STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676402	A. Building B. Wing	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windemere at Westover Hills	11106 Christus Hills San Antonio, TX 78251

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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** 39251 Based on and interview and record review, the facility failed to immediately inform the resident's physician when there was a significant change in the resident's physical, mental, or psychosocial status for 1 of 4 residents (Resident #1) reviewed for physician notification of changes. The facility failed to inform Resident #1's physician on 3/11/25 when a BP of 80/42 was obtained by LVN A before Resident #1 was transported to dialysis. Resident #1 was treated for hypotension at the hospital after being sent there from dialysis. An Immediate Jeopardy (IJ) was identified on 4/11/25. The IJ template was presented to the facility ED and DON on 4/11/25 at 6:30 pm. While the IJ was removed on 4/16/25 at 11:16 am, 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 due to the facility's need to evaluate the effectiveness of the corrective measures. This failure could affect residents by placing them at risk for a delay in medical treatment, decline in health, and death. Findings included: Record review of the Face Sheet, dated 4/10/25, reflected Resident #1 was admitted to the facility on [DATE] with diagnoses that included: End Stage Renal Disease (kidneys can longer function due to permanent damage). Record review of Resident #1's comprehensive MDS assessment, dated 3/14/25, reflected Resident #1 had a BIMS score of 12, suggesting moderately impaired cognition. Further review reflected Resident #1 had an ostomy (a surgical procedure to create an opening on the abdominal wall); renal insufficiency, renal failure, or end stage renal disease; received dialysis; received PT and OT. Record review of Resident #1's Care Plan, dated 4/16/25, reflected: . [Resident #1] is at risk for .abnormal BP related to renal failure .Notify MD of .BP concerns . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's dialysis Treatment Details Report, dated 3/11/25 10:31 am - 1:31 pm, reflected Resident #1 had a pre-treatment BP of 88/43. Further review revealed the Treatment Nurse Assessment section reflected: .Comment PRE Patient is hypotensive; MD was notified of low BP, verbal order given to .bolus 500 mLs of NS at start of treatment and see if BP stabilizes .O2 administered at 2 LMP [sic] for BP support; CN called nursing facility and they stated his BP was 80/42 and had requested to go to the [Hospital] prior to arrival here at the dialysis facility; Patient agreed to dialyze first then go to the [Hospital] post treatment, if still needed. POST patient is requesting to be taken to the [Hospital] for generalized weakness and hypotension .CLOSE TREATMENT REASON Patient Choice (AMA, feels unwell .) Record review of Resident #1's Progress Note, effective date 3/11/25 at 11:14 am and written by LVN A, reflected, .Resident complains of generalized pain and requesting to be sent out to [Hospital] to see Nephrologist. Resident VS 80/42 [BP], 70 [HR], 18 [RR], 92% [SpO2], 97.9 [T]. notified ADON [RN OO] and made resident aware that if he was [sic] to be sent out, he would more than likely be taken to an ER nearby and if he went to dialysis, he could follow up with his nephrologist there. Resident voiced understanding . Resident transferred to dialysis via [Ambulance company] at 0940 [9:40 am]. Received call from [Dialysis RN] who stated that resident BP remains low, [Dialysis RN] obtained orders from Nephrologist to administer IV fluids to stabilize BP, if unable to do so resident will be sent out to [Hospital] for further eval and treatment. [NP J] and [Facility] ADON made aware . Record review of Resident #1's Occupational Therapy Treatment Encounter Note, dated 3/11/25, reflected: . he was c/o max pain to posterior neck. he reported he did not want any therapy today .He reported after dialysis he was planning to go to [Hospital] (by [rideshare] if he had to) to get a full assessment to out why he has been feeling sick, having increased neck pain and having issues with low BP. Notified Nurse who reported she was aware of this .Electronically signed by [OT] 3/11/25 01:45:47 PM . Record review of Resident #1's Progress Note, effective date 3/12/25 at 3:32 am and written by LVN B, reflected, .this nurse received call from [Hospital A], and received report that pt was on transport back to [Facility]. as per report .pt was taken to hospital from dialysis for low BP. Pt was administered a total of 1500 cc of fluids and BP did increase with last set of vs before dc of 110/55 [BP], 60 [HR], 18 [RR], 97% [SpO2] Ra, and 98.4 [T] .vs obtained 105/45 [BP], 94 [HR], 92% [SpO2], 98.8 [T], and 16 [RR] . During a telephone interview on 4/11/25 at 12:36 pm, LVN A said she reported Resident #1's BP of 80/42 on 3/11/25 to RN OO (Former ADON), the Dialysis nurse, and believed she also spoke to the NP. LVN A said she called the DC on 3/11/25 to report Resident #1's BP of 80/42 and was told that Resident #1 had received fluids but was still requesting to go to the hospital, so the DC sent him to the hospital. LVN A then stated she did not initiate the call to the DC to notify them of Resident #1's BP of 80/42 but sent the dialysis communication form with the resident. LVN A further stated the dialysis called her to inform her of Resident #1's low BP. LVN A said the facility policy was to follow-up with the ADON and NP regarding changes in resident condition and swore she had documented her contact with the NP regarding Resident #1's BP of 80/42 on 3/11/25. LVN A said she was unable to find the text she sent NP J regarding Resident #1's BP on 3/11/25 but knew that NP J was notified and LVN A did not receive any new orders from NP J on 3/11/15 to treat Resident #1's BP but was told to send the resident to dialysis. