

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Forest Park Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 Harry Hines Blvd Dallas, TX 75235	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, interviews and record reviews, the facility failed to immediately consult with the resident's physician when there was a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) for one (Resident #1) of eight residents reviewed for change in condition. LVN A failed to contact Resident #1's Dr. on 06/08/24, for his drastically decreased BP and he was not transferred to the hospital until 06/09/24. Subsequently, Resident #1 was currently at the hospital diagnosed with septic shock and on a ventilator machine (mechanical life support). An Immediate Jeopardy (IJ) was identified on 06/13/24. An IJ Template was provided to the facility on [DATE] at 10:00 am. While the Immediate Jeopardy was removed on 06/14/24 at 5:00 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with the potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. This failure could place all residents at risk of not being assessed and treated in a timely manner and appropriately, with PA/MD interventions, which could result in a decline in their health and psycho-social well-being or death. Findings included: Record review of the facility's census revealed they had 114 residents. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a male who admitted to this facility 08/03/23 with a BIMS Score of 10 (moderate cognitive impairment). He had 1 sided upper extremity impairment and 2 sided lower extremity impairment and substantial maximal assist with ADL's. He was frequently incontinent to bladder and always incontinent to bowel. He had medically complex conditions with diagnoses anemia (low red blood cells and hemoglobin), hypertension (high blood pressure), peripheral vascular disease (circulatory condition/reduced blood flow). And he had diagnoses renal insufficiency (kidney failure), diabetes mellitus (high blood sugar), hyperlipidemia (high level fat particles), malnutrition (lack of nutrients), depression (lowered mood), and generalized muscle weakness (muscle weakness). (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Order Summary Report dated 06/12/24 revealed orders for: regular diet with thin liquids, 2.0 supplement 120cc 3xd, Amlodipine besylate oral tab 10 mg, 1-tab 1xd for HTN, hold SBP <110, DBP <60, HR 60, and Ondansetron HCl (hydrochloride) Oral tab 4 mg 1 tab by mouth every 6 hours as needed for nausea and vomiting, etc. Record review of Resident #1's Care Plan printed 06/12/24 revealed, date initiated: 08/08/23: dialysis due to chronic kidney disease, altered respiratory status/difficulty breathing related to history of respiratory failure, impaired cognitive function or thought processes. And had bladder incontinence, communication problem and dialysis and diabetes. Date initiated: 01/25/24: potential for fluid overload related to kidney failure: will remain free of signs/symptoms of fluid overload through review date, as evidenced by . changes in mood or behavior, nausea/vomiting . Monitor/document/report to MD PRN signs/symptoms of fluid overload. Hypertension related to Norvasc - Oral. Date Initiated: 08/09/2023, Revision on: 08/09/2023: will maintain a blood pressure within the following parameters: (110/60) through review date. Revision on: 03/03/2024, Target Date: 07/21/2024. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow Record review of Resident #1's Progress note by LVN A dated 06/08/24 at 9:13 am revealed, Resident noted with abnormal vital signs: BP 93/44, O2:88% room air . Weakness, vomiting, poor eating. Resident offered 120 ml of orange juice, elevated head of bed, and more fluid. (There was not any documentation showing LVN A checked Resident #1's BP on 06/08/24 from 12:09 pm to 10:00 pm. And there was no documentation LVN A notified Resident #1's PA/MD on 06/08/24 about Resident #1's change in condition). Record review of Resident #1's Progress note by LVN A dated 06/09/24 at 9:15 am revealed, Resident noted with abnormal vital signs: BP 83/44, O2:88% RA . Resident very weak, nausea, vomiting, poor eating. Resident is alert. PA notified and ordered resident to be sent to hospital using 911. 911 called and took resident to hospital. Family member informed that resident is sent to hospital. DON notified. Record review of Resident #1's SBAR Communication Form dated 06/09/24 by LVN A revealed, Before calling MD/NP/PA evaluate the resident, check vital signs, review record, review an INTERACT (Interventions to Reduce Acute Care Transfers) care path or acute change in condition file card. Have relevant information when reporting. Situation: This started on 06/08/24, since this started it has gotten worse, BP 83/44, altered level of consciousness, weakness, Full Code review and notify: Primary Care Clinician notified yes 06/09/24 8:15 am. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Hospital H&P (history & physical) dated 06/09/24 revealed, Upon arrival to the ED (emergency department), the patient was noted to be minimally responsive with poor oral care .he was hypotensive (low blood pressure) and tachycardiac (fast irregular heartrate), which was only transiently responsive to 1 L fluid bolus (single large dose medicine) .admitted to MICU. Vitals: BP 108/60, pulse 100, SP O2 92%. Labs: WBC (white blood cell) 13.64 (high), Assessment: admitted to MICU for shock of likely mixed etiology, requiring pressors (life support). Problem list: presumed septic shock (widespread infection causing organ failure), AMS (altered mental status), SOB (shortness of breath), Left calcareous wound (ulcer infection), history of osteomyelitis (bone inflammation), hyperbilirubinemia (liver disfunction) and abdominal pain, hypoglycemia (low blood sugar), ESRD (End Stage Renal Disease), hyponatremia (low sodium level), hypothyroidism (underactive thyroid) and HTN (high blood pressure). Addendum at 06/09/2024: Following arrival to the ICU, the patient was noted to have large volume emesis (vomit) that progressed to possible coffee ground emesis. Due to concern for inability to protect airway, the patient was intubated as per procedure note. Record review of Resident #1's Hospital follow-up note dated 06/11/24 revealed, BP 116/66, SP O2 100%, labs: WBC 13.43 (high), IV antibiotic for ESBL and VRE for sacral wound, placed on CRRT (continuous renal replacement therapy) and palliative care consult. Note: Assumed respiratory care of patient with ventilator settings. Interview on 06/11/24 at 3:06 pm with Hospital Representative stated Resident #1 admitted with AMS (altered mental status) and septic shock (widespread infection causing organ failure) and was currently on a ventilator in MICU. He stated Resident #1's prognosis was poor and he was still the same since he admitted . Observation on 06/11/24 at 5:05 pm, Resident #1 was at the hospital's MICU, he was nonresponsive and using a ventilator machine. Interview by phone on 06/12/24 at 12:28 pm, LVN A stated he worked double shift weekends and on 06/08/24 Resident #1 had a change in condition. LVN A said he was good and talking, but then around 7:00 am or 7:30 am he noticed his vitals were low 93/something. He stated he checked Resident #1's vitals again and it was 101/something and kept monitoring the resident and at 9:00 pm he forgot to document those vital signs in the EMR. He stated he checked his vitals several times throughout the day and was not sure why he did not document those readings and not call Resident #1's PA/MD. He stated he left on 06/08/24 around 10:00 pm and gave a report to LVN B to continue monitoring Resident #1 for his low BP. Then stated he did not contact the Dr. because he was able to get Resident #1's vitals up. He stated at the end of his shift he succeeded in getting Resident #1's vitals increased and he was stable. He stated he returned to work on 06/09/24 and checked Resident #1's BP and his vital signs were getting worse and his O2 sats were going down. He stated he called PA D and she told him to send Resident #1 to the hospital because he was having nausea/vomiting, poor eating, low blood sugar and low BP. He stated Resident #1 was able to respond but he was not drinking fluids like he was the day before. He stated he was doing everything he could for Resident #1. He stated he spoke to the corporate nurse and the DON this morning (06/12/24) from 8:00 am - 10:00 am about what he did when Resident #1's BP dropped. He stated they told him he was suspended because of his actions of not calling PA/MD. He stated in hindsight Resident #1 was stable and there was no need for him to go to the hospital until the next day 06/09/24. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/12/24 at 2:20 pm, LVN B stated she was Resident #1's night shift nurse on 06/08/24 from 10:00 pm to 06/09/24 at 6:00 am and she usually did her rounds between 4:00 am to 6:00 am. She stated the previous nurse LVN A did not say Resident #1 had a change in condition. She stated if he did, she would have called his Dr. and did another BP check to see what the Dr. wanted to do. She stated she would not play around with someone's life and did what she needed to do to take care of the residents properly. She stated if Resident #1's BP was too low she would have rechecked it and checked his orders to see if anything could have been given by talking to his Dr. She stated if a resident's BP were 93/44, she replied Oh yes she would have called the Dr. about that. She stated she would not play around with the resident's BP because she was there to help the residents. She stated if a resident's BP dropped, they could shut down and go into respiratory distress especially if their BP was low. She stated a resident might end up dying and pass away. Interview on 06/12/24 at 2:44 pm, CNA C stated on 06/09/24 she was doing her rounds and around 6:30 am - 6:45 am Resident #1's speech was slurred like he was tired. She stated she spoke to LVN A and he said he was aware and was making arrangements to send him to the hospital then he was sent to the hospital. She stated the previous time she saw him was 06/06/24 and he appeared to be fine. Interview on 06/12/24 at 4:15 pm, the Administrator stated they had an AD HOC meeting because Resident #1's BP dropped and it was not reported timely to the physician. He stated LVN A got focused on one thing, the vital signs and missed documenting the BP checks. He stated they had a meeting with their Medical Director and they were taking this matter seriously. He stated he had suspended some staff and currently doing countless in-service trainings with the other staff. Interview on 06/12/24 at 5:52 pm, PA D stated she was temporarily filling in working for the regular PA for this facility. She stated she received a call from a nurse that Resident #1's vitals were off on 06/09/24 and she told the LVN to send the resident to the hospital. She stated she had not received any calls from anyone about Resident #1 abnormal vitals on 06/08/24. She stated she expected the nurse to call her or the Dr. when the resident's BPs were low. She stated with Resident #1 being a dialysis patient, she would have ordered him Midodrine to bring his BP back up depending on his pulse and fluid buildup. She stated the treatment depended on the person because everybody was different. She stated if a resident's BP dropped, sepsis or dehydration could occur. She stated she had not spoken to the Administrator about any issues with Resident #1. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview 06/12/24 at 6:10 pm, the DON stated LVN A said Resident #1 went to the hospital for his irregular vital signs on 06/09/24. She stated the first time she heard about his irregular vitals was 06/09/24 and since finding out LVN A did not call Resident #1's Dr. they started staff trainings. She stated the staff were trained on change of condition and for the on-call person to start reviewing change of condition on the weekends. She stated after review of Resident #1's records he did not complete his dialysis treatment 06/07/24. She stated she saw on Saturday 06/08/24 Resident #1 had a low BP of 93/something then LVN A did another BP check again and it was 101/something. She stated LVN A said he felt like Resident #1's BP was fine so he did not call the Dr. and just gave him fluids and Zofran (prevents nausea). She stated she tried to call LVN A Monday 06/10/24 and spoke to him this morning 06/12/24 and educated him on reporting change of condition, reviewing the 24-hour report on EMR dashboard (EMR overview of all resident information), completing audits on vital signs and went over doing his documentation. She stated he told her he rechecked Resident #1's vital signs but did not document the results. She stated she wrote him up because he failed to follow their change of condition protocol and they reviewed what was a change of condition and abnormal vs. all vital sign types. She stated she spoke to LVN B who also did not do any BP checks and monitoring of Resident #1, because she said, She was not told Resident #1 had abnormal vitals. She stated LVN B said, She did not follow-up with Resident #1's vitals or contacted the Doctor because LVN A did not notify her of his abnormal vitals. She stated LVN B said, had she known she would have asked the PA/MD to get further direction. She stated had LVN A called the Doctor maybe the Doctor would have put Resident #1 on supplemental O2, to get his O2 sats greater than 90% or offer a 120-cc supplemental shake. She stated Resident #1's BP being 93/44 was not his baseline and the Doctor should have definitely been notified after LVN A received that BP reading on 06/08/24. She stated Resident #1 was currently at the hospital intubated with and elevated white blood cell count. She stated they started Inservice trainings with the nurses, CNAs, and MAs on change of condition, knowing when to contact the PA/MD and they had a QAPI meeting today (06/12/24) with the Medical Director. She stated he went over what should be done to prevent this from happening again. She stated she was not sure why every two-hour checks of Resident #1 had not been done because they should have been done on 06/08/24 and 06/09/24. She stated they needed to make sure the nurses looked at the vital audits screen, to review the EMR dashboard. Interview on 06/12/24 at 6:58 pm, the Administrator stated since finding out about Resident #1's condition they had an AD HOC meeting today (06/12/24) about the immediate interventions to put in place. He stated they started re-educating all nursing staff on physician notification, change in condition, and vital signs. He stated they suspended LVN A and gave him a corrective action memo. He stated they put in audit tools right now and the whole team was reviewing the residents' records to ensure vital sign abnormalities were done properly. He stated Resident #1 was currently at the hospital and the marketing director said he was intubated and that was the extent of what he was privy to. He stated the two ADONs and DON was responsible for ensuring change in conditions were being communicated to the PA/MD. In a group interview on 06/13/24 at 10:00 am, the RNC stated they were aware of the issues involving LVN A not notifying the PA/MD when Resident #1 had a change in condition. The RDO stated they were aware of what happened to Resident #1, prior to the HHSC investigator arriving on 06/11/24, but he was not able to say how many employees they had and how many had the in-service trainings. He stated he would follow up with HHSC investigator and provide their internal investigation later. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/13/24 at 10:32 am, RN E stated if a resident's BP were to get too low, it could cause the resident to have a significant declination and become lethargic, confused and beyond their baseline. Interview on 06/13/24 at 12:08 pm, the RDO stated all the nurses who worked Monday 06/10/24 were trained on change in condition, before their shifts started. He stated he was not sure who else had been trained and would have to check. He stated as of this day (06/13/24) the Monday-Friday staff were trained on change in condition but the weekend staff had not been yet. He stated LVN A was suspended on Monday 06/10/24 and they had their AD HOC meeting on Monday with the Medical Director. He stated the DON and ADON's did audits and said he was not sure if any other residents were negatively affected. He stated they implemented the Change in condition and using the interact tool stop and watch and notified the physician. He stated the PA/MD had to answer and nursing had to fully assess the residents. He stated they dropped the ball and wanted to ensure the staff were highly trained, to understand how to care for the residents. He stated he would provide the facility's Incident report and Internal investigation. Interview on 06/13/24 at 1:39 pm, the DON stated they spoke to LVN A about what occurred with Resident #1 on 06/08/24 and he was written up this morning 06/13/24 with a warning due to failure to not contact Resident #1's PA/MD when his BP dropped. Interview on 06/13/24 at 3:20 pm, the DON stated she was not sure how many staff had the change in condition training. She stated all staff who worked Monday 06/10/24 had the training but the PRN and weekend staff had not been trained yet. Interview on 06/13/24 at 4:52 pm, the DON stated she received Resident #1's updated hospital report today (06/13/24) and his condition was still the same with a sepsis diagnosis. Record review of the facility's Change in condition policy dated 06/2020 - revealed, Purpose: To ensure residents, family, legal representative, and physicians are informed of changes in the resident's condition in a timely manner. Procedure: The licensed nurse will notify the resident's attending physician, Reporting information to the attending physician, family notification and documentation. An Immediate Jeopardy (IJ) was identified on 06/13/24. An IJ Template was provided to the facility on [DATE] at 10:00 am. While the Immediate Jeopardy was removed on 06/14/24 at 5:00 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. Record review of the facility's Plan of Removal provided to the HHSC investigator on 06/14/24 at 10:45 am and approved at 11:00 am revealed, PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it may concern, Summary of Details which lead [sic] to outcomes: (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing and Assistant Director of Nursing to review plan of removal on 6/10/24 [sic] Who is responsible for the implementation of process? The Director of Nursing will be responsible for the implementation of the new process. The New Process/system was started on 6/10/2024. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy verbally issued on 6/13/2024. [END] In a group meeting on 06/14/24 at 11:00 am, The Administrator, DON, RDO and RNC was notified that the POR was accepted and this facility was in the monitoring phase to ensure their POR was implemented. Interview on 06/14/24 at 11:10 am, RNC stated they were still working on their investigation summary. Interview on 06/14/24 at 2:55 pm, the DON stated they would start having the on-call weekend nurse review the 24-hour EMR dashboard for any changes of the resident's vital signs. She stated she was responsible for ensuring the staff followed their change in condition policy. She stated her expectations were for the staff to monitor the residents and if anything was different from their baseline, they needed to notify the PA/MD and RP. She stated not monitoring the residents and notifying the PA/MD could cause the staff to miss something that could delay care. She stated it could further delay getting the resident evaluated resulting in a number of things such as a worsening condition or death. Interview on 06/14/24 at 4:00 pm, the Administrator stated based on what occurred with Resident #1, they planned on terminating LVN A, and complete the Inservice trainings with everyone. He stated the DON and two ADON's would continue reviewing the residents' vital signs daily with his oversight over the nurse management team. He stated the weekend nurse supervisor would be doing the monitoring of the vitals on the weekends to ensure the nurses were notifying the PA/MD. He stated all staff had to do their change in condition trainings with the post tests before they were able to work on the floor. He stated they had 117 employees total and was not sure how many more staff needed to be trained then said maybe one or two staff. He stated in the QA (Quality Assurance) Meeting they reviewed with the medical director Resident #1's change in condition and what could be done to prevent this from happening again. He stated if residents had a change in condition and the PA/MD was not notified, could result in the deterioration of the resident and exacerbation of the resident's symptoms. He stated his expectation for resident care was for PA/MD notifications and documentation were done. Record review of the Facility's Investigation undated provided by the Administrator on 06/14/24 at 1:24 pm revealed, Internal Investigation Re: Resident #1 Patient Information: Resident is a [AGE] year-old male who admitted to facility on xx/xx/xxxx under the care of Dr. XXX. Resident is cognitively intact as evidenced by a BIMS score of 15. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Primary diagnosis: osteomyelitis, left ankle and foot. Additional diagnosis: PVD, major depressive disorder, type 2 diabetes, acute and subacute infective endocarditis (heart infection), anemia (low iron), and hypertension. Incident: On 6/8/2024 LVN A documented Resident #1 to have the following vital signs: BP 93/44, O2:88% room air, P106, FSBS 67 mg/dl. Weakness, vomiting, poor eating. LVN A did not document notification of these abnormal vital signs to Physician. On 6/9/2024 LVN A documented Resident #1 to have the following vital signs: BP83/44, P111, O2:88% RA, R21/min, T97.8, FSBS 85mg/dl LVN A called physician's PA and resident was sent to acute care hospital via EMS. Investigation: Interview with LVN A revealed the following: LVN A said he was concerned about the blood sugar level and that is why he gave the patient 120 mL of orange juice. He said that he repositioned the patient in the bed to address the other abnormal vital signs. He says that he had remeasured his BP and that it had started going up into the normal ranges. Review of the Medication Aides charting she had recorded a BP high enough that BP reducing medication according to parameters was administered. The medication aide said that the patient seemed stable and normal with no signs of distress during medication administration, and he received medications well. LVN A admits that he did not notify the physician of the abnormal vitals on Saturday. He also admits that he did not document the later vital signs that he had taken in the medical record. Actions to Address: LVN A was given one on one in-service by DON on expectations for physician notification for any abnormal vital signs and medication administration. Employee suspended pending investigation. [END] Interviews on 06/13/24 between 10:32 am - 11:40 am with RN E, RN F, LVN G, MA H, CNA I revealed they were trained between 06/10/24 and 06/13/24 on change in condition, notifying PA/MD of drops in resident's BPs., Interviews on 06/14/24 between 11:44 am - 3:34 pm revealed, LVN K, Medical Record L, MA M, Housekeeper/Laundry aide N, Housekeeper O, Dietary aide P, Dietary cook Q, Laundry aide R, Laundry aide S, RN T, ADON U, OT (Occupational Therapy) V, PTA (Physical Therapy Assistant) W, CNA X, MA Y, RN Z stated they were trained between 06/10/24 and 06/14/24 on change in condition, notifying the PA/MD, stop and watch and notifying the nurses, the DON and ADONs when a resident had a change in condition. (continued on next page)		

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review on 06/13/24 of the facility's Supporting documents emailed by the Administrator on 06/12/24 at 9:10 pm revealed, Inservice trainings on 06/10/24 with mostly administrative/department head staff and some floor staff. And on 06/11/24 and 06/12/24 more floor staff were trained on change in condition and stop and watch reporting. Record review on 06/13/24 of the facility's Supporting documents emailed by the Administrator on 06/13/24 at 2:22 pm, revealed three duplicate in service signature sheets dated 06/10/24. There was signed training sheets from the 8:00 am to 5:00 pm staff on 06/10/24 on topics change in condition and. And signature sheets on 06/12/24, posttests from 06/10/24 - 06/13/24 and resident chart audits from 06/10/24 to 06/13/24 revealed staff were proficient in change in condition procedures. Record review of signage posting currently being put at all nurses stations: NOTIFY MD/NP OF LOW BLOOD PRESSURES . SYSTOLIC LESS THAN 95 DIASTOLIC LESS THAN . SYSTOLIC GREATER THAN 170 AND DIASTIC GREATER THAN 90 . ASSESS YOUR PATIENT AND DOCUMENT. Record review of LVN A's Corrective Action Memo dated 06/12/24 by DON revealed, Violation of policy and procedure, carelessness, Employer Statement: Acute change in condition is a sudden, clinically important deviation from the patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. Alert charting is documentation done to track a medical event for a period of 72 hours or longer. Events may include but not necessarily limited to suspected or actual change in condition. Action being taken Suspension Objective/Solution: Employee will understand the importance of communicating change of condition with MD, NP, DON, ADON, on call phone. Employee will review abnormal vital signs and verbalize values in EMR Failure to document indicates task was not completed. Employee will be suspended pending investigation. Employee statement: blank. Signed by LVN A and DON. Record review of LVN B's Corrective Action memo dated 06/13/24 by DON revealed, Violation of policy and procedure Employer Statement: Treatments completed and documented as per physician's order. Documentation will be completed by the end of the assigned shift. Failure to document means task was not completed. Written warning. Objective/Solution: Employee will document task completed by the end of assigned shift. Employee Statement: Blank. Signed by LVN B and DON. An Immediate Jeopardy (IJ) was identified on 06/13/24. An IJ Template was provided to the facility on [DATE] at 10:00 am. While the Immediate Jeopardy was removed on 06/14/24 at 5:00 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility continuing to monitor the implementation and effecti [TRUNCATED]		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on observation, record reviews and interviews the facility failed to ensure that based on the comprehensive assessment of a resident, residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (Resident #1) of eight residents reviewed for quality of care. 1. LVN A failed to provide appropriate treatment and care on 06/08/24 as indicated: a. Did not monitor and check Resident#1's BP after 12:08 pm. b. Did not notify the DON and LVN B, about Resident #1's change in condition and need for continued BP monitoring. c. Did not follow Resident #1's Nephrologist's Doctor order and this facility's Care Plan to ensure the resident did not experience possible fluid overload. 2. LVN B failed to check on Resident #1 throughout her shift and she said she did a BP check on Resident #1 at 5:00 am on 06/09/24 but failed to document it. An Immediate Jeopardy (IJ) was identified on 06/13/24. An IJ Template was provided to the facility on [DATE] at 10:00 am. While the Immediate Jeopardy was removed on 06/14/24 at 5:00 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. These failures could place residents at risk of harm which could cause a decline in their health and psycho-social well-being and lead to need for hospital intervention or death. Findings included: Observation on 06/11/24 at 5:05 pm, Resident #1 was at the hospital's MICU, he was nonresponsive and using a ventilator machine (life support). Record review of the facility's census revealed they had 114 residents. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a male who admitted to this facility 08/03/23 with a BIMS Score of 10 (moderate cognitive impairment). He had 1 sided upper extremity impairment and 2 sided lower extremity impairment and substantial maximal assist with ADL's. He was frequently incontinent to bladder and always incontinent to bowel. He had medically complex conditions with diagnoses anemia (low red blood cells and hemoglobin), hypertension (high blood pressure), peripheral vascular disease (circulatory condition/reduced blood flow). And diagnosed with renal insufficiency (kidney failure), diabetes mellitus (high blood sugar), hyperlipidemia (high level fat particles), malnutrition (lack of nutrients), depression (lowered mood), and generalized muscle weakness (muscle weakness). (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Order Summary Report dated 06/12/24 revealed orders for: regular diet with thin liquids, 2.0 supplement 120cc 3xd, Amlodipine besylate oral tab 10 mg, 1-tab 1xd for HTN, hold SBP <110, DBP <60, HR 60, and Ondansetron HCl (hydrochloride) Oral tab 4 mg 1 tab by mouth every 6 hours as needed for nausea and vomiting. And there was not any standing orders for renal diet with fluid restrictions. Record review of Resident #1's Care Plan printed 06/12/24 revealed, date initiated: 08/08/23: dialysis due to chronic kidney disease, altered respiratory status/difficulty breathing related to history of respiratory failure, impaired cognitive function or thought processes. And had bladder incontinence, communication problem and dialysis and diabetes. Date initiated: 01/25/24: potential for fluid overload related to kidney failure: will remain free of signs/symptoms of fluid overload through review date, as evidenced by . changes in mood or behavior, nausea/vomiting . Date Initiated: 01/25/2024: Monitor/document/report to MD PRN signs/symptoms of fluid overload Hypertension related to Norvasc - Oral. Date Initiated: 08/09/2023, Revision on: 08/09/2023: will maintain a blood pressure within the following parameters: (110/60) through review date. Revision on: 03/03/2024, Target Date: 07/21/2024. Record review of Resident #1's Progress note by LVN A dated 06/08/24 at 9:13 am revealed, Resident noted with abnormal vital signs: BP 93/44, O2:88% room air . Weakness, vomiting, poor eating. Resident offered 120 ml of orange juice, elevated head of bed, and more fluid. (There was not any documentation showing LVN A monitored or checked Resident #1's BP on 06/08/24 from 12:09 pm to 10:00 pm. And there was no documentation LVN A notified the DON and LVN B on 06/08/24 about Resident #1's change in condition and fluid amounts given). Record review of Resident #1's Progress note by LVN A dated 06/09/24 at 9:15 am revealed, Resident noted with abnormal vital signs: BP 83/44, O2:88% RA . Resident very weak, nausea, vomiting, poor eating. Resident is alert. PA notified and ordered resident to be sent to hospital using 911. 