STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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F 000	INITIAL COMMENTS The survey team entered the facility on 10/22/24 for a complaint survey and exited on 10/23/24. A surveyor returned to the facility on 10/29/24 to complete a complaint investigation. The survey exit conference was conducted by phone on 11/05/24. Therefore the exit date was changed to 11/05/24. Event ID #WJLJ11 The following intakes were investigated NC00221797, NC00222298, NC00223174 and NC00223523. Intake NC00223174 and NC00223523 resulted in immediate jeopardy. 5 of the 7 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity J CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/07/24 and was removed on 11/02/24. 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- (A) An accident involving the resident which results in injury and has the potential for requiring	F 580		11/22/24

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

Electronically Signed | 11/22/2024

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F 580	Continued From page 1	F 580		

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 locations that comprise the composite distinct part, and must specify the policies that apply to

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F 580	Continued From page 2 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 (NP), responsible party, and Resident interviews, the facility failed to notify the physician and responsible party of changes in condition for of 1 of 1 resident (Resident #7). Resident #7 had intact cognition and a history of stroke and on 10/21/24 at approximately 9:00 PM he reported to a nurse aide (NA) he had pain and numbness in his left arm and leg. The NA aide reported this to the nurse. On the next shift at approximately 6:00 AM Resident #7 informed another NA he could not feel his left side. The NA reported this to the nurse. On 10/22/24 between 7:00 and 7:15 AM Unit Manager (UM) #1 was called to the room by an NA and assessed Resident #7 and found his speech was slurred, his left arm and leg did not have any feeling, and they did not have any muscle tone. The Nurse Practitioner was in the facility and assessed Resident #7 and had him transferred to the Emergency Department (ED) for evaluation of stroke symptoms. There were no nursing progress notes entered on 10/21/24 or 10/22/24 regarding notification of the physician or responsible party regarding the change in Resident #7's condition until the note entered by UM #1 on 10/22/24 at 8:25 AM. Resident #7 presented to the Emergency Department (ED) with new onset vision changes and inability to use his left upper and lower extremities. Diagnoses included cerebral vascular accident (CVA-ischemic stroke) with following cognitive deficits and dysphagia (difficulty swallowing) post CVA. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat	F 580	F-580 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #7 was sent to the hospital 10/22/24. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: An audit to determine if any residents had reported any new change in condition that was not reported to the healthcare provider by a licensed nurse of residents with a brief interview for mental status (BIMS) score of 13 or higher was completed by the Administrator on 10/25/2024. The Audit revealed that no other residents were noted to be affected. An audit was completed on 10/25/24 by the Director of Nursing of progress notes for the past 7 days to ensure that anyone reporting a change of condition had provider notification. The audit revealed that no one else was affected. From 10/31/24-11/1/24 the Director of Nursing or Staff Development Coordinator interviewed all nursing assistants regarding knowledge of any residents having change of conditions in the last 7 days that were not reported to the	

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ischemic strokes. Resident #7 was admitted to the critical care stroke unit and was discharged on 10/29/24.

Immediate jeopardy began on 10/21/24 for Resident #7 he reported his left arm and leg were numb and a medical provider and responsible party were not notified. Immediate jeopardy was removed on 11/02/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective.

Findings included:

Resident #7 was admitted to the facility on 8/29/24, with diagnoses of history of right hemiparesis/hemiplegia (partial or complete paralysis of one side) with right side weakness related to a stroke and Type 1 diabetes mellitus.

The quarterly Minimum Data Set (MDS) dated 9/10/24 indicated Resident #7's cognition was intact.

An interview with NA # 5 at 10/29/24 4:33 PM revealed she worked the 3:00 pm to 11:00 PM shift on 10/21/24 and did first rounds with Resident #7 at 6:30 PM and he did not have any concerns. When she did her second round at 9:00 PM, the resident told her he had pain and numbness in his left arm and leg. NA #5 indicated she went to tell Nurse #5 Resident #7 had numbness and pain, and Nurse #5 nodded to NA #5. NA #5 stated Nurse #5 did not go in to check

healthcare provider. No negative findings were noted.

From 10/25/24-10/28/24, the Director of Nursing also questioned all of the licensed nurses regarding knowledge of any residents having had a change in condition that deviated from their baseline and did not have healthcare provider notification. Signatures accounted for both the education and the questionnaire. No residents were noted to be affected.

(3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:
On 10/25/2024 the Director of Nursing initiated education to all licensed nurses to complete a clinical assessment of a minimum vital signs and pertinent body systems once notified of a change in condition to include accident or incident, injuries of unknown source, significant change in residents physical, emotional, or mental condition which can include elevated vital signs, altered mental status, blurred vision, headaches, numbness or tingling to body parts, uncontrolled pain, etc., to notify the healthcare provider immediately of findings once the assessment is complete and to notify the responsible party as well. Education also included any changes reported by nursing assistants. Any licensed nurse that has not been educated by 10/28/2024 will be taken off the schedule until the educated has been received. All new hires will be educated by the Director of Nursing during

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F 580	Continued From page 4 on Resident #7, that she was aware of. An interview with Nurse # 5 on 10/29/24 at 6:06 PM revealed she worked the 3:00 PM to 11:00 PM shift on 10/21/24. Nurse #5 went to Resident #7's bedside to take his blood sugar at 5:00 PM. The Resident did not mention he was having any issues. Nurse #5 did not recall NA #5 telling her Resident #7 was having any change in condition. An interview with NA #4 on 10/29/24 at 5:05 pm revealed at 6:00 AM (on 10/22/24) Resident #7 stated, "I can't feel my left side". NA #4 went to tell Nurse #6 and Nurse #6 wrote something down but did not come with NA #4. NA #4 further stated she went back to the room and told Resident #7 she reported his symptoms to Nurse #6 and went on with her assignment. An interview with Nurse #6 on 10/30/24 at 12:47 PM revealed on 10/21/24 at around 6:00 AM NA #4 reported to her that Resident #7's left side wasn't feeling right. Nurse #6 stated that she did an assessment when she gave Resident #7 his medication and checked his blood sugar at around 6:00 AM. She stated she briefly spoke with him while doing the blood sugar and Resident #7 did not indicate anything was wrong at that time. Nurse #7 stated she had not been given any kind of report from the prior shift that anything was going on with Resident #7. An interview with NA #8 on 10/29/24 at 4:25 PM revealed she worked the 7:00 AM to 3:00 PM shift on 10/22/24 and had taken breakfast to the resident around 7:15 am and asked Resident #7 how he was doing. He said, "I am not well" and "I haven't felt well since last night" and he couldn't feel his left side, and this had started after dinner.	F 580	orientation. The Director of Nursing will ensure all licensed nurses are in-serviced. On 11/1/2024, the Regional Director of Clinical Services educated the Administrator, The Director of Nursing, Staff Development Coordinator, and The Human Resource Director on the orientation process for nursing staff that will include education on recognizing change in condition, timely assessment and monitoring of change in condition, effective communication during a medical emergency, importance of notifying the healthcare provider, and effective communication during a medical emergency. On 11/1/2024, the Director of Nursing/Staff Development Coordinator re-educated all nursing assistants on change in condition of residents to include recognizing signs and symptoms of a stroke such as blurred vision, slurred speech, weakness to one side of the body, and facial drooping. Education also included the importance of reporting any change in condition or any of these symptoms to their nurse Any nursing assistant that has not received the education on 11/1/2024 will be taken off the schedule until the education has been received. The Director of Nursing will ensure all nursing assistant educated. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Director of Nursing or designee(s) will	

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Resident #7 further revealed that his vision was blurred on the left side, and he was numb and could not feel anything on the left side. NA #8 stated she noticed his speech was slurred too.

A review of the medical record revealed there were no nursing progress notes entered on 10/21/24 notification to the family or physician regarding a change in Resident #7's change in condition.

An interview with Unit Manager (UM) #1 on 10/29/24 at 11:40 AM revealed she was requested by NA #8 to come to Resident #7's room as soon as possible at 7:15 AM (on 10/22/24). Upon arrival, she found Resident #7 with left-sided paralysis, including the left arm and left leg. UM #1 further revealed Resident #7 stated he had been unable to move his left side since last night after dinner. UM #1 stated she began her assessment and called for the Nurse Practitioner (NP). UM #1 stated Resident #7's left arm and leg were flaccid, dropping to the bed when she raised them up. The NP arrived, assessed Resident #7 and asked for EMS to be called because Resident #7 had had a stroke.

A phone interview on 10/29/24 at 4:48 PM with the family member/responsible party revealed she was called by NA #8 around 8:15 AM (on 10/22/24) and was told that Resident #7 had been sent to the hospital for a stroke.

A phone interview with Resident #7 on 10/30/24 at 5:30 PM revealed after dinner on 10/21/24 he could not feel his left arm and left side when the nurse aide was trying to change him. He could not help due to the lack of movement. NA #5 and NA #9 (3:00 pm to 11:00 pm shift) helped him

monitor the 24 hour summary and progress notes for any indication of a change in condition and will interview 2 staff member and 2 residents with a BIMS of 13 or higher for any indication of a change in condition to ensure assessment, notification, and provider follow up as indicated. Monitoring will take place 5x/wk for 4 weeks, 3x/wk for 4 weeks, and 1x/wk for 4 weeks.

The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.

The facility alleges compliance on 11/22/2024.

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because one person couldn't do it. He further stated he usually could position himself on his side with the use of the bed rails and a push on his hip to the turning side. This was when he noticed he couldn't move his left side. Nurse #5 came in and he told her he couldn't move his left arm or left leg, and he did not know what was going on. Resident #7 further stated Nurse #5 did not respond. Resident #7 indicated Nurse #5 should have checked him and called the doctor. Resident #7 explained his condition stayed the same until NA #4 came in on third shift and he told NA #4 he could not feel his left side and she went and told Nurse #6. Nurse #6 came into his room around 6:00 am or so and gave him his medicine. Resident #7 indicated Nurse #6 did not assess him or ask if anything was wrong. When the first shift NA (NA #8) came in with breakfast at 7:15 AM, Resident #7 told her he was not himself and she asked what was going on. Resident #7 told her he could not move his left side, and NA #8 immediately called Unit Manager #1. NP #1 came in and assessed him then sent him to the local hospital.

An interview with the NP on 10/29/24 at 4:40 pm revealed she was called by the Unit Manager #1 on 10/22/24 because Unit Manager #1 thought Resident #7 had a stroke, and that UM #1 called EMS. NP #1 stated neuro-checks should have been done when his symptoms started on the evening of 10/21/24 and he should have been sent out to the ED on 10/21/24. She further indicated if Resident #7 had been assessed when he first was having numbness (after dinner), and nursing staff had called our on-call provider, we would have instructed them to send Resident #7 to the hospital where his condition could have been managed. NP #1 confirmed Resident #7

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had been admitted to the local hospital with a left side stroke.

An interview with DON 10/29/24 4:07 PM revealed that when the NA tells the nurse that something was wrong with a Resident, the nurse goes in and does an assessment and notifies the provider, she then notifies the party responsible.

The Emergency Department (ED) note dated 10/22/24 indicated Resident #7 had a medical history significant for congested heart failure, chronic renal insufficiency, coronary artery disease, and prior stroke with left-sided deficits. Resident #7 presented to the Emergency Department with new onset vision changes and inability to use his left upper and lower extremities. Stroke code was called upon arrival. A National Institute of Health Stroke Scale (NIH) was documented as an 8 which indicated a mild to moderately severe stroke. Resident #7 reported he was unable to move his arm or leg at 6:00 PM on 10/21/24, which was new for him. The computed tomography (CT) scan showed a right posterior frontal lobe hypodensity concerning edema which could be related to an acute/subacute infarct. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat ischemic strokes. Resident #7 was admitted to neurology stroke service. Resident #7's vitals were blood pressure 162/59, pulse rate 60, temperature 98.5, and oxygen saturation 90%. The clinical impression after evaluation findings were Cerebral vascular accident (CVA) with following cognitive deficits and dysphagia (oropharyngeal phase) post CVA.