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A phone interview was attempted on 4/11/25 at 2:06 pm with LVN A that was unsuccessful, no call back received. A phone interview was attempted on 4/11/25 at 2:20 pm with LVN A that was unsuccessful, no call back received. During a telephone interview on 4/11/25 at 1:22 pm, NP H said she did not have any text messages from the facility on 3/11/25. NP H further stated that the facility was responsible for notifying her of any abnormal findings. NP H said she should have been notified of Resident #1's BP of 80/42 on 3/11/25. NP H said had she been notified of Resident #1's condition on 3/11/25, Resident #1 would have been sent to the hospital via EMS. NP H further stated she would not have told the facility staff to send Resident #1 to dialysis because he was hypotensive, and his BP was not sustainable for dialysis or everyday life. During a telephone interview on 4/11/25 at 2:25 pm, RN OO (Former ADON), who was no longer employed at the facility, said he did not remember what happened with Resident #1 on 3/11/25, he said he should have been notified of Resident #1's BP but did not remember if he was. RN OO said the facility had a protocol that stated the physician/NP was to be notified if a resident had a low BP. RN OO said the charge nurse, he believed was LVN A, was responsible for notifying the physician/NP regarding Resident #1's BP of 80/42 for recommendations. During an interview on 4/11/25 at 2:56 pm, the DON said Resident #1 was sent to the hospital from the DC, where he received fluids on 3/11/25. The DON said she was not notified of Resident #1's BP of 80/42 on 3/11/25. The DON further stated that Resident #1's documentation reflected that RN OO (Former ADON) was notified and that RN OO would have recommended that the NP be called. The DON said that according to Resident #1's documentation, it seemed the NP was notified of Resident #1's BP of 80/42 on 3/11/25 before he went to dialysis. During an interview on 4/11/25 at 4:12 pm, the DON said that Resident #1's fluctuation in BP was due to dialysis, he was new to dialysis, and this was common with dialysis residents. During an interview on 4/14/25 at 1:16 pm, the OT said she saw Resident #1 before dialysis. The OT said that Resident #1 complained of pain to his neck. The OT said that she was told by Resident #1 that he had told the nurse he wanted to go to the hospital and wanted a full assessment because his BP had been low. The OT further stated she did let the nurse know that Resident #1 was not feeling well and wanted to go to the hospital and would go however he could. The OT said she believed the nurse she reported this to was LVN A and LVN A said she was aware of Resident #1's concerns. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/16/25 at 2:28 pm, the DON said nurses were responsible for communicating any changes in resident condition and the ADON was responsible for monitoring to ensure nurses were notifying the physician/NP about changes in resident condition through communication with the nurses. The DON said that LVN A said she contacted NP J regarding Resident #1's BP and thought that Resident #1 would have been able to see the nephrologist quicker if he went to dialysis. The DON said it was important to communicate with the DC and the physician/NP about changes in resident condition prior to dialysis because it might be determined that the resident should not go to dialysis or intervention may be ordered for the resident. The DON further stated that LVN A documented she contacted NP J, and it was determined Resident #1 should go to dialysis. The DON said dialysis residents' BP fluctuated and it was the responsibility of the DC to decide whether they will treat the resident or not. A phone interview was attempted on 4/16/25 at 3:01 pm with the ADON that was unsuccessful, no call back received. During a telephone interview on 4/16/25 at 12:36 pm, NP J said she was not familiar with Resident #1. NP J further stated she did not have recollection of a notification regarding a BP of 80/42 or request to go to the hospital on 3/11/25. NP J said if she had been notified, she would have addressed the BP by asking questions and assessing the situation further to see what interventions to put in place. During a telephone interview on 4/16/25 at 3:06 pm, the DCS said the DC was not called prior to Resident #1 arriving to the center on 3/11/25. The DCS further stated the DC did not have a physician on-site. The DCS said the physician was notified by the DC on 3/11/25 that Resident #1 had low BP and an order was received to administer fluids to rule out dehydration. The DCS said IV fluids were administered to Resident #1, but the low BP did not resolve so the resident had to be sent to the hospital. During an interview on 4/16/25 at 3:04 pm, the ED said the nurse manager, or the DON were responsible for ensuring the physician/NP was contacted when there was a change in resident condition by reviewing the 24-hour report. The ED further stated the facility policy stated the physician/NP should be notified regarding changes in resident condition. Record review of facility policy Resident Rights, revised December 2016, reflected: .1. Federal and state laws guarantee certain basic rights to all resident of this facility. These rights include the resident's right to .f. communication with and access to people and services, both inside and outside the facility; g. exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; h. be supported by the facility in exercising his or her rights; i. exercise his or her rights without interference, coercion, discrimination or reprisal from the facility . Record review of facility policy Change in a Resident's Condition or Status, revised February 2021, reflected: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .1. The nurse will notify the resident's attending physician or physician on call when there has been a(an) .d. significant change in resident' physical/emotional/mental condition. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This was determined to be an Immediate Jeopardy (IJ) on 4/11/25. The IJ template was presented to the facility ED and DON on 4/11/25 at 6:30 pm. The following Plan of Removal (POR) was accepted on 4/12/25 at 3:12 pm: [Facility] Plan of Removal for Immediate Jeopardy F580 IJ- Notification of Change Date/Time of Notification to the Facility: 04/11/2025 at 6:30pm This is to confirm the submission of our Plan of Removal (POR) provided by this facility. For F580 IJ. The submission of this POR does not constitute an admission on the part of the facility as to accuracy of the surveyor's findings, the conclusion drawn from there, nor is the scope and or severity regarding any deficiency cited applied correctly. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 is no longer in the facility. On 4/11/2025 at 7:32 PM the facility Executive Director and Director of Nursing notified the Medical Director of receiving the Immediate Jeopardy. The Executive Director and DON notified the Medical Director and the Attending Physician of the resident who had an adverse reaction. All notifications were completed by 4/11/2025. On 04/11/25 at 7:30pm An Emergency QAPI meeting, via TEAMS was held with the Medical Director, LNHA, DON, ADON's, the Regional Director of Clinical Services, the Director of Regulatory Compliance, The CNO and the Regional [NAME] President to review present policies and protocols on Notification of Change and Abuse, Neglect and Misappropriation Prevention. The policies and protocols were deemed sufficient. The QAPI team also formulated the interventions to be presented for the Plan of Removal. On 04/11/2025 The Administrator, DON and ADON's were re in serviced by the RDCS (Regional Director of Clinical Services) on Policies and Protocol concerning Physician Notification, Change in Condition, Abuse Prevention, and Hydration Dashboard review. On 4/11/2025 an in-service was initiated by DON/Designee on the Change of Condition/Interact policy to include a pre and post test, Physician notification, and the abuse policy to include what to do in the event the patient request to go to the hospital. On 4/11/2025, the facility initiated education to CNA/CMA, and Therapists will be in-serviced on notification of condition changes and utilization of our stop and watch tool to report changes in patient condition to the licensed staff, to include if a patient requests to go to the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility will complete education with licensed nursing staff by 4/12/2025. Any staff who are not present to complete the in-servicing by 4/12/2025 will be required to complete the in-servicing at the start of their next shift before beginning work. The facility will complete in-service with CNA/CMA and Therapist by 4/12/2025. Any staff who are not present to complete in-service by 4/12/2025 will be required to complete the in-service at the start of their next shift before beginning work. New Hires, PRN and any agency staff will also be in-serviced prior to the start of their shift. Abuse, neglect, and exploitation education with licensed and non-licensed staff will be completed by 4/13/2025. Any staff who are not present to complete the training by 4/13/2025 will be required to complete the in-service at the start of their next shift before beginning work. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 4/11/25-The Director of Nursing and nurse leadership completed 100% checks of resident vital signs, identifying any vitals that are not within normal limits and will ensure the providers were notified. This was completed on 4/11/2025, all residents were at their baseline and stable. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/11/2025-The facility initiated, at a minimum, daily vital signs for all patients to assist in identifying changes in resident conditions. On 4/11/2025-The physician notification policy was updated to include if a resident requests to go to the hospital. On 4/11/2025- The DON/designee initiated in-servicing with the licensed nurses to review vital signs every shift by running the patient vital sign report in the EHR for abnormal results and initiating the change of condition process, if indicated. Any staff who are not present to complete the training by 4/11/2025 will be required to complete the in-service at the start of their next shift before beginning work. New hires will also be in-serviced prior to the start of their shift. On 4/11/2025- the Director of Nursing and Administrator were in-serviced by the Sr. Regional Director of Clinical Services on the following policies: reporting change in condition, the Interact process, change of condition, abuse and neglect, and the hydration dashboard review. The was completed on 4/11/2025. How the facility plans to monitor its performance to make sure that solutions are sustained: The DON/designee will review the hydration dashboard daily for patient changes of condition such as abnormal vital signs, poor meal intake and dehydration symptoms, and will follow up with the charge nurses to ensure the change of condition process was followed. On the weekend, the supervisor/designee will review the hydration dashboard daily for patient changes of condition and will follow up with the charge nurses to ensure the change of condition process was followed. The hydration dashboard will be printed and filed in a binder daily for 1 week then weekly for 3 weeks beginning 4/11/25. