STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676405	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forum Parkway Health & Rehabilitation	2112 Forum Parkway Bedford, TX 76021

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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46403 Based on observation, interview, and record review the facility failed to ensure a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable for 1 of 2 residents (Resident # 1) reviewed for quality of care. The facility did not prevent the development of one facility-acquired Stage IV pressure injury on the right calf for Resident #1. An Immediate Jeopardy (IJ) was identified on 09/18/2024. The IJ Template was provided to the facility on [DATE] at 12:55PM. While the IJ was removed on 09/19/2024, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not Immediate Threat and a scope of Isolated due to the need for monitoring of corrective measures and the effectiveness of its corrective plan. This failure could place residents at risk for worsening of an ulcer, infection, and a decreased quality of life. Findings included: Record review of Resident#1's face sheet dated 08/19/24 reflected: She is an [AGE] year-old female admitted to the facility on [DATE] from the hospital. Resident#1 was diagnosed with unspecified fracture of shaft of right tibia (shin bone- the stronger of the two bones in the leg below the knee, and it connects the knee with the ankle),)subsequent encounter for closed fracture with routine healing, muscle weakness, anxiety, osteopetrosis (bones grow abnormally and become overly dense), Alzheimer's Disease (Brain disorder that causes memory loss, thinking problems and behavior changes) and systemic inflammatory response syndrome (SIRS) of non-infectious origin (life-threatening medical emergency caused by your body's overwhelming response to a stressor). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident#1's Admission MDS assessment dated [DATE] reflected Resident#1 had a BIMS score of 05 which indicated serve cognitive impairment. Review of section GG0115 functional limitation in range of motion reflected: Resident#1 had Code for limitation that interfered with daily functions or placed resident at risk of injury in the last 7 days. Coding indicated Resident#1 had impairment on one side of the lower extremity (hip, knee, ankle, foot). Record review of section GG- Functional abilities and goals reflected: Resident#1 was dependent helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity effort. Review of section G reflected: Resident#1 was dependent of care. lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear. Record Review of pain assessment interview reflected: section Jo410 pain frequency: Coded at 2 which indicated occasionally pain or hurting that was experienced over the last 5 days. Review of section M0150: Risk of pressure ulcers/injuries reflected: yes, Resident#1 was at risk of developing pressure ulcer/injuries. Review of section Record review of Resident#1's care plan dated 08/19/24 reflected: [Resident#1] had potential for future pressure injury development. Resident#1 Goal intact skin reflected: will have skin, free of redness, blisters or discoloration. Resident#1 interventions reflected: Administer treatments as ordered and monitor for effectiveness. Resident#1 focus reflected has actual impairment to skin integrity related to fragile skin. No specific information provided on record on where the impairment of skin integrity was located. Noncompliance with offloading/turning and repositioning. Resident#1 Goal reflected: skin injury will be healed by review date. Resident#1 interventions included: Observe skin injury for abnormalities, failure to heal, S/SX of infection, maceration (injuries that result in open wounds activate an immune response from the body) etc. and report MD. Resident#1 focus reflected: She had limited physical mobility related to weakness. Resident#1 goal reflected: Will remain free of complications related to immobility, including: contractures (Permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult), thrombus formation (blood clot forms or travels), skin-breakdown, fall related injury through the next review date. Resident#1 interventions reflected: invite resident to activity programs that encourage activity, physical mobility . Record review of Resident#1 care plan reflected no notation related to brace. Record review of hospital records that were in the facility electronic monitoring system reflected: Resident#1 was discharged on [DATE] from the hospital to the facility. Resident#1 had an order that reflected: splint must be off while in bed. Remaining occurrences: Until specified. Review of notation reflected no documentation of ulcer on right calf. Record review of Resident #1's orthopedic visit summary on 08/28/24 reflected: physical exam: musculoskeletal: examination of the right lower extremity there is overall neutral clinical alignment (body function within a cone of equilibrium) Knee immobilizer was removed in office today. She has increased pain to the medial (Being or occurring in the middle) joint line. Mild swelling to the knee joint. No ecchymosis (discoloration of the