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Resident #7 was released to a skilled nursing facility on 10/29/24.

The Administrator was notified of the immediate jeopardy 10/29/24 at 2:15 PM.

The facility provided the following credible allegation of IJ removal:

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

Resident #7, who has a history of a prior stroke with left sided weakness, reported to Nursing Assistant (NA) #7 on 10/21/24 at 9:00 PM he was experiencing pain and numbness to his left side. Nursing assistant #7 reported to the nurse who did not identify any acute changes, did not complete a neurological assessment, obtain vital signs, did not notify healthcare provider or, initiate emergency medical services. On 10/21/24 at 11:30 PM the resident reported to NA #4 he was moving slowly and could not move his left arm. Nursing assistant #4 reported to the nurse who did not identify any acute changes, did not complete a neurological assessment, obtain vital signs, did not notify healthcare provider, or initiate emergency medical services. The resident reported further symptoms to NA #4 on 10/22/24 at 6:00 AM about being unable to move his left side who then reported to the nurse who did not identify any acute changes, did not complete a neurological assessment, obtain vital signs, did not notify healthcare provider, or initiate emergency medical services.

NA took Resident #7 his breakfast tray on 10/22/24 between 7 and 7:15 AM, the resident

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had slurred speech and was unable to move his left side. The CNA immediately reported the change in condition to Unit Manager #1. Unit Manager #1 assessed the resident and found his left side to be flaccid. The Resident was also complaining of blurry vision. Resident stated that he had been able to move his left side since last night after dinner. The Nurse Practitioner then assessed the resident and directed the resident to be sent out to the hospital via Emergency Medical Services because he had had a stroke. The resident was admitted to the hospital with an acute stroke on 10/22/24.

An audit to determine if any residents had reported any new change in condition that was not reported to the healthcare provider by a licensed nurse of residents with a brief interview for mental status (BIMS) score of 13 or higher was completed by the Administrator on 10/25/2024. The Audit revealed that no other residents were noted to be affected.

An audit was completed on 10/25/24 by the Director of Nursing of progress notes for the past 7 days to ensure that anyone reporting a change of condition had provider notification. The audit revealed that no one else was affected.

As part of the staff education from 10/25/24-10/28/24, the Director of Nursing also questioned all of the licensed nurses regarding knowledge of any residents having had a change in condition that deviated from their baseline and did not have healthcare provider notification. Signatures accounted for both the education and the questionnaire. No residents were noted to be affected.

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From 10/31/24-11/1/24 the Director of Nursing or Staff Development Coordinator interviewed all nursing assistants regarding knowledge of any residents having change of conditions in the last 7 days that were not reported to the healthcare provider. No negative findings were noted.

(2) 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:

On 10/25/2024 the Director of Nursing initiated education to all licensed nurses to complete a clinical assessment of a minimum vital signs and pertinent body systems once notified of a change in condition to include accident or incident, injuries of unknown source, significant change in residents physical, emotional, or mental condition which can include elevated vital signs, altered mental status, blurred vision, headaches, numbness or tingling to body parts, uncontrolled pain, etc., to notify the healthcare provider immediately of findings once the assessment is complete. Education also included any changes reported by nursing assistants. Any licensed nurse that has not been educated by 10/28/2024 will be taken off the schedule until the educated has been received. All new hires will be educated by the Director of Nursing during orientation. The Director of Nursing will ensure all licensed nurses are in-serviced.

On 11/1/2024, the Regional Director of Clinical Services educated the Administrator, The Director of Nursing, Staff Development Coordinator, and The Human Resource Director on the orientation process for nursing staff that will include education on recognizing change in

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DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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F 580	Continued From page 11	F 580		

condition, timely assessment and monitoring of change in condition, effective communication during a medical emergency, importance of notifying the healthcare provider, and effective communication during a medical emergency.

On 11/1/2024, the Director of Nursing/Staff Development Coordinator re-educated all nursing assistants on change in condition of residents to include recognizing signs and symptoms of a stroke such as blurred vision, slurred speech, weakness to one side of the body, and facial drooping. Education also included the importance of reporting any change in condition or any of these symptoms to their nurse Any nursing assistant that has not received the education on 11/1/2024 will be taken off the schedule until the education has been received. The Director of Nursing will ensure all nursing assistant educated.

The facility alleges removal of immediate jeopardy on 11/02/2024.

An on-site validation of the facility's implementation of their credible allegation of immediate jeopardy removal was conducted on 11/4/24. Review of the completed facility audits included daily 24-hour resident report, resident clinical assessments to include neurological, pain and vital signs were documented in the record. Multiple interviews were conducted with nurse aides and licensed nurses to ensure the in-service/ education was provided prior to working their shift. The nurse aides and licensed nurses consistently reported they received in-service education, which included ensuring the medical team and Resident Representative was

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F 580	Continued From page 12 notified of the resident's change of condition assessment and verifying any new orders with a facility provider prior to initiating the orders. All nursing staff were educated on the reporting and documentation process of any signs of change of condition on the daily 24-hour report and in the resident record. An interview with the Director of Nursing and Staff Development Coordinator on 11/4/24 at 3:00 PM confirmed that re-education was done for all nurse aides and licensed nurses on the change of condition of residents including signs/symptoms of stroke, the importance of reporting any change of condition and documentation of notifying healthcare providers of a medical emergency. The Director of Nursing stated daily record reviews and monthly monitoring will be done to ensure the assessments and notification process was maintained. The immediate jeopardy removal date of 11/02/24 was validated.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		11/22/24

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F 583	Continued From page 13 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the privacy of a resident's record by leaving a medication cart laptop unattended, with resident health information exposed in an area accessible and visible to the public, for 1 of 4 medication carts (Zone 1 medication cart). The findings included: An observation of the Zone 1 medication cart was completed on 10/23/24 at 9:57 AM, inclusive of the medication cart laptop which was unattended. The laptop displayed resident personal health information including name, medications and diagnoses. Staff and residents were observed to	F 583	F-583 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 10/23/2024, Nurse #4 closed the laptop lid immediately. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected. (3) What measure(s) will be put in place	

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F 583	Continued From page 14 pass by the medication cart during this time. An interview with Nurse #4 was completed on 10/23/24 at 9:59 AM. Nurse #4 stated her medication cart was locked but she should have closed or locked her laptop screen so that resident personal health information was not displayed. An interview with the Director of Nursing (DON) was completed on 10/23/24 at 12:22 PM. The DON verbalized that Nurse #4 should have locked her laptop screen with the lock button prior to moving away from the medication cart. An interview with the Administrator was completed on 10/23/24 at 12:31 PM. He indicated staff should lock the laptop screen prior to leaving the medication cart unattended.	F 583	or systemic changes made to ensure that the identified issue does not re-occur in the future: On 10/23/2024, the Director of Nursing re-educated Nurse #4 regarding the requirement that at any time a medication cart laptop is unattended, the screen is to be closed or locked so that resident personal health information is not displayed. On 10/23/2024, the Director of Nursing and designee(s) initiated re-education to all licensed nursing staff including med-aides and agency staff regarding the requirement that at any time a medication cart laptop is unattended, the screen is to be closed or locked so that resident personal health information is not displayed. Any newly hired Med-Aides or licensed nurses will be educated during orientation upon hire. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Through the utilization of an observation monitoring tool, the Director of Nursing or designee(s) will monitor 5x/wk for 4 weeks, 3x/wk for 4 weeks, and 1x/wk for 4 weeks to ensure that the 4 medication cart laptops remain free of displaying resident personal health information when not attended. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance	

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F 583	Continued From page 15	F 583	Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	
F 684 SS=J	Quality of Care 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 observation, record review, resident, family member, staff, Emergency Medical Technician (EMT), Physician, and Nurse Practitioner (NP) interviews, the facility failed to comprehensively assess a resident (Resident #1) who had untreated obstructive sleep apnea (a condition that causes the upper airway to become blocked during sleep, reducing or stopping airflow) to determine the root cause of periodic abdominal pain, change in mental status, and migraines that occurred intermittently over the last 6 months in conjunction with Carbon Dioxide (CO_2) levels near the upper limit of the reference range (a set of numbers that are the high and low ends of the range of results that's considered to	F 684	F-684 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 10/7/2024 At 4:08 PM, Resident #1 had an acute change in status and was unable to answer questions and was sent to the hospital. Resident #7 was admitted to the hospital on 10/22/24. (2) How corrective action will be accomplished for resident(s) having the	11/22/24

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F 684	Continued From page 16 be normal) in August 2024 and October 2024. When breathing is reduced due to sleep apnea it can lead to a decrease in oxygen and an increase in CO2 in the blood. The facility also failed to implement Physician's orders for Resident #1 for a Continuous positive Airway Pressure (CPAP) machine (used to treat sleep apnea by keeping the airways open while sleeping) ordered on 4/13/24, pulmonary consultation (insurance requirement for obtaining the CPAP) ordered on 5/10/24, neurology consultation (ordered for "constant migraines") ordered on 8/24/24, and an x-ray (ordered for abdominal pain) ordered on 8/24/24. On 10/6/24 Resident #1 was excessively sleeping, difficult to rouse, and had no oral intake. On 10/7/24 Emergency Medical Service (EMS) were contacted for altered mental status changes and upon EMS assessment Resident #1 was confused and hypoxic (low oxygen saturation) with an oxygen (O2) saturation of 60% (normal 90-100%) and a CO2 level in the 90's (normal 22-31). The resident's Glasgow Coma Scale (scale used to measure a person's level of consciousness) showed she was in a comatose state, and she was assessed at the hospital with hypercapnia (CO2 retention with elevated CO2 levels), prolonged systemic hypoxemia/severe respiratory failure, acute kidney injury, and transaminitis (high level of liver enzymes in the blood) suspected due to the prolonged systemic hypoxemia/severe respiratory failure. The contributing factors included untreated obstructive sleep apnea. Resident #1 was admitted to the Intensive Care Unit (ICU) on 10/7/24 and spent 10 days in the hospital. In addition, the facility failed to identify the seriousness of a change in condition, complete ongoing comprehensive assessments and	F 684	potential to be affected by the same issue needing to be addressed: An audit was done on 10/24/2024 by the Director of Nursing in the last 6 months to determine if any other residents missed any appointments due to needing any special accommodations due to weight and any other residents with diagnoses of obstructive sleep apnea for any untreated signs and symptoms. The audit revealed that that no other residents were affected. An audit to determine if any residents had reported any new change in condition that was not followed up on by a licensed nurse of residents with a brief interview for mental status (BIMS) score of 13 or higher was completed by the Administrator on 10/25/2024. The Audit revealed that no other residents were noted to be affected. An audit was completed on 10/25/2024 by the Director of Nursing of progress notes for the past 7 days to ensure that anyone reporting a change of condition had a prompt follow up and provider notification. The audit revealed that no one else was affected. From 10/25-10/28, the Director of Nursing also questioned all of the licensed nurses regarding knowledge of any residents having had a change in condition that deviated from their baseline with no follow up. Signatures accounted for both the education and the questionnaire. No residents were noted to be affected.	