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Director of Nursing/or designee will review resident 24-hour report and dashboard (nursing documentation) daily for 1 week, then weekly for 3 weeks beginning 4/11/2025 to monitor for patient change of conditions and ensure notification to providers was done utilizing a check off tool. The Director of Nursing/or designee will monitor to ensure the nurses are running the patient vital sign report every shift daily for 1 week, then weekly for 3 weeks beginning 4/11/2025 utilizing a check off tool. This process will be validated and checked off, by the Administrator/and or designee to ensure compliance of notification change utilizing a check off tool daily used for compliance. Results of audits and reviews will be reported to and reviewed by QAPI committee monthly for three months. POR verification: During a telephone interview on 4/14/25 at 4:11 pm, the MD said he was informed of the IJ. Record review of QAPI meeting minutes, dated 4/11/25, reflected the facility immediately contacted the executive team and MD of the IJ. Further review revealed 100% of residents VS were reviewed, education regarding changes in condition, notifying the physician of clinical changes, and abuse/neglect/exploitation will be completed, and the DON will review the Hydration Dashboard (report used to review residents' VS, meal intake, etc. to monitor residents for dehydration) and results of audits reported to the QAPI committee. Record review of staff training reflected 30 of 30 full time licensed nursing staff across all shifts had been in-serviced. In-services included: Change in Condition (including when a resident requested to go to the hospital), reviewing the VS reports every shift, Physician Notification (including notifying the physician/NP of changes in resident condition). Record review of staff training reflected 40 of 40 unlicensed staff/Therapists across all shifts had been in-serviced. In-service included Stop and Watch, an early warning tool used to identify changes in resident condition. Record review of staff training reflected 88 of 88 full time staff had been in-serviced regarding abuse and neglect, including when to report and to whom to report. Interviews between 4/13/25 at 11:51 am and 4/14/25 at 2:24 pm with 37% of staff employed at the facility (LVN B, RN F, LVN I, CNA K, CNA L, CMA M, CMA N, LVN O, RN P, HSKPR Q, REC R, HSKPR S, CNA T, CNA U, CNA V, CNA W, CMA X, LVN Y, LVN AA, LVN BB, CNA DD, CNA EE, CNA FF, CNA GG, CNA JJ, REC LL, REC MM, LVN NN, OT, PT, and DOR) revealed in-services were conducted. Interviewed staff said ins-services included: abuse/neglect and who to report it to, Stop and Watch (a tool used to document/report changes in resident condition), notifying the Physician/NP of changes in resident condition, documentation of changes in condition using SBAR, and review/documentation of VS every shift, and what to do if a resident requests to go to the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Staff interviewed included: 7 staff worked 6:00 am - 2:00 pm, 7 staff worked 2:00 pm - 10:00 pm, 5 staff who worked 10:00 pm - 6:00 am, 3 staff who worked 8:00 AM - 5:00 PM, 5 staff worked 6:00 AM - 10:00 PM, and 4 staff who worked PRN. Record review of VS logs reflected 100% of residents' VS were reviewed by the DON and abnormal values were noted and the physician/NP notified as needed for resident with abnormal VS values. During an interview on 4/13/25 at 12:32 pm, the DON said nurses were expected to obtain and document VS every shift and she or the weekend supervisor would review the report daily for abnormal values. Record review of staff training reflected the ED and DON were in-serviced on 4/11/25 by RDCS regarding physician notification, change in condition, abuse/neglect, SBAR, and Hydration Dashboard review. Record review of staff training reflected 8 of 8 nurse supervisors were in-serviced on 4/13/25 by the DON regarding the Vital Sign Monitor Tracking Tool. Interviews between 4/13/25 at 1:47 pm - 2:00 pm with 3 nurse supervisors (RN F, LVN I, and LVN LL) revealed an in-service was conducted regarding the Vital Sign Monitor Tracking Tool. The nurse supervisors said they were expected to review their assigned residents' VS every shift for trends, sign the form to document completion, and give it to the ADON/DON. The nurse supervisors further stated they were expected to complete a CIC form and notify the physician/NP for any abnormal values noted. During an interview on 4/14/25 at 3:38 pm, the DON said she reviewed VS for 100% of residents residing at the facility. The DON further stated all abnormal VS were reported to the physician/NP and SBARs completed for all residents identified. the DON said she/designee/staffing coordinator were responsible for ensuring all new hires, PRN and agency staff were in-serviced related to abuse/neglect, Stop and Watch Early Warning Tool, change in condition, and SBAR, prior to the start of their next shift. During an interview on 4/14/25 at 3:40 pm, the DON said she was responsible for ensuring nurses reviewed resident VS every shift. The DON further stated a log was implemented and nurses were expected to review VS for their assigned resident, document on the log whether any trends/patterns were identified, sign the log, contact the physician/MD if needed, and complete a progress note or SBAR if needed. During an interview on 4/14/25 at 3:43 pm, the DON said she was in-serviced on 4/11/25 by the RDCS regarding her responsibility related to VS, the Hydration Monitoring Tool, physician notifications, CIC, SBAR, and abuse/neglect. During an interview on 4/14/25 at 3:46 pm, the ED said she was in-serviced on 4/11/25 by the RDCS regarding CIC, abuse/neglect, notifying the physicians regarding any changes in resident condition, SBAR, Hydration Dashboard, VS, and weight summaries. Record review of the facility policy Physician Notification, revised April 2025, reflected it was updated to include resident requests to go to the hospital. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The ED, DON, and RDCN were informed the Immediate Jeopardy was removed on 4/16/25 at 11:16 am. While the IJ was removed, 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, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.

