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	345261	A. BUILDING _____ B. WING _____	C 04/08/2024

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LOTUS VILLAGE CENTER FOR NURSING & REHABILITATION	179 COMBS STREET SPARTA, NC 28675

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F 000	INITIAL COMMENTS A onsite complaint investigation survey was conducted from 04/01/24 through 04/03/24. The immediate jeopardy removal plan was validated on 04/08/24. Therefore, the exit date was changed to 04/08/24. Event ID #VEJS11. The following intake was investigated: NC00215086. One (1) of three allegations resulted in a deficiency. Intake #NC00215086 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F 580 at a scope and severity of J. CFR 483.12 at tag F 600 at a scope and severity of K. CFR 483.25 at tag F 684 at a scope and severity of K. The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/23/24 and ended on 04/05/24. It should be noted that the immediate jeopardy start date was determined as 2/23/24 because the exit date from the recertification and complaint investigation survey was 2/22/24. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		5/2/24

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

Electronically Signed | 05/02/2024

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(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various

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F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff, Nurse Practitioner, and Medical Doctor interviews the facility failed to notify the Nurse Practitioner or the Medical Doctor when a Urology Consult was not able to be scheduled per the Nurse Practitioner's order after a CT (computed tomography) scan noted decreased vascular flow to Resident #1's left testicle. Resident #1 experienced serious adverse outcome after an acute change in condition was noted on 03/11/24 and was transferred to the hospital emergency department (ED), diagnosed with severe sepsis and underwent a left orchiectomy (removal of the testicle) on 3/12/24. This practice affected 1 of 3 residents (Resident #1) reviewed for notification. Immediate Jeopardy began on 02/23/24 when the facility failed to notify a medical provider that they were not able to schedule a urology consultation per the Nurse Practitioner's order for as soon as possible. Immediate jeopardy was removed on 04/05/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place. The findings included: Resident #1 was admitted to the facility on 12/21/23 with diagnoses that included anoxic	F 580	1- Resident #1 is no longer at the center with no intention of returning. 2- All residents have protentional to be impacted by the deficit practice. House audit was completed by Administrator to capture any orders for consultations on 4.3.2024. Any issues identified were immediately addressed by Interdisciplinary Team. On 4.3.2024 and 4.4.2024 Nurse Manager reviewed all changes of condition in the last 30 days to ensure notification to the physician or nurse practitioner had taken place. Any issues identified was corrected by nurse managers. 3- Education was conducted with nursing by the Regional Nurse Consultant (RNC) on 4.4.2024 about the requirements of change of conditions and notification expectations. Director of Nursing (DON) was informed on 4.3.2024 that she will be responsible for education to the nursing staff moving forward about how to handle change of conditions and the required notifications to the Physician or Nurse Practitioner. Education was also conducted by the Administrator to the Transportation Scheduler on 4.4.2024 that she is to notify the DON when orders for consultation appointments can't be scheduled per order. So, the DON can notify the Physician or Nurse Practitioner. DON was made aware of this expectation	

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F 580	Continued From page 3 brain injury, persistent vegetative state and neurogenic bladder. An interview was conducted with the Nurse Practitioner (NP) on 04/01/24 at 5:00 PM, 04/02/24 at 1:00 PM and 04/04/24 at 2:05 PM. The NP explained that she was notified of Resident #1's scrotal swelling on 02/14/24 and assessed his scrotum to be swollen to approximately the size of a softball with a little redness. The NP stated she offered to the family member to send the Resident to the local ED, but the family member did not want the Resident to go to the ED but wanted him treated at the facility. The NP stated she ordered an ultrasound to be performed on the scrotum immediately and antibiotics to be administered twice a day for 10 days. She reported the ultrasound was completed on 02/15/24 and she learned the results of the ultrasound on 02/19/24 when she went to the facility for rounds. The ultrasound showed decreased vascular flow to the left testicle, and she felt that Resident #1 needed a urology consult as soon as possible because anytime you have decreased vascular flow "you need to get scooting", so she wrote the ordered for the urology consult as soon as possible that day on 02/19/24. She stated she assessed the Resident's scrotum on 02/19/24 and 02/28/24 and there was no change in the scrotum since the first time she assessed the scrotum on 02/14/24. She stated the facility needed to monitor the scrotum closely for changes and they could send him to the ED for any changes if need be. At the time of the interview the NP stated that she was not aware that the facility was having a difficult time getting a urology consult scheduled for Resident #1 and assumed the appointment had been made. She also stated she was not aware	F 580	on 4.4.2024 by (RNC). Education will be ongoing with new clinical hire by the DON / Nurse leadership. 4- DON / Nurse Leadership will be responsible for ensuring that consolation orders are followed up timely in accordance with the order as well as ensuring that change in conditions are captured and the required notifications take place. Audits will be 3 charts 2 times a week for 4 weeks, then 3 charts 1 time a week for 8 weeks. Findings will be tracked, trended, and subject to review in monthly QAPI. 5- Compliance 5.2.2024	

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that Resident #1's urology consult was scheduled for 03/27/24 and explained that was too long away. She stated she could see maybe being scheduled for 2 weeks out from when it was ordered but 5 to 6 weeks away was too long.

On 04/01/24 at 11:40 AM an interview was conducted with the Scheduler who explained that she was working on the hall as a nurse aide on 02/19/24 when she was given the order for Resident #1 to have a urology consult as soon as possible from the Staff Development Coordinator. She explained that as soon as possible meant it needed to schedule with high priority like then and there, but she was on the hall and knew she would have to follow up the next day. When she was able to follow up, she called a urology office that told her to fax over the information on Resident #1 and they would get back to her. She stated she waited several days, and they never followed up with her so when she was able to get back in touch with the urology office, they told her there was a mix-up in their records and they needed more information. The Scheduler stated that by that time it was about 03/03/24 or 03/04/24 so she decided to try to get Resident #1 a urology appointment at a local urology clinic and on 03/08/24 she was able to schedule a urology appointment for the Resident for 05/22/24. The Scheduler stated she kept that appointment and tried another clinic 03/08/24 and was able to schedule a urology appointment for the Resident for 03/27/24. The Scheduler stated she did not inform anyone that she was having difficulties with scheduling Resident #1 for a urology appointment because she thought she could manage it but now she knew different.

During an interview with the Staff Development

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Coordinator (SDC) on 04/02/24 at 10:35 AM revealed that on 02/19/24 she put the order in Resident #1's electronic medical record for a urology consultation as soon as possible that was written by the NP on 02/19/24. She stated her routine was to make 2 copies of the orders and she kept one for herself and gave the other order to the Scheduler on 02/19/24 to make an appointment for the Resident. The SDC explained that she always highlighted the area of the order for the consultation and pointed it out to the Scheduler when she gave it to her on 02/19/24. If the Scheduler had any questions about the order, then she would get back to her, but the SDC stated she did not recall that the Scheduler had any questions about the order. The SDC stated that she did not know if the urology consultation was ever made because she did not follow up with the order.