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F 684	Continued From page 17 identify the urgent need for medical attention for a resident with a history of a stroke. Resident #7 had intact cognition and on 10/21/24 at approximately 9:00 PM he reported to a nurse aide (NA) he had pain and numbness in his left arm and leg. The NA aide reported this to the nurse. On the next shift at approximately 6:00 AM Resident #7 informed another NA he could not feel his left side. The NA reported this to the nurse. There were no documented comprehensive assessments for Resident #7 by either nurse. On 10/22/24 between 7:00 and 7:15 AM a NA took Resident #7 his breakfast and Resident #7 stated he was not well, couldn't feel his left side, and his vision was blurred on the left side, and this had all started after dinner (on 10/21/24). Unit Manager #1 was called to the room and assessed Resident #7 and found his speech was slurred, his left arm and leg did not have any feeling, and they did not have any muscle tone. The Nurse Practitioner was in the facility and assessed Resident #7 and had him transferred to the Emergency Department (ED) for evaluation of stroke symptoms. Resident #7 presented to the ED with new onset vision changes and inability to use his left upper and lower extremities. Diagnoses included cerebral vascular accident (CVA- ischemic stroke) with following cognitive deficits and dysphagia (difficulty swallowing) post CVA. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat ischemic strokes. Resident #7 was admitted to the critical care stroke unit and was discharged on 10/29/24. This deficient practice occurred for 2 of 3 residents reviewed for professional standards of	F 684	On 10/31-11/1/2024 the Director of Nursing or Staff Development Coordinator interviewed all nursing assistants regarding knowledge of any residents having change of conditions in the last 7 days that were not addressed. No negative findings were noted. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 10/23/2024 the Regional Nurse Consultant re-educated the administrative nursing team that consists of the Director of Nursing, Staff Development Coordinator and the 2-Unit Managers on following physician orders to include consultations, diagnostics, special equipment, and to ensure comprehensive assessments are done as indicated. On 10/24/2024 the Director of Nursing/Designee re-educated all nurses on following physician orders to include consultations, diagnostics, special equipment and to ensure comprehensive assessments are done as ordered. Any nurse who has not received the education will not be permitted to work after 10/24/2024 until the education has been completed. Beginning 10/24/2024, to ensure all orders are implemented for consultation, diagnostics, and special equipment the Director of Nursing/designee will audit the order listing report in morning clinical meeting.	

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F 684	Continued From page 18 care. Immediate jeopardy for Resident #1 began on 10/7/24 when Resident #1 had a significant change in condition and was assessed by EMS with an O2 saturation of 60% and a CO2 level in the 90s and immediate jeopardy ended on 10/25/24. Immediate jeopardy began on 10/21/24 for Resident #7 when he reported his left arm and leg were numb and a comprehensive assessment was not completed to determine if medical interventions were necessary. Immediate jeopardy ended for Resident #7 on 11/02/24. Immediate jeopardy was removed on 11/02/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. The findings included: Resident #1 was admitted to the facility on 5/22/22 with multiple diagnoses that included tachycardia (increased heart rate), asthma, and obstructive sleep apnea. The resident did not have a diagnosis of migraines on admission. A Physician order dated 3/28/23 revealed Resident #1 was to receive Fioricet 50-300-40 milligrams (mg) every 6 hours as needed for headache. A Physician order for Resident #1 dated 7/11/23 indicated Protonix (acid reflux medication) 40 milligrams (mg) twice a day.	F 684	Beginning 10/24/2024, the nurse administrative team will review the order listing report and progress notes during clinical morning meeting to ensure that any consultations and diagnostics have been completed and results provided to the practitioners so that a complete and accurate comprehensive assessment can be completed. In the event a consultation or diagnostics was not completed as ordered, the Director of Nursing or Unit Manager will notify the Physician to determine further recommendation. The Unit Managers were educated on this process by the Director of Nursing on 10/24/2024. Beginning 10/24/2024, all alternate transportation companies will be contacted by the Transportation Scheduler should weight limits exceed normal transportation capabilities. Transportation is scheduled when the appointment is received. If unable to find alternative transportation, the Transportation Scheduler will notify the Director of Nursing or Unit Manager. The Director of Nursing or Unit Manager will notify the provider to determine if appointment can be re-scheduled or if emergent transportation is necessary. The transportation Scheduler and the Unit Managers were educated on this process on 10/24/2024 by the Director of Nursing. The Director of Nursing will train any new transportation schedulers and Unit Managers upon hire.	

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F 684	Continued From page 19 A Physician order for Resident #1 dated 11/8/23 indicated Propranolol (beta blocker) 20mg three times a day for headaches and migraines. A Physician order for Resident #1 dated 1/6/24 indicated Topamax 25mg daily for migraine headache. A Physician order dated 4/13/24 revealed an order for Resident #1 to receive a CPAP machine for obstructive sleep apnea. Another Physician order dated 5/10/24 revealed Resident #1 was to receive a pulmonology consult for her obstructive sleep apnea and CPAP machine. The Physician order dated 4/12/24 revealed an order for Acetaminophen 325mg give 2 tablets 3 times a day for pain. A phone interview occurred with Physician #1 on 10/22/24 at 3:52pm. Physician #1 verified he had written the order for Resident #1 to receive a CPAP machine and a Pulmonology consultation. He stated he had ordered the CPAP machine in April 2024 first because he understood Resident #1 already had a CPAP machine. Physician #1 stated Resident #1 required a CPAP machine for her obstructive sleep apnea. The Physician stated "about" a month later he learned (could not remember from who) that Resident #1 did not have a CPAP machine and needed a Pulmonology appointment to obtain a CPAP machine, so he wrote an order for a Pulmonology consultation in May 2024. He stated he did not know if Resident #1 ever attended the Pulmonology consultation but said he knew Resident #1 never had a CPAP machine.	F 684	Beginning 10/24/2024, any resident who requires a treatment/test that can only be performed in the hospital will be educated by the Director of Nursing on the importance of why the hospital treatment is recommended. On 10/25/2024 the Director of Nursing initiated education to all licensed nurses to complete a clinical assessment of a minimum vital signs and pertinent body systems once notified of a change in condition/medical emergency to include accident or incident, injuries of unknown source, significant change in residents physical, emotional, or mental condition which can include elevated vital signs, altered mental status, blurred vision, headaches, numbness or tingling to body parts, uncontrolled pain, etc., to call 911 and to notify the healthcare provider of findings once the assessment is complete and the assessment is documented in the medical record. Education also included any changes reported by nursing assistants. Any licensed nurse that has not been educated by 10/28/2024 will be taken off the schedule until the educated has been received. All new hires will be educated by the Director of Nursing during orientation. The Director of Nursing will ensure all licensed nurses are in-serviced. On 11/1/2024, the Regional Director of Clinical Services educated the Administrator, The Director of Nursing, Staff Development Coordinator, and The Human Resource Director on the orientation process for nursing staff that	

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F 684	Continued From page 20 During a telephone interview with Physician #2 on 10/22/24 at 3:36pm, the Physician stated Resident #1 was required by insurance to receive a Pulmonary consultation prior to receiving a CPAP machine. He explained that the insurance company needed proof and severity of Resident #1's obstructive sleep apnea before they would approve Resident #1 for a CPAP machine. The Physician stated Resident #1 required a CPAP machine due to her obstructive sleep apnea. Physician #2 stated Resident #1 was never able to receive the consultation due to transportation difficulties. An interview with Transport Staff occurred on 10/22/24 at 4:54pm. Transport Staff confirmed she was responsible for making residents' appointments. She also discussed being responsible for securing alternate transportation if a resident did not fit in the facility's van. Transport Staff discussed Resident #1 being too large to transport in a wheelchair van and would need non-emergency stretcher transport. She stated the facility had a contract with a non-emergency transport company but said "they are always booked up." Transport Staff discussed not receiving the consultation request for Pulmonology until 7/30/24. She stated since 7/30/24 she had been periodically trying to schedule the appointment with Pulmonology that would also meet the non-emergency transportation schedule. She stated she had been unsuccessful in getting Resident #1 to the Pulmonologist. A review of a Physicians note dated 6/19/24 written by Physician #1 revealed Resident #1 had "episodic altered awareness", ongoing chronic	F 684	will include education on recognizing change in condition, timely assessment and monitoring of change in conditions, recognizing a medical emergency, effective communication during a medical emergency, and calling 911. On 11/1/2024, the Director of Nursing and Staff Development Coordinator re-educated all nursing assistants on change in condition of residents to include recognizing signs and symptoms of a stroke such as blurred vision, slurred speech, weakness to one side of the body, and facial drooping. Education also included the importance of residents receiving immediate medical attention should any of these signs be identified. Any nursing assistant that has not received the education on 11/1/2024 will be taken off the schedule until the education has been received. The Director of Nursing will ensure all nursing assistants are educated. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Director of Nursing or designee(s) once a change of condition is identified, will monitor if the change of condition was identified appropriately as urgent or non-urgent, if a comprehensive assessment has been completed or appropriate follow up steps were conducted. Monitoring will take place 5 x/wk for 4 weeks, 3x/wk for 4 weeks, and 1x/wk for 4 weeks.	

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F 684	Continued From page 21 headaches that were being treated with Topamax (migraine medication) daily and Fioricet (migraine medication) as needed, and insomnia with tiredness during the day which was documented as being treated with a CPAP machine and follow up with a Pulmonologist. The quarterly Minimum Data Set (MDS) dated 8/8/24 revealed Resident #1 was cognitively intact, no rejection of care, and no shortness of breath. The MDS also documented Resident #1 did not have a CPAP machine. Resident #1 was documented as having a weight of 430 pounds. The MDS documented the resident also had pain that occasionally interfered with her daily routine and that she received pain medication. The physician order dated 8/18/24 revealed an order for lab work that included a complete blood count (CBC), comprehensive metabolic panel (CMP), lipid panel (for cholesterol), and an A1C (for diabetes). Resident #1's lab work dated 8/20/24 revealed her CO2 level was 30. On 8/24/24 there was a physician order for Resident #1 to receive a neurology consultation for constant migraines. There was an order on 8/24/24 for Resident #1 to receive an x-ray for abdominal pain. A nurses note dated 8/25/24 written by Nurse #3 revealed the x-ray technician told her the x-ray was unable to be performed because Resident #1 weighed more than the machine can hold. The care plan dated 8/26/24 for Resident #1 revealed no goals or interventions related to her	F 684	The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	

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diagnosis of sleep apnea. The resident's care plan also did not include information on migraines, abdominal pain, or refusals of care.

A Physician's order revealed Resident #1's Fioricet 50-300-40 milligrams (mg) every 6 hours as needed for headache was discontinued on 9/8/24.

Nursing documentation on 9/11/24 written by Unit Manager #1 revealed Resident #1 did not want to get out of bed due to not feeling well and having a headache.

A Physician order for Resident #1 dated 9/14/24 indicated Fioricet 50-300-40 milligrams (mg) every 6 hours as needed for headache.
On 9/14/24 a nursing note written by the Director of Nursing (DON) revealed Resident #1 requested Fioricet be re-started as needed for the resident's headaches.

Review of Resident #1's Medication Administration Record (MAR) from October 2023 through August 2024 revealed Resident #1 received as needed (PRN) Fioricet 39 times and in September 2024 Resident #1 received Fioricet on 9/3, 9/7, 9/25, 9/26, and 9/30/24 for complaints of a headache.

The resident's medical record revealed no evidence the orders were implemented for the CPAP ordered on 4/13/24, pulmonology consultation ordered on 5/10/24, or the neurology consultation and x-ray ordered on 8/24/24.

On 10/1/24 Resident #1 was administered PRN Fioricet for complaints of a headache.

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A Physician order dated 10/4/24 for Resident #1 indicated Protonix 40mg once a day. This Protonix order indicated Resident #1's medication was lowered from the initial order dated 7/11/23 of Protonix 40mg twice a day.

The Nurse Practitioner (NP) note dated 10/4/24 revealed Resident #1 had continued to complain of headaches that were not responding to the current treatment. The NP documented she was seeing Resident #1 today (10/4/24) for complaints of stomach pain rating a 9 out of 10 (10 being the worst pain). She documented due to the resident's size, imaging such as x-rays could not be completed, so no imaging had been done. The NP noted that Resident #1 had refused to go to the emergency room but that the resident told her she would go if the pain became "intolerable." She documented Resident #1's stomach pain was due to eating but then documented Resident #1 has stomach pain when she is not eating. The NP noted that Resident #1 expressed that her migraines were returning daily without other neurological deficits. The NP's plan for stomach pain was to order lab work. There was no documented plan for Resident #1's increased migraines.