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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** 39251 Based on interviews and record reviews, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 4 residents (Resident #1) reviewed for quality of care. The facility failed to immediately intervene when Resident #1 was found to have a BP of 80/42, complained of generalized pain, and requested to go to the hospital on 3/11/25. An Immediate Jeopardy (IJ) was identified on 4/14/25. The IJ template was presented to the facility ED, DON, RDCS, and VPO (via telephone) on 4/14/25 at 1:58 pm. While the IJ was removed on 4/16/25 at 11:16 am, 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, due to the facility's need to evaluate the effectiveness of the corrective measures. This failure could affect residents who experience a change in condition by placing them at risk for a delay in medical treatment, decline in health, and death. Findings included: Record review of the Face Sheet, dated 4/10/25, reflected Resident #1 was admitted to the facility on [DATE] with diagnoses that included: End Stage Renal Disease (kidneys can longer function due to permanent damage). Record review of Resident #1's comprehensive MDS assessment, dated 3/14/25, reflected Resident #1 had a BIMS score of 12, suggesting moderately impaired cognition. Further review reflected Resident #1 had an ostomy (a surgical procedure to create an opening on the abdominal wall); renal insufficiency, renal failure, or end stage renal disease; received dialysis; received PT and OT. Record review of Resident #1's Care Plan, dated 4/16/25, reflected: . [Resident #1] is at risk for .abnormal BP related to renal failure .Notify MD of .BP concerns . Record review of Resident #1's dialysis Treatment Details Report, dated 3/11/25 10:31 am - 1:31 pm, reflected Resident #1 had a pre-treatment BP of 88/43. Further review revealed the Treatment Nurse Assessment section reflected: .Comment PRE Patient is hypotensive; MD was notified of low BP, verbal order given to .bolus 500 mLs of NS at start of treatment and see if BP stabilizes .O2 administered at 2 LMP [sic] for BP support; CN called nursing facility and they stated his BP was 80/42 and had requested to go to the [Hospital] prior to arrival here at the dialysis facility; Patient agreed to dialyze first then go to the [Hospital] post treatment, if still needed. POST patient is requesting to be taken to the [Hospital] for generalized weakness and hypotension .CLOSE TREATMENT REASON Patient Choice (AMA, feels unwell .) (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 Progress Note, effective date 3/11/25 at 11:14 am and written by LVN A reflected, .Resident complains of generalized pain and requesting to be sent out to [Hospital] to see Nephrologist. Resident VS 80/42 [BP], 70 [HR], 18 [RR], 92% [SpO2], 97.9 [T] .made resident aware that if he was to be sent out, he would more than likely be taken to an ER nearby and if he went to dialysis, he could follow up with his nephrologist there. Resident voiced understanding .Resident transferred to dialysis via [Ambulance company] at 0940 [9:40 am]. Received call from [Dialysis RN] who stated that resident BP remains low, [Dialysis RN] obtained orders from Nephrologist to administer IV fluids to stabilize BP, if unable to do so resident will be sent out to [Hospital] for further eval and treatment . Record review of Resident #1's Occupational Therapy Treatment Encounter Note, dated 3/11/25, reflected: . he was c/o max pain to posterior neck. he reported he did not want any therapy today .He reported after dialysis he was planning to go to [Hospital] (by [Rideshare] if he had to) to get a full assessment to find out why he has been feeling sick, having increased neck pain and having issues with low bp. Notified Nurse who reported she was aware of this .Electronically signed by [OT] 3/11/25 01:45:47 PM . Record review of Resident #1's Progress Note, effective date 3/12/25 at 3:32 am and written by LVN B reflected, .pt was taken to hospital from dialysis for low BP. Pt was administered a total of 1500 cc of fluids and BP did increase with last set of vs before dc of 110/55 [BP], 60 [HR], 18 [RR], 97% [SpO2] Ra, and 98.4 [T] .vs obtained 105/45 [BP], 94 [HR], 92% [SpO2], 98.8 [T], and 16 [RR] . During a telephone interview on 4/11/25 at 12:36 pm, LVN A said she reported Resident #1's BP of 80/42 and request to go to Hospital A on 3/11/25 to RN OO (Former ADON), the dialysis nurse, and believed she also spoke to the NP. LVN A further stated she was told by RN OO not to send Resident #1 to the hospital but to inform the NP and send Resident #1 to dialysis as scheduled. LVN A said she was told by RN OO that Resident #1 usually had low BPs and it would be best for him to go to dialysis. LVN A said Resident #1 requested to go to the ER and wanted to be seen by his nephrologist and was told by RN OO that