An interview was conducted with Nurse #1 on 04/01/24 at 3:00 PM who confirmed she was the Nurse on duty on 03/11/24 and sent Resident #1 to the emergency department. Nurse #1 continued to explain that Resident #1 seemed quieter than normal during her shift, and she did not have any trouble flushing his catheter and his feeding tube was patent and she took the Resident's blood pressure several times throughout the shift that fluctuated. She stated the third time she took his blood pressure it was 86/42 and that was lower than it had been all day and he seemed weaker, and she felt at that time that he was septic. The Nurse explained that she called the Nurse Practitioner and got an order to send Resident #1 to the emergency department.

Review of Resident #1 progress notes from the local hospital ED dated 03/11/24 at 4:15 PM

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revealed the Resident presented with an oxygenation saturation of 89% and blood pressure of 73/46 with an additional reading of 70/39 during his limited stay at the local hospital. Abnormal labs included an elevated white blood cell (WBC) of 11.08 (normal range 4.80-10.80) and a blood urea nitrogen (BUN) of 107 (normal range 7-10) and Urine culture with greater than 100,000 CFU/ML (greater than 100,000 CFU/ML would indicate infection) gram negative bacilli (bacteria). Resident #1 was administered three liters of intravenous fluids and started on two different intravenous antibiotics. After consultation with internal and external providers it was decided Resident #1 would need to be transferred to a hospital with a higher level of care capabilities due to Resident #1's condition, the need for a bed in the intensive care unit and the specialty of an intensivist (physician who provides special care for critically ill patients) and infectious disease. The progress note described Resident #1's specific medical risks of worsening pneumonia, sepsis or death. Resident #1 had to be air lifted to the secondary hospital. There was no documentation in the ED progress notes about Resident #1's scrotum. Discharge date and time was 03/11/23 at 11:14 PM with discharge diagnoses of dehydration, facility acquired pneumonia and kidney stone in the right ureter.

Attempts to interview the local emergency department physician were unsuccessful.

A review of Resident #1's progress notes dated 03/12/24 at 2:18 AM from the second hospital revealed he had a continuous medication infusing via intravenous access to improve his blood pressure which was effective. It was noted that he had received 3 liters of intravenous and the two

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antibiotics ordered at the previous hospital would be continued. The Resident was admitted with diagnosis of severe septic shock secondary to urinary tract infection, dehydration, aspiration pneumonia and right stone in ureter with hydronephrosis. A urology consultation was obtained on the morning 03/12/24 and orders were received for ultrasounds of the kidneys and testicles to be completed. The urology consultation revealed Resident #1 had a history of left testicular swelling and pain for one month with a previous ultrasound demonstration of decreased vascular flow to the left testicle. The ultrasound of the left testicle completed on 03/12/24 demonstrated no blood flow with surrounding necrotic changes consistent with the left testicle. On 03/12/24 an emergency stent was placed in the right ureter and a left orchiectomy (removal of the left testicle) was performed.

An interview was conducted with the Medical Doctor (MD) on 04/01/24 at 4:30 PM. The MD explained he reviewed Resident #1's ultrasound done on 02/15/24 and noted that the Nurse Practitioner wrote an order to have a urology consultation as soon as possible, so it should have been done right away. He stated the facility should have let them know if they were having difficulty obtaining a urology consult because it was possible that he could have intervened and arranged for the Resident to be seen sooner to avoid the outcome of the orchiectomy.

During an interview with the Director of Nursing (DON) on 04/02/24 at 9:00 AM the DON stated the Staff Development Coordinator at the time was the one who wrote the order for the urology consultation for Resident #1 so it would have been her responsibility to follow up with the

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Scheduler to make sure she made the appointment. She stated they normally discussed the new orders in the morning clinical meeting but the morning they would have discussed the order was when the state was in the building, and they did not have the morning meeting. The DON stated she did not know who the Scheduler's contact person was in house to go to if she was having scheduling problems but regardless the DON stated the Scheduler should have let someone in management know that she was having difficulty scheduling the urology appointment.

An interview was conducted with the Administrator on 04/02/24 at 10:40 AM and 04/03/24 at 2:00 PM who explained that that the facility discussed physician orders in the clinical meeting which was held in the morning after a general meeting with all the managers. The Administrator stated she knew Resident #1 had an order for a urology consult but she did not know that he had a problem with his testicle. She reported the Scheduler received training from the previous Scheduler, but she could not say what the training entailed just that it was completed. She indicated, if need be, the Scheduler could have reached out to the previous Scheduler for instruction and at the least she could have notified the DON of difficulties in making the urology appointment for Resident #1. The Administrator indicated that the Physician should have been notified if they were having difficulty in scheduling a urology appointment.

The Administrator was notified of Immediate Jeopardy on 04/03/24 at 3:55 PM.

The facility provided the following Immediate

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Jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as the result of noncompliance.

On 2/19/21 the Nurse Practitioner wrote an order for Resident #1 to have a urology appointment as soon as possible due to ultrasound of scrotum showing possible decreased vascular flow to left testicle. The facility transport scheduler scheduled the urology appointment for 3/27/24. The facility did not contact the nurse practitioner to notify her of the date of the appointment. On 3/11/24 Resident #1 experienced an acute change in condition with a blood pressure of 86/42 and weakness. Resident #1 was sent to the emergency department where he was diagnosed with severe septic shock, urinary tract infection and aspiration pneumonia. The left testicle was found to have no blood flow with necrotic changes to the left testicle and removal of the testicle had to be performed.

On 4/3/24 and 4/4/24 the Nurse Managers reviewed residents who have change of condition during the last 30 days using 24-hour reports, x-rays, lab tests and vital signs. These items were reviewed for indicators of a change such as not at baseline, not normal for resident, lethargic, shortness of breath, new onset pain, out of range results, etc. Falls with major injuries for the last 30 days were reviewed. This audit included notification to the physician or nurse practitioner. Any opportunities identified during this audit will be corrected by the Nurse Managers by 4/4/24.

On 4/3/24 the Administrator did an audit of all consult orders for all residents in the last 90 days.