The NP was interviewed on 10/23/24 at 8:18am. The NP discussed 10/4/24 was the first time she had ever seen Resident #1. She stated she saw Resident #1 on 10/4/24 for complaints of abdominal pain. The NP explained that was why she had ordered the lab work. She explained by doing lab work it would let her know if Resident #1 had an abdominal infection that maybe caused her pain. She stated Resident #1 had told her that x-rays had been ordered for her abdominal pain but had not been completed. The NP said when

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she asked Unit Manager #1 why the x-ray had not been completed, the nursing supervisor told her it was because Resident #1 did not fit into the facility van. She stated she offered to send Resident #1 to the hospital to have the x-rays completed on 10/4/24 but the resident refused. The NP discussed being aware that Resident #1's CO2 levels had been in the high range since August 2024 but stated Resident #1 did not show any signs of respiratory distress.
Resident #1's lab work dated 10/5/24 revealed her CO2 level was 31.

On 10/5/24 Resident #1 was provided with PRN Fioricet for complaints of a headache.

Review of Resident #1's intake for 10/6/24 revealed she did not have any intake.

Review of Resident #1's medical record revealed no nursing documentation for 10/6/24.

Nursing Assistant (NA) #1 was interviewed on 10/23/24 at 8:55am. NA #1 stated she worked 11:00pm to 7:00am the night of 10/6/24 to the morning of 10/7/24 with Resident #1. She explained at the start of her shift Resident #1 was talkative and oriented, which NA #1 stated was Resident #1's baseline, but then said Resident #1 usually asked for food to be warmed between 1:00-2:00am and stated the resident did not request for any food to be warmed up. NA #1 stated the next time she saw Resident #1 was between 5:00-6:00am. She said at that time the resident was "a little groggy" but interacting with the NA. The NA stated she did not notice anything "alarming" or she would have told the nurse.

During a telephone interview with Nurse #1 on

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10/23/24 at 10:40am, the nurse discussed being familiar with Resident #1 and confirmed she worked with the resident on 10/6/24 from 7:00am to 3:00pm shift. Nurse #1 stated on 10/6/24 Resident #1 was talkative, but her speech was quiet and slow. She stated she could not remember if the resident ate or appeared sleepy but said Resident #1 took all her medications.

NA #2 was interviewed on 10/23/24 at 11:35am. The NA confirmed she worked with Resident #1 on 10/6/24 on the 3:00pm to 11:00pm shift and stated she had been familiar with the resident. NA #2 discussed resident being usually very talkative, alert, and oriented but said on 10/6/24 Resident #1 was "very sleepy" and difficult to wake up. The NA stated she had to shake the resident to arouse her and then the resident would say "I'm awake" but the NA stated Resident #1 would fall right back to sleep. She discussed telling the nurse on shift (could not remember the nurses name) and the nurse performing vital signs then telling her Resident #1 was "ok" and "I just gave her an Ativan." NA #2 stated Resident #1 would become very sleepy after receiving medication, so she stated she did not think anything was wrong. The NA stated Resident #1 did not eat or drink anything during her shift. Review of Resident #1's MAR for 10/6/24 revealed, the resident had not received any Ativan (antianxiety medication).

There were no vital signs documented for Resident #1 on 10/6/24.

During an interview with NA #3 on 10/23/24 at 11:45am, the NA confirmed she had worked with Resident #1 on 10/6/24 and 10/7/24 during the 7:00am to 3:00pm shift. NA #3 discussed not

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being very familiar with Resident #1 but said she had been assigned to her a "few" times before 10/6/24. She stated on 10/7/24 Resident #1 was "very sleepy" and had refused care which the NA stated had not happened before when she was assigned to her. The NA said she could not remember if Resident #1 had anything to eat or drink. NA #3 stated she informed Nurse #1 of Resident #1 refusing care.

Review of Resident #1's intake for 10/7/24 revealed she did not have any intake.

The NP note dated 10/7/24 documented Resident #1 was sleeping, would open her eyes, and respond to questions but remained "very sleepy". She documented that Resident #1 was still reporting abdominal pain and that she checked with nursing to ensure Resident #1 was still receiving medication for her continued headaches. The NP documented her plan for the continued abdominal pain was to order further testing to rule out an infection. There was no plan noted related to Resident #1's headaches or documentation/plan for the resident's increased CO2 level. There was no documentation that the NP offered for Resident #1 to go to the hospital.

A nursing progress note written by Nurse #1 dated 10/7/24 documented at 2:16pm revealed that Resident #1 was alert and able to answer, "simple questions." The note documented Resident #1 was hard to arouse and the Medical Doctor (MD) was at the bedside. Nurse #1 documented Resident #1 refused care and refused her 2:00pm medication.

During a telephone interview with Nurse #1 on 10/23/24 at 10:40am the Nurse discussed when

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she returned to work at 7:00am on 10/7/24, she saw a difference in Resident #1. She explained the resident was not talking, excessively sleepy, and difficult to arouse. The nurse stated she went and got the NP to assess Resident #1, and that the NP offered Resident #1 to go to the hospital, but the resident refused. Questioned Nurse #1 about her documentation and what she met by would "only answer simple questions." Nurse #1 explained Resident #1 would usually provide long answers but on 10/7/24 Resident #1 would only provide 1-2-word answers. Nurse #1 stated Resident #1 remained sleepy, and it was difficult to arouse her whole shift and late in the shift Resident #1 started complaining of her stomach hurting and not feeling well. The nurse stated she offered to send the resident to the hospital, but the resident refused. Nurse #1 discussed Resident #1 having symptoms of a headache, abdominal pain, and sleepiness "often" but could not remember for how long the resident had the symptoms.

Unit Manager #1 was interviewed on 10/22/24 at 5:47pm. The Unit Manager discussed Resident #1 "being off" in her "demeanor" on 10/7/24 in the morning. She explained Resident #1's speech was quiet, and that the resident told her she did not feel well. The Unit Manager stated she offered to send Resident #1 to the hospital on 10/7/24 in the morning but the resident refused. She said the morning of 10/7/24 there were no prominent noticeable issues but by the afternoon when she stopped in to see Resident #1, she noticed the resident had right side facial drooping and thought Resident #1 may be having a stroke. The Unit Manager stated that was when she asked Nurse #2 to assess the resident. She discussed not being aware Resident #1 had sleep

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apnea but said she remembered at "some point" it was mentioned that Resident #1 needed a CPAP machine. The Unit Manager also discussed Resident #1 having periods of headaches, abdominal pain, and sleepiness for at least 6 months. The Unit Manager stated she was not aware

Resident #1 had no oral intake on 10/6/24 or 10/7/24.

Nurse #2 wrote a progress note on 10/7/24 documented at 4:08pm. Nurse #2 documented Resident #1 was observed with the right side of her mouth drooping, right eye drooping, unable to use right hand, and was unable to answer questions. The note showed 911 was contacted and the resident was transferred to the hospital.

During an interview with Nurse #2 (the facility's skills development coordinator) on 10/22/24 at 5:32pm, the nurse clarified that an MD did not see Resident #1 on 10/7/24 but that it was the NP. Nurse #2 explained she saw Resident #1 on 10/7/24 after being asked to assess the resident by Unit Manager #1. When asked what time she saw Resident #1 she stated it was the time documented on her note which was 4:08pm. Nurse #2 described Resident #1 on 10/7/24 with drooping to the right side of her mouth, right eye drooping, unable to squeeze her hands, and unable to answer questions. Nurse #2 stated Resident #1 was normally alert and oriented x4 (person, place, time, and situation) and talkative. Nurse #2 explained as soon as she saw Resident #1 on 10/7/24 she immediately called EMS. She stated she did not know the resident well enough to say how long Resident #1 had been complaining of headaches, sleepiness, or

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abdominal pain. Nurse #2 stated she was not aware Resident #1 did not have any oral intake on 10/6/24 or 10/7/24.

The Emergency Medical Service (EMS) report dated 10/7/24 revealed a call was placed to 911 at 3:56pm, dispatch was notified at 4:00pm, EMS arrived at the facility at 4:07pm and was at Resident #1's bedside at 4:09pm. EMS documented upon their arrival Resident #1 was sitting on her bed confused and repeating "take me to the hospital." EMS noted Resident #1 was altered and could not tell the EMS staff who she was, where she was, or what was going on. Resident #1's skin was cold and sweaty, pupils constricted, oxygen sats were 60% (normal 90-100%) and her CO2 was 90. The EMS staff documented they placed Resident #1 on high flow oxygen with improvement and provided 2 milligrams (mg) of Narcan (medication used to reverse opioid effects) due to Resident #1's pupils being constricted (sign of possible overdose) with improvement. Resident #1 would show improvement but then the resident would become confused again and her sats would drop.

A telephone interview occurred with Emergency Medical Technician (EMT) #1 on 10/29/24 at 5:17pm. The EMT discussed they arrived at the facility "shortly" after 4:00pm on 10/7/24. He stated he was escorted to Resident #1's room by the facility's receptionist. EMT #1 said when he arrived at Resident #1's room she was by herself in bed with the head of the bed in a full upright position and Resident #1 was "slumped" over. He explained the resident was not conscious and only responded to painful stimuli. EMT #1 stated when she did open her eyes and try to speak, Resident #1's speech was incoherent and that

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she would only stay awake for a 'few" seconds. He stated "approximately 5 minutes" of being in Resident #1's room, "an older nurse" entered and told him EMS was called because of "abnormal" vital signs but the EMT stated the vital signs the nurse provided were with in normal range. EMT #1 stated upon his assessment Resident #1 had decreased respirations, altered mental status, and was hypoxic. He explained Narcan was given due to Resident #1 having constricted pupils which he stated could occur if there was an opioid overdose. EMT #1 also explained the overdose may not have been intentional but said if Resident #1 had not been fully conscious when given her medication or if she had an infection, this could impede the resident being able to fully process her medications through her system causing an overdose. He stated Resident #1's high CO2 levels would not have caused constricted pupils but would have caused the altered mental status. The EMT said upon leaving the facility Resident was unconscious and not talking.

Review of Resident #1's medical record revealed no documentation of vital signs on 10/7/24.

Review of Resident #1's hospital records revealed the resident was admitted on 10/7/24 and discharged on 10/17/24. Upon admission, Resident #1's CO2 level was 90.5 and her oxygen level was 73%. The resident was assessed at the hospital with hypercapnia (CO2 retention with elevated CO2 levels), prolonged systemic hypoxemia/severe respiratory failure, acute kidney injury, and transaminitis (high level of liver enzymes in the blood) suspected due to the prolonged systemic hypoxemia/severe respiratory failure. The contributing factors included untreated obstructive sleep apnea. The

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resident had a Glasgow Coma Scale completed which showed Resident #1 was in a comatose state. She was transferred to intensive care where Resident #1 was treated with a BiPAP machine (a machine that helps to provide oxygen and remove CO2 from the lungs) for her hypercapnia. The hospital records documented Resident #1's migraines exacerbated due to untreated sleep apnea and the resident was given medication.