Resident #1 would be seen by the nephrologist at the dialysis center. LVN A said she did not know if there was a nephrologist at the dialysis center. LVN A said she was told by the dialysis center that they reached out to the nephrologist and was told to administer fluids to Resident #1. LVN A further stated she was told by the dialysis center that Resident #1 requested to the hospital and Resident #1 was sent to the hospital by the dialysis center. LVN A said she was asked by the dialysis center why Resident #1 was not sent to the hospital when he requested to go. LVN A said if a resident requested to go the hospital, she was expected to assess the resident and notify the ADON. A request for Resident #1's medical records was submitted to Hospital A on 4/16/25, records are pending. During a telephone interview on 4/11/25 at 1:22 pm, NP H said had she been notified of Resident #1's condition on 3/11/25, Resident #1 would have been sent to the hospital via EMS. NP H further stated she would not have told the facility staff to send Resident #1 to dialysis because he was hypotensive, and his BP was not sustainable for dialysis or everyday life. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 4/11/25 at 2:25 pm, RN OO (Former ADON), who was no longer employed at the facility, said he did not remember what happened with Resident #1 on 3/11/25. RN OO said if a resident requested to go the hospital, the physician would be called for orders and the resident was usually transported to the hospital per resident request. RN OO said the charge nurse, he believed was LVN A, was responsible for notifying the physician/NP regarding Resident #1's BP of 80/42 for recommendations. RN OO said he would not have sent Resident #1 to dialysis; the physician would have been contacted for orders. RN OO further stated it was his understanding there was a nephrologist at the dialysis center, but he was not sure. During an interview on 4/11/25 at 2:56 pm, the DON said Resident #1 was sent to the hospital from the DC, where he received fluids on 3/11/25. The DON further stated LVN A should have sent Resident #1 to the hospital on 3/11/25, adding this was the resident's right. The DON said the nephrologist managed the DC but did not think he was always at the DC. During an interview on 4/11/25 at 4:12 pm, the DON said that Resident #1's fluctuation in BP was due to dialysis, he was new to dialysis, and BP fluctuations were common with dialysis residents. During an interview on 4/1/425 at 1:16 pm, the OT said she saw Resident #1 before dialysis. The OT said that Resident #1 complained of pain to his neck. The OT said that she was told by Resident #1 that he had told the nurse he wanted to go to the hospital and wanted a full assessment because his BP had been low. The OT further stated she did let the nurse know that Resident #1 was not feeling well and wanted to go to the hospital and would go however he could. The OT said she believed the nurse she reported this to was LVN A and LVN A said she was aware of Resident #1's concerns. During an interview on 4/16/25 at 2:28 pm, the DON said LVN A thought that Resident #1 would have been able to see the nephrologist quicker if he went to dialysis. The DON said it was important to communicate with the DC and the physician/NP about changes in resident condition prior to dialysis because it might be determined that the resident should not go to dialysis or intervention may be ordered for the resident. The DON further stated that LVN A documented she contacted NP J, and it was determined Resident #1 should go to dialysis. The DON said dialysis residents' BP fluctuated and it was the responsibility of the DC to decide whether they will treat the resident or not. During a telephone interview on 4/16/25 at 3:06 pm, the DCS said the DC did not have a physician on-site. The DCS said the physician was notified by the DC on 3/11/25 that Resident #1 had low BP and an order was received to administer fluids to rule out dehydration. The DCS said IV fluids were administered to Resident #1, but the low BP did not resolve so the resident had to be sent to the hospital. Record review of facility policy Change in a Resident's Condition or Status, revised February 2021, reflected: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status .1. The nurse will notify the resident's attending physician or physician on call when there has been a(an) .d. significant change in resident' physical/emotional/mental condition. (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 facility policy Physician Notification, revised April 2025, reflected: The types of conditions which arise frequently are listed. This list is not inclusive .Vital signs .Patient requests to go to the hospital. It is the responsibility of the nursing staff to observe the change, make an assessment, and notify the physician as indicated based on the assessment .The nurse will: - Recognize the condition change .