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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 745021	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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 - Some

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 41093

Based on interview and record review, the facility failed to consult with the physician when the resident experienced a change in condition / a need to alter treatment significantly for 1 (Resident #1) of 6 residents reviewed for a change of condition.

The facility failed to notify the physician when Resident #1 refused all oral medications for 4 days ([1/18/24 to 1/21/24], which included Furosemide, Isosorbide Mononitrate ER, Carvedilol, Sacubitril-Valsartan [medications used in the treatment of heart failure] and Metformin HCl [used to treat diabetes]) leading up to his hospitalization on [DATE] during which he was diagnosed with urosepsis.

The facility failed to notify the physician when Resident #1 refused to have ordered labs (CBC, CMP and UA) obtained on 1/17/24, which would have identified an urinary tract infection.

The facility failed to notify the physician when Resident #1 had decreased oral intake 3 days leading up to his hospitalization (dehydration contributes to bacterial growth).

These failures resulted in an identification of an Immediate Jeopardy (IJ) on 4/12/24 at 5:12 p.m. While the IJ was removed on 4/13/24, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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 for Resident #1 dated 3/28/24 indicated he was [AGE] years old admitted to the facility on [DATE] with diagnoses including, aftercare following joint replacement surgery, fracture of the right femur (the head of the hip joint), acute bronchitis, bradycardia (slow heart rate), dementia, sick sinus syndrome (disease in which the heart's natural pacemaker becomes damaged and is no longer able to generate normal heartbeats at the normal rate) presence of a cardiac pacemaker, insulin dependent diabetes with chronic kidney disease, and high blood pressure.

(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 - Some	Record review of Resident #1's MDS dated [DATE] indicated he usually understood others and usually made himself understood. The MDS indicated Resident #1 had severe cognitive impairment (BIMS of 6). The MDS indicated he had no behavior of rejecting care. The MDS indicated he had no physical (hitting, kicking pushing etc.) or verbal behaviors (threatening others, screaming at others cursing at others). The MDS indicated Resident #1 was dependent on staff for lower body dressing and the putting on/taking off of footwear. The MDS indicated Resident #1 required moderate assistance with upper body dressing, showering, and toileting. The MDS indicated he required supervision or touch assistance with personal hygiene and eating. The MDS indicated he required set up or clean up assistance only with eating. The MDS indicated Resident #1 was dependent on staff for sit to stand transfers, chair/bed- to- chair transfers, toilet transfers, and tub/shower transfers. The MDS indicated Resident #1 required substantial/maximal assistance with walking ten feet, and the ability to move from lying on the back to sitting on the side of the bed with no back support. The MDS indicated Resident #1 required supervision or touch assistance with the ability to roll to the left or right side while in the bed and the ability to move from setting on the side of the bed to lying flat on the bed. The MDS indicated Resident #1 was occasionally incontinent of bladder and was always incontinent of bowel. Record review of the baseline care plan dated 12/22/23 for Resident #1 did not indicate Resident #1 had a catheter. The baseline care plan did not indicate Resident #1 refused care, treatment, or medications. Record review of the comprehensive care plan dated 1/5/24 for Resident #1 did not indicate Resident #1 had a catheter. The baseline care plan did not indicate Resident #1 refused care, treatment, or medications. Record review of the physician order summary report from 12/21/23 to 1/22/24 reflected Resident #1's medication and supplement orders included the following (theis medication orders were active prior to Resident #1's discharge from the facility on 1/22/24); *Aspirin Oral Tablet Delayed Release 81 MG- Give 1 tablet by mouth one time a day for Heart health (start date 12/22/23); *Atorvastatin Calcium Oral Tablet 40 MG -Give 1 tablet by mouth at bedtime for hyperlipidemia (start date 12/21/23); *Furosemide Oral Tablet 20 MG -Give 1 tablet by mouth one time a day for Heart failure (start date 12/22/23); *Isosorbide Mononitrate ER Oral Tablet Extended Release 24 Hour 30 MG-Give 1 tablet by mouth one time a day for Heart failure (start date 12/22/23); *Spironolactone Oral Tablet 25 MG -Give 0.5 tablet by mouth one time a day for Heart failure (start date 12/22/23); *Carvedilol Oral Tablet 12.5 MG -Give 1 tablet by mouth two times a day for Heart failure (start date 12/21/23); *Metformin HCl Oral Tablet 500 MG- Give 2 tablet by mouth two times a day for DM (diabetes) (start date 12/21/23) (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Sacubitril-Valsartan Oral Tablet 24-26 MG -Give 1 tablet by mouth two times a day for Heart failure (start date 12/21/23) *Calcium Carb-Cholecalciferol Oral Tablet 600-10 MG-MCG-Give 1 tablet by mouth one time a day for Supplement (start date 12/22/23) *Ferrous Gluconate Oral Tablet 324 MG -Give 1 tablet by mouth one time a day for anemia (start date 12/22/23); *Fish Oil Oral Capsule 1000 MG Give 2 capsule by mouth one time a day for supplement (start date 12/22/23); *Multi Vitamin/Minerals Tablet -Give 1 tablet by mouth one time a day for Dietary/Nutritional Supplement for 60 Days (start date 1/13/24); *Zinc Sulfate Tablet 220 MG- Give 1 tablet by mouth one time a day for Nutritional/Dietary Supplement for 60 Days (start date 1/13/24); *Prostat two times a day for Wound healing for 60 Days -Give 30 ml by mouth two times a day (start date 1/12/24); and *Vitamin C Tablet 500 MG -Give 1 tablet by mouth two times a day for Nutritional/Dietary Supplement for 60 Days (start date 1/12/24). Record review of the physician's order summary report from 12/21/23 to 1/22/24 reflected Resident #1 was to have a CBC (A complete blood count, also known as a full blood count, is a set of medical laboratory tests that provide information about the cells in a person's blood. The CBC indicates the counts of white blood cells, red blood cells and platelets, the concentration of hemoglobin, and the hematocrit), CMP (a blood test that gives doctors information about the body's fluid balance, levels of electrolytes like sodium and potassium, and how well the kidneys and liver are working), and UA (urinalysis is a test of your urine. Doctors use urine tests to find issues including UTI)/CS (culture and sensitivity- a culture is a test to find germs (such as bacteria or a fungus) that can cause an infection. A sensitivity test checks to see what kind of medicine, such as an antibiotic, will work best to treat the illness or infection) one time only related to cystitis (inflammation if the urinary bladder). The order was dated 1/13/24. Record review of the January 2024 MAR for Resident #1 for January 2024 indicated Resident #1 refused the following medications and supplements on the following dates/ times; *Aspirin Oral Tablet Delayed Release 81 MG refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; *Atorvastatin Calcium Oral Tablet 40 MG- refused on, 1/19/24 at 7:00 p.m., 1/20/24 at 7:00 p.m., and 1/21/24 at 7:00 p.m.; *Furosemide Oral Tablet 20 MG refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Isosorbide Mononitrate ER Oral Tablet Extended Release refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; *Spironolactone