An interview with Resident #1 occurred on 10/22/24 at 12:08pm. Resident #1 discussed her change in condition that started on 10/6/24. She explained she slept all day on 10/6/24 and 10/7/24 then woke up in intensive care at the hospital on 10/8/24. Resident #1 stated she did not remember having any conversations with staff, taking any medications or having anything to eat on 10/6/24 or 10/7/24. Resident #1 stated she never had a CPAP machine since she has been in the facility. She explained that the Physician (Physician #1) had discussed with her needing to see a Pulmonologist "several months ago" and explained to her the appointment was needed so she could obtain a CPAP machine but stated she never saw a Pulmonologist or received a CPAP machine. Resident #1 also explained another Physician (Physician #2) had also told her he wanted her to see a Pulmonologist a "few months ago" and have a CPAP machine but she was told by the facility (could not remember who) that the facility could not find transportation to get her to the pulmonologist so she could receive the CPAP machine. Resident #1 stated she was told there was no transportation available for someone her size. The resident discussed periods of excessive sleepiness, trouble remembering, headaches, and abdominal pain

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"for at least the past 6 months". She stated one of the Physician's had ordered her to see a Neurologist for her headaches and to have an x-ray of her abdomen but said none of the appointments happened. Resident #1 discussed remembering a mobile x-ray coming to the facility but said she was told by the x-ray technician that she was too large for the mobile x-ray machine. Discussed with Resident #1 her refusal to go to the hospital. Resident #1 stated on 10/4/24 when the NP offered to send her to the hospital, she did not think she needed to go to the hospital and on 10/7/24 she said she had no recollection of talking to the NP or saying she did not want to go to the hospital. The resident stated no one explained to her that she would have been able to see a Pulmonologist and/or a Neurologist and have an x-ray at the hospital. She also stated no one explained to her that some of her symptoms could have been caused by increased CO2 levels. Resident #1 stated if she had known the information, she would have agreed to go to the hospital.

The NP stated she saw Resident #1 again in the "early morning" of 10/7/24 and the resident was sleeping. She explained Resident #1 needed to be "shaken" to wake up but said she felt this was due to it being "so early in the morning" and the resident told her "I am catching up on my sleep." The NP commented Resident #1 appeared "sleepy." She stated she was unaware Resident #1 did not have any oral intake from 10/6/24 to 10/7/24. The NP stated she did not see Resident #1 again on 10/7/24. She stated she was not aware Resident #1 was ordered a CPAP machine back in April 2024 or that Resident #1 had an order to see a Pulmonologist in May 2024. She also stated she was not aware there had been a

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Neurology consultation order in August 2024 or that Resident #1 had not attended any of these appointments due to transportation issues. Discussed with the NP Resident #1's periodic symptoms of headaches, altered mental status, and abdominal pain. The NP confirmed all of Resident #1's symptoms could have been caused by her increased CO2 levels. She stated since Resident #1's CO2 levels were not considered out of range she did not inform Resident #1 that her symptoms could be caused by her increased CO2 levels. The NP commented that the only way to assess CO2 levels was to conduct an arterial blood gas test which she stated was normally completed in the hospital. She explained the arterial blood gas test would draw blood directly from the arteries which would show higher oxygen levels. She stated she had offered on 10/4/24 and 10/7/24 to send Resident #1 to the hospital but the resident refused. The NP stated she did not know if Resident #1 understood why going to the hospital was important.

The Director of Nursing (DON) was interviewed by telephone on 10/29/24 at 10:09am. The DON explained she had not had much contact with Resident #1 and that the resident never voiced any concerns to her. She stated she was aware Resident #1 was not able to attend any of her scheduled appointments due to transportation issues and explained the need for non-emergency transportation company required a month in advance notice and the facility could not coordinate transportation with the time of the appointments. The DON discussed not being aware of Resident #1's increased CO2 levels or that Resident #1 did not have any intake on 10/6/24 or 10/7/24. She stated she did see Resident #1 on 10/7/24 right before the resident

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left the facility. The DON stated Resident #1 was awake but "looked drowsy."

The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to Resident #1's hospitalization or how the lack of follow-through with Resident #1's appointments correlated to her hospitalization.

The Administrator was notified of immediate jeopardy on 10/23/24 at 3:20pm.

The facility provided the following credible allegation of immediate jeopardy removal:

(1) Identify those recipients who have suffered, or are likely to suffer a serious adverse outcome because of the noncompliance:
The facility failed to comprehensively assess a resident (Resident #1) who had untreated obstructive sleep apnea to determine the root cause of periodic abdominal pain, change in mental status, and migraines that occurred intermittently over the last 6 months in conjunction with elevated CO2 levels on labs completed in August and October 2024. The facility also failed to implement physician's orders for Resident #1 for a CPAP ordered on 4/13/24, pulmonology consultation (insurance requirement for obtaining CPAP) ordered on 5/10/24, neurology consultation ordered on 8-24-24 (ordered for "constant migraines"), x-rays and ultrasound ordered on 8/24/24 (ordered for abdominal pain). Resident #1 was identified as being affected by the noncompliance.

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The nurse practitioner performed a comprehensive assessment on 10/4/2024 and 10/7/2024 and it was recommended that she be transferred to hospital on both dates. Resident #1 refused to go to the hospital on 10/4/2024. On 10/7/2024 at 2:36 PM a note was documented at this time; Resident #1 was comprehensively assessed by the nurse practitioner who recommended she go to the hospital. However, Resident # 1 refused to go.
On 10/7/2024 at 4:08 PM, Resident #1 had an acute change in status and was unable to answer questions and was sent to the hospital. Resident #1 was diagnosed in the hospital with altered mental status, acute respiratory failure, acute kidney injury, transaminitis, and migraines. Resident #1 was placed on a BIPAP and admitted to an intensive care unit. She received IV Lasix and supplemental oxygen. An Ultrasound was done due to transaminitis which demonstrated steatosis. In addition, Resident #1 received an order for Fioricet for migraines.

Resident # 1's pulmonary and neurology consultations were discontinued on 10/7/2024 upon discharge to hospital. Upon return to the facility on 10/17/2024, Resident #1 did not have any new orders for pulmonology consultation or follow up as she currently has BIPAP in place.

Upon review, Resident #1's August carbon dioxide levels were within normal limits. Upon documentation review, Resident #1's October carbon dioxide levels were within normal limits.

On 5/10/2024 a pulmonary consultant order was received for CPAP. The consultation was not completed. On 8/24/2024 a neurology consultant order was received due to migraines. The

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consultation was not completed.

On 8/24/2024 an x-ray ultrasound was ordered for abdominal pain. Mobile x-ray technician was in the facility on 8/25/2024 and was unable to do the procedure due to Resident #1's weight. Per Nurse Practitioner note on 10/4/2024, resident refused to go to Emergency Department to have abdominal x-ray that was unable to be completed in house due to Resident # 1's weight. No other alternative methods were attempted prior to 10/4/2024.

The root cause for not implementing orders to address Resident # 1's symptoms was due to the facility's failure to acquire alternative transportation methods, failure to look at Resident #1's symptoms as a whole, and to provide education to Resident #1 on the importance of the need to go to the hospital for further testing.

An audit was done on 10/24/2024 by the Director of Nursing in the last 6 months to determine if any other residents missed any appointments due to needing any special accommodations due to weight and any other residents with diagnoses of obstructive sleep apnea for any untreated signs and symptoms. The audit revealed that no other residents were affected.

(2) 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:
On 10/23/2024 the Regional Nurse Consultant re-educated the administrative nursing team that consists of the Director of Nursing, Staff Development Coordinator and the 2-Unit

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Managers on following physician orders to include consultations, diagnostics, special equipment, and to ensure comprehensive assessments are done as indicated.

On 10/24/2024 the Director of Nursing/Designee re-educated all nurses on following physician orders to include consultations, diagnostics, special equipment and to ensure comprehensive assessments are done as ordered. Any nurse who has not received the education will not be permitted to work after 10/24/2024 until the education has been completed.

Beginning 10/24/2024, to ensure all orders are implemented for consultation, diagnostics, and special equipment the Director of Nursing/designee will audit the order listing report in morning clinical meeting.

Beginning 10/24/2024, the nurse administrative team will review the order listing report and progress notes during clinical morning meeting to ensure that any consultations and diagnostics have been completed and results provided to the practitioners so that a complete and accurate comprehensive assessment can be completed. In the event a consultation or diagnostics was not completed as ordered, the Director of Nursing or Unit Manager will notify the Physician to determine further recommendation. The Unit Managers were educated on this process by the Director of Nursing on 10/24/2024.

Beginning 10/24/2024, all alternate transportation companies will be contacted by the Transportation Scheduler should weight limits exceed normal transportation capabilities. Transportation is scheduled when the

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appointment is received. If unable to find alternative transportation, the Transportation Scheduler will notify the Director of Nursing or Unit Manager. The Director of Nursing or Unit Manager will notify the provider to determine if appointment can be re-scheduled or if emergent transportation is necessary. The transportation Scheduler and the Unit Managers were educated on this process on 10/24/2024 by the Director of Nursing. The Director of Nursing will train any new transportation schedulers and Unit Managers upon hire.

Beginning 10/24/2024, any resident who requires a treatment/test that can only be performed in the hospital will be educated by the Director of Nursing on the importance of why the hospital treatment is recommended.

Alleged immediate jeopardy removal date: 10/25/24

On 10/29/24 the facility's immediate jeopardy removal was validated by the following:
The facility provided documentation to support immediate jeopardy removal that included audits completed by the Director of Nursing. The audits included residents that may need special transportation accommodation within the last 6 months, chart reviews of 8 residents for any other residents with diagnoses of obstructive sleep apnea for any untreated signs and symptoms that were not treated and/or reported to the provider, and accuracy of documentation. These audits revealed there were no untreated symptoms that were not reported to the provider and all progress notes were accurate. Resident #1 did not have any new orders for pulmonology consultation or follow up. Resident #1 was observed to have a

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BIPAP in place. Another audit tool examined orders to ensure they were implemented for consultations, diagnostics, and special equipment. The results showed that all other orders, consultations, comprehensive assessments were done as ordered and diagnostics were completed. The facility also provided documentation on the education they provided. One Education included that in the event a consultation or diagnostics was not completed as ordered, the Director of Nursing or Unit Manager will notify the Physician to determine further recommendation. The Unit Managers were educated on this process by the Director of Nursing. The education also included the following: physician orders to include labs, x-rays, special equipment, diagnostics, and consultations. The training was provided to all nurses, the Director of Nursing, Unit Managers, and the Staff Development Coordinator starting on 10/23/24 and ending on 10/24/24. Documentation showed the Transportation Scheduler, and the Unit Managers were educated on 10/24/2024 by the Director of Nursing. The education included all alternate transportation companies will be contacted by the Transportation Scheduler should weight limits exceed normal transportation capabilities. Transportation was scheduled when the appointment was received. If unable to find alternative transportation, the Transportation Scheduler will notify the Director of Nursing or Unit Manager. The Director of Nursing or Unit Manager will notify the provider to determine if the appointment could be re-scheduled or if emergent transportation was necessary.

The immediate jeopardy removal date of 10/25/24 was validated.

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2. Resident #7 was admitted to the facility on 8/29/24, with diagnoses of history of right hemiparesis/hemiplegia (partial or complete paralysis of one side) with right side weakness related to a stroke, Type 1 diabetes mellitus.

The quarterly Minimum Data Set (MDS) dated 9/7/24 indicated Resident #7 was cognitively intact and had functional impairment of the lower extremities bilaterally with use of a wheelchair, set up assistance for eating and oral hygiene/care, dependent care for toileting, showers, and lower extremity dressing including shoes, and maximum assistance for repositioning, sitting from lying, and transfers.

The care plan dated 9/7/24 indicated that Resident #7 had a communication problem related to hearing loss (Right), hemiplegia/hemiparesis related to a stroke, needed assistance with transfers, mobility.

A review of the medical record revealed there were no nursing progress notes entered on 10/21/24.

The Medication Administration Record (MAR) indicated Resident #7 had his blood sugar checked at 10/21/24 at 5:00 PM by Nurse #5. Resident #7's blood sugar was 270 and he received 4 units of insulin lispro. Resident #7 was administered his evening oral medication at 9:00 PM by Nurse #5.