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This information was pulled from the orders in the electronic health record. Any issues identified were addressed immediately by the Interdisciplinary Team.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The Director of Nursing and The Regional Nurse Consultant educated all nurses, including agency, regarding the requirements for notification to the Physician or Nurse Practitioner following a change of condition. Verbal education was given on a change of condition is noted when a resident presents different than known baseline, lethargic, restless or short of breath. Furthermore, education was provided on how to use the on-call MD system after hours and on weekends. Hall nurses are responsible for retrieving faxed x-ray and lab results from the fax machine which is located at the nurse's station. Critical lab and x-ray results are called to the on-call provider at that time they are received. All other lab and x-ray results are to be placed in the communication book for physician/nurse practitioner follow up. The Director of Nursing will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift. This education was provided both in person and via telephone. Verbal understanding was demonstrated by conversation and return of information. Education will be completed by 4/4/24. On 4/3/24 the Director of Nursing was made aware that it was her responsibility to educate staff members prior to working their next scheduled shift and that she is to track this

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F 580	Continued From page 11 education. On 4/4/24 the Administrator educated the resident transport scheduler on notifying the Director of Nursing so that she can notify the physician and nurse practitioner when orders for consultation appointments cannot be scheduled per the physician or nurse practitioner orders. The Director of Nursing (DON) was notified of this responsibility on 4/4/24. In the event the DON is not in the building, the transport scheduler will notify the MDS Coordinator who will notify the physician or nurse practitioner. The MDS Coordinator was made aware of this responsibility 4/4/24. Newly hired transport schedulers will be educated in orientation. Effective 4/3/24 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 4/5/24 An onsite validation of the immediate jeopardy removal plan was conducted on 04/8/24. Residents' information including vital signs, orders, assessments and incidences for the last 30 days were reviewed to identify if the providers had been notified of changes in condition. Specific orders for consultations were reviewed and all issues were corrected when identified. All nursing staff were educated on the new system of notification and ensured the nurses knew how to contact the on call provider when necessary. Return demonstration of understanding the system was ensured. All new nurses will be educated on the system upon hire. The Scheduler was educated to inform the DON when she was having trouble making appointments for	F 580		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12 consultations ordered by the providers. The immediate jeopardy removal date of 04/05/24 was validated.	F 580		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, family member, Nurse Practitioner, Urology Surgeon, Wound Physician and Medical Doctor interviews the facility failed to protect a Resident's right to be free from neglect when the facility failed to identify the seriousness of a left swollen testicle, complete thorough and ongoing nursing assessments, schedule a urology appointment per the Nurse Practitioner's order which led to a delay in care and treatment for a serious medical emergency for 1 of 3 residents (Resident #1) reviewed for neglect. Resident #1 experienced a serious adverse outcome when an acute change in condition was noted on 03/11/24 with a blood	F 600	1- Resident #1 is no longer at the center with no intention of returning. 2- All current residents have the potential to be impacted by the deficit practice. On 4.4.2024 Social Worker completed a house review of residents with a BIMS 12 or higher regarding care and questioned if they felt neglected. No issues reported at that time. All other residents receive skin checks on 4.4.2024 by MDS Nurse . No signs of neglected were reported from this audit. Center reported cited event on 5.3.2024. 3- 4.3.2024 Director of Nursing and	5/4/24

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	345261	A. BUILDING _____ B. WING _____	C 04/08/2024

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F 600	Continued From page 13 pressure of 86/42 and weakness. The Resident was sent to the local emergency department where he was transferred to a hospital for a higher level of care and diagnosed with severe septic shock and urinary tract infection. An ultrasound showed no blood flow with necrotic changes to the left testicle and an orchiectomy (removal of the testicle) had to be performed. This practice affected 1 of 3 residents (Resident #1) reviewed for neglect. Immediate Jeopardy began on 02/23/24 when the facility failed to protect a Resident's right to be free from neglect when they failed to identify the seriousness of a left swollen testicle, complete thorough and ongoing assessments and schedule a urology appointment per the Nurse Practitioner's order which led to a delay in care and treatment for a serious medical emergency. Immediate jeopardy was removed on 04/05/24 when the facility provided and implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place. The findings included: This tag is crossed referenced to: F 684: Based on record reviews and staff, family member, Nurse Practitioner, Urologist and Wound Physician's interviews the facility failed to identify the seriousness of decreased vascular flow to Resident #1's left testicle and complete and document thorough and ongoing nursing assessments of left testicle after 03/23/24 to	F 600	Regional Nurse Consultant educated the current staff on the definition of Neglect. Education will be ongoing and shared upon hire with all new staff. 4- Administrator will be responsible for ensuring that residents remain free from neglect. Audit will be completed 2 times a week for 4 weeks with residents who have a BIMS 12 or higher, then 1 time a week for 8 weeks. Findings will be tracked, trended, and subject to review in monthly QAPI. 5- Compliance 5.4.2024	

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determine the need for further medical attention. In addition, a Urology Consultation for evaluation of the Resident's left testicle was scheduled for after 3/23/24 not as ordered by the NP which further delayed the determination of what medical interventions were necessary. The Resident experienced an acute change in condition on 03/11/24 with a blood pressure of 86/42 (normal blood pressure range 120/80) and weakness. The Resident was sent to the local hospital emergency department (ED) and was then life flighted to a second hospital due to the need for a higher level of care and capabilities. The Resident was diagnosed with severe septic shock and urinary tract infection. A renal ultrasound showed an obstructing stone in the right ureter with hydronephrosis (excessive fluid in the kidney due to a backup of urine) and a testicular ultrasound showed no blood flow with necrotic (death of cells or tissue due to disease or injury) changes to the left testicle. On 03/12/24 an emergency stent was placed in the right ureter and the left testicle was removed. This practice affected 1 of 3 residents reviewed for providing care according to professional standards of practice (Resident #1).

F 580: Based on record reviews, and staff, Nurse Practitioner, and Medical Doctor's interviews the facility failed to notify the Nurse Practitioner or the Medical Doctor when a Urology Consult was not able to be scheduled per the Nurse Practitioner's order after a CT (computed tomography) scan noted decreased vascular flow to Resident #1's left testicle. Resident #1 experienced serious adverse outcome after an acute change in condition was noted on 03/11/24 and was transferred to the hospital emergency department (ED), diagnosed with severe sepsis and

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underwent a left orchiectomy (removal of the testicle) on 3/12/24. This practice affected 1 of 3 residents (Resident #1) reviewed for notification.

The Administrator was notified of Immediate Jeopardy on 04/03/24 at 3:55 PM.

The facility provided the following Immediate Jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to identify the seriousness of a swollen left testicle, complete thorough and ongoing assessments, schedule a urology appointment per the Nurse Practitioner's order which led to a delay in care and treatment for a serious medical emergency.

On 12/21/23 Resident #1 was admitted to Lotus Village Center for Nursing and Rehabilitation with diagnosis of brain damage, dysphagia, hypertension and gastrostomy. On 2/19/24 the physician ordered Resident #1 to have urology appointment as soon as possible due to ultrasound showing possible decreased vascular flow to the left testicle. The facility scheduled the appointment for 3/27/24 and did not notify the ordering nurse practitioner of the delay between order and available appointment. Nursing staff did not complete ongoing and thorough assessments of the scrotal area to identify changes. On 3/11/24 Resident #1 had an acute change of condition noted with a blood pressure of 86/42 and weakness. Resident #1 was sent to the emergency room and was diagnosed with severe septic shock, urinary tract infection and

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aspiration pneumonia. Necrotic changes were found to the left testicle and removal of the testicle was performed.