skin resulting from bleeding underneath, typically caused by bruising) noted to the extremity. Calf is soft and supple. Increased pain with ROM and RLE. Record review of Resident #1's orthopedic visit reflected. Plan: May sleep without brace but should be worn when ambulating or for transfers. Plan reflected: brace may be removed at rest, however she may continueto use brace for somfort. Follow-up in clinic in about 3 weeks. Record review Wound Care doctor assessment and evalution dated 09/05/24 reflected: Post-debridement assessment of this previously unstageable necrotic wound has revealed the underlying deep tissue at the muscle/fascia (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	level, which had been obscured by necrosis prior to this point. Thiswound has now revealed itself to be a Stage 4 pressure injury. This is not a wound deterioration. Wound care was related to wound on sacrum. Record review of progress notes dated 8/16/24 to 9/11/24 reflected: Record review of Resident #1's facility progress notes dated 08/16/24 to 09/11/24 reflected: No notation of care to knee immobilizer and care to right calf. Progress note written by RN D dated 09/10/24 reflected: Family member was notified taking patient to the ER at this time would not benefit as they would send patient back if stable. Home wound care with [wound company] was offered up as a plan if they discharge home. Also discussed non-compliance of patient in being able to reposition off the wound site and Complications. Progress note written by LVN I dated 09/11/24 reflected: resident family member asked this nurse about edema (swelling caused due to excess fluid accumulation in the body tissue) to R foot and drainage on pillow under RLE. while inspecting skin under brace this nurse noted wound to back of leg just above ankle where brace covers leg. ankle below wound red and swollen, 2+ edema to top of R foot. foul odor noted coming from wound. MD notified. while waiting for MD response family member requested that resident be sent to ER. MD notified of family member request and order given to send to ER. EMS arrived to take resident to ER. [family member] took all personal belongings from facility when resident left facility. PER EMS resident going to [hospital name]. DON notified. Record review of progress noted reflected no notation of Resident#1 refusing care for knee immobilizer. Record review of hospital record history of Resident#1 dated 09/11/24 reflected: she is currently staying in a nursing home. She has had a boot on the right leg due to a recent admission to the hospital for right tibial plateau (the flat top part of your tibia bone) fracture. Today the boot was removed for the first time in some time. It was noticed that the patient had a large ulceration (open sore caused by poor blood flow) to the right calf. Record review of Resident#1 skin assessment reflected: No notation of care to right calf. Record review of wound care doctors progress notes dated 09/05/24 reflected: No notation of care related to the care of the right calf were knee immobilizer was worn. Record review of Resident #1's hospital record dated 09/11/24 at 8:55pm reflected: Pressure injury of skin of right calf, unspecified injury stage: undiagnosed new problem with uncertain prognosis.Record review of physical exam section reflected: Skin: General: Skin is warm and dry. Comments: Large decubitus ulcer (injuries to the skin and tissue caused by pressure, friction or shear) noted to the right leg with foul odor. Record review of Assessment & Plan section reflected: Decubitus ulcer of right leg - right tibial plateau fracture with nonoperative management. Ulceration due to prolonged knee immobilizer use. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's hospital record dated 09/12/24 reflected Wound Care: The lateral RLE Stage 4 pressure injury from This full-thickness wound (deep; extend beyond the first 2 layers of the skin and may reveal subcutaneous (fatty) tissue, muscle tendon, or even bone) presents with active infection and the wound is covered majority with devitalized tissue (tissue that has become nonviable due to lack of blood supply). Tendon is visible, Peri-wound tenderness (Any break of the skin), swelling and erythema (Abnormal redness of the skin or mucous membranes caused by dilation and irritation of the superficial capillaries) noted. Record review of Resident#1 Wound cultures reflected: positive preliminarily (coming before a more important action or event, especially introducing or preparing for it) for Staph aureus (Infection caused by specific round shaped bacteria called staphylococcus) and mixed flora (culture yielded two or, at most, three different organisms). Record review of Resident #1's facility progress notes dated 08/16/24 to 09/11/24 reflected: Progress note written by RN A dated 09/10/24 reflected: Family member was notified taking patient to the ER at this time would not benefit as they would send patient back if stable. Home wound care with [wound company] was offered up as a plan if they discharge home. Also discussed non-compliance of patient in being able to reposition off the wound site and Complications. Progress note written by LVN I dated 09/11/24 reflected: Resident#1 family member#1 asked this nurse about edema (swelling caused due to excess fluid accumulation in the body tissue) to R foot and drainage on pillow under RLE. while inspecting skin under brace this nurse noted wound to back of leg just above ankle where brace covers leg. ankle below wound red and swollen, 2+ edema to top of R foot. foul odor noted coming from wound. MD notified. while waiting for MD response family member requested that resident be sent to ER. MD notified of family member request and order given to send to ER. EMS arrived to take resident to ER. [family member] took all personal belongings from facility when resident left facility. PER EMS resident going to [hospital name]. DON notified. Record review of progress noted reflected no notation of Resident#1 refusing care for knee immobilizer. Record review of EMAR dated 09/01/24 to 09/11/24 reflected: Circulation check under rt lower leg brace- check Capillary Refill for soft cast circulation q shift N = Normal A =Abnormal every shift. Review reflected EMAR was marked 0 on September 3rd and 4th on 1st shift. September 2nd, 3rd, 5th and 6th were marked wnl on 2nd shift. The remaining days, evening and overnight shifts were marked normal. Circulation check under rt lower leg brace - check Color q shift for soft circulation N= Normal A = Abnormal every shift Review reflected EMAR was marked 0 on September 3rd and 4th on 1st shift. September 2nd, 3rd, 5th and 6th were marked wnl on 2nd shift. The remaining days, evening and overnight shifts were marked normal. Circulation Check under rt lower leg brace - check Sensation for soft cast circulation q shift Y = Yes N = No every shift for under rt lower leg brace Circulation Check under rt lower leg brace - check Sensation for soft cast circulation q shift Y = Yes N = No every shift. Review reflected EMAR was marked 0 on September 3rd and 4th on 1st shift. September 2nd, 3rd, 5th, and 6th shift were marked wnl. The remaining days and shift were marked Yes. Circulation check under rt lower leg brace- check Swelling for soft cast circulation q shift and document N = Normal and A =Abnormal every shift. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review reflected EMAR was marked 0 on the September 2nd and 3rd on 1st shift. September 2nd, 3rd, 5th and 6th on 2nd shift were marked 0 The remaining days and shifts were marked Normal. In an interview and observation with Resident#1 on 09/17/24 at 7:00 AM. Resident#1 was not able to recall living in the facility and if she received care to her right leg. Resident#1 was asked if surveyor could see her leg. Resident#1 stated please do not move my leg because she was afraid it would hurt. Resident#1 allowed surveyor to view her knee immobilizer. In an interview on 09/17/24 at the family member#1 stated she visited the facility every day to check on her mother. On the 09/10/24 she noticed Resident#1 feet were swollen and she was told by the CNA that the wound care doctor would be in Thursday and he could check on the swollen. Family membe#1 stated she came back on Thursday and noticed a foul odor coming from Resident#1 and requested for her mother to be sent out to the hospital. Interview on 09/17/24 at 5:40 AM CNA A stated Resident#1's knee immobilizer always stayed on overnight. CNA A stated the knee immobilizer was never removed on the overnight shift. In an interview on 09/17/24 at 5:45 AM RN A stated Resident#1's RN A stated Resident#1 did not have physician orders for the knee immobilizer to be removed. RN A stated the physician orders should be followed to prevent problems for patients. RN A stated she never took off resident's #1 knee immobilizer because she would cry and yell in pain if you tried to touch it. In an interview on 09/17/24 at 5:58 AM CNA C stated Resident#1 always kept her knee immobilizer on and she never saw the resident's leg without the knee immobilizer. In an interview with the treatment nurse on 09/17/24 at 8:20 AM revealed Resident#1 had an unstageable pressure ulcer on her bottom when she entered the facility. The treatment nurse stated Resident#1 was very hard to reposition and would yell out in pain when trying to move her. Treatment nurse stated Resident#1 would have to take pain medication before being treated. The Treatment Nurse stated she always had her knee immobilizer on, and she did not remove it or provide care to her right leg. In an interview on 09/17/24 at 2:15 PM RN D stated she put in Resident#1's orders in the electronic monitoring system when she admitted . RN D stated she did not recall orders for the knee immobilizer at that time. RN D stated that Resident#1's orders had to be followed to prevent concerns/issue for the resident. RN D stated Resident#1 always kept her leg immobilizer on and did not allow anyone to touch it and would scream. In an interview on 09/17/24 at 2:45 PM DON stated Resident#1 did not have orders for the knee immobilizer to be removed. DON stated Resident#1's knee immobilizer was not removed because she did not have an order. In an interview on 09/17/24 at 3:00 PM the Director of Rehabilitation stated the brace, full leg immobilizer or splint are the same thing. The Director of Rehabilitation stated different practices label the assistant devices differently. The Director of Rehabilitation stated the purpose of the device was to keep the leg extended and not flex the knee. The Director of Rehabilitation stated without an order to remove the knee immobilizer it could not be removed. The Director of Rehabilitation stated Resident#1's family member#2 did not want the facility to remove the knee immobilizer because it would hinder her progress. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 09/17/24 at 3:45 PM CNA E stated Resident #1 was given bed baths and she would have to calm the resident down and she would allow her to bathe her. CNA E stated she was told by the nursing staff not to remove the knee immobilizer and she did not. In an interview over the phone on 09/17/24 at 4:10pm the front desk clerk at the orthopedic doctor office stated Resident#1 came in on 08/28/24. Resident was transported to the appointment by the facility. The doctor noted in his notes under plan that [Resident#1] could remove brace at rest. In an Interview on 09/17/24 at 4:45 pm the Wound care doctor stated he did a head-to-toe assessment on 08/29/24 to satisfy CMS requirements and she did not have that wound on her right calf. The wound care doctor stated he only saw patient twice. The wound care doctor stated the next visit was on 08/05/24 and she had her knee immobilizer on. In an interview on 09/17/24 at 5:00 PM the Administrator stated Resident#1 was non-compliant with all care and family member#2 wanted the knee immobilizer to stay on all the time. The Administrator stated, What should we do? In an interview on 09/18/24 at 10:00 AM the DON stated Resident#1 was non-compliant with care which included repositioning to relieve the pressure ulcers on her sacrum. and would not allow anyone to touch her knee immobilizer. The DON stated Resident#1 would refuse care from the nursing staff and would scream and yell. The DON stated Resident#1 did not have an order for the knee immobilizer to be removed. The DON stated the X on the EMAR represented refusal by the resident. DON stated the EMAR could be confusing and staff could have signed off that they viewed the resident leg for swelling and discoloration and they really meant to put that she refused to allow staff to look at Resident#1 leg. The DON stated a capillary refill is when you pressed down on the skin to see how fast that space fills back up. The DON stated he could not explain why staff would document different than what the EMAR abbreviations instructions. The DON stated he had provided in services on documentation, and it is also done at onboarding. In an Interview on 09/19/24 at 10:15 AM the DON stated no documentation in progress notes of doctor being notified of family member not wanting Resident#1 knee immobilizer to be removed. The DON stated charges nurses are responsible for documenting and making the call to physician. In an Interview on 09/19/24 at 11:45AM the Medical Director stated Resident#1 had a fracture from a fall and was seeing her Orthopedic doctor and was to have non weight bearing on that right leg. The Medical Director stated She wore a knee immobilizer and refused any kind of care to the knee immobilizer. The Medical Director stated She did not remove knee immobilizer and did not want to cause any harm. The Medical Director stated She was on pain medication and wanted her orthopedic doctor to provide care to the knee immobilizer. The Medical Director stated she did not recall any call about family member not wanting the knee immobilizer to be removed. Medical Director stated she was not aware that Resident#1 had developed a stage 4 pressure ulcer on that leg. Attempted to call family member#2 on 09/17/24 at 9:00 AM and no return call received. Attempted to call LVN I on the phone on 09/17/24 at 5:32 PM and no return call. Attempted to do an in-person interview with the Orthopedic surgeon at his office on 09/18/24 at 8:00 AM. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of facility policy undated title admission packet reflected: 4. Nursing care: Facility shall provide twenty-four (24) hours a day nursing and personal care to resident. Request was made to Administrator on 09/19/24 at 9:00 AM for policy on wound care/pressure ulcers. The policy was not received before exiting the facility. The IJ Template was provided to the Administrator on 09/19/2024 at 12:55PM The Administrator was provided with the IJ template, and a Plan of Removal was requested at that time. The following served as documentation of the implementation of the Plan of Removal: What corrective actions were taken? 1. The following actions were initiated immediately on 9/19/2024. . On 9/19/2024 an audit was completed by DON (Director of Nursing) and/or designee on all residents who have orders for splints, casts, or boots to ensure that to determine if there is any unidentified skin breakdown. . Inservice by DON/Designee with Licensed nurses on circulation checks 9/19/2024. . Inservice on following physician orders by DON/Designee with Licensed nurses 9/19/2024. . Licensed nurses, CNA and CMA were educated on the process of accurate documentation of refusal. 