An interview with Nurse # 5 on 10/29/24 at 6:06 PM revealed she worked the 3:00 PM to 11:00 PM shift on 10/21/24. Nurse #5 went to Resident #7's bedside to take his blood sugar at 5:00 PM.

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The Resident did not mention he was having any issues. Nurse #5 did not recall NA #5 telling her Resident #7 was having any change in condition.

An interview with NA # 5 on 10/29/24 at 4:33 PM revealed she worked the 3:00 pm to 11:00 PM shift on 10/21/24 and did first rounds with Resident #7 at 6:30 PM and he did not have any concerns. When she did her second round at 9:00 PM, the resident told her he had pain and numbness in his left arm and leg. NA #5 indicated she went to tell Nurse #5 Resident #7 had numbness and pain, and Nurse #5 nodded to NA #5. NA #5 stated Nurse #5 did not go in to check on Resident #7, that she was aware of.

An interview with NA #4 on 10/29/24 at 5:05 PM revealed she came in and started her rounds about 11:30 PM on 10/21/24. NA #4 stated she told Resident #7 she was coming in to change him. Resident #7 said, "I'm moving slowly, I can't use my left arm." NA #4 stated Resident #7 didn't complain, just said he was moving slowly. She further indicated that Resident #7 was able to help himself using the bedrail prior to this. At 6:00 AM, Resident #7 said, "I can't feel my left side". NA #4 went to tell Nurse #6 and Nurse #6 wrote something down but did not come with NA #4. NA #4 further stated she went back to the room and told Resident #7 she reported his symptoms to Nurse #6 and went on with her assignment. NA #4 did not take vital signs, as she was waiting on the nurse for further instructions.

A follow up interview with NA #4 on 10/29/24 at 5:48 PM revealed she did not receive report from Nurse #6 when coming on to her shift. She did say that NA #5 told her that Resident #7 was not feeling his lower left side, and NA #5 had

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informed Nurse #5, and Nurse #5 just nodded her head.

A review of Resident #7's medical administration record (MAR) indicated Nurse #6 gave an injection of 42 units Lantus insulin subcutaneously in the left arm on 10/21/24 at 10:41 PM.

A review of the medical record indicated Nurse #6 did a fingerstick blood sugar at 6:30 AM on 10/22/24 and obtained a result of 112. There was no other documentation regarding Resident #7's condition.

An interview with Nurse #6 on 10/30/24 at 12:47 PM revealed on 10/21/24 at around 6:00 AM NA #4 reported to her that Resident #7's left side wasn't feeling right. Nurse #6 stated that she did an assessment when she gave Resident #7 his medication and checked his blood sugar at around 6:00 AM. She stated she briefly spoke with him while doing the blood sugar and Resident #7 did not indicate anything was wrong at that time. Nurse #7 stated she had not been given any kind of report from the prior shift that anything was going on with Resident #7.

An interview with NA #8 on 10/29/24 at 4:25 PM revealed she worked the 7:00 AM to 3:00 PM shift on 10/22/24 and had taken breakfast to the resident around 7:15 AM and asked Resident #7 how he was doing. He said, "I am not well" and "I haven't felt well since last night" and he couldn't feel his left side, and this had started after dinner. Resident #7 further revealed that his vision was blurred on the left side, and he was numb and could not feel anything on the left side. NA #8 stated she noticed his speech was slurred too.

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She further stated that the resident told her he had reported to NA #4, Nurse #5 and NA #5 he was numb in his left arm and leg and could not move them.

An interview with NA #6 on 10/29/24 at 3:31 PM revealed he had been called to Resident #7's room by NA #8 on 10/22/24 at about 7:15 AM to help NA #8 sit Resident #7 up. NA #6 stated that Resident #7 told NA #8 and him (NA #6) that he could not move his left side, and NA #8 went to get the nurse. Unit Manager #1 and NP #1 came in to assess Resident #7 and the Unit Manager asked NA #8 to call 911.

The nursing progress note dated 10/22/24 at 8:25 AM by Unit Manager #1 indicated she was called to Resident #7's room by NA #8. Resident #7 was alert and oriented, and stated he could not move his left side, and could not raise his left arm; writer lifted the arm, and it was flaccid, falling back to the bed. Resident #7 was unable to move his left foot or toes. Resident#7 stated his vision was gone in his left eye. The Nurse Practitioner (NP) was called to the room, and an order was written to transfer Resident #7 to the Emergency Department. The note further indicated the family was made aware. EMS arrived and transported Resident #7 to the local hospital at 8:18 AM on 10/22/24.

An interview with Unit Manager (UM) #1 on 10/29/24 at 11:40 AM revealed she was requested by NA #8 to come to Resident #7's room as soon as possible at 7:15 AM on 10/22/24. Upon arrival, she found Resident #7 with left-sided paralysis, including the left arm and left leg. UM #1 further revealed Resident #7 stated he had been unable to move his left side

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since last night after dinner. UM #1 stated she began her assessment and called for the Nurse Practitioner (NP). UM #1 stated Resident #7's left arm and leg were flaccid, dropping to the bed when she raised them up. The NP arrived, assessed Resident #7 and asked for EMS to be called because Resident #7 had had a stroke.

An additional interview with UM #1 on 10/29/24 at 4:40 PM revealed Resident #7 was doing fine before she left on 10/21/24 after 1st shift. On the morning of 10/22/24 NA #8 and NA #6 were in with the resident to get him out of bed. NA #8 yelled out for her to come quickly to check the resident. UM #1 stated she did an assessment and Resident #7 was talking differently, his left arm and leg were flaccid, and his arm and leg were not reacting or feeling when she ran the curved side of a paper clip down his arm and leg. NP #1 came in immediately and said to send him to the ED for a stroke. UM #1 stated the family was informed. EMS came and took Resident #7 to the hospital. UM #1 further revealed that there had not been any documentation to support the change in condition of Resident #7 on 10/21/24.

A phone interview with Resident #7 on 10/30/24 at 5:30 PM revealed after dinner on 10/21/24 he could not feel his left arm and left side when the nurse aide was trying to change him. He could not help due to the lack of movement. NA #5 and NA #9 (3:00 PM to 11:00 PM shift) helped him because one person couldn't do it. He further stated he usually could position himself on his side with the use of the bed rails and a push on his hip to the turning side. This was when he noticed he couldn't move his left side. Nurse #5 came in and he told her he couldn't move his left arm or left leg, and he did not know what was

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going on. Resident #7 further stated Nurse #5 did not respond. Resident #7 explained his condition stayed the same until NA #4 came in on third shift. He told NA #4 he could not feel his left side and she went and told Nurse #6. Nurse #6 came into his room around 6:00 am or so and gave him his medicine. Resident #7 indicated Nurse #6 did not assess him or ask if anything was wrong. When the first shift NA (NA #8) came in with breakfast at 7:15 AM, Resident #7 told her he was not himself and she asked what was going on. Resident #7 told her he could not move his left side, and NA #8 immediately called Unit Manager #1. NP #1 came in and assessed him then sent him to the local hospital.

Attempts to interview NA #9 on 10/30/24 were not successful.

A phone interview on 10/29/24 at 4:48 PM with the family member revealed she was called by NA #8 around 8:15 AM (on 10/22/24) and was told that Resident #7 had been sent to the hospital for a stroke. The DON told the family member that the NA reported the symptoms to the Nurse and the nurse (no name was given) then went in and asked if he was ok, and he replied yes. The family member indicated Resident #7 denied any assessment by a nurse or doctor until the next morning (10/22/24). The family member further stated if Resident #7 could tell the people at the hospital what had happened to him the day before (10/21/24), he certainly would have known if a nurse came to check on him.

A review of NP #1's progress note dated 10/22/24 revealed that on physical assessment, Resident #7 exhibited 100% left arm drop. The Resident

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was alert and oriented, though his speech was slightly slurred. He was able to follow her finger with his eyes but reported blurred vision. Emergency Medical Services (EMS) were activated for stroke symptoms. The residents' vital signs were blood pressure 161/77, oxygen saturation 99% on room air, and blood sugar 192. The patient had a history of left-sided weakness and cerebrovascular accident (CVA), but according to both the patient and the nurse, he had been able to move and feel his left arm and leg previously. Now, he has completely lost mobility on his left side and reported numbness in his left arm and leg. The resident was transferred to the Emergency Department for evaluation of stroke symptoms.

An interview with the NP on 10/29/24 at 4:40 PM revealed she was called by the Unit Manager #1 on 10/22/24 because Unit Manager #1 thought Resident #7 had a stroke, and that UM #1 called EMS. The NP stated she was told by Unit Manager #1 his symptoms started the night before. The NP indicated she spoke with Resident #7, and he stated he told the nurse after dinner, but she did not do anything. Resident #7 stated his numbness and ability to move his limbs had gotten worse through the night. NP #1 stated neuro-checks should have been done when his symptoms started on the evening of 10/21/24 and he should have been sent out to the ED on 10/21/24. She further indicated if he had been assessed when he first was having numbness and sent to the hospital his worsening condition could have been managed. NP #1 confirmed Resident #7 had been admitted to the local hospital with a left side stroke.

The Emergency Department (ED) note dated

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10/22/24 indicated Resident #7 had a medical history significant for congested heart failure, chronic renal insufficiency, coronary artery disease, and prior stroke with left-sided deficits. Resident #7 presented to the Emergency Department with new onset vision changes and inability to use his left upper and lower extremities. Stroke code was called upon arrival. A National Institute of Health Stroke Scale (NIH) was documented as an 8 which indicated a mild to moderately severe stroke. Resident #7 reported he was unable to move his arm or leg at 6:00 PM on 10/21/24, which was new for him. The computed tomography (CT) scan showed a right posterior frontal lobe hypodensity concerning edema which could be related to an acute/subacute infarct. It was noted Resident #7 was outside of the window for the administration of Alteplase (tPA) which is a medicine that dissolves blood clots used to treat ischemic strokes. Resident #7 was admitted to neurology stroke service. Resident #7's vitals were blood pressure 162/59, pulse rate 60, temperature 98.5, and oxygen saturation 90%. The clinical impression after evaluation findings were Cerebral vascular accident (CVA) with following cognitive deficits and dysphagia (oropharyngeal phase) post CVA.

A review of the Emergency Department (ED) admission summary dated 10/22/24 indicated that Resident #7 presented the ED at 8:45 AM with left hemiplegia and stated that he was unable to move his left side. Resident #7 stated he had reported it to the facility staff last evening and nothing was done. Resident #7 reported it again this morning to the NA and 911 was called. He was transported to the local hospital. The physician assessment indicated Resident #7's left

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limb had no effort against gravity, and falls, left leg having no movement, and left facial weakness. Resident #7 was admitted to the hospital with a left side stroke. Resident #7 was admitted on 10/22/24 at 2:14 PM to the hospital Critical Care stroke unit, with a stroke on the posterior right frontal lobe. Neuro checks revealed no grip in the left hand, no left dorsiflexion or plantarflexion, motor response to the left upper and lower extremities are flaccid and without motor strength. The right side was normal with some weakness in the right lower extremity.
Resident #7 was released to a skilled nursing facility on 10/29/24.

An interview with DON 10/29/24 4:07 PM revealed that when the NA tells the nurse that something was wrong with a Resident, the nurse goes in and does an assessment and notifies the Provider, she then notifies the party responsible. The nurse should document the findings. She further stated that documentation is done by exception. The DON indicated she interviewed Nurse #5 and Nurse #5 stated did not find any change in condition for Resident #7 on 10/21/24, and did not recall being notified of any change. The DON further stated Nurse #6 reported when she checked Resident # 7's blood sugar on 10/22/24 at 6:00 AM she did not see any change in his condition. She further revealed that she had not completed the investigation but had several notes on pieces of paper that she had not put into a report yet.

The Administrator was notified of the immediate jeopardy on 10/29/24 at 2:00 PM.