Current residents residing in the facility have the potential to be affected by the deficient practice.

On 4/4/24 all alert and oriented residents with a BIMS of 12 or greater were interviewed by the Social Worker regarding care and questioned if they felt they were neglected of care and services. There were no issues reported. All residents with cognitive impairment, a BIMS of 11 or less had total body skin assessments completed by the MDS Coordinator. There were no signs of neglect identified.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

Beginning on 4/3/24 the Director of Nursing and Regional Nurse Consultant educated the staff in all departments including agency staff on the definition of neglect: "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Some examples of neglect include lack of sufficient staffing to be able to provide services, lack of knowledge of the needs of the resident, lack of supplies to provide care, or indifference or disregard for resident care and safety. The Director of Nursing and Administrator will ensure that staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. The Director of Nursing and

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F 600	Continued From page 17 Administrator are responsible for tracking who has received the education and who still needs to receive it prior to working their next shift. Both the Director of Nursing and the Administrator were made aware of this responsibility on 4/3/24. The Director of Nursing will provide this education to newly hired staff, including agency, during orientation. Education was given verbally either in person or via phone and/or written format and the staff were asked to restate the information to confirm understanding of the education. Staff will not be able to work their next scheduled shift until education has been completed. Effective 4/3/2024, the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 4/5/23 On 04/08/24 an onsite validation of the immediate jeopardy removal plan was conducted. The facility assessed all residents either through interviews or skin assessments for signs and symptoms of neglect and there were no issues noted. The entire staff was educated on the definition of neglect and different examples of neglect and will ensure that no staff will be allowed to work without receiving the education. Newly hired staff as well as agency staff will be educated on neglect. Return understanding of neglect was demonstrated verbally after the education was completed. The immediate jeopardy removal date of 04/05/24 was validated.	F 600		
F 684 SS=K	Quality of Care	F 684		5/2/24

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F 684	Continued From page 18 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff, family member, Nurse Practitioner (NP), Urology Surgeon and Wound Physician interviews the facility failed to identify the seriousness of decreased vascular flow to Resident #1's left testicle and complete and document thorough and ongoing nursing assessments of left testicle after 03/23/24 to determine the need for further medical attention. In addition, the Urology Consultation for evaluation of the Resident's left testicle was scheduled for 3/27/24 which further delayed the determination of what medical interventions were necessary. The Resident experienced an acute change in condition on 03/11/24 with a blood pressure of 86/42 (normal blood pressure range 120/80) and weakness. The Resident was sent to the local hospital emergency department (ED) and was then life flighted to a second hospital due to the need for a higher level of care and capabilities. The Resident was diagnosed with severe septic shock and urinary tract infection. A renal ultrasound showed an obstructing stone in the right ureter with hydronephrosis (excessive fluid in the kidney due to a backup of urine) and a testicular ultrasound showed no blood flow with necrotic	F 684	1. Resident #1 is no longer at the center with no intention of returning. 2. All resident have the potential to be impacted by the deficit practice. On 4.4.2024 Minimal Data Set (MDS) nurse and Director of Nursing (DON) reviewed 30 days of vital signs and progress notes for all current residents to identify change in condition. If there was indications of acute changes both monitoring and assessments were reviewed. Consultation orders, lab findings and X-rays from providers were also assessed. In the event issues were found they were addressed by the Director of Nursing, MDS nurse and Regional Nurse Consultant. 3. Education was conducted by both the Regional Nurse Consultant and DON with all nursing staff on 4.3.2024. Education included proper notification to nurse by the nurse aid when there is a change in condition. Nurses are then required to document changes and completing assessments when notified of the change. MDS is responsible for opening up the	

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F 684	Continued From page 19 (death of cells or tissue due to disease or injury) changes to the left testicle. On 03/12/24 an emergency stent was placed in the right ureter and the left testicle was removed. This practice affected 1 of 3 residents reviewed for providing care according to professional standards of practice (Resident #1). Immediate Jeopardy began on 02/23/24 when the facility failed to complete and document thorough and ongoing nursing assessments of Resident #1's left testicle. Immediate jeopardy was removed on 04/05/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure the completion of education and monitoring system are in place. The findings included: Resident #1 was admitted to the facility on 12/21/23 with diagnoses that included anoxic brain injury, persistent vegetative state and neurogenic bladder. The quarterly Minimum Data Set (MDS) assessment dated 12/29/23 revealed Resident #1 had long and short-term memory problems, functional impairment of upper and lower extremities for range of motion, totally dependent on staff for all activities of daily living and had an indwelling urinary catheter. A review of Resident #1's medical record from 02/23/24 through discharge on 03/11/24 revealed there were no documented nursing assessments of the Resident's scrotum.	F 684	User Defined Assessments (UDA) which will ensure that nursing is monitoring the changes. IDT will determine who is in of the UDA and MDS will open the assessment up during the morning or afternoon meeting. On 4.4.2024 the Regional Nurse Consultant educated the DON of her responsibility to education clinical staff during their onboarding process about the need to identify, document and monitor changes. Additionally, DON was also educated on running a comprehensive morning clinical meeting. The DON is responsible for gathering the information prior to the meeting. 4. The Administrator is responsible for ensuring that clinical meetings are conducted Monday – Friday and are comprehensive and there is proper dialogue with the team when a change in condition has been identified. Audits will be completed weekly for 12 weeks. Finding will be track, trended and discussed in the monthly QAPI meeting. 5. Compliance Date 5.2.2024	

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An interview was conducted with the Nurse Practitioner (NP) on 04/01/24 at 5:00 PM, 04/02/24 at 1:00 PM and 04/04/24 at 2:05 PM. The NP explained that she was notified of Resident #1's scrotal swelling on 02/14/24 and assessed his scrotum to be swollen to approximately the size of a softball with a little redness. The NP stated she offered to the family member to send the Resident to the local ED, but the family member did not want the Resident to go to the ED but wanted him treated at the facility. The NP stated she ordered an ultrasound to be performed on the scrotum immediately and antibiotics to be administered twice a day for 10 days. She reported the ultrasound was completed on 02/15/24 and she learned the results of the ultrasound on 02/19/24 when she went to the facility for rounds. The ultrasound showed decreased vascular flow to the left testicle, and she felt that Resident #1 needed a urology consult as soon as possible because anytime you have decreased vascular flow "you need to get scooting", so she wrote the ordered for the urology consult as soon as possible that day on 02/19/24. She stated she assessed the Resident's scrotum on 02/19/24 and 02/28/24 and there was no change in the scrotum since the first time she assessed the scrotum on 02/14/24. She stated the facility needed to monitor the scrotum closely for changes and they could send him to the ED for any changes if need be. At the time of the interview the NP stated that she was not aware that the facility was having a difficult time getting a urology consult scheduled for Resident #1 and assumed the appointment had been made. She also stated she was not aware that Resident #1's urology consult was scheduled for 03/27/24 and explained that was too long

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away. She stated she could see maybe being scheduled for 2 weeks out from when it was ordered but 5 to 6 weeks away was too long.

