cognitive function/dementia or impaired thought processes r/t dx of Dementia, metabolic encephalopathy (serious neurological condition when the brain is damaged). BIMS score of 6 (Severe Impairment). Date initiated 7/19/2024 and revision on 8/6/2024. Goal: [CR#2] Will maintain the level of cognitive function through the review date. Target Date: 1/21/2025. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: [CR#2] Communicate with family/caregivers regarding residents' capabilities and needs; Discuss concerns about confusion, disease process and alternative placement with family/caregivers; monitor/document/report to MD any changes in cognitive function, specifically changes in: decision understanding others, level of consciousness, mental status. Date created 8/6/2024. Focus: [CR#2] ADL Self Care Performance Deficit r/t impaired mobility, dementia. Created 7/19/2024 and Revision on 8/6/2024. Goal: [CR#2] Will safely perform Bed Mobility, Transfers, Eating, Dressing, Grooming, Toilet Use and personal hygiene with modified independence through the review date. Target date 1/21/2025. Interventions: [CR#2] Discuss with resident/family POA care any concerns related to loss of independence, decline in function; Monitor/document/report to MD PRN any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function; Skin Inspection: Requires SKIN inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. Focus: [CR#2] Has bowel/bladder incontinence r/t Dementia, History of UTI, Impaired Mobility. Created and initiated on 8/6/2024. Goal: [CR#2] Risk for septicemia will be minimized/prevented via prompt recognition and treatment of symptoms of UTI through the review date. Target date: 1/21/2025. Interventions: [CR#2] Monitor/document for s/sx UTI: Pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Initiate and Created 8/6/2024; Monitor/Document/report to MD possible medical causes of incontinence bladder infection, constipation, loss of bladder tone, weakening of control muscles, decreased bladder capacity, diabetes, Stroke, medication side effects. Date initiated 8/6/2024. Focus: [CR#2] I am resistive to care will not allow staff to dress change, shower, and is refusing medication. CR#2 pulled out midline 1/28. Dated initiated 7/22/2024 and revision 1/29/2025. Goal: [CR#2] Will cooperate with care through next review date. Target 1/21/2025. Interventions: [CR#2] Allow to make decisions about treatment regime to provide a sense of control; educate resident/family/caregivers of possible outcome(s) of not complying with treatment care; encourage as much participation/interaction by the resident as possible during care activities. Initiated 7/22/2024. Focus: [CR#2] Potential for a behavior problem r/t not drinking water, only consuming coffee and eating sugar packets. Educate provided on the need for water consumption. Goal: [CR#2] Will have fewer episodes by review date. Created and initiated 11/15/2024. Target 1/21/2025. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interventions: [CR#2] Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Created 11/15/2024. Focus: [CR#2] Potential to demonstrate physical behaviors r/t Dementia; I have a habit of unplugging items to conserve energy. Date initiated and revision 1/10/2025. Goal: [CR#2] Will demonstrate effective coping skills through the review date. Target 1/21/2025. Interventions: [CR#2] Assess and address for contributing sensory deficits; provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated; Document observed behavior and attempted interventions; Monitor/document/report to MD of danger to self and others. Date initiated 1/10/2025. Focus: [CR#2] At risk for falls r/t hx of falls, impaired mobility. Initiated 7/19/2024. Revision 8/6/2024. Goal: [CR#2] Will be free of falls through the review date. Target: 1/21/2025 Interventions: [CR#2] Be sure call light is within reach and encourage to use it to call for assistance as needed; Falling star program; Keep items, water, etc, in reach. Focus: [CR#2] CR#2 had an actual fall related to poor communication/comprehension: 12/18/2024: Fall with no injury; 12/22/2024: Fall with no injury. (Created 11/19/2024. Revision on 2/24/2025) Goal: [CR#2] Will resume usual activities without further incident through the review date. Target 1/21/2025. Interventions: [CR#2] Psych consult (Continue interventions on the at-risk plan. Focus: [CR#2] Has potential for pressure ulcer development r/t impaired mobility. Dated initiate 7/19/2024; Revision 8/6/2024. Goal: [CR#2] Will have intact skin, free of redness, blisters, or discoloration by/through review date. Target 1/21/2025. Interventions: [CR#2] Weekly head to toe skin at risk assessment. Initiated and Created 7/19/2024. Record Review of hospital discharge summary dated 2/13/2025 revealed, instructions for administering the medication through catheter every other day. Give after HD for 3 sessions Monday, Wednesday Friday. Record Review of nursing notes dated 2/17/2025 at 1:12pm by LVN D revealed, attempted to put IV line in CR#2 to receive post HD medication. CR#2 refused. Will try again upon return. Record review of nursing notes dated 2/17/2025 at 1:12pm by LVN D revealed an attempt to put IV line in resident to receive post HD medication. Resident refused. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of nursing notes dated 2/18/2025 at 10:11am by LVN D revealed, CR#2 continues to refuse IV insertion. NP contacted for other options. Awaiting reply. Record Review fax dated 2/20/2025 at 1:30pm from ADON to dialysis, revealed CR#2 face sheet, diagnosis, hospital orders and hospital discharge instructions. Record Review of nursing notes dated 2/24/2025 at 11:55am by ADON revealed dialysis called in regards of tobramycin IV CR#2 is to receive x3 doses after dialysis. Facility stated fax received and antibiotics on order. Record Review of nursing notes dated 2/24/2025 at 1:42pm by RN revealed CR#2 leaving for dialysis via EMS, vitals stable BP 110/62 T 98.4, HR 88 RR 18. Orientation at baseline CR#2 stated he was tired. No signs of distress noted. Record review of nursing notes dated 2/25/2025 at 12:14pm revealed CR#2 lethargic, temp of 100.3 NP notified. New orders given for Rocephin injection, labs, cxr. 02 at 2L NC. FM at bedside. 650 mg of Tylenol given for fewer per NP. COC complete, labs drawn, results pending. Change of Condition: Symptoms or signs noted of condition change: Abnormal vital signs (low/high BP, heart rate, respiratory rate, weight change) Altered mental status. Vital signs on 2/25/2025 revealed the following: BP 103/54 - 2/25/2025 at 1:13 sitting l/arm P76 -2/25/2025 at 1:13 R 18.0 2/25/2025 at 1:13 T 98.3 2/25/2025 (Forehead) at 1:13 02 92% 2/25/2025 at 1:12 Method: Oxygen via Nasal Cannula Record Review of nursing notes regarding CR#2's last vitals taken below: O2 Stats: 2/26/2025 at 9:45am 92% Oxygen via Nasal Cannula Pain Level: 2/24/2025 at 9:06pm O value Numerical Respiration: 2/26/2025 at 9:45am 32 Breaths/min Pulse: 2/26/2025 at 9:45am 75 bpm regular Blood Pressure: 2/26/2025 at 6:53am 12//65 Lying arm; 2/26/2025 at 9:45am 140/72 Lying arm. Weights: 2/18/2025 at 9:56am 200.4 lbs. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing notes dated 2/26/2025 at 12:14am revealed CR#2's Xray results: Bilateral Interstitial infiltrates, concerning for edema vs PNA, nonspecific: Reported to On-Call N/O: Lasix 40mg QD x 3 days Cefdinir 300 mg BID x 7 days Record review of nursing notes dated 2/26/2025 at 9:46am by ADON, revealed Medical Director given the results of the Xray and lab results and ordered CR#2 to be sent out to ER for further work up. Record review of CR#2's report from hospital revealed the following report dated 2/26/2025: CR#2 arrived at the hospital at 9:43am via, EMS. O2 Flow rate (l/min) 4 l/min 02 Delivery Method: Nasal Canula. Vitals: BP: 137/67 Pulse: 76 Resp: 16 Temp: 102.5 F (39.2 C) Temp src: Temporal GCS Total: 12 Blood Glucose Meter (mg/dl): 158 ECG Performed: Yes (NSR) (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephoned Interview on 3/4/25 at 10:02am with FM stated CR #2 is no longer able to walk, talk, eat or swallow because of sepsis in his blood from having a serious UTI that the facility would not ensure he received his medicine for. FM stated her Resident #2 came to the facility because of his chronic UTI and Infusion (antibiotics through IV). She stated her Resident #2 had a picc line (a thin, flexible tube inserted into a vein near the heart), which is where the antibiotics were administered by a nurse. She stated the UTI is a chronic issue for CR #2. FM stated CR #2 did not have sepsis when he was released from the hospital February 13, 2025. FM stated she came to the facility Tuesday February 25, 2025, at 9:00am. Stated she gave CR #2 a kiss on his forehead and his eyes were rolling in the back of his head. She spoke with the nurse at this time. She stated she was a little irritated that the nurse didn't know he had a temperature but did not checked vitals. She stated ADON A came to the room and the nurse was finally getting the temperature. She stated the nurse took Resident #2's temperature and it was 102.8 and he appeared to be lethargic. At this time, she requested CR #2 to be put on oxygen. She stated CR #2 had received orders when he was released from the hospital on February 13, 2025, for antibiotics due to his UTI. FM stated at this time she was informed by the ADON A, that the medication (Tobramycin) for his UTI that was ordered on February 13, 2025, was never administered, and had expired because the Dialysis never gave it to him per hospital orders. FM stated this negligence caused CR #2 to have a more serious UTI and infection in his blood. FM stated ADON A told