Oral Tablet 25 MG refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; *Carvedilol Oral Tablet 12.5 MG refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m. and 7:30 p.m., 1/20/24 at 7:30 a.m. and 7:30 p.m., and 1/21/24 at 7:30 a.m. and 7:30 p.m. ; *Metformin HCl Oral Tablet 500 MG refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m. and 5:00 p.m., 1/20/24 at 7:30 a.m. and 5:00 p.m., and 1/21/24 at 7:30 a.m. and 5:00 p.m.; *Sacubitril-Valsartan Oral Tablet 24-26 MG refused on, 1/18/24 at 9:00 a.m., 1/19/24 at 9:00 a.m. and 5:00 p.m., 1/20/24 at 9:00 a.m. and 5:00 p.m., and 1/21/24 at 9:00 a.m. and 5:00 p.m.; *Calcium Carb-Cholecalciferol Oral Tablet 600-10 MG-MCG refused on, 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; *Ferrous Gluconate Oral Tablet 324 mg refused on, -- 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; *Fish Oil Oral Capsule 1000 MG refused on, - 1/18/24 at 7:30 a.m., 1/19/24 at 7:30 a.m., 1/20/24 at 7:30 a.m., and 1/21/24 at 7:30 a.m.; *Multi Vitamin/Minerals Tablet refused on, 1/18/24 at 7:00 a.m., 1/19/24 at 7:00 a.m., 1/20/24 at 7:00 a.m., and 1/21/24 at 7:00 a.m.; *Zinc Sulfate Tablet 220mg refused on, 1/18/24 at 7:00 a.m., 1/19/24 at 7:00 a.m., 1/20/24 at 7:00 a.m., and 1/21/24 at 7:00 a.m.; *Prostat refused on, 1/18/24 at 7:00 a.m., 1/19/24 at 7:00 a.m. and 5:00 p.m., 1/20/24 at 7:00 a.m. and 5:00 p.m., and 1/21/24 at 7:00 a.m. and 5:00 p.m.; *Vitamin C Tablet 500 MG refused on, 1/18/24 at 7:00 a.m., 1/19/24 at 7:00 a.m. and 5:00 p.m., 1/20/24 at 7:00 a.m. and 5:00 p.m., and 1/21/24 at 7:00 a.m. and 5:00 p.m. Record review lab sheet dated 1/17/24 indicated Resident #1 had refused to have the CBC, CMP and UA/CS collected that were ordered on 1/13/24. Record review of the nursing progress notes from 1/13/24 to 1/21/24 for Resident #1 did not document reflect the Physician or Nurse Practitioner had been notified of any of Resident #1's oral medication/supplement refusals or that Resident #1 had refused to have the ordered labs (CBC, CMP and UA/CS) collected. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility assignment sheets from 1/18/24 to 1/22/24 indicated LVN A took care of Resident #1 on 1/18/24 from 6am-6pm and MA H passed medications to Resident #1 on 1/18/24. The facility assignment sheets indicated MA G was assigned to Resident #1 on 1/19/24 -1/21/24. The assignment sheets indicated LVN I took care of Resident #1 on 1/19/24 from 6am -6pm. The assignment sheets indicated LVN D had taken care of Resident #1 from 6am-6pm on 1/20/24-1/22/24. The facility assignment sheets indicated CNA K took care of Resident #1 from 6a-6p on 1/19/24 and 1/21/24. The facility assignment sheets indicated CNA J took care of Resident #1 on 1/20/24. During an interview on 4/9/24 at 3:50 p.m., CNA K said she could not recall Resident #1. CNA K said she could not remember if Resident #1 had decreased intake (what is consumed orally, what is eaten and drank). CNA K said if any Resident had a decrease in their food or fluid intake she would notify the nurse caring for that Resident. CNA K said any record of Resident #1's intake and output (that which is produced, ejected, or expelled [urine, vomit, stool]) would be documented in the EMR. During an interview on 4/9/24 at 3:54 p.m., CNA J said she remembered Resident #1 and took care of him regularly during his most recent stay at the facility (12/21/23 to 1/22/24). CNA J said Resident #1 had good days and bad days in regard to his oral intake. CNA J said towards the end of his stay it did seem Resident #1 had declined. CNA J said she could not say that his oral intake had decreased substantially but would have notified the nurse caring for Resident #1 if she had noticed a decrease in his intake CNA J said any record of Resident #1's intake and output would be documented in the EMR. During an interview on 4/10/24 at 3:00 p.m., LVN I said she could not remember if she had been told Resident #1 had refused to take any medications. LVN I said she did not think it (Resident #1 refusing oral meds) had been reported to her because she would always go and attempt the administration herself if a MA reported a resident was refusing. LVN I said if a Resident still refused medication during her attempt she would notify the Physician or Nurse Practitioner. LVN I said she could not recall making an attempt to administer Resident #1 medications, thus she believed she had not been notified but could not say for sure. LVN I said she could not remember if Resident #1 had decreased intake leading up to 1/22/24. LVN I said she would have notified the Physician or Nurse Practitioner if she had been notified and had unsuccessfully attempted to increase Resident #1's intake. LVN I said she could not recall if any CNA had reported to her that Resident #1 had decreased intake. LVN I said she could not recall if the independent lab company had notified her that Resident #1 had refused to labs obtained on 1/17/24. LVN I said the Physician or Nurse Practitioner should have been notified of Resident #1's refusal for lab collection. During an interview on 4/10/24 at 3:15 pm, MA G said Resident #1 was refusing all his oral medications leading up to his hospitalization on [DATE]. MA G said she notified the nurse with each pass that Resident #1 was refusing to take his medications. MA G said she would not have waited for him (Resident #1) to refuse all day before notifying the nurse because missing medications could be very serious depending on the medication and purpose of the medication. MA G said the nurse was notified promptly with each refusal as the nurse would need to attempt the administration themself and notify the physician accordingly. MA G could not recall which nurse she notified or the specific dates she cared for him when he was refusing all his oral medications. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/10/24 at 3:29 p.m., LVN D said that it had been reported to him before his shift on 1/22/24 was that Resident #1 had decreased intake over the past 3 days and had no input in the past 24 hours. LVN D was asked to clarify his statement as his note written on 1/22/24 stated Resident has not eaten or had any fluids x3 days. LVN D said that was a mistake., he said Resident #1 had no intake x3 meals (in the past 24 hours) and a decrease in intake in the days leading up to 1/22/24, based on what had been reported to him. LVN D said he had been told by the MAs that Resident #1 had refused some of his oral medications in the days leading up (1/20/24 and 1/21/24) to his hospitalization on [DATE] but was not aware that he (Resident #1) was refusing all of his oral medications. LVN D said he could not recall what medications the MAs said Resident #1 had refused. LVN D said he had not reported to the physician or nurse practitioner Resident #1 was refusing medications and having decreased oral intake prior to 1/22/24 because he had been told that was normal behavior for Resident #1. LVN D explained he had not regularly taken care of Resident #1. During an interview on 4/11/24 at 2:00 p.m., DON Q said she had contacted the lab in order to see if there were any further documents related to Resident #1's ordered labs on 1/13/24, but the lab was not able to provide any additional documents related to the labs ordered on 1/13/24. The DON said the Physician and/or Nurse Practitioner should have been notified that the labs ordered on 1/13/24 had been refused by Resident #1. The DON said it was not acceptable to fail to notify the medical provider that a resident had been refusing oral medications for four days. The DON said the medical provider should have been notified with each refusal. The DON said it was not acceptable for the physician not to be notified that Resident #1 had decreased oral intake for several days. The DON