During an interview with the Wound Physician (who was also a Surgeon) on 04/03/24 at 11:35 AM the Physician explained that he consulted weekly on Resident #1's pressure ulcers and when he made rounds on 02/14/24 it was brought to his attention by Resident #1's family member that his scrotum was swollen and appeared to be tender. He continued that he noticed that Resident #1's scrotum was swollen and tender and he would recommend a scrotal ultrasound to determine whether it was a cystocele (a bulge of the bladder) or a torsion. He indicated he spoke with the Nurse Practitioner about it on 02/14/24 who was already aware of the Resident's swollen scrotum and was going to order an ultrasound. The Wound Physician stated he made note of the assessment in his 02/14/24 notes but not after that because the NP was aware of the issue and that was not the area of his consultation. He continued to explain that when he made rounds on Resident #1 the following weeks, he noticed his scrotum was still swollen and he was told by the Resident's family member that he had a urology appointment scheduled. The Physician stated he informed the family member that Resident #1 would probably have to have the testicle removed. The Physician explained that the amount of time it took for the testicle to die depended on what the cause was, for example if the cause was torsion, then it would be faster. He stated the last two times (02/21/24 and 02/28/24) he looked at the Resident's scrotum it looked about the same as it did on 02/14/24 and he did not feel like it needed to be an emergency urology consultation, but it needed to be evaluated. He

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explained that according to the ultrasound where it showed decreased vascular blood flow Resident #1 may not have needed an orchiectomy but only more or a different antibiotic. He stated Resident #1 did not seem to have the pain the second and third time he saw him and the last time he rounded on Resident #1 (02/28/24) his scrotum did not seem painful or tender. The Physician stated it was possible the testicle could have twisted and untwisted and if so, the pain would have come and gone.

On 04/01/24 at 11:40 AM an interview was conducted with the Scheduler who explained that she was working on the hall as a nurse aide on 02/19/24 when she was given the order for Resident #1 to have a urology consult as soon as possible from the Staff Development Coordinator. She explained that as soon as possible meant it needed to schedule with high priority like then and there, but she was on the hall and knew she would have to follow up the next day. When she was able to follow up, she called a urology office that told her to fax over the information on Resident #1 and they would get back to her. She stated she waited several days, and they never followed up with her so when she was able to get back in touch with the urology office, they told her there was a mix-up in their records and they needed more information. The Scheduler stated that by that time it was about 03/03/24 or 03/04/24 so she decided to try to get Resident #1 a urology appointment at a local urology clinic and on 03/08/24 she was able to schedule a urology appointment for the Resident for 05/22/24. The Scheduler stated she kept that appointment and tried another clinic 03/08/24 and was able to schedule a urology appointment for the Resident for 03/27/24. The Scheduler stated

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she did not inform anyone that she was having difficulties with scheduling Resident #1 for a urology appointment because she thought she could manage it but now she knew different.

An interview was conducted with the Social Worker (SW) on 04/03/24 at 10:25 AM who explained that she had heard from the Scheduler (she could not remember when) that she was having trouble getting a urology appointment scheduled for Resident #1 and the family member did not agree with the first appointment that was made for him. The SW thought they worked it out because the final urology appointment was in the books for a urology clinic out of town but did not know when it was scheduled for. The SW stated she was made aware of the difficulty that the Scheduler was having making the urology appointment through the family member.

During an interview with Nurse #7 on 04/02/24 at 2:00 PM the Nurse stated she had only worked with Resident #1 one time (Medication Administration Record indicated she worked with the Resident on 03/07/24 and 03/8/24) and the Resident's family member brought the Resident's swollen scrotum to her attention. The Nurse explained that the scrotum appeared to be swollen and the scrotum was elevated using a pillow. There was no documentation in the Resident's medical record of the assessment.

On 04/02/24 at 3:05 PM an interview was conducted with Nurse Aide (NA) #1 who stated that she mostly worked the hall where Resident #1 resided. The NA explained that she knew of the Resident's scrotum being swollen and hard and reported it to several nurses but could not

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remember which nurses she reported it to. She stated she did not know what was being done about the swelling other than keeping his scrotum elevated which they always did, and his family member did as well. The NA explained that Resident #1 flinched when you touched his scrotum but he flinched every time you touched him so she could not be sure it was painful. She stated the swelling eventually subsided.

During an interview with Nurse Aide (NA) #2 on 04/02/24 at 3:06 PM the Nurse Aide explained that she worked on all the halls including the hall that Resident #1 resided. The NA continued to explain that she noticed Resident #1's scrotum to be slightly larger than the normal scrotum and it was fleshy looking. She stated the family member was very particular with his care and always kept his scrotum elevated on pillows. The NA stated she did not notice his scrotum being painful when touched because the Resident always yelled and screamed when he was touched even before his scrotum was swollen. She stated she would not have identified the scrotum to be swollen but maybe slightly enlarged therefore she did not report the swollen scrotum to the nurses.

An interview was conducted with Nurse Aide #3 on 04/02/24 at 3:15 PM. The NA explained that she often worked the hall where Resident #1 resided and took him to the shower room for his showers. The NA continued to explain that she noticed that Resident #1's scrotum was swollen and red like it was irritated and she knew that nursing was aware of it but did not know what was being done. She stated the family member was particular about his care and kept his scrotum elevated all the time. The NA reported she did not notice his scrotum being painful

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because he hollered every time he was touched not just when you touched his scrotum.

A review of Resident #1's progress notes dated 03/10/24 at 5:33 AM and written by the Director of Nursing (DON) revealed cleaned scant amount of blood from around catheter when providing resident care. Catheter patent and draining and not leaking at this time. Flushed catheter. Resident slept very soundly this shift. Tried not to disturb the resident too much because he does not sleep well usually.

An interview was conducted with Nurse #3 on 04/02/24 at 12:00 PM and 04/03/24 at 8:50 AM who confirmed that she worked from 7:00 AM to 7:00 PM on 03/10/24 with Resident #1. Nurse #3 stated she never knew anything about Resident #1 having scrotal swelling and she even worked on 02/16/24 and flushed his catheter and did not notice any scrotal swelling. She stated she felt like if he had scrotal swelling, she would have seen it when she flushed his catheter on 03/10/24 and if so, she would have notified the Physician.