- Notify the physician, patient and patient representative of any change in condition . This was determined to be an Immediate Jeopardy (IJ) on 4/14/25. The IJ template was presented to the facility ED, DON, RDCS, and VPO (via telephone) on 4/14/25 at 1:58 pm. The following Plan of Removal (POR) was accepted on 4/15/25 at 11:19 am: [Facility] Plan of Removal for Immediate Jeopardy F684 IJ- Quality of Care Date/Time of Notification to the Facility: 04/14/2025 at 1:58 pm This is to confirm the submission of our Plan of Removal (POR) provided by this facility. For F684 IJ. The submission of this POR does not constitute an admission on the part of the facility as to accuracy of the surveyor's findings, the conclusion drawn from there, nor is the scope and or severity regarding any deficiency cited applied correctly. How corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #1 is no longer in the facility. On 4/11/2025 at 7:32 PM the facility Executive Director and Director of Nursing notified the Medical Director of receiving the Immediate Jeopardy. The Executive Director and DON notified the Medical Director and the Attending Physician of the resident who had an adverse reaction. All notifications were completed by 4/11/2025. On 4/14/2025- The facility Executive Director and Director of Nursing notified the facility Medical Director of the F684 Quality of Care Immediate Jeopardy tag. On 04/11/25 at 7:30pm An Emergency QAPI meeting, via TEAMS was held with the Medical Director, LNHA, DON, ADON's, the Regional Director of Clinical Services, the Director of Regulatory Compliance, The CNO and the Regional [NAME] President to review present policies and protocols on Notification of Change and Abuse, Neglect and Misappropriation Prevention. The policies and protocols were deemed sufficient. The QAPI team also formulated the interventions to be presented for the Plan of Removal. On 04/11/2025 The Administrator, DON and ADON's were re in-serviced by the RDCS (Regional Director of Clinical Services) on Policies and Protocol concerning Physician Notification, Change in Condition, Abuse Prevention, and Hydration Dashboard review. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/11/2025 an in-service was initiated by DON/Designee on the Change of Condition/Interact policy to include a pre and post test, Physician notification, and the abuse policy to include what to do in the event the patient request to go to the hospital. The Interact process incorporates the resident's request to go to the hospital. On 4/11/2025, the facility initiated education to CNA/CMA, and Therapists will be in-serviced on notification of condition changes and utilization of our stop and watch tool to report changes in patient condition to the licensed staff, to include if a patient requests to go to the hospital. The facility completed education with licensed nursing staff on 4/12/2025. Any staff who were not present to complete the in-servicing by 4/12/2025 are required to complete the in-servicing at the start of their next shift before beginning work. The facility completed in-service with CNA/CMA and Therapist on 4/12/2025. Any staff who are were not present to complete in-service by 4/12/2025 are required to complete the in-service at the start of their next shift before beginning work. New hires or PRN staff will also be in-serviced prior to the start of their shift. Abuse, neglect, and exploitation education with licensed and non-licensed staff was completed on 4/13/2025. Any staff who were not present to complete the training on 4/13/2025 are required to complete the in-service at the start of their next shift before beginning work. On 4/12/2025- The facility completed in-service with licensed nursing staff on recognizing abnormal versus normal vital signs. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 4/11/25-The Director of Nursing and nurse leadership completed 100% checks of resident vital signs, identifying any vitals that are not within normal limits and will ensure the providers were notified. This was completed on 4/11/2025, all residents were at their baseline and stable. Measures to be put into place or systemic changes made to ensure that the deficient practice will not recur: On 4/11/2025-The facility initiated, at a minimum, daily vital signs for all patients to assist in identifying changes in resident conditions. On 4/11/2025-The physician notification policy was updated to include if a resident requests to go to the hospital. This policy incorporates the resident requesting to go to the hospital. On 4/11/2025- The DON/designee initiated in-servicing with the licensed nurses to review vital signs every shift by running the patient vital sign report in the EHR for abnormal results and initiating the change of condition process, if indicated. The nurses will document on a vital sign tracking log to validate this process was done daily for 1 week then weekly for 3 weeks thereafter. Any staff who were not present to complete the training on 4/11/2025 are required to complete the in-service at the start of their next shift before beginning work. New hires will also be in-serviced prior to the start of their shift. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/11/2025- the Director of Nursing and Administrator were in-serviced by the Sr. Regional Director of Clinical Services on the following policies: reporting change in condition, the Interact process, change of condition, abuse and neglect, and the hydration dashboard review. This was completed on 4/11/2025. How the facility plans to monitor its performance to make sure that solutions are sustained: The DON/designee will review the hydration dashboard daily for patient changes of condition such as abnormal vital signs, poor meal intake and dehydration symptoms, and will follow up with the charge nurses to ensure the change of condition process was followed. On the weekend, the supervisor/designee will review the hydration dashboard daily for patient changes of condition and will follow up with the charge nurses to ensure the change of condition process was followed. The hydration dashboard will be printed and filed in a binder daily for 1 week then weekly for 3 weeks beginning 4/11/25. The Director of Nursing/or designee will review resident 24-hour report and dashboard (nursing documentation) daily for 1 week, then weekly for 3 weeks beginning 4/11/2025 to monitor for patient change of conditions and ensure notification to providers was done utilizing a check off tool. The Director of