The facility provided the following credible

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allegation of immediate jeopardy removal:

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

Resident #7, who has a history of a prior stroke with left sided weakness, reported to Nursing Assistant (NA) #7 on 10/21/24 at 9:00 PM he was experiencing pain and numbness to his left side. Nursing assistant #7 reported to the nurse who did not identify any acute changes, did not complete a neurological assessment or obtain vital signs, and did not initiate emergency medical services. On 10/21/24 at 11:30 PM the resident reported to NA #4 he was moving slowly and could not move his left arm. Nursing assistant #4 reported to the nurse who did not identify any acute changes, did not complete a neurological assessment or obtain vital signs, and did initiate emergency medical services. The resident reported further symptoms to NA #4 on 10/22/24 at 6:00 AM about being unable to move his left side who then reported to the nurse who did not identify any acute changes, did not complete a neurological assessment or obtain vital signs, and did not initiate emergency medical services.

NA took Resident #7 his breakfast tray on 10/22/24 between 7 and 7:15 AM, the resident had slurred speech and was unable to move his left side. The CNA immediately reported the change in condition to Unit Manager #1. Unit Manager #1 assessed the resident and found his left side to be flaccid. The Resident was also complaining of blurry vision. Resident stated that he had been unable to move his left side since last night after dinner. The Nurse Practitioner then assessed the resident and directed the

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resident to be sent out to the hospital via Emergency Medical Services because he had had a stroke. The resident was admitted to the hospital with an acute stroke on 10/22/24.

An audit to determine if any residents had reported any new change in condition that was not followed up on by a licensed nurse of residents with a brief interview for mental status (BIMS) score of 13 or higher was completed by the Administrator on 10/25/2024. The Audit revealed that no other residents were noted to be affected.

An audit was completed on 10/25/2024 by the Director of Nursing of progress notes for the past 7 days to ensure that anyone reporting a change of condition had a prompt follow up and provider notification. The audit revealed that no one else was affected.

As part of the staff education from 10/25-10/28, the Director of Nursing also questioned all of the licensed nurses regarding knowledge of any residents having had a change in condition that deviated from their baseline with no follow up. Signatures accounted for both the education and the questionnaire. No residents were noted to be affected.

On 10/31-11/1/2024 the Director of Nursing or Staff Development Coordinator interviewed all nursing assistants regarding knowledge of any residents having change of conditions in the last 7 days that were not addressed. No negative findings were noted.

(2) Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete:

On 10/25/2024 the Director of Nursing initiated education to all licensed nurses to complete a clinical assessment of a minimum vital signs and pertinent body systems once notified of a change in condition/medical emergency to include accident or incident, injuries of unknown source, significant change in residents physical, emotional, or mental condition which can include elevated vital signs, altered mental status, blurred vision, headaches, numbness or tingling to body parts, uncontrolled pain, etc., to call 911 and to notify the healthcare provider of findings once the assessment is complete and the assessment is documented in the medical record. Education also included any changes reported by nursing assistants. Any licensed nurse that has not been educated by 10/28/2024 will be taken off the schedule until the educated has been received. All new hires will be educated by the Director of Nursing during orientation. The Director of Nursing will ensure all licensed nurses are in-serviced.

On 11/1/2024, the Regional Director of Clinical Services educated the Administrator, The Director of Nursing, Staff Development Coordinator, and The Human Resource Director on the orientation process for nursing staff that will include education on recognizing change in condition, timely assessment and monitoring of change in conditions, recognizing a medical emergency, effective communication during a medical emergency, and calling 911.

On 11/1/2024, the Director of Nursing and Staff Development Coordinator re-educated all nursing

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assistants on change in condition of residents to include recognizing signs and symptoms of a stroke such as blurred vision, slurred speech, weakness to one side of the body, and facial drooping. Education also included the importance of residents receiving immediate medical attention should any of these signs be identified. Any nursing assistant that has not received the education on 11/1/2024 will be taken off the schedule until the education has been received. The Director of Nursing will ensure all nursing assistants are educated.
Alleged date of immediate jeopardy removal: 11/2/2024

An on-site validation of the facility's implementation of their credible allegation of immediate jeopardy removal was conducted on 11/4/24. Review of the completed facility audits included daily 24-hour resident report, resident clinical assessments to include neurological, pain and vital signs were documented in the record. The nursing notes reflected a narrative of the clinical assessment, and the change of condition reported to the medical team. Multiple interviews were conducted with nurse aides and licensed nurses to ensure the in-service/ education was provided prior to working their shift. The nurse aides and licensed nurses consistently reported they received in-service education, which included the change of condition assessment process, completion of facility neurological and pain assessment, signs/symptoms of stroke, vital signs, verifying any new orders with a facility provider prior to initiating the orders. All nursing staff were educated on the reporting and documentation process of any signs of change of condition on the daily 24-hour report and in the resident record.

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F 684	Continued From page 53 An interview with the Director of Nursing and Staff Development Coordinator on 11/4/24 at 3:00 PM confirmed that re-education was done for all nurse aides and licensed nurses on the change of condition of residents including signs/symptoms of stroke, the importance of reporting any change of condition and documentation of notifying healthcare providers of a medical emergency. The Director of Nursing stated daily record reviews and monthly monitoring will be done to ensure the assessments process was maintained. The IJ removal date of 11/02/24 was validated.	F 684		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a performance review every 12 months for 5 of 5 nurse aides (NAs) reviewed (NA # 4, #5, NA 7, NA #9 and NA #10). The findings included: a. Review of Nurse Aide #4's employee file revealed a date of hire of 4/10/23. The employee file for NA #4 did not include annual performance review documents based on the date of hire	F 730	F-730 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were noted to be affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:	11/22/24

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F 730	Continued From page 54 including April 2024. b. Review of NA #5's employee file revealed a date of hire of 3/28/23 . The employee file for NA #5 did not include annual performance review documents based on the date of hire including March 2024. c. Review of NA #7's employee file revealed a date of hire of 10/18/22. The employee file for NA #7 did not include annual performance review documents based on the date of hire including October 2023 and October 2024. d. Review of Nurse Aide #9's employee file revealed the date of hire of 11/9/22. The employee file for NA #9 did not include annual performance review documents based on the date of hire including November 2023. e. Review of NA #10's employee file revealed the date of hire of 1/31/23. The employee file for NA #10 did not include annual performance review documents based on the date of hire including January 2023 and January 2024. An interview was conducted 11/4/24 at 3:15 PM with the Director of Nursing who stated she was hired in May 2024 and was unaware of the facility's process for maintaining nurse aide competency skills training and performance reviews. She was unaware the mandatory requirements for nurse aide training/competency performance reviews had not been done for 2023 and 2024 for several employees. She stated she was unable to provide any evidence of any training done prior to her employment. She stated she began restructuring the documentation and records of staff training with the initiation of a new	F 730	All residents have the potential to be affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 11/4/2024, the Director of Nursing re-educated the Staff Development Coordinator regarding the requirement that a performance review of every nurse aide is required at least once every 12 months along with the 12 hours of required in-service training. On 11/11/2024, The Director of Nursing and the Staff Development Coordinator initiated in-service training to all Nursing Assistants regarding the 12 hours of required training along with a performance evaluation. This training will be completed on 11/21/2024. Any Nursing Assistant that has not had the training by then will be taken off the schedule and will not be permitted to work until the training is completed. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Director of Nursing or designee(s) will monitor weekly for 12 weeks of any new nursing assistants hired receive a performance review and receives the necessary 12 hours of required in-service training during orientation. The Administrator, Director of Nursing, or designee will report findings of the	

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F 730	Continued From page 55 system developed with the Staff Development Coordinator that started with the new hires on 9/25/24 when the facility's skill fair was started to educate and provide nurse aide training to reinforce skills and best practices to practice skills used daily for the care of residents in a long term care setting in accordance with the healthcare regulations. An interview was conducted on 11/4/24 at 3:30 PM with the Staff Development Coordinator (SDC) who stated she was hired on 8/26/24 and was not aware of the facility's process for maintaining nurse aide competency skills training and performance reviews. She indicated after reviewing the employee files it was discovered the nurse aide competency skills and performance reviews had not been done for 2023 and 2024. She indicated she was currently doing new employee orientation in-services and competencies. She stated she had not been in the role of SDC for very long and she had not started to review employee training files or training nursing staff in order to complete annual performance evaluations or review. During an interview on 11/4/24 at 4:00 PM the Administrator stated Nurse Aides' skills assessment /competencies should be completed at hire and annually. The facility should also have a performance review completed annually to address the needs of staff. The Administrator stated at this time the facility was unable to provide documentation to indicate Nurse Aides' annual performance reviews were completed. The Administrator indicated the skill competencies evaluation and annual performance review should be completed and signed by Staff Development Coordinator (SDC)	F 730	monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	

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F 730	Continued From page 56 or her designee. The Administrator stated the facility had some turnover in the SDC position, resulting in no evidence that the training/education was completed and documented.	F 730		
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, Physician, and Nurse Practitioner (NP) interviews the facility failed to ensure a resident (Resident #1) had a Pulmonary consultation appointment ordered once on 4/13/24 and again on 5/10/24. Resident #1 was diagnosed with obstructive sleep apnea and the appointment was required so Resident #1 could obtain a continuous positive airway pressure (CPAP) machine (used to treat sleep apnea by keeping the airways open while sleeping) that was ordered on 4/13/24. The facility also failed to ensure Resident #1 attended a Neurology consultation appointment ordered on 8/24/24 which was made due to Resident #1 complaining of constant migraines/headaches. This occurred for 1 of 3 residents reviewed for medically related social services. The findings included: Resident #1 was admitted to the facility on 5/22/22 with multiple diagnoses that included tachycardia (increased heart rate), asthma, morbid obesity, and obstructive sleep apnea.	F 745	F-745 (1) How corrective action will be accomplished for resident(s) found to have been affected: Resident #1 has no current outstanding appointments or diagnostics at this time. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: An audit for the last 30 days was done on 10/24/2024 by the Director of Nursing to determine if any other residents missed any appointments due to needing any special accommodations due to weight. The audit revealed that that no other residents were affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:	11/22/24

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F 745	Continued From page 57 The resident did not have a diagnosis of migraines on admission. Physician #1 order dated 4/13/24 revealed an order for Resident #1 to receive a Pulmonary consultation and a CPAP machine for obstructive sleep apnea. Another Physician #1 order dated 5/10/24 revealed Resident #1 was to receive a pulmonology consult for her obstructive sleep apnea and CPAP machine. A phone interview occurred with Physician #1 on 10/22/24 at 3:52pm. Physician #1 verified he had written the order for Resident #1 to receive a CPAP machine and a pulmonology consultation. He stated he had ordered the pulmonology consultation and CPAP machine in April 2024 because he understood Resident #1 already had a CPAP machine, but it was not present at the facility. Physician #1 stated Resident #1 required a CPAP machine for her obstructive sleep apnea. The Physician stated "about" a month later he learned (could not remember from who) that Resident #1 did not have a CPAP machine and needed a Pulmonology appointment to obtain a CPAP machine, so he wrote an order for a Pulmonology consultation in May 2024. Physician #1 explained he did not remember writing the pulmonology consultation in April 2024 when he re-wrote the order in May 2024. He stated he did not know if Resident #1 ever attended the pulmonology consultation but said he knew Resident #1 never had a CPAP machine. A follow-up telephone interview with Physician #1 occurred on 11/4/24 at 11:03am. Physician #1 discussed due to Resident #1's weight, the lack	F 745	On 10/23/2024 the Regional Nurse Consultant re-educated the nurse management team that consists of the Director of Nursing, Staff Development Coordinator, the 2-Unit Managers, and the Transportation Scheduler that transportation is to be provided per physician order. The order is printed by nursing and given to the transportation scheduler. If services are unable to be provided via the facility due to excessive weight, upon the Transportation Scheduler's review of the weekly transport log, all available resources that provide accommodations for bariatric residents are to be contacted to ensure the appointment will be fulfilled. The Regional Nurse Consultant provided a list of additional non emergent bariatric transport companies to the nurse management team and the Transportation Scheduler. Beginning 10/24/2024, all alternate transportation companies will be contacted by the Transportation Scheduler should weight limits exceed normal transportation capabilities. Transportation will be scheduled when the appointment is received. If unable to find alternative transportation, the Transportation Scheduler will notify the Director of Nursing or Unit Manager. The Director of Nursing or Unit Manager will notify the provider to determine if appointment can be re-scheduled or if emergent transportation is necessary. On 10/24/2024, the Director of Nursing provided education to the Transportation	