On 04/02/24 at 11:45 AM an interview was conducted with Nurse #2 who confirmed she worked with Resident #1 on 03/10/24 from 7:00 PM to 7:00 AM on 03/11/24. The Nurse reported she had never noticed any scrotal swelling on Resident #1 at that time nor had she ever noticed any scrotum swelling on the Resident nor was she aware that he had a scrotal ultrasound or what the results were.

A review of Resident #1's progress note dated 03/11/24 at 4:05 PM and written by Nurse #1 revealed Resident was just not himself and appeared to be weaker than usual. Blood

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pressure 86/42 and heart rate was 80. His pupils were not as reactive as his baseline and the urinary catheter was draining adequate urine output. The feeding tube was intact. The Resident's family insisted that something was wrong and wanted the physician to send him to the hospital. Nurse Practitioner contacted and received an order to send him to the emergency department for further evaluation.

An interview was conducted with Nurse #1 on 04/01/24 at 3:00 PM and 04/03/24 at 10:10 AM who stated she had recently worked with Resident #1 more often and confirmed she was the Nurse on duty on 03/11/24 from 7:00 AM to 7:00 PM and sent Resident #1 to the ED. Nurse #1 continued to explain that Resident #1 seemed quieter than normal during her shift. She did not have any trouble flushing his catheter and his feeding tube was patent and she took the Resident's blood pressure several times throughout the shift which fluctuated. She stated the third time she took his blood pressure it was 86/42 and that was lower than it had been all day and he seemed weaker, and she felt at that time that he was septic. The Nurse explained that she called the Nurse Practitioner and got an order to send Resident #1 to the ED. Nurse #1 reported that she did not know about Resident #1's scrotal swelling but she did know that he had an ultrasound ordered because she noted the order for the ultrasound of the scrotum on 02/14/24 the day it was written. She explained that she only occasionally worked with Resident #1, and she did not have to assess his scrotal swelling but that if he had scrotal swelling, she would have noticed it when she flushed his catheter. Nurse #1 stated that when she worked with Resident #1, she never noticed any swelling of his scrotum.

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When asked how she would know to assess for scrotal swelling the Nurse responded that would be considered an acute episode or a change in condition and when the issue was first identified the nurse who discovered the issue should set up a user defined assessment (UDA) that would automatically populate to be done once a shift for 72 hours or until it was resolved.

Review of Resident #1 progress notes from the local hospital ED dated 03/11/24 at 4:15 PM revealed the Resident presented with an oxygenation saturation of 89% and blood pressure of 73/46 with an additional reading of 70/39 during his limited stay at the local hospital. Abnormal labs included an elevated white blood cell (WBC) of 11.08 (normal range 4.80-10.80) and a blood urea nitrogen (BUN) of 107 (normal range 7-10) and Urine culture with greater than 100,000 CFU/ML (greater than 100,000 CFU/ML would indicate infection) gram negative bacilli (bacteria). Resident #1 was administered three liters of intravenous fluids and started on two different intravenous antibiotics. After consultation with internal and external providers it was decided Resident #1 would need to be transferred to a hospital with a higher level of care capabilities due to Resident #1's condition, the need for a bed in the intensive care unit and the specialty of an intensivist (physician who provides special care for critically ill patients) and infectious disease. The progress note described Resident #1's specific medical risks of worsening pneumonia, sepsis or death. Resident #1 had to be air lifted to the secondary hospital. There was no documentation in the ED progress notes about Resident #1's scrotum. Discharge date and time was 03/11/23 at 11:14 PM with discharge diagnoses of dehydration, facility acquired

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pneumonia and kidney stone in the right ureter.

Attempts to interview the local emergency department physician were unsuccessful.

A review of Resident #1's progress notes dated 03/12/24 at 2:18 AM from the second hospital revealed he had a continuous medication infusing via intravenous access to improve his blood pressure which was effective. It was noted that he had received 3 liters of intravenous and the two antibiotics ordered at the previous hospital would be continued. The Resident was admitted with diagnosis of severe septic shock secondary to urinary tract infection, dehydration, aspiration pneumonia and right stone in ureter with hydronephrosis. A urology consultation was obtained on the morning 03/12/24 and orders were received for ultrasounds of the kidneys and testicles to be completed. The urology consultation revealed Resident #1 had a history of left testicular swelling and pain for one month with a previous ultrasound demonstration of decreased vascular flow to the left testicle. The ultrasound of the left testicle completed on 03/12/24 demonstrated no blood flow with surrounding necrotic changes consistent with the left testicle. On 03/12/24 an emergency stent was placed in the right ureter and a left orchiectomy (removal of the left testicle) was performed.

An interview was conducted with the Urology Surgeon on 04/02/24 at 4:35 PM. The Surgeon explained that he received a call from the hospital emergency department for a consultation for Resident #1 on the early morning of 03/12/24 and was informed that he was an air transfer from another hospital. The Physician Assistant (PA) reported that Resident #1 had tests from the

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previous hospital that showed an obstructing stone in the right ureter and was showing signs of sepsis, and the Surgeon's initial thought was that if it was a stone or stones then it was reason for urgent intervention and a stent needed to be placed to allow the infected urine to pass through which was a common procedure. The Surgeon continued to explain that the PA informed him that Resident #1's family member reported that the Resident had endured scrotal swelling and pain for about one month with a previous ultrasound that showed decreased vascular flow in the left testicle therefore, the Surgeon wanted a stat (immediate) ultrasound on the kidneys and testicles before the Surgeon arrived at the hospital so he would know what he was dealing with and what needed to be done. The Surgeon explained that when he read the results of the ultrasounds, he knew he needed to remove the stone in the right ureter and place a stent to relieve the hydronephroses in the right ureter and he needed to remove the left testicle because the repeat ultrasound showed no blood flow to the left testicle at all. He stated the ultrasound completed 03/12/24 showed missed to late torsion (twisting) and also showed the left testicle had been dead for a long time. He reported his belief was that the reason for the sepsis was the dead testicle. When asked if Resident #1's dead testicle was painful the Surgeon informed that during the process of dying (decreased blood flow) the testicle would be painful but after the testicle died there would be no pain and when the testicle died it was necessary to be removed. He stated there was no way to tell how long the testicle had been dead. The Surgeon indicated that he could tell that the testicle did not die from torsion that more than likely it died from orchitis (an inflammation of one or both testicles mainly caused by a bacterial

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or viral infection) that was not treated appropriately. The Surgeon was asked if the orchiectomy could have been prevented if Resident #1 had been sent for a urology consult when it was ordered on 02/19/24 the Surgeon stated that it was hard to say but that initially an antibiotic would be necessary to treat the infection (orchitis) but if after a few days of no improvement then he would have switched the antibiotic and obtained a repeat ultrasound.