Nursing/or designee is monitoring to ensure the nurses are running the patient vital sign report every shift daily for 1 week, then weekly for 3 weeks beginning 4/11/2025 utilizing a check off tool to validate the v/s report she completed by the nurses were done. Results of audits and reviews will be reported to and reviewed by QAPI committee monthly for three months. POR verification: During a telephone interview on 4/14/25 at 4:11 pm, the MD said he was informed of the IJ. Record review of QAPI meeting minutes, dated 4/11/25, reflected the facility immediately contacted the executive team and MD of the IJ. Further review revealed 100% of residents VS were reviewed, education regarding changes in condition, notifying the physician of clinical changes, and abuse/neglect/exploitation will be completed, and the DON will review the Hydration Dashboard (report used to review residents' VS, meal intake, etc. to monitor residents for dehydration) and results of audits reported to the QAPI committee. Record review of staff training reflected 30 of 30 fulltime licensed nursing staff across all shifts had been in-serviced. in-services included: Change in Condition (including when a resident requested to go to the hospital), reviewing the VS reports every shift, Physician Notification (including notifying the physician/NP of changes in resident condition). Record review of staff training reflected 40 of 40 unlicensed staff/Therapists across all shifts had been in-serviced. in-service included Stop and Watch, an early warning tool used to identify changes in resident condition. Record review of staff training reflected 88 of 88 fulltime staff had been in-serviced regarding abuse and neglect, including when to report and to whom to report. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews between 4/13/25 at 11:51 am and 4/14/25 at 2:24 pm with 37% of staff employed at the facility (LVN B, RN F, LVN I, CNA K, CNA L, CMA M, CMA N, LVN O, RN P, HSKPR Q, REC R, HSKPR S, CNA T, CNA U, CNA V, CNA W, CMA X, LVN Y, LVN AA, LVN BB, CNA DD, CNA EE, CNA FF, CNA GG, CNA JJ, REC LL, REC MM, LVN NN, OT, PT, and DOR) revealed in-services were conducted. Interviewed staff said ins-services included: abuse/neglect and who to report it to, Stop and Watch (a tool used to document/report changes in resident condition), notifying the Physician/NP of changes in resident condition, documentation of changes in condition using SBAR, and review/documentation of VS every shift, and what to do if a resident requests to go to the hospital. Of staff interviewed, 7 staff worked 6:00 am - 2:00 pm, 7 staff worked 2:00 pm - 10:00 pm, 5 staff who worked 10:00 pm - 6:00 am, 3 staff who worked 8:00 AM - 5:00 PM, 5 staff worked 6:00 AM - 10:00 PM, and 4 staff who worked PRN. Record review of 100% of residents' VS was conducted by the DON and abnormal values were noted and the physician/NP notified. During an interview on 4/13/25 at 12:32 pm, the DON said nurses were expected to obtain and document VS every shift and she or the weekend supervisor would review the report daily for abnormal values. Record review of staff training reflected the ED and DON were in-serviced on 4/11/25 by RDCS regarding physician notification, change in condition, abuse/neglect, SBAR, and Hydration Dashboard review. Record review of staff training reflected 8 of 8 nurse supervisors were in-serviced on 4/13/25 by the DON regarding the Vital Sign Monitor Tracking Tool. Interviews between 4/13/25 at 1:47 pm - 2:00 pm with 3 nurse supervisors (RN F, LVN I, and LVN LL) revealed an in-service was conducted regarding the Vital Sign Monitor Tracking Tool. The nurse supervisors said they were expected to review their assigned residents' VS every shift for trends, sign the form to document completion, and give it to the ADON/DON. The nurse supervisors further stated they were expected to complete a CIC form and notify the physician/NP for any abnormal values noted. During an interview on 4/14/25 at 3:38 pm, the DON said she reviewed VS for 100% of residents residing at the facility. The DON further stated all abnormal VS were reported to the physician/NP and SBARs completed for all residents identified. the DON said she/designee/staffing coordinator were responsible for ensuring all new hires, PRN and agency staff were in-serviced related to abuse/neglect, Stop and Watch Early Warning Tool, change in condition, and SBAR, prior to the start of their next shift. During an interview on 4/14/25 at 3:40 pm, the DON said she was responsible for ensuring nurses reviewed resident VS every shift. The DON further stated a log was implemented and nurses were expected to review VS for their assigned resident, document on the log whether any trends/patterns were identified, sign the log, contact the physician/MD if needed, and complete a progress note or SBAR if needed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/14/25 at 3:43 pm, the DON said she was in-serviced on 4/11/25 by the RDCS regarding her responsibility related to VS, the Hydration Monitoring Tool, physician notifications, CIC, SBAR, and abuse/neglect. During an interview on 4/14/25 at 3:46 pm, the ED said she was in-serviced on 4/11/25 by the RDCS regarding CIC, abuse/neglect, notifying the physicians regarding any changes in resident condition, SBAR, Hydration Dashboard, VS, and weight summaries. Record review of the facility policy Physician Notification, revised April 2025, reflected it was updated to include resident requests to go to the hospital. The ED, DON, and RDCN were informed the Immediate Jeopardy was removed on 4/16/25 at 11:16 am. While the IJ was removed, 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, due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.