said she knew the Corporate Nurse had conducted multiple in-services during her time as the Interim DON. The DON said she started at the facility on 3/26/24 and had conducted in-services over notification on 3/29/24. The DON said the facility had no intake/output records to provide for Resident #1. She explained unless a resident had a specific order for intake and output monitoring the records were generally not entered. The DON said she did look to see if there were any paper intake records to provide but there were none. During an interview on 4/12/24 at 10:22 a.m., LVN A said she did remember being notified Resident #1 was refusing medications but could not recall the exact date. LVN A said she had notified the DON at the time (DON X) but had not notified the Physician or Nurse Practitioner. LVN A said the former DON (DON X) had told her that Resident #1 was going to go on hospice. LVN A said the assumed the DON had would take care of the notification if it was needed. LVN A said she never saw any paperwork and Resident #1 was never put on hospice. LVN A said Resident #1 had an overall decline in the few weeks before his hospitalization after his family member had discharged home. LVN A said he had a decrease in oral intake and increased combative behaviors. LVN A said again she had not notified the physician but had notified the DON under the assumption the DON was attempting to move him to hospice care. LVN A said she could not recall Resident #1 having an order for CBC, CMP and UA/CS on 1/13/24. LVN A said she should have documented the refusal of care (including the refusal of medications and ordered labs) should have been documented in the progress notes; the Physician or the Nurse Practitioner notified and the notification documented in the progress notes. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/12/24 at 1:47 p.m., the Nurse Practitioner said she had not been notified prior to 1/22/24 that Resident #1 had decreased oral intake in the days leading up to 1/22/24. The Nurse Practitioner said she had not been notified Resident #1 had been refusing medications and was not notified Resident #1 refused ordered labs. The Nurse Practitioner said the labs had been ordered on 1/13/24 by Resident #1's physician because a CNA had reported Resident #1 had increased agitation. The Nurse Practitioner said there was no documentation that Resident #1's physician had been notified of Resident #1's decreased oral intake for days leading up to his hospitalization , medication refusals leading up to hospitalization or refusal of the ordered labs. The Nurse Practitioner said had she been notified of she would have ordered to have Resident #1 sent to hospital sooner. During an interview on 4/12/24 at 3:20 p.m., ADON P said the Physician and/or Nurse Practitioner should have been notified that the labs ordered on 1/13/24 had been refused by Resident #1. ADON P said it was not acceptable to fail to notify the medical provider that a resident had been refusing oral medications for four days. ADON P said the medical provider should have been notified with each refusal. ADON P said it was not acceptable for the physician not to be notified that Resident #1 had decreased oral intake for several days. ADON P said DON Q had completed an in-service over notification but would ensure more specific in-services would be completed as well. During an interview on 4/12/24 at 3:40 p.m., the Administrator said she started at the facility in February of 2024. The Administrator said she expected staff to follow policy and procedure related to physician notification. The Administrator said she believed the DON had conducted in-services over notification. During an interview on 4/13/24 at 12:41 p.m., Resident #1's Physician said he had no recollection or documentation that the facility had notified him regarding Resident #1's decreased oral intake for days leading up to his hospitalization , medication refusals leading up to hospitalization or refusal of the ordered labs. Record review of the facility policy and procedure dated 03/01/23 titled Notification of Changes stated, Policy: the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician .when there is a change requiring notification Circumstances requiring notification include: (2) Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include (a) Life threatening conditions or (b) Clinical complications. (3) Circumstances that require a need to alter treatment . Record review of the facility policy and procedure dated March of 2022, titled Medication Administration stated, Policy: Medications are administered .as ordered by the physician in accordance with professional standards of practice .(19) Report and document any adverse effects or refusals . The Administrator was notified on 4/12/24 at 5:40 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided with the Immediate Jeopardy template on 4/12/24 at 5:43 p.m. The facility's Plan of Removal was accepted on 4/13/24 at 1:22 p.m. and included: *The Medical Director was notified by the Assistant Director of Nursing on 4/12/24. The medical director was notified of the concurrent IJ on 4/13/24 by the VP of Clinical Operation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	*Nursing staff were in-serviced on 4/12/24 regarding change in condition and refusal of care notification of the provider, DON, and RP, by the ADON and VP of Clinical Operations. All nurses will be in-serviced on this procedure prior to the start of their shift. *The DON and ADON will monitor documentation, as part of the daily clinical meeting, to ensure that any residents who refuse care, all notifications were completed. The DON and ADON were in-serviced by the VP of Clinical Operations on 4/13/24. On 4/13/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: During an interview on 4/13/24 at 12:41 p.m., the Medical Director confirmed he had been notified of the Immediate Jeopardy regarding notification on 4/13/24. Record review of the facility's audit document dated 4/13/24 reflected the ADON reviewed all residents for the last 24 hours, to determine if any residents who refused care, had the proper notifications documented. During an interview on 4/13/24 at 12:57 p.m., ADON P confirmed she reviewed all residents for the last 24 hours, to determine if any residents who refused care, had the proper notifications documented. She said the review included MAR/TAR review and nursing progress notes. ADON P said no refusals without documentation/notification were identified. ADON P said herself and the DON will would continue to monitor documentation, as part of the daily clinical meeting, to ensure that any residents who refused care had all notifications completed (medical provider, family and RP as pertinent). During an interview on 4/13/24 at 3:21 p.m., DON Q said she would continue to monitor documentation, as part of the daily clinical meeting, to ensure that any residents who refused care had all notifications completed (medical provider, family and RP as pertinent). Record review of the in-service training report and accompanied sign in sheet dated 4/12/24, titled Residents that refuse care, indicated nursing in-services over response to resident refusal of care was to include provider notification and documentation of that notification, as well as family and/or RP notification, had been initiated. Record review of the in-service training report and accompanied sign in sheet dated 4/12/24, titled Resident Change of Condition, indicated direct care staff in-services over any change in resident condition was to be communicated to the charge nurse and the charge nurse was to assess the resident, document the change on the 24 hour report and notifications (provider, RP and family)completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindale Specialty Care Center	13905 Fm 2710 Lindale, TX 75771