On 04/01/24 at 10:37 AM during an interview with Resident #1's family member she explained that the Resident had a history of recurrent urinary tract infections and had several trips to the emergency department for catheter changes due to blockages related to thick sediment in his urine that was treated with a medication used to flush the catheter. She informed Resident #1 had a 5 day stay at the hospital in January 2024 due to a severe urinary tract infection. The family member continued to explain that in mid-February she noticed his scrotum was swollen to the size of an orange and asked for him to be evaluated by the Nurse Practitioner (NP) which she did, and the NP ordered an ultrasound to be done. The ultrasound was done which showed a decreased vascular flow of his left testicle and on 02/19/24 the NP ordered an antibiotic and a urology consult as soon as possible due to decreased vascular flow to his left testicle. The family member stated she approached the Scheduler and Social Worker several times with her concerns about not getting a urology consult for the Resident and even helped with obtaining an appointment herself before one was eventually made on 03/08/24 for 03/27/24 at a urology clinic in a nearby town. The family member continued to inform that on the afternoon of 03/11/24 she

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went to the facility and found Resident #1 appearing white as a ghost, his gums were white, and he was clammy and barely breathing. She called for Nurse #1 to assess him, and the Nurse got a blood pressure of 68/33, then she told the Nurse to call 911. The family member reported that while at the local ED the doctor informed her that they were going to airlift him to another hospital when he was stable because he was severely dehydrated, malnourished and possible renal failure or septic shock. She stated they did a CT scan of his kidneys to verify the need to send him to the other hospital to see a kidney specialist. The family member stated Resident #1 was sent by helicopter to the other hospital late that same night on 03/11/24. She informed that when she got to the hospital she informed the doctors of everything the Resident had been through and around 5:30 AM on 03/12/24 the Urology Surgeon told her that he was going to do emergency surgery because Resident #1 had a blockage related to a kidney stone in his right ureter and he had to place a stent (a tubular support placed temporarily inside a blood vessel, canal or duct to aid healing or relieve an obstruction). The Surgeon also informed that Resident #1's left testicle was dead, and he would have to remove it while he was placing the stent. The family member stated the surgery was successful and Resident #1 was due to be discharged on 04/03/24 to her home for her to provide his care.

During an interview with the Director of Nursing (DON) on 04/02/24 at 9:00 AM and 04/02/24 at 5:30 PM the DON stated that she vaguely remembered Resident #1 having scrotal swelling, but she was not involved with it. She stated she saw his scrotum a couple of days after the

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reported swelling, but she did not think it looked swollen. The DON continued to explain that she assisted the nurse aide in turning and repositioning the Resident a couple nights before he was sent out and even changed and flushed his catheter and she did not see any signs of a swollen scrotum. The DON was asked how the facility managed the documentation on acute changes or changes in condition to ensure they were being monitored and documented correctly and she indicated the documentation was subject to the nurses' judgement as to whether the acute change warranted documentation. If so, the nurse would set up UDA documentation or at the very least she should document the assessment in the Resident's progress notes until the issue resolved. The DON was asked if Resident #1's scrotal swelling and decreased vascular blood flow to his left testicle should be considered an acute episode or a change in condition and the DON replied yes. When asked what the facility's policy stated about documentation on acute episodes or changes in conditions the DON informed, they did not have a policy on documentation of acute episodes or changes in the residents' conditions.

The Administrator was notified of Immediate Jeopardy on 04/03/24 at 3:55 PM.

The facility provided the following Immediate Jeopardy removal plan:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #1 was admitted to the facility on 12/21/23 with diagnosis brain damage,

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dysphagia, hypertension, and gastrostomy. On 2/19/24 the physician ordered Resident #1 to have a urology appointment as soon as possible due to ultrasound of scrotum showing possible decreased vascular flow to the left testicle. A urology appointment was scheduled for 3/27/24. Nursing staff failed to document on-going thorough assessments to include Resident #1's scrotum once the swelling was identified. On 3/11/24 Resident #1 had a change of condition noted with a blood pressure of 86/42 and weakness. Resident #1 was sent to the emergency room and was diagnosed with severe septic shock, urinary tract infection and aspiration pneumonia. Necrotic changes were found to the left testicle and removal of the testicle was performed.

All residents residing in the facility have the potential to be affected by the deficient practice.

On 4/4/24 the Director of Nursing and MDS Nurse Coordinator reviewed 30 days of vital signs and progress notes for all current residents to identify if there was a change in condition. If acute changes were identified, monitoring and assessments were reviewed for proper documentation. Physician and Nurse Practitioner orders including consultations, laboratory tests and x-rays were reviewed. Any issues were addressed upon identification by the Director of Nursing, MDS Nurse Coordinator and Regional Nurse Consultant.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

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On 4/3/24 the Director of Nursing and Regional Nurse Consultant educated both in person and via phone the nursing staff to include nurses and nurse aides including agency staff. Verbal understanding was demonstrated by conversation and return of information. Education included when they recognize a resident with a change of condition nurse aides are to notify the nurse immediately. This is to include the definition of change in conditions. A change of condition was explained as changes from the resident's baseline, lethargy, confusion, increase/decrease vital signs, behaviors, skin issues, shortness of breath, swelling. Nurses were educated on completing and documenting their thorough assessment after a change has been noted. The MDS Coordinator will open a user defined assessment (UDA) which will flag in the resident's electronic medical record for the nurses to complete every shift on residents requiring on-going monitoring. The MDS Coordinator will be made aware of the need to open the UDA during daily stand-up and stand-down meetings. The Interdisciplinary Team will determine who needs the UDA opened based on the change of condition. The MDS Coordinator was made aware of this responsibility on 4/4/24. This assessment will be left open until the IDT team resolves the issue. The need for monitoring will remain on the 24-hour report until resolved by the IDT team during the daily stand up and stand down meeting. Residents who are identified with changes in condition requiring on-going thorough assessments will be documented on every shift until resolved. The 24-hour summary will continue to be used for nurses to pass along information to the oncoming shift. Nurses were educated on changes in condition needing continuous monitoring to be reported to the oncoming nurse

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at shift change and placed on the 24-hour report. The 24-hour report communication will also be used for nurses to be aware of residents that require more than routine assessments. Nurses will notify their nurse aides at the beginning of the shift of the need to monitor said residents for changes and the frequency of the monitoring. Any change in condition needs to be documented in the medical record as well as physician notification and any new orders. On 4/3/24 the Director of Nursing was made aware that it was her responsibility to ensure staff members have the education prior to working their next scheduled shift and that she is to track this education. The Director of Nursing is responsible for ensuring any staff that have not been educated will be prior to their next shift. The Director of Nursing was notified of this responsibility on 4/3/24. Effective immediately this education will be added to the new hire orientation and the Director of Nursing will educate newly hired staff. Education completed 4/4/24.