her the dialysis people were supposed to give the anti-biotics through the picc line, but they hadn't as of this date. She further stated the ADON A told her the medication had expired; however, due to CR #2's fever, ADON A administered a medication called, Rocephin (used for infections). FM stated after being administered the shot CR #2 immediately broke out into a profuse sweat all over his body. The ADON A told her that CR #2 was breaking his fever and that the sweating was okay. FM stated she's not sure how long CR #2 had been in this feverish lethargic condition. She stated facility sent CR #2 out to the hospital early that morning and never called her to even ensure he was sent out. She stated CR #2 had fallen a few weeks ago and now he has seizures. She stated CR #2 was in ICU a few weeks ago before he was released from the hospital, he now has had dialysis and he had the dialysis port, which is how the medication for his UTI was to be administered. FM stated the ADON told her that CR #2 would get antibiotics in the dialysis, but failed to tell her Dialysis never gave him the anti-biotics. She stated now the infection has spread from a UTI to Blood Infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676251	A. Building B. Wing	03/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr Houston, TX 77070

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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 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an Interview on 3/4/25 at 2:44pm with ADON stated CR #2 was sent to hospital because he was lethargic. He stated there was an order for Tobramycin, an antibiotic for the UTI, which was identified through labs while at the hospital. ADON A stated CR #2 returned to facility from hospital on 2.13.25. The CR #2 also returned from hospital with and order to be given 3 doses of tobramycin over the next 3 dialysis services which was to be administered after dialysis session, starting February 14, 2025. The ADON A stated he personally sent the medication to dialysis, along with the order from hospital. He stated he did not know that the initial dose was not administered to CR #2 until he went into the medicine refrigerator on February 17, 2025, to retrieve CR #2's second dose. At this time, he stated he seen the initial dose from February 14, 2025. He stated he immediately called Dialysis and was informed that their protocol was to receive an email from the hospital, and they would fill the medication through their own system. The ADON A stated they further told him that they are not allowed to accept medication. ADON stated resident had been without the medication for a week and he wasn't getting any antibiotics during that time. He stated he called the doctor. Stated the Dr stated to send the order to dialysis, but ADON A told her that they refused to administer. At this time, he was given an order from the NP to put an IV in Resident #2's arm so facility nurses could administer the antibiotic. He stated on February 17, 2025, at 1:13pm, attempted prevention measures by trying to put an IV in Resident #2's arm and he refused on 2/17/25 at 1:13pm and again on 2/18/25 at 10:11am. The ADON A stated with Resident refusal for the IV port, the medication expired. ADON A stated he received an order from the NP to administer the Rocephin 1mg and Tylenol 650. He stated he was not aware that Resident #2 began to sweat profusely. He stated Resident #2 was talking to his FM during this time. The ADON stated on 2/20/2024, he faxed the order to dialysis in hopes of them filling the Thrombosis prescription. He stated he called dialysis to let them know he just faxed the order and was told they did not have the medication and it would take 7-10 to get it. During an Interview on 3/5/2025 at10:00am with HAP- HAP stated CR #2 had an admittance from February 5, 2025 and discharged on [DATE]. HAP stated on February 6, 2025, CR #2 labs showed he had a bacteria called pseudomonas, which is why he was prescribed Tobramycin. He stated there was an order for the medication to be administered by dialysis staff after his procedure. The antibiotic was for three doses. He stated the medication should have been given by the dialysis staff through the dialysis IV port, not the facility staff. He stated that according to the records, on February 11, 2025, at 10:00am, dialysis was set up by the hospital social worker. At this time, the order was given to the dialysis staff. HAP stated that there must have been a mix-up in the communication between the hospital, dialysis, and the facility. However, he stated that the attending physician at the nursing facility should've figured it out even if CR #2 was sent back to the hospital to get the medication. This medicine was extremely important as the resident had an active bacterium. HAP stated CR #2 return to the