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Staff interviewed on 4/13/24 between 1:30 p.m. and 3:38 p.m., (LVN O, LVN I, LVN N, LVN BB, LVN A, LVN R, LVN C, MA M, CNA S, CNA T, CNA L, CNA V, CNA W, HA U, MA H and CNA AA [this was all direct care staff from all shifts that had worked since 4/12/24]) MAs indicated that if a resident refused a medication they would notify the nurse promptly and that each med pass refusal would require notification to the charge nurse. CNAs said if the noticed an abrupt or gradual change in a resident's intake they would notify the nurse. The nurses said they would document any medication refusal and notify the medical provider as well as the resident RP. Nurses said if they were notified a resident had decrease (abrupt or gradual) in oral intake they would notify the physician, DON and responsible party. Nurses said if a resident refused ordered labs they would notify the medical provider, the DON and the RP. Nurses indicated that part of the daily clinical stand-up meeting was discussing any changes in resident condition, behaviors and status. During an interview on 4/13/24 at 3:40 p.m., the Administrator said no staff would be allowed to work until they completed in-services. While the IJ was removed on 4/13/24 at 3:44 p.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on observations, interviews, and record review the facility failed to ensure a resident who had a urinary catheter received appropriate treatment and services to prevent urinary tract infections and pain for 1 of 6 (Resident #1) residents reviewed for urinary catheters. The facility did not ensure the needed an order for catheter care was entered when Resident #1 returned from the hospital with a Foley catheter in place on 1/1/24. The facility did not ensure catheter care was documented for Resident #1 from 1/1/24 to 1/17/24. The facility did not ensure Resident #1 was provided catheter care from 1/1/24 to 1/17/24. The facility did not clearly document the discontinuation of Resident #1's foley catheter or circumstances for it's discontinuation. Resident #1 was admitted to the hospital on 1/22/24 and was found to have Urosepsis (sepsis caused by infections of the urinary tract). Resident #1 passed away at the hospital on 1/22/24. These failures resulted in an identification of an Immediate Jeopardy (IJ) on 4/12/24 at 5:12 p.m. While the IJ was removed on 4/13/24, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility need to complete in-service training and evaluate the effectiveness of their corrective systems. These failures could place residents at risk of urinary tract infections, sepsis (sepsis occurs when chemicals released in the bloodstream to fight an infection trigger inflammation throughout the body) and death. Findings included: Record review of the face sheet dated 3/28/24 indicated Resident #1 was an 87- year- old male admitted to the facility on [DATE] with diagnoses including, aftercare following joint replacement surgery, fracture of the right femur (the head of the hip joint), acute bronchitis, bradycardia (slow heart rate), dementia, sick sinus syndrome (disease in which the heart's natural pacemaker becomes damaged and is no longer able to generate normal heartbeats at the normal rate), presence of a cardiac pacemaker, insulin dependent diabetes with chronic kidney disease, and high blood pressure. Record review of the baseline care plan 12/22/24 for Resident #1 indicated he had the potential /actual elimination deficit related to bowel incontinence and bladder incontinence. The care plan interventions included use/ incontinent pads /briefs/pull- ups as needed. The baseline care plan did not indicate Resident #1 had a catheter. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the comprehensive care plan dated 1/5/24 for Resident #1 did not indicate Resident #1 had a catheter. Record review of the nursing note dated 12/31/24 at 6:17 p.m., stated Notified by aide resident did not have output this shift, VS (vital signs):109/74 (blood pressure),67 (pulse),18 (respiration rate) ,98.9 (temperature) 92% (oxygen saturation) at room air. Resident lethargic. NP (Nurse Practitioner) notified. Order for straight cath (catheter) if no output send to ER. No output noted, TX nurse at bedside to assist. EMS notified Residents RP . DON made aware. This note was written by LVN A. Record review of the hospital discharge instructions/ summary dated 12/31/23 indicated Resident #1 had a diagnosis of urinary retention and was returning to the facility with a Foley catheter in place. Record review of the physician's order summary report from 12/21/23 to 1/22/24 found it did not list an order for catheter care. Record review of the nursing note dated 1/1/24 at 9:01 a.m., stated Resident returned from hospital via EMS at approx. (approximately) 0900 (9:00 a.m.) to room . foley catheter in place r/t (related to) urinary retention. Call light placed within reach. DON and NP aware. This note was written by LVN I. Record review of the daily skilled nursing notes from 1/1/24 to 1/17/24 indicated Resident #1 had a Foley catheter in place on the following dates; *01/02/2024- (this skilled note was completed by LVN I); *01/05/2024- (this skilled note was completed by LVN I); *01/07/2024- (this skilled note was completed by LVN E); *01/10/2024- (this skilled note was completed by LVN E); *01/11/2024- (this skilled note was completed by LVN E); *01/14/2024- (this skilled note was completed by LVN Z); *01/16/2024- (this skilled note was completed by LVN I); and *01/17/2024- this skilled note was completed by LVN I). None of the daily skilled notes indicated catheter care was provided to Resident #1. Record review of the daily skilled nursing note on 1/18/24 indicated Resident #1 did not have a Foley catheter in place. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of nursing progress notes from 1/2/24- 1/22/24 found documentation of Resident #1's foley catheter being in place on 1/2/23 and 1/3/24. These notes did not indicate catheter care was provided. There was no other documentation regarding Resident #1's Foley catheter from 1/3/24 to 1/22/24 in the nursing progress notes. Record review of the MAR for January 2024 did not indicate Resident #1 had received catheter care. There was no order on the MAR for Foley catheter care. Record review of the facility staffing assignment sheets from 1/1/24 to 1/18/24 indicated LVN E had been assigned to Resident #1 two of the days from 6:00 a.m. to 6:00 p.m. During an interview on 4/10/24 at 12:55 p.m., LVN E said she remembered Resident #1 but could not remember if he had a catheter. LVN E said if she had provided catheter care to Resident #1 it should be documented on Resident #1's MAR. LVN E said it was important to provide catheter to decrease the risk of infection. Record review of the facility staffing assignment sheets from 1/1/24 to 1/18/24 indicated LVN I had been assigned to Resident #1 nine of the days from 6:00 a.m. to 6:00 p.m. During an interview on 4/10/24 at 3:00 p.m., LVN I said she could not recall if Resident #1 had a catheter. LVN I said she could not recall performing catheter care for Resident #1 because she could not recall if he had a catheter. LVN I said if Resident #1 had a catheter then she would have documented catheter care on the MAR. LVN I said when a resident returned from the hospital with a catheter in place there was a set orders entered related to the catheter and those orders included catheter care on each shift. LVN I said the nurse receiving the resident usually puts the orders in but that the DON or ADON would also assist with entering the necessary orders. LVN I said she did not recall being the nurse that received Resident #1 from the hospital on 1/1/24 and could not recall if she entered