On 4/4/24 the Regional Nurse Consultant educated the Director of Nursing on completing a comprehensive clinical meeting. This meeting is attended by the Director of Nursing, Wound Nurse, Director of Therapy and Social Worker daily Monday through Friday immediately following 9 a.m. stand up meeting. This meeting will consist of reviewing physician orders, labs, x-rays and consultations to ensure that these items are followed up as needed. The DON is responsible for the gathering of this information. The Director of Nursing, Wound Nurse, Director of Therapy and Social Worker were made aware of these responsibilities on 4/4/24.

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F 684	Continued From page 36 Effective 4/3/24 the Administrator will be ultimately responsible for ensuring implementation of this immediate jeopardy removal. Alleged Date of IJ Removal: 4/5/24 An onsite validation of the immediate jeopardy removal plan was conducted on 04/08/24. Thirty days of residents' vital signs and progress notes were reviewed to identify if there were changes in conditions and if the changes were identified, monitoring and assessments were reviewed for proper documentation. Physician and Nurse Practitioner's orders such as lab tests and x-ray orders were reviewed as well, and any issues were addressed. All nursing staff including nurse aides were educated about reporting any changes in the residents' conditions related to anything from their baseline and informed to report changes. The Administrative staff will be responsible for setting up the assessments and responsible for monitoring the documentation until resolution. The changes will be discussed and monitored in the morning clinical meetings. The nursing staff will not be allowed to work until they have been educated on the new procedures and were expected to voice their understanding of the new procedures. The immediate jeopardy removal date of 04/05/24 was validated.	F 684		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		5/2/24

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F 867	Continued From page 37	F 867		

policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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F 867	Continued From page 38 §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct	F 867		

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F 867	Continued From page 39 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, family member, Nurse Practitioner, Urology Surgeon, Wound Physician, and Medical Doctor interviews, the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the Complaint Survey on 07/12/23 and Recertification and Complaint Survey of 09/14/22.	F 867	The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor interventions the committee put into place in prior surveys over the past 3 years. This failure was for three deficiencies that were originally cited in the areas of Resident Assessment (F580) Notification of Change, (F600) Neglect and Abuse, and (F684) Quality of	

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F 867	Continued From page 40 This failure was for 3 deficiencies that were originally cited in the areas of (F580) Notification of Change, (F600) Neglect and (F684) Quality of Care that were subsequently recited on the current Complaint Survey on 04/08/24. The repeat deficiencies during the three surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. The finding included: This tag is cross referenced to: F-580: Based on record reviews, and staff, Nurse Practitioner, and Medical Doctor interviews the facility failed to notify the Nurse Practitioner or the Medical Doctor when a Urology Consult was not able to be scheduled per the Nurse Practitioner's order after a CT (computed tomography) scan noted decreased vascular flow to Resident #1's left testicle. Resident #1 experienced serious adverse outcome after an acute change in condition was noted on 03/11/24 and was transferred to the hospital emergency department (ED), diagnosed with severe sepsis and underwent a left orchiectomy (removal of the testicle) on 3/12/24. This practice affected 1 of 3 residents reviewed for notification. During the complaint survey on 07/12/23 the facility failed to notify the Medical Director when a resident experienced an acute change in condition. During the recertification and complaint survey on 09/14/22 the facility failed to notify the physician of a medication unavailability. F-600: Based on record reviews and staff, family	F 867	Care. All tags were subsequently recited on the current complaint investigation of 04/08.2024. Plan of correction was put into place at the time of each deficiency cited. Each plan of correction included monitoring tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated in-service to all administrative staff on 5.2.2024 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. The Quality Assurance Performance Improvement Committee will review the	

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F 867	Continued From page 41 member, Nurse Practitioner, Urology Surgeon, Wound Physician and Medical Doctor interviews the facility failed to protect a Resident's right to be free from neglect when the facility failed to identify the seriousness of a left swollen testicle, complete thorough and ongoing nursing assessments, schedule a urology appointment per the Nurse Practitioner's order which led to a delay in care and treatment for a serious medical emergency for 1 of 3 residents (Resident #1) reviewed for neglect. Resident #1 experienced a serious adverse outcome when an acute change in condition was noted on 03/11/24 with a blood pressure of 86/42 and weakness. The Resident was sent to the local emergency department where he was transferred to a hospital for a higher level of care and diagnosed with severe septic shock and urinary tract infection. An ultrasound showed no blood flow with necrotic changes to the left testicle and an orchiectomy (removal of the testicle) had to be performed. This practice affected 1 of 3 residents reviewed for neglect. During the complaint survey on 07/12/23 the facility failed to prevent a resident from being neglected when he experienced an acute change in condition and neglected to call or seek medical assistance. F-684: Based on record reviews and staff, family member, Nurse Practitioner (NP), Urology Surgeon and Wound Physician interviews the facility failed to identify the seriousness of decreased vascular flow to Resident #1's left testicle and complete and document thorough and ongoing nursing assessments of left testicle after 03/23/24 to determine the need for further medical attention. In addition, the Urology	F 867	compliance audits to evaluate continued compliance. The committee will make recommendations if any noncompliance is identified and reevaluate the plan of correction for possible revisions. This process will continue until the facility has achieved three months of consistent compliance. The Administrator will be responsible for the plan of correction. Date of Compliance: 5.2.2024	

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Consultation for evaluation of the Resident's left testicle was scheduled for 3/27/24 which further delayed the determination of what medical interventions were necessary. The Resident experienced an acute change in condition on 03/11/24 with a blood pressure of 86/42 (normal blood pressure range 120/80) and weakness. The Resident was sent to the local hospital emergency department (ED) and was then life flighted to a second hospital due to the need for a higher level of care and capabilities. The Resident was diagnosed with severe septic shock and urinary tract infection. A renal ultrasound showed an obstructing stone in the right ureter with hydronephrosis (excessive fluid in the kidney due to a backup of urine) and a testicular ultrasound showed no blood flow with necrotic (death of cells or tissue due to disease or injury) changes to the left testicle. On 03/12/24 an emergency stent was placed in the right ureter and the left testicle was removed. This practice affected 1 of 3 residents reviewed for providing care according to professional standards of practice.

During the recertification and complaint survey on 09/14/22 the facility failed to perform a skin assessment on admission and failed to initiate treatment for a rash.

On 04/08/24 at 12:50 PM an interview was conducted with the Administrator who explained that the facility was still monitoring and auditing the plans of corrections that they developed from the numerous citations they received from the recent recertification. She stated that she personally reviewed the plan of corrections and discussed them during the monthly QA meetings and encouraged feedback for areas of

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F 867	Continued From page 43 opportunity. The Administrator explained that she was not employed at the facility for the initial citations but that she was starting at the ground and working up in making sure she had the right people in the right place to effectively get the job done.	F 867		