hospital, February 26, 2025, and he now has a different bacteria called Staphylococcus Aureus. The order for Tobramycin would not have been affective for CR #2 anyway. Therefore, the resident, even if he had taken, the order would not have gotten better because he had a different bacterium. Doctor indicated that both bacteria are more healthcare bacteria, where they are contracted in healthcare rehab facilities. During an Interview on 3/5/25 at 12:10pm with Dialysis CNM who stated he was made aware CR #2 was to receive 3 doses of Tobramycin; however, dialysis did not receive any notification from the hospital which is protocol. CR #2's first dialysis appointment was 2/14/2025. States the order was sent with medication and they don't take orders from other doctors. He also stated there was no medicine on hand at this time. He stated he received a fax order from the facility on February 20, 2025, and the medicine arrived at the Dialysis center on February 28, 2025. He stated they have no records of the orders from the hospital on 2/11/2025. (continued on next page)

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Misty Willow Healthcare and Rehabilitation Center	12921 Misty Willow Dr Houston, TX 77070

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an telephone Interview on 3/9/2025 at 11:19am with FM - Stated she received a call from a doctor at the hospital who told her that based on CR#2's wounds he would require surgery to insert a rectal tube. She stated the doctor reiterated CR#2's should be strongly considered for Hospice due the wound and blood infection. During a follow up Interview on 3/10/2025 at 9:45am with FM - who stated the facility never called and say CR#2 was refusing medication. The facility would call FM when he needed a shower and was refusing, then family would talk with CR#2 and CR#2 would comply. During a follow-up Interview on 3/11/2025 at 10:00am with FM stated the facility has always called her or another family member whenever CR #2 would refuse showers. She stated either of them would come to the facility and assist staff in giving Resident #2 his showers. FM stated this has happened on at least two occasions. She stated other times the facility had called was when CR #2 was walking and naked and pee, poop, and urine everywhere in the middle of the night. The facility called FM. However, FM stated she never received a called saying there was any problem getting the meds thru dialysis or that CR #2 had refused his med. She stated when she was informed by the facility that CR #2 hadn't had his medicine from dialysis, she went to the dialysis to speak with someone. FM stated Dialysis told her that they had already explained to the nursing facility they could not administer that kind of medication, so they would have to get another kind of med. During this time, FM stated CR #2 had already missed all 3 doses of his medication and at this time he was not talking, his fever was 102, and his forehead was hot, yet the ADON stated he was ok. FM stated the ADON told nurse to go get meds so they can start administering medications for his infection. The ADON administered Rocephin medication, which he gave a shot in the buttocks area. FM stated ADON asked her to hold CR #2 while he administered the shot because it would typically burn. FM stated she tried getting him to eat doughnuts, but CR #2 would only open his mouth but could not chew. FM stated the ADON informed her that CR #2 had a sacrum wound. FM stated CR #2 had never had a wound prior to admittance to this facility. She stated had she known CR #2 had a wound she would not have left him in the facility. She found out about the wound Tuesday February 24, 2025, and he was sent to the hospital on Wednesday February 25, 2025. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/11/25 at 10:50am with NP - Confirmed CR#2 was his resident when CR#2 was in the facility. NP initially stated he didn't' know why CR#2 was given the medication to be administered at dialysis, then stated, I think it was an antibiotic because CR#2 had recurring UTI's. NP confirmed the medication should have been administered to CR#2 while at dialysis. He stated it was an IV medication to be administered in the dialysis port and the dialysis people know how to administer it. If the medication was given at facility, it will be washed out by dialysis procedure, which is why the nephrologist always want to administer at dialysis. However, NP stated dialysis did not carry the medication, and they refused to give the medication that accompanied CR#2 from NF. He stated at this time he was informed that CR#2 had missed one dose. NP stated he informed the nursing facility staff to reach out to the nephrologist to see if they could order another medication or something else that they had since CR#2 was not getting the medication he should be getting for an