orders or if DON X or ADON Y had entered the orders. LVN I said it was important for the order to be entered as it would prompt the nurse to complete catheter care. LVN I said it was important for nurses to complete catheter care to help prevent bladder infections. Record review of the facility staffing assignment sheets from 1/1/24 to 1/18/24 indicated LVN A had been assigned to Resident #1 six of the days from 6:00 a.m. to 6:00 p.m. During an interview on 4/12/24 at 10:22 a.m., LVN A said she remembered Resident #1 and remembered he had a catheter. LVN A said she remembered performing catheter care and it should be documented on Resident #1's MAR. LVN A said she did not think Resident #1 had a catheter the entire time he was at the facility. LVN A said she had heard he had pulled it out but could not say for sure. LVN A said it was important for the resident to with catheters to receive catheter care to decrease the risk of infection. Record review of the nursing progress note dated 1/22/24 at 8:58 a.m. stated, spoke with .NP (nurse practitioner) and DON about the resident change of condition. Resident has not eaten or had any fluids x3 days although they have been highly encouraged. Upon assessing resident after getting report from (previous shift nurse) that resident went from being alert and combative to very lethargic and slow to respond to pain stimuli .Vitals were wnl (within normal limits) but blood sugar was 445 .orders were to send him out for further evaluation . (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the hospital problems list dated 1/22/24 stated Resident #1 had a primary diagnosis of sepsis with encephalopathy (a broad term for any brain disease that alters brain function or structure, causes include infection) without shock (condition that occurs when the body is not getting enough blood flow). Record review of the hospital critical care note dated 1/22/24 indicated Resident #1 had been diagnosed with urosepsis (sepsis caused by infections of the urinary tract). The note detailed that the presumed source of sepsis was a urinary tract infection with MRSA (staph infection that is difficult to treat because of resistance to some antibiotics). Record review of the hospital final disposition of body report dated 1/28/24 indicated Resident #1 had passed away. The cause of death was identified as sepsis. During an interview with ADON P on 4/12/24 at 3:20 p.m., ADON P said she had been at the facility as the ADON since 02/19/24. ADON P said the VP of clinical operations was the interim DON at that time and they were working to correct a lot of issues at the facility. ADON P said nurses should be performing catheter care each shift and as needed. ADON P said catheter care was important to decrease the risk of urinary tract infections. ADON P said the system in place to ensure residents received catheter care was to ensure the appropriate orders were entered for catheter care. ADON P said since she had been with the facility morning clinical meetings were held Monday through Friday. ADON P said during these clinical meetings every resident in the facility was reviewed. ADON P said part of this clinical meeting was reviewing any new admissions, re-admissions and any residents that had been out to the hospital, had all appropriate orders entered for any new appliances they might have received while out of the facility such as catheters. ADON P said she believed she had performed an audit at the beginning of April 2024 to ensure residents with catheters had appropriate orders and nurses were documenting catheter care. During an interview with DON Q on 4/12/24 at 3:35 p.m., DON Q said she had been at the facility as the DON since 3/26/24. DON Q said the VP of clinical operations had been acting as the interim DON. DON Q said the previous DON (DON X) had been terminated and walked out of the facility. DON Q said they were working to correct a lot of issues at the facility. DON Q said nurses should be performing catheter care each shift and as needed. DON Q said it was important to ensure residents with catheters received catheter care to decrease the risk of urinary tract infections. DON Q said since she had been with the facility morning clinical meetings had been daily Monday through Friday. DON Q said part of this clinical meeting was reviewing any new admissions, re-admissions and any residents that had been out to the hospital had all appropriate orders entered for any new appliances they had such as catheters. Record review of the facility policy and procedure dated July of 2022, titled Catheter Care, stated It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . Policy Explanation (1) Catheter care will be performed every shift and as needed by nursing personnel . An interview was attempted with ADON Y (the former ADON) regarding catheter care and order entry process on the following dates 4/10/24 and 4/11/24 but was not completed. An interview was attempted with DON X (the former DON) on the following dates 4/9/24 and 4/10/24 but was not completed. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Administrator was notified on 4/12/24 at 5:40 p.m. that an Immediate Jeopardy situation was identified due to the above failures. The Administrator was provided with the Immediate Jeopardy template on 4/12/24 at 5:43 p.m. The facility's Plan of Removal was accepted on 4/13/24 at 9:36 a.m. and included: *The Medical Director was notified by the Assistant Director of Nursing on 4/12/24. *All residents with indwelling catheters were audited by the ADON on 4/2/24 and again 4/12/24, to ensure all catheter care orders were in place. *Daily clinical meeting has been held daily M-F since February 16, 2024. In this clinical meeting, the new order listing, 24-hour report, and omissions report were reviewed. All new admits, and re-admits were also reviewed by the DON, the ADON, the MDS, the Treatment Nurse, and the Administrator. Any residents sent to the ER were also reviewed/hospital records were reviewed for changes or new orders. This process has been in place since February 2024. *Action plan was in place to ensure the facility staff were aware of the expectation of what was to be reviewed in the daily clinical meeting by the VPCO and documented. This daily clinical meeting has been held since February 16, 2024, by the VP of Clinical Operations (interim DON at that time), and now held by the current DON since March 26, 2024. The action plan was implemented 3/26/24, for all of the company's facilities as a reminder of the process, by the VP of Clinical Operations. *All nurses on shift at this time were in-serviced on initiating catheter care orders for any new catheter orders, admission, or readmission catheter orders, by the ADON on 4/12/24. All remaining nurses will be in-serviced on this policy prior to their shift. *All nursing staff present on 4/12/24, received written procedure related to catheter care by the ADON on 4/12/24. All nursing staff will be provided with the written procedure on catheter care prior to their shift, by ADON or VP of Clinical Operations, beginning 04/13/24. *All nurses present at this time, 4/13/24, have received in-service education on implementing the catheter care orders for any resident with a new catheter. All nurses will be in-serviced on this process prior to their shift, by the ADON or VP of Clinical Services. *Medical Director - The Medical Director has been notified of the Immediate Jeopardy. *QAPI Committee Review - An interim QAPI committee meeting was completed on 04/12/2024. On 4/13/24 the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the Immediate Jeopardy (IJ) by: Record review of the other six sampled residents on 4/12/24 (Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) found that orders for catheter care were in place and catheter care was being documented. During an observation on 4/12/24 at 12:45 p.m., catheter care was observed for Resident #6. No failures were identified during the catheter care. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 4/12/24 at 1:30 p.m., catheter care was observed for Resident #2. No failures were identified during the catheter care. During an interview on 4/13/24 at 12:41 p.m., the Medical Director confirmed he had been notified of the Immediate Jeopardy on 4/12/24 and attended the interim QAPI meeting via phone. Record review of the facility audit documents dated 4/2/24 detailed the facility residents with indwelling catheters (9 residents) had the necessary order batch in place (including the order for catheter care), and care was being documented. Record review of the facility audit documents dated 4/12/24 detailed the facility residents with indwelling catheters (11) had the necessary order batch in place (including the order for catheter care), and care was being documented. Record review of the daily clinical meeting sign sheets from 2/16/24 to 4/12/24 were reviewed and indicated daily clinical stand- up meeting was held daily Monday through Friday 2/16/24 to 4/12/24. Record review of the facility Action Plan dated 3/26/24 titled AM clinical meeting stated the clinical meeting would be held Monday through Friday after the morning standup meeting. The action plan included that all new residents were to be reviewed in the clinical meeting and all associated orders entered. Record review of the facility QA agenda and sign in sheet dated 4/12/24 reflected a QA meeting with the Medical Director in attendance via phone was held on 4/12/24 regarding the facilities Plan of Removal related to Immediate Jeopardy. During an interview on 4/12/24 at 5:50 p.m., the VP of clinical operations said the Action plan was put in place to ensure all facility staff were made of aware of what was expected in regards to daily clinical meeting, including the review of all new admissions, re-admissions, and any residents that had been sent to the ER and returned to the facility without discharge. The VP of clinical operations said this review would include ensuring all new orders were entered and any new medical appliances, such peripheral IV's , PICC lines, feeding tubes, and indwelling catheters etc., had the appropriate orders for care. The VP of Clinical operations said she had been the interim DON and held the meetings since from 2/16/24 until 3/26/24 at which time the new DON (DON Q) held the meetings. During an interview on 4/13/24 at 12:57 p.m., ADON P said the daily clinical meetings that she knew had been in place since she started at the facility would continue to ensure new admissions, re-admissions, and any residents that had been out to the hospital and returned to the facility had all appropriate orders entered for any new appliances they had such as catheters. ADON P said she had performed and additional audits of all residents in the facility with catheters on 4/12/24 and all residents had the appropriate orders and care implemented. ADON P said no staff would return to work until they had received the in-service over Catheter Care orders for new catheters. During an interview on 4/13/24 at 3:21 p.m., DON Q said the daily clinical meetings that she knew had been in place since she started at the facility would continue to ensure new admissions, re-admissions, and any residents that had been out to the hospital and returned to the facility had all appropriate orders entered for any new appliances they had such as catheters. DON Q said no staff would return to work until they had received the in-service over Catheter Care orders. (continued on next page)

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F 0690 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the in-service training report and accompanied sign in sheet dated 4/12/24, Titled Catheter Care orders for new catheters, indicated nursing in-services over ensuring catheter care orders were initiated for all admissions, re-admissions, or new catheter as appropriate. Nurses interviewed on 4/13/24 between 1:30 p.m. and 3:38 p.m., (LVN O, LVN I, LVN N, LVN BB, LVN A, LVN R, and LVN C) confirmed all nurses that worked on 4/12/24 and 4/13/24 (both on the 6a.m.-6:00 p.m.) had received in-services over ensuring catheter care orders were initiated. The nurses said residents with catheters were to receive catheter care every shift and as needed. The nurses said they would document catheter care provided on the resident's MAR. The nurses explained that when the order batch for catheters were entered it included an order for catheter care, which once entered will display on the MAR. The nurses said they had been instructed on how to enter these orders if a resident with a catheter was found to not have the batch orders for catheters entered. The nurses said if they had any trouble entering the orders, they would document the catheter care on they provided on a nursing progress note and notify the DON or the ADON that they needed assistance entering the batch orders. The nurses said they attended the morning meetings and provided a report on each resident they cared for. The day shift nurses said the daily stand- up meetings included any new admissions, re-admissions, or residents that had been out of the facility to the hospital. The nurses said any new devices or appliances the resident might have, were discussed, and reviewed to ensure any associated orders and care were implemented. They said this included catheters. The nurses also indicated they had received the catheter care procedure list and verbalized appropriate steps for catheter care. During an interview on 4/13/24 at 3:39 p.m., the Administrator said all nurses that have worked since the identification of the IJ had received in-services and that no nurse would be allowed to work until in-services were completed. While the IJ was removed on 4/13/24 at 3:44 p.m., the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope identified as isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41093 Based on interviews, and record review, the facility failed to provide care that would ensure acceptable parameters of nutritional status for 1 of 6 residents reviewed for nutritional status. (Resident #1). The facility did not appropriately monitor Resident #1's weights during his stay at the facility from 12/21/23 to 1/22/24 and it resulted in Resident #1 had a 15 % weight loss in 26 days. This noncompliance was identified as PNC. The non-compliance began on 12/21/23 and ended 2/29/24. The facility had corrected the non-compliance before the survey began. This failure could place residents at risk for altered nutritional status, and complications of chronic conditions, and decline in health status. Findings included: Record review of the face sheet dated 3/28/24 indicated Resident #1 was an 87- year-s old male admitted to the facility on [DATE] with diagnoses including, aftercare following joint replacement surgery, fracture of the right femur (the head of the hip joint), acute bronchitis, bradycardia (slow heart rate), dementia, sick sinus syndrome (disease in which the heart's natural pacemaker becomes damaged and is no longer able to generate normal heartbeats at the normal rate) presence of a cardiac pacemaker, insulin dependent diabetes with chronic kidney disease, and high blood pressure. Record review of Resident #1's MDS dated [DATE] indicated he usually understood others and usually made himself understood. The MDS indicated Resident #1 had severe cognitive impairment (BIMS of 6). The MDS indicated he had no behavior of rejecting care. The MDS indicated Resident #1 was dependent on staff for lower body dressing and the putting on/taking off of footwear. The MDS indicated Resident #1 required moderate assistance