911 called and took resident to hospital. Family member informed that resident is sent to hospital. DON notified. Record review on Resident #1's Progress note from 06/08/24 from 10:00 pm to 06/09/24 at 6:00 am, revealed LVN B did not document she checked on Resident #1 every two hours or at all during her shift. Record review of Resident #1's SBAR Communication Form dated 06/09/24 by LVN A revealed, Before calling MD/NP/PA evaluate the resident, check vital signs, review record, review an INTERACT(Interventions to Reduce Acute Care Transfers) care path or acute change in condition file card. Have relevant information when reporting. Situation: This started on 06/08/24, since this started it has gotten worse, BP 83/44, altered level of consciousness, weakness, Full Code review and notify: Primary Care Clinician notified yes 06/09/24 8:15 am. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's Hospital H&P (history & physical) dated 06/09/24 revealed, Upon arrival to the ED (emergency department), the patient was noted to be minimally responsive with poor oral care .he was hypotensive (low blood pressure) and tachycardiac (fast irregular heartrate), which was only transiently responsive to 1 L fluid bolus (single large dose medicine) .admitted to MICU. Vitals: BP 108/60, pulse 100, SP O2 92%. Labs: WBC (white blood cell) 13.64 (high), Assessment: admitted to MICU for shock of likely mixed etiology, requiring pressors (life support). Problem list: presumed septic shock (widespread infection causing organ failure), AMS (altered mental status), SOB (shortness of breath), Left calcareous wound (ulcer infection), history of osteomyelitis (bone inflammation), hyperbilirubinemia (liver disfunction) and abdominal pain, hypoglycemia (low blood sugar), ESRD (End Stage Renal Disease), hyponatremia (low sodium level), hypothyroidism (underactive thyroid) and HTN (high blood pressure). Addendum at 06/09/2024: Following arrival to the ICU, the patient was noted to have large volume emesis (vomit) that progressed to possible coffee ground emesis. Due to concern for inability to protect airway, the patient was intubated as per procedure note. Record review of Resident #1's Hospital follow-up note dated 06/11/24 revealed, BP 116/66, SP O2 100%, labs: WBC 13.43 (high), IV antibiotic for ESBL and VRE for sacral wound, placed on CRRT (continuous renal replacement therapy) and palliative care consult. Note: Assumed respiratory care of patient with ventilator settings. Interview on 06/11/24 at 3:06 pm with Hospital Representative stated Resident #1 admitted with AMS and septic shock and was currently on a ventilator in MICU. He stated Resident #1's prognosis was poor and he was still the same since he admitted . Interview by phone on 06/12/24 at 12:28 pm, LVN A stated he worked double shift weekends and stated on 06/08/24 Resident #1 had a change in condition. LVN A said he was good and talking, but then around 7:00 am or 7:30 am he noticed his vitals were low 93/something. He stated Resident #1 was alert/orient and drank his Orange Juice then he vomited and then gave him Zofran (prevent nausea/vomiting) He stated he checked Resident #1's vitals again and it was 101/something and kept monitoring the resident and at 9:00 pm he forgot to document those vital signs in the EMR. He stated he checked his vitals several times throughout the day and was not sure why he did not document those readings. He stated he left on 06/08/24 around 10:00 pm and gave a report to LVN B to continue monitoring Resident #1 for his low BP. He stated at the end of his shift he succeeded in getting Resident #1's vitals increased and he was stable. He stated he forgot to document checking Resident #1's BP throughout the duration of his shift on 06/08/24, because it was the end of the shift but knew he should have documented that. He stated not documenting resident's vitals could make it very hard to follow up and compare previous conditions and limit communication because the documentation was missing. He stated he spoke to the corporate nurse and the DON this morning (06/12/24) from 8:00 am - 10:00 am about what he did when Resident #1's BP dropped. He stated they told him he was suspended because of his actions of not calling the DON. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/12/24 at 2:20 pm, LVN B stated she was Resident #1's night shift nurse on 06/08/24 from 10:00 pm to 06/09/24 at 6:00 am and she usually did her rounds between 4:00 am to 6:00 am. She stated on 06/09/24 she saw Resident #1 at 5:00 am and took his BP and it was normal and he had no fever, he was stable. She stated she put his vital signs on his dialysis paper and not the EMR. She stated he said good morning to her and was talking and she gave him some water. She stated there was only two nurses that worked upstairs on her shift and she had a lot to do and wrote Resident #1's BP reading on her pad. She stated the previous nurse LVN A did not say Resident #1 had a change in condition. She stated if he did, she would have called his Dr. and did another BP check to see what the Dr. wanted to do. She stated she would not play around with someone's life because she would ensure the residents were properly cared for. She stated if Resident #1's BP was too low she would have rechecked it and checked his orders to see if anything could have been given and by talking to his Dr. She stated if a resident's BP were 93/44, she replied Oh yes she would have called the Dr. about that. She stated she would not play around with the resident's BP and would check it more often because it could drop. She stated upstairs they only had two nurses on the night shift and she and other nurse had to split one of the halls (Hall E) for which Resident #1 was on. She stated she was not able to complete all her documentation at night, because they really needed a third night nurse upstairs to cover Hall E. She stated she asked about getting another nurse and the administrator said they would once they were full upstairs. She stated if a resident's BP dropped, they could shut down and go into respiratory distress especially if their BP was low. She stated a resident might end up dying and pass away. Interview on 06/12/24 at 4:15 pm, the Administrator stated LVN A got focused on one thing, the vital signs and missed documenting the BP checks. He stated they had a meeting with their Medical Director and they were taking this matter seriously. He stated he suspended some staff and currently doing countless in-service trainings with the other staff. Interview on 06/12/24 at 5:52 pm, PA D stated if a resident's BP dropped, sepsis or dehydration could occur. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/12/24 at 6:10 pm, the DON stated LVN A said Resident #1 went to the hospital for his irregular vital signs on 06/09/24. She stated the first time she heard about Resident #1's irregular vitals was 06/09/24. She stated on 06/08/24 they started staff trainings on change of condition and for the on-call person to start reviewing change of condition on the weekends. She stated she saw on Saturday 06/08/24 Resident #1 had a low BP of 93/something then LVN A did another BP check again and it was 101/something. She stated LVN A said, He felt like Resident #1's BP was fine and just gave him fluids and Zofran. She stated she tried to call LVN A Monday 06/10/24 and spoke to him this morning 06/12/24 and educated him on reporting change of condition, reviewing the 24-hour report on EMR dashboard, completing audits on vital signs, and went over doing his documentation. She stated she wrote him up because he failed to follow their change of condition protocol and they reviewed what was a change of condition and abnormal vs. all vital sign types. She stated LVN B said she did not follow-up with Resident #1's vitals because LVN A did not notify her of his abnormal BP. She stated LVN B said had she known she would have asked the MD/NP to get further direction. She stated Resident #1 was currently at the hospital intubated (tube place down throat to assist with breathing) and elevated white blood cell count. She stated they started Inservice trainings with the nurses, CNAs, and MAs on change of condition and they had a QAPI meeting today (06/12/24) with the Medical Director. She stated the Medical Director went over what should be done to prevent this from happening again. She stated they had enough nurses working upstairs, because they had roughly 80 residents on the 2nd floor and from 10:00 pm - 6:00 am there was two nurses because only PRN medications were given. She stated she was not sure why every two-hour checks of Resident #1 had not been done because they should have been done on 06/08/24 and 06/09/24. She stated they needed to make sure the nurses looked at the vital audits screens by reviewing the EMR dashboard for any abnormal vital readings. Resident #1 did not have any fluid restriction standing orders but could see LVN A gave Resident #1 120 cc of orange juice. She stated she was not aware the documentation showed LVN A gave the resident 'more fluids'. Interview on 06/12/24 at 6:58 pm, the Administrator stated since finding out about Resident #1's condition they had an AD HOC meeting today (06/12/24) about the immediate interventions to put in place. He stated they started re-educating all nursing staff on change of condition, and vital signs. He stated they suspended LVN A and gave him a corrective action memo. He stated they put in audit tools right now and the whole team was reviewing the residents' records to ensure vital sign abnormalities were done properly. He stated Resident #1 was currently at the hospital and the marketing director said he was intubated and that was the extent of what he was privy to. In a group interview on 06/13/24 at 10:00 am, the RNC stated they were aware of the issues involving LVN A not notifying the PA/MD when Resident #1 had a change in condition. The RDO stated they were aware of what happened to Resident #1, prior to the HHSC investigator arriving on 06/11/24, but he was not able to say how many employees they had and how many had the in-service trainings. He stated he would follow up with HHSC investigator and provide their internal investigation later. Interview on 06/13/24 at 10:32 am, RN E stated if a resident's BP were to get too low, it could cause the resident to have a significant declination and become lethargic, confused and beyond their baseline. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/13/24 at 10:50 am, RN F stated if a resident who was on dialysis had a drop in their BP, she would never give them fluids because they could retain the fluids and could get fluid overload. She stated especially if the Doctor did not order additional fluids. She stated if a resident's BP were too low or high, she would give them the PRN medication and check their BP within 30 minutes to an hour. She stated all of her focus would be on that resident. She stated she would get more BP readings to ensure the resident was stable. Interview on 06/13/24 at 11:16 am, LVN G stated if a resident's BP dropped, they could pass out and said she would not just give a resident fluids because she was just a nurse who worked based off of Dr. orders. She stated if a dialysis resident who was on dialysis had a 93/44 BP, she would never give them fluids without a Dr. order. Interview on 06/13/24 at 12:08 pm, the RDO stated all the nurses who worked Monday 06/10/24 were trained on change in condition and stop and watch reporting, before their shifts started. He stated he was not sure who else had been trained and would have to check. He stated as of this day (06/13/24) the Monday - Friday staff were trained on change in condition but the weekend staff had not been yet. He stated LVN A was suspended on Monday and they had their AD HOC meeting on Monday (06/10/24) with the Medical Director. He stated the DON and ADONs did audits and said he was not sure if any other residents were negatively affected. He stated they implemented the Change in condition interact tool stop and watch. He stated they dropped the ball and wanted to ensure the staff were highly trained, to understand how to care for the residents. Interview on 06/13/24 at 1:39 pm, the DON stated they were going to audit every resident getting BP medications. She stated they spoke to LVN A about what occurred with Resident #1 on 06/08/24. And LVN B was written up this morning (06/13/24) due to failure to not document Resident #1's vital signs. Interview on 06/13/24 at 3:20 pm, the DON stated she was not sure how many staff had the change in condition training. She stated all staff who worked Monday 06/10/24 had the training but the PRN and weekend staff had not been trained yet. Interview on 06/13/24 at 4:52 pm, the DON stated she received Resident #1's updated hospital report today (06/13/24) and his condition was still the same with a sepsis diagnosis. Record review of the facility's Care and Services Policy dated 06/2020 revealed, To ensure through an interdisciplinary team (IDT) process, that all residents receive the necessary care and services based on an individualized comprehensive assessment process. Policy: Residents are provided with the necessary care and services to maintain the highest practicable. physical, mental, and social well-being level of in an environment that enhances quality of life in the scope of a long-term care facility. Care and services are provided in a manner that consistently enhances self-esteem and self-worth. Procedure: I. The Facility will have sufficient staff to provides services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being as determined by individualized resident assessments and plans of care. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676293	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Forest Park Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 Harry Hines Blvd Dallas, TX 75235	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An Immediate Jeopardy (IJ) was identified on 06/13/24. An IJ Template was provided to the facility on [DATE] at 10:00 am. While the Immediate Jeopardy was removed on 06/14/24 at 5:00 pm, the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. Record review of the facility's Plan of Removal provided to the HHSC investigator on 06/14/24 at 10:45 am and approved at 11:00 am revealed, PLAN OF REMOVAL FOR IMMEDIATE JEOPARDY To Whom it may concern, Summary of Details which lead to outcomes: On 6/11/2024, a complaint was initiated at [This facility]. On 6/13/2024 a surveyor provided an IJ Template notification that the Survey Agency has determined that a condition at the center constitute immediate jeopardy to resident health. The notification of the alleged immediate jeopardy states as follows: F 684 Quality of Care - Based on observation, interviews, and record reviews LVN A failed to contact the resident's Doctor after Resident #1's BP decreased to 93/44 on 06/08/24 at 10:23 am. LVN A checked Resident #1's BP again 06/08/24 at 12:08 pm and it was 101/54 and did not do any further BP checks during the remainder of his shift. There's no documentation of the 10p - 6 a LVN B checking Resident #1 or doing vitals. Then on 06/09/24 at 8:37 am LVN A returned to work and checked Resident #1's BP was 83/44 then Resident #1 was sent to the hospital. Identify residents who could be affected: All residents have the potential to be affected. Identify responsible staff/ what action taken: 1. Director of Nurses were re-educated by the Regional Nurse Consultant on the facility policy on monitoring, documenting, and reporting abnormal signs or symptoms on 6/10/2024. Understanding was verified by a written posttest. 2. Licensed Nurses received a re-education by the DON on the facility policy and procedure on physician notification and documentation initiated on 6/10/2024. Knowledge of education was verified by written signatures and verbalization of understanding completed on 6/14/2024. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. Training for licensed nurses and medication aides on notification of changes in condition to physician and nurse management with proper documentation was initiated on 6/10/2024 by the Director of Nursing. Knowledge of education was verified by written signatures and verbalization of understanding completed on 6/14/2024. 4. Training for non-clinical staff on notification of changes in condition to the charge nurse or nurse manager 6/10/2024 by the Director of Nursing. Knowledge of education was verified by written signatures and verbalization of understanding completed on 6/14/2024. 5. Training for licensed nurses on Physician notification on critical lab results and abnormal vital signs with proper documentation was initiated on 6/10/2024 by the Director of Nursing. Knowledge of education was verified by written signatures and verbalization of understanding completed on 6/14/2024. 6. An audit of all resident vital signs was initiated on 6/10/2024 by DON and ADON. To verify that physician was notified of any abnormal reading. Audit was completed on 6/10/2024. In-Services conducted: 1. Change in condition. 2. Medication administration 3. Physician notification 4. Labs and Vitals 5. Documentation of care provided The in-services were attended by licensed caregivers which include Registered Nurse, Licensed Vocational Nurse, Certified Medication Aide, Certified Nurse Aides and staff from all other departments. Understanding of in-services was verified with a written/and or verbal posttest. This in-service was initiated on 6/10/2024 and completed on 06/14/2024. All staff must be in-serviced before they are allowed to work. New staff will be educated about resident change in condition, medication administration, physician notification before their floor orientation and monitoring will be continued ongoing by the DON/Designee. Implementation of changes (Monitoring all or any medication not given and change in condition of residents through 24-hour report). The changes which include daily monitoring of lab results, vital sign readings, change in condition and physician notification of residents through 24-hour reports were started by the Director of Nursing. The changes of monitoring of all residents with a change in condition and abnormal vital signs or labs /imaging results over 24hr were implemented effective on 6/10/2024 and completed on 06/14/2024. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	No staff will be allowed to work before completion of these in-services. The Director of Nursing will ensure competency through verbalization of understanding by staff and in servicing. Monitoring The Administrator/Director of Nursing/Assistant Director of Nursing will be responsible for monitoring the implementation and effectiveness of in-service on 6/10/2024. o The Director of Nursing/Designee will monitor/review vital signs daily and review 24-hour reports for change in condition and physician notification x4 weeks, then weekly x2 weeks, then monthly and report any adverse finding during QAPI. o Director of Nursing/Designee will conduct a daily audit of resident vital signs and change in condition daily x4 weeks, then weekly x 2 weeks, then monthly and report any adverse findings during QAPI. Involvement of Medical Director The Medical Director met with the Interdisciplinary team on 6/10/2024 and conducted an Ad HOC QAPI regarding physician notification and change in condition. The Medical Director, Doctor was notified about the immediate Jeopardy on 6/13/2024, the Plan of removal was reviewed and accepted by Doctor. Involvement of QA An Ad Hoc QAPI meeting was held with the Medical Director, facility administrator, director of nursing, and social services director to review plan of removal on 6/13/2024. Who is responsible for the implementation of the process? The Director of Nursing will be responsible for the implementation of the new process. The New Process/system was started on 6/10/2024. The Administrator will ensure DON implements the new process. Regional Nurse Consultant will audit the implementation of the new process. Please accept this letter as our plan of removal for the determination of Immediate Jeopardy verbally issued on 6/13/2024. [END] In a group interview on 06/14/24 at 11:00 am, The Administrator, DON, RDO and RNC was notified that the POR was accepted and this facility was in the monitoring phase to ensure their POR had been implemented. Interview on 06/14/24 at 11:10 am, RNC stated they were still working on their investigation summary. She stated LVN A gave Resident #1 120 cc of orange juice from his meal tray and was not aware more fluids was given as reported in the progress notes, she said Resident #1 was not on a fluid restriction or renal diet and they just recently scheduled a meeting with Resident #1's dialysis staff to get fluid restriction and renal diet and go over other dialysis orders to ensure their accurate. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 06/14/24 at 2:33 pm, RN Z stated the nurses needed to give treatments to the residents that were PA/MD ordered and he would ensure checking the resident's BP for the remainder of the shift if they had a change in condition. Interview on 06/14/24 at 2:55 pm, the DON stated they would start having the on-call weekend nurse review the 24-hour EMR dashboard for any changes of the resident's vital signs and nurses' documentation. She stated she was responsible for ensuring the staff followed their change in condition policy. She stated her expectations was for the staff to monitor the residents and if anything was different from their baseline, . She stated not monitoring the residents and could cause the staff to miss something that could delay care. She stated it could further delay in getting the resident evaluated resulting in a number of things such as a worsening condition or death. Interview on 06/14/24 at 4:00 pm, the Administrator stated based on what occurred with Resident #1, they planned on terminating LVN A and completed Inservice trainings with almost everyone. He stated the DON and two ADONs would continue reviewing the residents' vital signs daily with his oversight over the nurse management team. He stated the weekend nurse supervisor would be doing the monitoring of the vitals on the weekends to ensure the nurses were He stated all staff had to do their change in condition trainings with the post tests before they were able to work on the floor. He stated they had 117 employees total and was not sure how many more staff needed to be trained. He stated in the QA (Quality Assurance) Meeting they reviewed with the medical director about Resident #1's change in condition and what could be done to prevent this from happening again. He stated if residents had a change in condition and not documented timely, could result in the deterioration and exacerbation of the resident's symptoms. He stated his expectation for resident care was for documentation of the residents were done. He stated they have a care meeting scheduled with the resident's dialysis center next week to ensure the Doctor order were correct. He stated the Medical Doctor agreed the meeting with dialysis was a good idea. Interviews on 06/13/24 between 10:32 am - 11:40 am with RN E, RN F, LVN G, MA H, CNA I revealed they were trained between 06/10/24 and 06/13/24 on change in condition, of drops in resident's BP and documentation residents vital signs. Interviews on 06/14/24 between 11:44 am - 3:34 pm revealed, LVN K, Medical Record L, MA M, Housekeeper/Laundry aide N, Housekeeper O, Dietary aide P, Dietary cook Q, Laundry aide R, Laundry aide S, RN T, ADON U, , CNA X, MA Y, RN Z stated they were trained between 06/10/24 and 06/14/24 on change in condition, documentation, stop and watch and notifying the nurses, the DON and ADONs when a resident had a change in condition. Record review on 06/13/24 of the facility's Supporting documents emailed by the Administrator on 06/12/24 at 9:10 pm revealed, Inservice trainings on 06/10/24 with mostly administrative/department head staff and some floor staff. And on 06/11/24 and 06/12/24 more floor staff were trained on change in condition and stop and watch reporting. Record review on 06/13/24 of the facility's Supporting documents emailed by the Administrator on 06/13/24 at 2:22 pm, revealed three duplicate in service signature sheets dated 06/10/24. There was signed training sheets from the 8:00 am to 5:00 pm staff on 06/10/24 on topics change in condition and documentation. And signature sheets on 06/12/24, posttests from 06/10/24 - 06/13/24 and resident chart audits from 06/10/24 to 06/13/24 revealed staff were proficient in change in condition and documentation procedures. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of signage posting currently being put at all nurses stations: NOTIFY MD/NP OF LOW BLOOD PRESSURES . SYSTOLIC LESS THAN 95 DIASTOLIC LESS THAN . SYSTOLIC GREATER THAN 170 AND DIASTIC GREATER THAN 90 . ASSESS YOUR PATIENT AND DOCUMENT. Record review of LVN A's Corrective Action Memo dated 06/12/24 by DON revealed, Violation of policy and procedure, carelessness, Employer Statement: Acute change in condition is a sudden, clinically important deviation from the patient's baseline in physical, cognitive, behavioral, or functional domains. Clinically important means a deviation that, without intervention, may result in complications or death. Alert charting is documentation done to track a medical event for a period of 72 hours or longer. Events may include but not necessarily limited to suspected or actual change in condition. Action being taken Suspension Objective/Solution: Employee will understand the importance of communicating change of condition with DON, ADON, on call phone. Employee will review abnormal vital signs and verbalize values in EMR Failure to document indicates task was not completed. Employee will be suspended pending investigation. Employee statement: blank. Signed by LVN A and DON. Record review of LVN B's Corrective Action memo dated 06/13/24 by DON revealed, Violation of policy and procedure Employer Statement: Treatments completed and documented as per physician's order. Documentation will be completed by the end of the assigned shift. Failure to document means task was not completed. Written warning. Objective/Solution: Employee will document task completed by the end of assigned shift. Employee Statement: Blank. Signed by LVN B and DON. Record review of the facility Dialysis Care policy dated 06/2020 revealed, To provide care for residents diagnosed with renal disease requiring ongoing dialysis treatments. Policy: I. The Facility will be responsible for the overall care delivered to the resident, monitoring of the resident prior to and after the completion of each dialysis treatment, and providing for all nondialysis needs of the resident including during the time period when the resident is receiving dialysis. II. The Facility maintains a contract with a dialysis service provider which addresses communications between the Facility and Provider. Record review of the facility's Licensed		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on record review and interviews the facility failed to provide or obtain laboratory services to meet the needs of its residents for one (Resident #1) of eight residents reviewed for laboratory services. ADON AA failed to follow-up with Resident #1's PA/MD after he received abnormal lab results on 06/03/24. ADON AA failed to get Resident #1's lab reviewed by PA D on 06/05/24. ADON AA faxed lab results for three residents on 06/05/24 but PA D faxed back responses for only two of the residents' labs which did not include Resident #1's labs. This failure could place residents at risk of not getting adequate and timely care and treatment which could cause declines in their health and psychosocial well-being. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a male who admitted to this facility 08/03/23 with a BIMS Score of 10 (moderate cognitive impairment). He had 1 sided upper extremity impairment and 2 sided lower extremity impairment and substantial maximal assist with ADL's. He was frequently incontinent to bladder and always incontinent to bowel. He had medically complex conditions with diagnoses anemia (low red blood cells and hemoglobin), hypertension (high blood pressure), peripheral vascular disease (circulatory condition/reduced blood flow). And he had diagnoses renal insufficiency (kidney failure), diabetes mellitus (high blood sugar), hyperlipidemia (high level fat particles), malnutrition (lack of nutrients), depression (lowered mood), and generalized muscle weakness (muscle weakness). Record review of Resident #1's Order Summary Report dated 06/12/24 revealed orders for, regular diet, 2.0 supplement 120cc 3xd, Amlodipine besylate oral tab 10 mg, 1-tab 1xd for HTN, hold SBP <110, DBP <60, HR 60, and Ondansetron HCl (Hydrochloride) Oral tab 4 mg 1 tab by mouth every 6 hours a needed for nausea and vomiting. And a Doctor's Order dated 06/01/24 for: CBC, CMP, TSH, Hgb A1c, Lipid panel, Mg. Record review of Resident #1's Care Plan printed 06/12/24 revealed, date initiated: 08/08/23: dialysis due to chronic kidney disease, altered respiratory status/difficulty breathing related to history of respiratory failure, impaired cognitive function or thought processes. And had bladder incontinence, communication problem and dialysis and diabetes. Date initiated: 01/25/24: potential for fluid overload related to kidney failure: will remain free of signs/symptoms of fluid overload through review date, as evidenced by . changes in mood or behavior, nausea/vomiting . Monitor/document/report to MD PRN signs/symptoms of fluid overload. Hypertension related to Norvasc - Oral. Date Initiated: 08/09/2023, Revision on: 08/09/2023: will maintain a blood pressure within the following parameters: (110/60) through review date. Revision on: 03/03/2024, Target Date: 07/21/2024. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Progress note by ADON AA dated 06/05/2024 revealed, PA D notified of CBC w Diff, Platelets / Glycohemoglobin (Hgb A1C) / TSH / CMP / Lipid Panel w/ Calc LDL /Magnesium results waiting for response for PA D. Record review of Resident #1's Progress note by ADON AA Late Entry dated 06/06/24 revealed, Np was notified Lab results didn't give any new orders. Record review on 06/12/24 at 10:25 am, of Resident #1's Lab Results in the EMR dated 06/03/24 revealed, Flagged abnormal - CBC w diff, platelets .completed .collection date: 06/03/24 at 5:15 am .Reported date: 06/03/24 at 9:50 am -Review Status: To be reviewed. Record review on 06/14/24 at 10:15 am of Resident #1's Lab results in the EMR dated 06/03/24 revealed, Flagged abnormal - CBC w diff, platelets .completed .collection date: 06/03/24 at 5:15 am .Reported date: 06/03/24 at 9:50 am -Review Status: Reviewed. Interview on 06/12/24 at 1:07 pm, ADON AA stated Resident #1's lab results showed he had an elevated white blood cell count that was abnormal. She stated she faxed his lab results with two other resident's lab results to PA D on Wednesday 06/05/24. She stated PA D only faxed back orders for the two other residents which did not include the review of Resident #1's Lab work. She stated it was time for her shift to end and she told LVN CC about following up with the Doctor. She stated the norm was if the PA/MD did not fax the labs back with new orders it meant there were no new orders. She stated in hindsight she should have called Resident #1's PA/MD for clarification. She stated if a resident's Doctor did not review the resident's labs, could cause a resident to get worse if the issue with the labs was not addressed. Interview on 06/12/24 at 5:52 pm, PA D stated she was temporarily working in the place of the main PA for this facility. She stated she last saw Resident #1 on 06/01/24 and ordered labs because of his elevated blood sugars, because he was noncompliant with dialysis at times. She stated she was notified about his 06/03/24 lab results just recently this week and was not sure who she spoke to or when. Interview on 06/12/24 at 6:10 pm, DON stated they started training the staff on lab services because Resident #1's abnormal lab report showed his WBC was 12 and not critical but was abnormal enough for the PA/MD to have been contacted on 06/05/24 when it was available for review. She stated ADON AA needed to have a follow up confirmation on if there really were no new orders even if she did not hear from PA/MD. The DON said she should have reached out again. She stated if she still had no PA/MD response she should have reached out to the Medical Director. She stated they wrote up ADON AA today 06/12/24 and started Inservice trainings with the nurses on what the they were supposed to do when they received labs. Interview on 06/12/24 at 6:58 pm, the Administrator stated that ADON AA did not follow-up with PA/MD, and just recently heard PA D told ADON AA she overlooked Resident #1's lab results by accident. He stated for abnormal lab results ADON AA was supposed to call PA/MD immediately and if she was having any problems, she should have called the DON the same day 06/05/24. He stated the ADON and DON were responsible for ensuring the labs were being communicated to the PA/MD. Record review on 06/13/24 at 8:30 am of the facility's Trainings signature, sheet for Labs/Xray procedures revealed they were adequately training and proficient. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interviews on 06/13/24 between 10:32 am - 11:40 am with RN E, RN F, LVN G, revealed they were trained on what to do once they received and ensuring the PA/MD reviewed the lab orders. Interview on 06/13/24 at 4:52 pm, the DON stated the resident's primary nurse was responsible for notifying the resident's doctor and following up on the reviewed labs. She stated she was responsible for ensuring labs were relayed to the PA/MD and added they had standup meetings to review labs but they were also going to have the On-call nurse review the labs over the weekends to ensure none were being missed. Interview on 06/14/24 at 12:50 pm, RN T stated if the lab results were slow getting completed within four hours, they needed to clarify with their laboratory provider and notify the DON and the resident's PA/MD of status. Interview on 06/14/24 at 1:16 pm, ADON U stated she had a lot of education by the DON, RNC and other ADON's about labs /x-rays and PA/MD notification and acting on new orders from the PA/MD. She stated if the PA/MD did not respond to them she would call them and if they still did not respond she would contact the DON and Medical Director. Interview on 06/14/24 at 2:55 pm, the DON stated they needed to start reviewing the resident's labs on a daily basis doing radiology audits to ensure PA/MDs followed up with the resident's lab reviews. She stated if there was a problem, the ADONs and herself needed to assist with contacting the PA/MD. She stated she was responsible for ensuring the staff followed their and laboratory services policy. She stated not getting the PA/MD to review labs could cause the staff to miss something that could delay care. She stated it could further cause a delay in getting the resident evaluated resulting in a number of things such as a worsening condition. Interview on 06/14/24 at 4:00 pm, the Administrator stated they had done Inservice trainings with everyone. He stated his expectation for resident care was for all testing results, PA/MD notifications and documentation needed to be done. He stated lab results usually came back within four hours and went straight to their EMR system so that all the nurses had to do was check the lab results and give to the PA/MD to review. Record review of ADON AA's Corrective Action memo by DON and dated 06/12/24 revealed, Violation of policy and procedures. Employer Statement: The ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner's order. If the ordering practitioner does not immediately respond to communication of critical values, the licensed Nurse will contact the facility's Medical Director for direction and orders, as indicated. Written warning. Objectives/Solution: Employee is expected to continue trying to reach NP for direction or new orders for abnormal labs. If unable to reach NP, the employee is expected to reach out to the Facility's Medical Director will review during standdown (meeting to review and facility/resident concerns) that all labs have been followed up on with proper documentation. Employee statement: Faxed PA D all the labs that I received that day and didn't get any orders. Gave oncoming nurse to report to follow-up. Signed by ADON AA and DON. (continued on next page)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's Laboratory, Diagnostic and Radiology Services dated 06/2020 revealed, Purpose: To ensure that laboratory, diagnostic and radiology services are provided to meet the resident's needs. Policy: III. The ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner's order. Procedure: I. Laboratory, diagnostic and radiology services ordered will be documented on the 24-Hour Report or electronic health record, to ensure that services are coordinated and results are received timely . III. The ordering practitioner will be notified of results that fall outside of clinical reference or expected normal ranges per the ordering practitioner's order. B. If the ordering practitioner does not immediately respond to communication of critical values, the Licensed Nurse will contact the Facility's Medical Director for direction and orders, as indicated. C. The Licensed Nurse will document the time when results were reported to the ordering practitioner and the ordering practitioner's response or additional orders, if any.		

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NAME OF PROVIDER OR SUPPLIER Forest Park Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6825 Harry Hines Blvd Dallas, TX 75235	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32581 Based on interview and record review, the facility failed to maintain medical records on each resident that were complete and accurately documented for one (Resident #1) of eight residents reviewed for medical records. The facility failed to ensure LVN A and LVN B completely document Resident #1's BP checks and monitoring after Resident #1's BP dropped to 83/44 on 06/08/24 and 06/09/24. The facility failed to ensure Resident #1's standing orders from his nephrologist for a renal diet with fluid restrictions was added to his facility Doctor's orders. These failures could affect all residents and cause errors in care, treatments and diets which could result in a decline in their health and psycho-social well-being. Findings included: Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a male who admitted to this facility 08/03/23 with a BIMS Score of 10 (moderate cognitive impairment). He had 1 sided upper extremity impairment and 2 sided lower extremity impairment and substantial maximal assist with ADL's. He was frequently incontinent to bladder and always incontinent to bowel. He had medically complex conditions with diagnoses anemia (low red blood cells and hemoglobin), hypertension (high blood pressure), peripheral vascular disease (circulatory condition/reduced blood flow). And he had diagnoses renal insufficiency (kidney failure), diabetes mellitus (high blood sugar), hyperlipidemia (high level fat particles), malnutrition (lack of nutrients), depression (lowered mood), and generalized muscle weakness (muscle weakness). Record review of Resident #1's Doctor Order dated 06/28/23 by his dialysis Nephrologist revealed, Diet Order: Calories: 2459, protein 104 gm .fluid: 1000 ML (32 oz.). Record review of Resident #1's Order Summary Report dated 06/12/24 revealed orders for, regular diet, 2.0 supplement 120cc 3xd, Amlodipine besylate oral tab 10 mg, 1-tab 1xd for HTN, hold SBP <110, DBP <60, HR 60, and Ondansetron HCl (hydrochloride) Oral tab 4 mg 1 tab by mouth every 6 hours as needed for nausea and vomiting. After review, there were no Doctor's orders for renal diet with fluid restrictions. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #1's Care Plan printed 06/12/24 revealed, date initiated: 08/08/23: dialysis due to chronic kidney disease, altered respiratory status/difficulty breathing related to history of respiratory failure, impaired cognitive function or thought processes. And had bladder incontinence, communication problem and dialysis and diabetes. Date initiated: 01/25/24: potential for fluid overload related to kidney failure: will remain free of signs/symptoms of fluid overload through review date, as evidenced by . changes in mood or behavior, nausea/vomiting . Monitor/document/report to MD PRN signs/symptoms of fluid overload. Hypertension related to Norvasc - Oral. Date Initiated: 08/09/2023, Revision on: 08/09/2023: will maintain a blood pressure within the following parameters: (110/60) through review date. Revision on: 03/03/2024, Target Date: 07/21/2024. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow Record review of Resident #1's Progress note by LVN A dated 06/08/24 at 9:13 am revealed, Resident noted with abnormal vital signs: BP 93/44, O2:88% room air . Weakness, vomiting, poor eating. Resident offered 120 ml of orange juice, elevated head of bed, and more fluid. (There was not any documentation showing LVN A monitored or checked Resident #1's BP on 06/08/24 from 12:09 pm to 10:00 pm. And there was no documentation LVN A notified the DON and LVN B on 06/08/24 about Resident #1's change in condition). And there was no documentaton of how much fluid was given to Resident #1. Record review of Resident #1's Progress note by LVN A dated 06/09/24 at 9:15 am revealed, Resident noted with abnormal vital signs: BP 83/44, O2:88% RA . Resident very weak, nausea, vomiting, poor eating. Resident is alert. PA notified and ordered resident to be sent to hospital using 911. 