infection. He stated the nephologist was the physician who originally ordered the medication and staff needed to follow up with them. The NP stated at this time he assumed the facility had reached out to the nephrologist as directed and they were given a different type of medication. NP further stated he directed staff to put in a Peripheral IV only with nephrologist approval to give medication. He stated nursing staff can't just put line on dialysis patient without nephrologist approval. NP stated nursing staff could have either got the medication changed or administer themselves through a midline (a thin tube inserted into a vein), but they needed to consult with nephologist first. NP stated the facility never called him back afterwards with any results, so he assumed the medication was either changed or given. NP stated facility staff did not report any clinical symptoms that CR#2 had an untreated infection, no fever no chills reported, and no change in mood. He stated there was nothing reported to him that would indicate CR#2 had an untreated infection. NP stated he received a second telephone call from the facility indicating CR#2 had a symptom but couldn't recall what it was. He stated the exact time he was notified by nursing staff would be in the nursing notes, because he couldn't remember. He stated he knew he was not getting it, but don't know how many doses were missed at that time. NP stated he thought he ordered a dose of Rocephin, which was an antibiotic that would treat CR#2 symptoms for 24-48 hours and directed nursing staff to monitor vitals, and report to him any changes of conditions. NP stated he would have not advised staff to send CR#2 out to the hospital unless his vitals and symptoms worsen after given Rocephin. NP stated he was not saying to wait for a problem before doing something, but 24-48 hours would have been a good time to see if medication from nephologist could be changed. NP stated he reinforced instructions to facility staff to follow-up with nephrologist. He doesn't know if the nephologist ordered anything else. NP stated hospitals expects certain levels of care from nursing facilities then just always sending residents out without doing a full work up. He stated hospitals diagnose and do interventions, but they expect nursing facilities to treat residents as much as they can. He stated nursing should report any other change of condition to him. NP stated a lot of things that could happen when a resident's medication for infection isn't administered. He stated lethargy on dialysis patient could be caused by conditions other than sepsis. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an Interview on 3/11/2025 at 11:54 am. with DON stated she knew on Friday, February 14, 2025, that the facility was sending abx with CR #2 to dialysis. DON stated she was at a function with other administrative staff and was not in the facility the week of February 17, 2025, but to her understanding she did not give any additional order, just waiting for dialysis to obtain the meds. DON stated she did know on Friday February 14, 2025, CR #2 did not get his medication. She stated ADON informed her on Monday February 17th, 2025, he was sending the orders to dialysis center. DON stated she never spoke with the nephrologist concerning CR #2 not getting his medication. She stated when a resident does not get prescribed antibiotics there is a potential to go septic (life threatening condition that occurs when a body-wide infection causes dangerously low blood pressure and organ damage). DON stated CR #2 situation was unique because the order was for dialysis to administer the medication and not the facility. DON stated CR #2's physician was Medical Director for the facility and was also aware of what was going on. She stated the nursing notes noted CR #2's change of condition. The DON stated she understood that there was an attempt to start IV on Resident #2 in the facility, but CR #2 refused the IV. DON feels staff were communicating and following up with Resident #2's doctor, but unsure if staff painted a clear enough picture of everything they did as far documentation goes. During a Telephone interview on 3/11/25 at 1:55pm with Medical Director revealed, she was aware of the issues surrounding CR #2 and his medication. She stated staff was in constant contact with the Dialysis and informed the Nephologist is the prescribing doctor over that department and ordered the medication. She stated without the medication a resident could present confused, infection. She further stated the facility attempted to initiate an IV in CR#2's arm and he refused. An Immediate Jeopardy (IJ) was identified on 03.27.25 at 4:34 p.m. While the IJ was lowered on 03.29.25 at 3:30pm, the facility remained out of compliance at the severity level of no actual harm with potential for more tha [TRUNCATED]