with upper body dressing, showering, and toileting. The MDS indicated he required supervision or touch assistance with personal hygiene and eating. The MDS indicated he required set up or clean up assistance only with eating. The MDS indicated Resident #1 dependent on staff for sit to stand transfers, chair/bed- to- chair transfers, toilet transfers, and tub/shower transfers. The MDS indicated Resident #1 required substantial/maximal assistance with walking ten feet, and the ability to move from lying on the back to sitting on the side of the bed with no back support. The MDS indicated Resident #1 supervision or touch assistance with the ability to roll to the left or right side while in the bed and the ability to move from setting on the side of the bed to lying flat on the bed. The MDS indicated Resident #1 was occasionally incontinent of bladder and was always incontinent of bowel. The MDS indicated Resident #1 was 75 inches tall (6 feet 3 inches) and weighed 159 lbs. The MDS indicated Resident #1 had no significant weight gain or loss in the last 6 months. The MDS indicated during the 7 days look back period while not a resident at the facility, Resident #1 had received Parenteral/IV (feeding through a vein). The MDS indicated during the 7 days look back period while a resident at the facility, Resident #1 had received a mechanically altered, therapeutic diet. The MDS indicated he had an active diagnosis of protein or calorie malnutrition or was at risk for malnutrition. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of the care plan dated 12/22/23 for Resident #1 indicated he was at risk for dehydration and malnutrition. The care plan interventions included mechanical soft diet and vitamin supplements. The care plan also indicated Resident #1 would receive ST and was dependent on staff for all care. Record review of the physician order summary report from 12/21/23 to 1/22/24 reflected Resident #1 had the following physician orders.; *daily weight .start date 12/22/24; *Prostat 30 ml twice a day for 60 days, start date 1/12/24; *multi-vitamin 1 tablet once a day for 60 days, start date 1/12/24; *vitamin C 500 mg 1 tablet twice a day for 60 days, start date 1/12/24; *zinc sulfate 220 mg 1 tablet once a day for 6 days, start date 1/12/24; During an interview on 3/28/24 at 11:00 a.m., LVN Z said Resident #1 had been started on the Prostat, multi-vitamin vitamin C, and zinc as part of a wound protocol order set on 1/12/24, not because he had been identified as nutritional risk or significant weight loss. Record review of the Hospital discharge summary dated 12/21/23 indicated Resident #1's weight was 157 lb. and 13.6 oz. Record review of nursing progress notes from 12/21/23 to 1/22/24 displayed no weights for Resident #1. Record review of the nutrition risk assessment for Resident #1 dated 12/27/23 stated his most recent weight was 159.4 lbs. (a date was not specified). The nutrition risk assessment stated Resident #1 was at high nutritional risk at that time and was underweight with a BMI of 19 and had increased nutrient needs. The note indicated the Resident ate fair consuming approximately 25-50 percent of most meals with minimal assist/supervision/cueing. The nutritional interventions recommended by the RD at that time were fortified foods, offer snacks three times a day, Medpass 90 ml three times a day, Liquid protein 30 ml twice a day, a daily multivitamin, and vitamin C 500 mg BID. This note was written by the RD. Record review of the nursing progress notes from 12/21/23 to 1/1/24 revealed there was no documentation regarding Resident #1's oral intake. Record review of the nursing progress note dated 1/2/24 at 2:51 a.m., indicated Resident #1 took oral fluids fair. This note was written by LVN BB. Record review of the nursing progress note dated 1/3/24 at 12:23 a.m., indicated Resident #1 took oral fluids fair. This note was written by LVN BB. Record review of the nursing progress notes from 1/4/24 to 1/21/24 revealed there was no documentation regarding Resident #1's oral intake. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Record review of the nursing progress note dated 1/22/24 at 4:09 a.m., Indicated Resident #1 had not eaten breakfast lunch or dinner on 1/21/24, was combative during care and fluids were taken poorly. This note was written by LVN BB. Record review of the nursing progress note dated 1/22/24 at 8:58 am stated spoke with .NP (nurse practitioner) and the DON about the resident change of condition. Resident has not eaten or had any fluids x3 days although they have been highly encouraged. Upon assessing resident after getting report from (previous shift nurse) that resident went from being alert and combative to very lethargic and slow to respond to pain stimuli .Vitals were wnl (within normal limits) but blood sugar was 445 .orders were to send him out for further evaluation . This note was written by LVN D. Record review of the Hospital Critical Care History and Physical described Resident #1 as cachectic (general state of ill health involving great weight loss and muscle loss) in appearance and listed unintentional weight loss as an active problem, indicating the need to rule out malignancy and that NGT tube would be placed if indicated. The History and Physical listed the principal diagnosis of Sepsis with encephalopathy. Record review of the hospital pharmacy consult note dated 1/23/24 indicated Resident #1's weight was 135 lb. and 12.9 oz. During an interview on 3/11/24 at 10:00 am, the VPCO said she was acting as the DON. She said the DON and ADON had been terminated for multiple issues identified by the facility including issues with the oversight of weight assessments. The corporate RN said there was a performance improvement plan in place that the QAPI committee was overseeing. During an interview on 3/12/24 at 10:10 a.m., LVN A said new admissions were to be weighed weekly for 4 weeks. LVN A said as a nurse this was something she checks on now. LVN A said residents were weighed monthly after 4 weeks of weekly weights, unless there was an order to weigh more often. LVN A said the weekly weights were completed by the restorative aide. During an interview on 3/12/24 at 10:23 a.m., LVN E said all new admissions were weighed weekly for 4 weeks, then monthly unless ordered more frequently, or if the resident has had an order to stop weights. During an interview on 3/12/24 at 10:47 a.m., LVN F said all new admissions were weighed weekly for 4 weeks, then monthly unless ordered more frequently, or if the resident has had an order to stop weights. During an interview on 3/12/24 at 12:54 pm, Resident #1's family member said she shared a room at the facility with Resident #1 until a few weeks before he had to go the hospital (1/13/24). She said she could recall the staff coming to get him to weigh him regularly. Resident #1's significant other said she thought maybe one time they came to get him and said they were going to weigh him. She said she was weighed every day. Resident #1 said he was going to the dining room regularly to eat lunch with a friend, but would usually be in the room for breakfast and dinner. Resident #1's significant other said Resident #1 could eat better on his own but that he seemed to eat more when staff assisted him. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview with the DON on 3/28/24 at 10:00 am, she stated weights were currently being reviewed during the daily meeting. The DON said she was new to the facility but that the monitoring of weights and interventions as needed was something she continued to keep a close eye on. The DON clarified,; weight lists were reviewed during the daily stand-up meeting. Weights were being obtained by the same staff member, CNA B, for accuracy and the CNA gave the weights to her. The DON said Resident #1 should have been weighed weekly on his admission. During an interview on 3/28/24 at 10:20 a.m., CNA B said she was new to her role as staffing coordinator/restorative and has been obtaining resident weights. CNA B said all new admissions/re-admissions were to be weighed weekly for 4 weeks. CNA B said she also performs daily weights for residents as directed by the DON. CNA B said most residents get weighed monthly. During an interview on 3/28/24 at 10:53 a.m., the RD said she comes the facility weekly. The RD said she printed a report that notified her of all significant weight changes, new admissions, and residents with wounds. The RD said that was how she knew which residents to prioritize week to week. She said if weight information was not documented in EMR system the report she prints would not identify any weight changes. The RD said she did see Resident #1 upon his most recent admission on 12/27/23. When asked how the RD had the information of Resident #1's weight on 12/27/23, she stated if the weight was not documented in the EMR, she would have told staff she needed a weight for him, and they would have obtained it for her. The RD said Resident #1 would have shown on the report as a new admission, and it appeared that was why she saw him according to her note on 12/27/23. The RD said she had no other notes for Resident #1, but had he flagged as significant weight loss she would have seen him again. During an interview on 3/28/24 at 12:20 p.m., the Administrator said the facility policy and procedure should have been followed. She said Resident #1 should have had daily weights as ordered. Items such as this were part of the DON's termination and implementation of facility action to ensure corrective measures were taken. Record review of the facility assignment sheets from 1/18/24 to 1/22/24 indicated LVN A took care of Resident #1 on 1/18/24 from 6am-6pm and MA H passed medications to Resident #1 on 1/18/24. The facility assignment sheets indicated MA G was assigned to Resident #1 on 1/19/24 -1/21/24. The assignment sheets indicated LVN I took care of Resident #1 on 1/19/24 from 6am -6pm. The assignment sheets indicated LVN D had taken care of Resident #1 from 6am-6pm on 1/20/24-1/22/24. The facility assignment sheets indicated CNA K took care of Resident #1 from 6a-6p on 1/19/24 and 1/21/24. The facility assignment sheets indicated CNA J took care of Resident #1 on 1/20/24. During an interview on 4/9/24 at 3:50 p.m., CNA K said she could not recall Resident #1. CNA K said she could not remember if Resident #1 had decreased intake. CNA K said if any Resident had a decrease in their food or fluid intake, she would notify the nurse caring for that Resident. During an interview on 4/9/24 at 3:54 p.m., CNA J said she remembered Resident #1 and took care of him regularly during his most recent stay at the facility (12/21/23 to 1/22/24). CNA J said Resident #1 had good days and bad days in regard to his oral intake. CNA J said towards the end of his stay it did seem Resident #1 had declined. CNA J said she could not say that his oral intake had decreased substantially but would have notified the nurse caring for Resident #1 if she had noticed a decrease in his intake. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/10/24 at 3:00 p.m., LVN I said she could not recall if any CNA had reported to her that Resident #1 had decreased intake. During an interview on 4/10/24 at 3:29 p.m., LVN D said that it had been reported to him before his shift on 1/22/24 that Resident #1 had decreased intake over the past 3 days and had no input in the past 24 hours. LVN D was asked to clarify his statement as his note written on 1/22/24 stated Resident has not eaten or had any fluids x3 days. LVN D said that was a mistake, he said Resident #1 had no intake x3 meals (in the past 24 hours) and a decrease in intake in the days leading up to 1/22/24, based on what had been reported to him. LVN D said he could not recall the night shift nurse he received report from. During an interview on 4/11/24 at 2:00 p.m., DON Q said the facility had no intake/output records to provide for Resident #1. She explained unless a resident had a specific order for intake and output monitoring the records are generally not entered. The DON said she did look to see if there were any paper intake records to provide but there were none. During an interview on 4/12/24 at 10:22 a.m., LVN A said Resident #1 had overall decline in the few weeks before his hospitalization after his wife had discharged home. LVN A said he had a decrease in oral intake and increased combative behaviors. LVN A said she had not notified the physician but had notified DON X under the assumption DON X was attempting to move him to hospice care. During an interview on 4/12/24 at 1:47 p.m., the Nurse Practitioner said she had not been notified prior to 1/22/24 that Resident #1 had decreased oral intake in the days leading up to 1/22/24. The Nurse Practitioner said she had not been notified of Resident #1's dietary recommendations on 12/27/23. The Nurse Practitioner said had she been notified she would have ordered all of the Dietitians recommendations. During an interview on 4/13/24 at 3:30 p.m., LVN BB said she could not remember Resident #1. Record review of the facility policy and procedure dated June of 2022, titled Weight Monitoring, stated Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status such as usual body weight or desirable body weight range .(5) A weight monitoring schedule will be developed upon admission for all residents: .(b) newly admitted weights -monitor weight weekly for 4 weeks. (c) Residents with weight loss- monitor weight weekly. (d) if clinically indicated -monitor weight daily. (e) All others - monitor weight monthly. The facility had corrected the noncompliance by the following: - Termination of the DON and ADON that were to be overseeing weight assessments. - Notification of the Medical Director /NP - All residents being weighed - All new admits/ re-admits being weighed weekly x 4 weeks - Review of weights in the weekly in the weight/skin meeting (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	- Back up plan established for the DON or acting DON to assign staff to obtain weights in the absence of the restorative aide - The DON/designee will enter weights into EMR system Record review of a Quality Assurance (QA) Meeting Sign-in Sheet dated 2/14/24 indicated the facility had an QA meeting addressing weight assessments. The QA Meeting Sign-in Sheet indicated the nurse practitioner was present for the QA meeting. Record review of the Action Plan regarding weights dated 2/21/24 revealed: - All residents being weighed - All new admits/ re-admits being weighed weekly x 4 weeks - Review of weights in the weekly in the weight/skin meeting - Back up plan established for the DON or acting DON to assign staff to obtain weights in the absence of the restorative aide - DON/designee will enter weights into PCC Record review of the Weekly weights log dated 3/27/24 displayed all new admissions/readmissions weights obtained weekly. Record review of the Resident Weight summary report dated 3/28/24, displayed historical data for 90 days. Record review of the sampled residents ((Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7) revealed weights obtained appropriately and documented in the EMR. All staff interviewed (LVN A, CNA B, LVN E, LVN F, LVN C) on 3/28/24 verbalized that all new admission and re/admissions were to be weighed weekly x 4 weeks. All residents were to be weighed monthly unless given a specific order to weigh more often or less often (in the case of being ordered by hospice provider). The noncompliance was identified as PNC. The noncompliance began on 12/21/22 and ended on 2/29/23. The facility had corrected the noncompliance before the survey began.