9/19/2024. . New admissions will be reviewed in morning clinical meeting to ensure that all physician orders are being followed. . New Hires will be in-serviced on following physician orders and accurate documentation during the orientation process. The facility's Plan of Removal was accepted on 09/19/2024 at 3:27 PM and read as follows: Facility Name Facility Address September 19, 2024 The plan of removal represents the center's allegation of compliance. This plan of removal serves as {facility} response to the immediate jeopardy notification the center received during the exit conference on September 19, 2024, at 12:55 PM from the Texas Health and Human Services Commission related to identification of changes in skin integrity. The allegation is that staff did not identify changes in skin integrity for resident #1. Immediate Actions (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The resident with the deficient practice no longer resides in the facility. How will the system be monitored to ensure compliance? DON/Designee will audit all patients with soft cast/brace/sling for skin alterations once a week for 2 weeks. Once a week Random skin Audit by DON/Designee on residents that have a soft cast/brace weekly for 4 weeks. DON/Designee will review new physician orders related to soft cast/brace/sling during the morning clinical meeting. DON/Designee will review MARS for four weeks for resident with soft cast/brace/sling to ensure accurate documentation is completed. An impromptu Quality Assurance and Performance Improvement review of the plan of removal was completed on 9/19/2024 with the Medical Director. The Medical Director has reviewed and agrees with this plan of removal. Record review of the Daily Audits of all residents with soft cast revealed that wound care nurse began review on 09/12/2024 through 09/19/2024 daily. Record review of skin sweeps were conducted on all residents by wound care nurse on 09/12/2024. Record review of in-service training report named circulation checks was conducted on 09/12/2024 through 09/19/2024 for all staff. Record review of in-service training report named Abuse and Neglect was conducted on 09/12/2024 through 09/19/2024 for all staff. Record review of in-service training report named clinical Dashboard was conducted on 09/12/2024 for all staff. Monitoring started at 4:00 PM on 09/19/24 and reflected: Interview on 09/19/24 at 4:25 PM CNA E revealed that she had been in serviced on ANE, and when to tell the nurse about any incident with the residents. She stated that she was to tell the Nurses who then reported to the ADON and DON. In an interview 09/19/2024 at 4:35pm with LVN F stated that she has done the skin assessments for the week. She stated that she has been trained on ANE. She stated that the CNAs report to the nurses's and then the nurse reports to the ADON, DON and ADM. She also stated that the staff reports on incident report so that everyone is aware of the incident. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview 09/19/2024 at 4:45pm with ADON revealed that she had been trained on circulation checks, Daily audits and conducted skin sweeps, and abuse and neglect by the regional nurse. She stated that she then did the training for the staff on ANE, circulation checks and how to track it all in the clinical dashboard. She stated that the expectation is that the CNA's report to the Nurse's. The Nurse's then report to ADON, DON or Administrator. It is the expectation that the ADON, DON contact the physician for additional orders and notifications. It is the expectation that the staff will do circulation checks on the residents by the nurse's In an interview with 09/19/2024 at 4:45pm with, medication aide revealed that he had been trained on the procedures of reporting incidents to the nurses. He stated that he had been in-serviced on ANE and was aware that he needed to report to the ADON, DON and ADM. In an interview on 09/19/2024 at 5:00pm with, LVN stated that he was trained to do circulation checks, skin assessments and reporting incidents to the facility DON. He stated that he does circulation checks daily to ensure resident are getting good circulation in the braces and casts. He stated that he knew he was to report any findings to ADON and DON. He stated that he had been in-serviced on ANE. In an interview on 09/19/2024 at 5:35pm with Administrator he stated that he has been retained retrained by the regional staff. He stated that he was aware, and the expectations are that staff are to report changes to the ADON, DON and him. He stated that the facility staff had all been in-serviced on circulation checks, reporting ANE, and the nursing staff on the clinical dashboard . The clinical dashboard is used for daily reporting to the other staff, DON and ADON on additional incidents. The DON stated that in the IDT meetings they were discussing wound care daily. He stated that the ADON would be doing a monthly random audit. The Administrator was informed the IJ was removed on 09/19/2024 at 6:00 PM. The facility remained out of compliance at a severity of no actual harm with potential for more than minimal harm that was not Immediate Jeopardy and a scope of Isolated due to the need for implementation monitoring of corrective measures and the effectiveness of its corrective plan.