911 called and took resident to hospital. Family member informed that resident is sent to hospital. DON notified. Record review on Resident #1's Progress note from 06/08/24 from 10:00 pm to 06/09/24 at 6:00 am, revealed LVN B did not document she checked on Resident #1 every two hours or at all during her shift and how much fluid she said she gave him and what his BP results were. Interview by phone on 06/12/24 at 12:28 pm, LVN A stated he worked double shift weekends and stated on 06/08/24 Resident #1 had a change in condition. LVN A said he was good and talking, but then around 7:00 am or 7:30 am he noticed his vitals were low 93/something. He stated he checked Resident #1's vitals again and it was 101/something and kept monitoring the resident and at 9:00 pm he forgot to document those vital signs in the EMR. He stated he checked his vitals several times throughout the day and was not sure why he did not document those readings. He stated he left on 06/08/24 around 10:00 pm and gave a report to LVN B to continue monitoring Resident #1 for his low BP. He stated he forgot to document it because it was the end of the shift but knew he should have documented that. He stated not documenting resident's vitals could make it very hard to follow up and compare previous conditions and limit communication because the documentation was missing. Interview on 06/12/24 at 2:20 pm, LVN B stated she was Resident #1's night shift nurse on 06/08/24 from 10:00 pm to 06/09/24 at 6:00 am and usually did her rounds between 4:00 am to 6:00 am. She stated on 06/09/24 she saw Resident #1 at 5:00 am and took his BP and it was normal and he had no fever, he was stable. She stated she put his vital signs on his dialysis paper and not the EMR and should have also put the results in the EMR. She stated she did not complete all of her documentation that night because she had a lot to do. She stated they really needed a third nurse upstairs at night to cover the E Hall, where Resident #1's room was. There was no documentation from LVN B noted in Resident #1's EMR progress notes during this timeframe. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/12/24 at 5:52 pm, PA D stated she was temporarily filling in working for the regular PA for this facility. She stated she was not sure if Resident #1 had standing orders for fluid restrictions. Interview on 06/12/24 at 6:10 pm, the DON stated she spoke to LVN A this morning 06/12/24 and educated him on doing his documentation. She stated LVN A said he rechecked Resident #1's vital signs but did not document the results. She stated LVN A should have documented into the EMR system Resident #1's BP checks but he got off work at 10:00 pm and did not do it. She stated she spoke to LVN B who also did not do any documentation on Resident #1's BP checks, because she said she was not told Resident #1 had abnormal vitals. She stated LVN B said she did not follow-up with Resident #1's vitals because LVN A did not notify her of his abnormal vitals. Resident #1 did not have any fluid restriction standing orders but could see LVN A gave Resident #1 120 cc of orange juice on 06/08/24. She stated she was not aware Resident #1's progress note showed LVN A gave the resident 'more fluids'. Interview on 06/14/24 at 11:52 am, the Medical Records Director stated she was responsible for ensuring the medical records were accurate. Interview on 06/14/24 at 2:55 pm, the DON stated they would start having the on-call weekend nurse review the 24-hour EMR dashboard for any changes of the resident's vital signs and nurses' documentation. She stated she was responsible for ensuring the staff accurately completed their documentation. She stated if the staff did not document it could cause the staff to miss something that could delay care. She stated it could further cause a delay in getting the resident evaluated resulting in a number of things such as a worsening condition. Interviews on 06/14/24 between 11:44 am - 3:34 pm revealed, LVN K, RN T, ADON U and RN Z stated they were trained between 06/10/24 and 06/14/24 on documentation resident BP checks and change in conditions. Interview on 06/14/24 at 9:19 am, Resident #1's Dialysis nurse stated Resident #1 was on renal diet with fluid restrictions. Interview on 06/14/24 at 9:28 am, Resident #1's Dialysis Dietitian stated Resident #1 was on a 32 oz. per day fluid restriction. She stated if a resident went over the 32 oz. per day it could cause them to have breathing problems and edema (swelling). Interview on 06/14/24 at 11:10 am, RNC stated they were still working on their investigation summary. She stated LVN A gave Resident #1 120 cc of orange juice from his meal tray and was not aware more fluids was given as reported in the progress notes, she said Resident #1 was not on a fluid restriction or renal diet and they just recently scheduled a meeting with Resident #1's dialysis staff to get fluid restriction and renal diet clarified and go over other dialysis orders to ensure they were accurate. Interview on 06/14/24 at 4:00 pm, the Administrator stated they had a new weekend nurse supervisor and planned to complete Inservice trainings with everyone. He stated his expectation for resident care was for documentation to be done. He stated they have a care meeting scheduled with the resident's dialysis center next week to ensure the Doctor's orders were correct. He stated the Medical Director agreed the meeting with dialysis was a good idea. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/18/24 at 9:54 am, Resident #1's Dialysis Nurse Manager stated Resident #1 had a doctor's order for a renal diet, with a 32 oz. fluid restriction. He stated All patients on dialysis should have a standard protocol of standing orders for renal diet with fluid restrictions. He stated if the residents who were on dialysis were to have too much fluid they could get fluid overload, which could collect in their lungs and make it hard for them to breathe. He stated the facility exchanged communication sheets with them before and after each of Resident #1's treatment sessions. Record review of signage posting currently being put at all nurses stations: NOTIFY MD/NP OF LOW BLOOD PRESSURES . SYSTOLIC LESS THAN 95 DIASTOLIC LESS THAN . SYSTOLIC GREATER THAN 170 AND DIASTIC GREATER THAN 90 . ASSESS YOUR PATIENT AND DOCUMENT. Review of the facility's Physician Orders policy dated 06/2020, revealed. Purpose: This will ensure that all physician orders are complete and accurate. Policy: The Medical Records Department will verify that physician orders are complete, accurate and clarified, as necessary. Procedure: I. Telephone Orders A. A Licensed Nurse will transcribe telephone orders with date, time, and signature of the person receiving the order. II. Orders will include a description complete enough to ensure clarity of the physician's plan of care. III. Physician orders will only include abbreviations that have been approved by the Facility. IV. Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. V. Medication/treatment orders will be transcribed onto the appropriate resident administration record. Orders pertaining to other health care disciplines will be transcribed onto the appropriate communication system for that discipline. VI. Documentation pertaining to physician orders. Review of the facility's Medical records policy dated 06/2020 revealed, Purpose: To ensure adequate and accurate documentation of care provided to each resident while at the Facility. Policy: The Facility will maintain a medical record for each resident admitted to the Facility that will contain sufficient information to identify the resident, support the diagnosis, justify the medical necessity for treatment, and facilitate continuity of care among health care providers. Procedure: The medical record will be accurate, timely and complete and may include the following content: . (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CC. Notification to Physician - Documentation and notification to the physician promptly of the following: ii. Change of condition. iii. Unusual occurrences involving the resident. iv. Significant change in weight. v. Side effects or reaction to medication/treatment. viii. Attempts to notify the physician will be noted, including the time, method of communication, the name of the person acknowledging contact, if any. If the Attending Physician is not readily available, emergency care will be provided. DD. Physician Orders. Record review of the Facility's Documentation policy dated 06/2020 revealed, Purpose. To provide documentation of resident status and care given by nursing staff. Policy Nursing documentation will be concise, clear, pertinent, accurate and evidence based. Narrative charting, as outlined in specific policies and procedures, will be used for initial treatments or procedures .Nursing staff will not falsify or improperly correct nursing documentation. Procedure: I. Nursing Documentation A. Admission nursing assessments completed by individual assessment on the day of admission. D. Any communications with family, durable power of attorney (DPOA), or physician is to be noted in nurse's notes. E. All laboratory data will be dated, timed, and initialed when received and initially reviewed by a licensed [sic]. o This notation may be made on the laboratory results page. - o The date, time, and signature of the licensed nurse reviewing the laboratory data and the disposition of that information shall be noted in the nurse's notes. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F. Nurse's notes are dated, timed, and signed when written. J. Treatments completed and documented as per physician's order. K. Documentation will be completed by the end of the assigned shift. II. Alert Charting A. Alert charting is documentation done to track a medical event for a period of 72 hours or longer. B. Alert charting is completed by professional staff rather than non-professional staff. C. Events may include but are not necessarily limited to: (a) New physician orders; (b) Suspected or actual change in condition. D. Alert charted describes what is going on. (a) Describe the resident's condition, include what you see, hear, smell, feel, etc. (c) Describe what you have done in response to what is going on with the resident.		