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F 745	Continued From page 58 of follow-through with her Pulmonology consultation, Neurology consultation, and lack of obtaining a CPAP machine could not have caused her hospitalization on 10/7/24. He explained Resident #1 had been stable without her CPAP prior to her hospitalizations. During a telephone interview with Physician #2 on 10/22/24 at 3:36pm, Physician #2 explained he began seeing Resident #1 after Physician #1 had left the facility. The Physician stated Resident #1 was required by insurance to receive a pulmonary consultation prior to receiving a CPAP machine. He explained that the insurance company needed proof and severity of Resident #1's obstructive sleep apnea before they would approve Resident #1 for a CPAP machine. The Physician stated Resident #1 required a CPAP machine due to her obstructive sleep apnea. Physician #2 stated Resident #1 was never able to receive the consultation due to transportation difficulties. An interview with Transport Staff occurred on 10/22/24 at 4:54pm. Transport Staff confirmed she was responsible for making residents' appointments. She also discussed being responsible for securing alternate transportation if a resident did not fit in the facility's van. Transport Staff discussed Resident #1 being too large to transport in a wheelchair van and would need non-emergency stretcher transport. She stated the facility had a contract with a non-emergency transport company but said "they are always booked up." Transport Staff discussed not receiving the consultation request for Pulmonology until 7/30/24. She stated since 7/30/24 she had been periodically trying to schedule the appointment with Pulmonology and Neurology that would also meet the	F 745	Scheduler and the Unit Managers regarding this process. The Director of Nursing will train any new Transportation Schedulers and Unit Managers upon hire. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Administrator or the Director of Nursing will audit all resident appointments weekly to ensure that no appointments have been unable to be scheduled due to excessive weight. This monitoring will take place weekly for 12 weeks. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	

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non-emergency transportation schedule. The Transport staff explained "periodically" met she would try to call both the Pulmonology office and the Neurology office plus the transportation company every 2-3 weeks to try to arrange the schedules. She stated she had been unsuccessful in getting Resident #1 to the Pulmonologist. The Transport Staff also discussed her neurology consultation. She stated Resident #1 was not able to attend the consultations due to not being able to arrange transportation with the non-emergency transportation company. She stated she kept Unit Manager #1 and the DON up to date in her failed attempts to arrange the appointments.

The quarterly Minimum Data Set (MDS) dated 8/8/24 revealed Resident #1 was cognitively intact, no rejection of care, and no shortness of breath. The MDS also documented Resident #1 did not have a CPAP machine. Resident #1 was documented as having a weight of 430 pounds. Resident #1 was documented as having impairment on one side for her upper and lower extremities, dependent on toileting, bathing, upper and lower dressing, substantial/max assist with bed mobility, and dependent with transfers.

On 8/24/24 there was a physician order from Physician #3 for Resident #1 to receive a neurology consultation for constant migraines.

The resident's medical record revealed no evidence was documented that Resident #1 received her CPAP. The medical record also revealed Resident #1 never attended her pulmonology consultation, or the neurology consultation.
Unit Manager #1 was interviewed on 10/22/24 at

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5:47pm. She discussed not being aware Resident #1 had sleep apnea but said she remembered at "some point" it was mentioned that Resident #1 needed a CPAP machine. She also stated she was aware Resident #1 was unable to attend her Neurology consultation and Pulmonary consultation due to transportation issues.

An interview with Resident #1 occurred on 10/22/24 at 12:08pm. Resident #1 stated she never had a CPAP machine since she had been in the facility. She explained that the Physician (Physician #1) had discussed with her needing to see a Pulmonologist "several months ago" and explained to her the appointment was needed so she could obtain a CPAP machine but stated she never saw a Pulmonologist or received a CPAP machine. Resident #1 also explained another Physician (Physician #2) had also told her he wanted her to see a Pulmonologist a "few months ago" and have a CPAP machine but she was told by the facility (could not remember who) that the facility could not find transportation to get her to the pulmonologist so she could receive the CPAP machine. Resident #1 stated she was told there was no transportation available for someone her size. The resident discussed periods of excessive sleepiness, trouble remembering, headaches, and abdominal pain "for at least the past 6 months". She stated one of the Physician's had ordered her to see a Neurologist for her headaches but said none of the appointments happened. The resident stated no one explained to her that she would have been able to see a Pulmonologist and/or a Neurologist.

The NP was interviewed on 10/23/24 at 8:18am. She stated she was not aware Resident #1 was ordered a CPAP machine or to see a

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F 745	Continued From page 61 Pulmonologist back in April 2024 or that Resident #1 had an order to see a Pulmonologist in May 2024. She also stated she was not aware there had been a Neurology consultation order in August 2024 or that Resident #1 had not attended any of these appointments due to transportation issues. The Director of Nursing (DON) was interviewed by telephone on 10/29/24 at 10:09am. The DON explained she had not had much contact with Resident #1 and that the resident never voiced any concerns to her. She stated she was aware Resident #1 was not able to attend any of her scheduled appointments due to transportation issues and explained the need for non-emergency transportation company required a month in advance notice and the facility could not coordinate transportation with the time of the appointments. The Administrator was interviewed on 10/23/24 at 3:20pm. The Administrator discussed being aware Resident #1 was unable to attend her scheduled appointments due to transportation issues. He had no comments related to the lack of follow-through with Resident #1's appointments.	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		11/22/24

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F 761	Continued From page 62 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure resident medications left in an unattended medication cart for 1 of 4 medication carts (Zone 1 medication cart). The findings included: An observation of the Zone 1 medication cart on 10/22/24 at 5:20 PM revealed the medication cart was unlocked and unattended. The locking mechanism on the right front of the medication cart was observed to be popped out in the unlocked position. Staff and residents were observed to pass by the unlocked medication cart during this time. On 10/22/24 at 5:23 PM Nurse #3 was observed approaching the medication cart from a resident's room. Nurse #3 was observed to lock the cart	F 761	F-761 (1) How corrective action will be accomplished for resident(s) found to have been affected: On 10/22/2024, Nurse #3 locked the medication cart immediately. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future:	

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F 761	Continued From page 63 and proceed to gather items on the top of the cart. An interview was completed with Nurse #3, she stated she was giving evening medications to a resident in the resident's room. Nurse #3 stated the medication cart should have been locked when she was not in attendance of the cart. Observation of the medication cart contained resident medications, insulin pens, medicated ointments and medicated eye drops. An interview was completed with the Director of Nursing (DON) on 10/23/24 at 12:22 PM. The DON stated nurses should lock their medication cart when not in attendance.	F 761	On 10/22/2024, the Director of Nursing re-educated nurse #3 regarding the requirement that at any time a medication cart is unattended, the medication cart is to be locked to secure resident medications. On 10/22/2024, the Director of Nursing and designee(s) initiated re-education to all licensed nursing staff including med-aides and agency regarding the requirement that at any time a medication cart is unattended, the cart is to be locked securing resident medications. Any newly hired Med-Aides or licensed nurses will be educated during orientation upon hire. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Through the utilization of an observation monitoring tool, the Director of Nursing or designee(s) will monitor 5x/wk for 4 weeks, 3x/wk for 4 weeks, and 1x/wk for 4 weeks to ensure that the 4 medication carts are locked when not attended. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance.	

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F 761	Continued From page 64	F 761	The facility alleges compliance on 11/22/2024.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and service technician interviews the facility failed to cover facial hair and wear gloves during food preparation; keep food service equipment clean and free from debris and maintain a clean kitchen environment; label and date open food items in 1 of 1 walk in coolers; maintain and monitor the kitchen's dish machine that was utilized to clean the dishware and eating utensils to ensure the machine's wash cycle and rinse cycle temperature reached a minimum temperature of 120 degrees Fahrenheit (F); and insulated dome	F 812	F-812 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly identified as being affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:	11/22/24

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F 812	Continued From page 65 lids and bases were dry before they were stacked for use. The findings included: 1. On 10/22/24 at 4:11 PM Dietary Aide #2 was observed placing lids on insulated mugs full of liquid for meal service with no gloves or facial covering in place. Dietary Aide #2 was observed to have facial hair (beard). Dietary Aide #2 observed surveyors in the kitchen and placed gloves at 4:13 PM on but no facial hair covering and continued placing lids on the insulated mugs full of liquid for meal service. A continuous observation on 10/23/24 from 10:16 AM to 10:18 AM revealed Cook #2 used a spatula to remove cooked fish filets from a large pan to a smaller holding container while not wearing gloves. During an interview with the Dietary Supervisor on 10/22/24 at 4:26 PM she indicated facial hair coverings should be in place while in the kitchen. She stated she had facial hair coverings available for staff in her office. The Dietary Supervisor also stated gloves should be worn during food preparation. An interview with Cook #2 on 10/23/24 at 10:18 AM indicated she should have been wearing gloves when handling the food but thought it was alright not to because she was using a spatula. An interview with the Administrator on 10/23/24 at 12:35 PM revealed staff should have facial hair coverings in place while in the kitchen and should wear gloves for food preparation.	F 812	All residents have the potential to be affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 11/15/2024 the Administrator re-educated the Dietary Director regarding the requirements of covering facial hair and to wear gloves during food preparation. Keep food service equipment clean and free of debris and maintain a clean kitchen environment. Label and date open food. Maintain and monitor the kitchens dish machine to ensure the machines wash cycle and rinse cycle temperature reach a minimum temperature of 120 degrees Fahrenheit. And insulated dome lids and bases are to be dry before they are stacked for use. On 11/15/2024, the Dietary Director re-educated the dietary staff regarding the requirements of covering facial hair and to wear gloves during food preparation, keep food service equipment clean and free of debris and maintain a clean kitchen environment, label and date open food, maintain and monitor the kitchens dish machine to ensure the machines wash cycle and rinse cycle temperature reach a minimum temperature of 120 degrees Fahrenheit, and insulated dome lids and bases are to be dry before they are stacked for use. Any newly hired dietary employee will be educated during new hire orientation.	

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F 812	Continued From page 66 2. Further observation of the kitchen revealed the following. -Continuous observation of the kitchen on 10/22/24 from 4:11 PM to 4:26 PM revealed the 3-compartment sink heavily soiled in all 3 compartments with food debris, a greasy jelly-like light brown substance and a deceased insect stuck to the inside wall of the right end sink. The sink was observed at 4:15 PM. An interview on 10/22/24 at 4:26 PM with the Dietary Supervisor revealed the kitchen was deep cleaned every Thursday. -Observation of the dish washing area on 10/23/24 at 8:00 AM revealed wooden material surrounding the garbage disposal electrical control box attached to the wall in the corner of the dish washing area. The wooden material was decaying, chipped, and covered with black matter/ growth. Observation and interview completed with Maintenance Director on 10/23/24 at 8:03 AM. The Maintenance Director discussed knowing the garbage disposal electrical control box wooded area needed repair. He stated the wooden area around the garbage disposal electrical control box was decaying, chipped and covered with black matter/growth prior to his employment. 3. An observation of the walk-in cooler on 10/22/24 at 4:23 PM revealed 9 unshelled hard-cooked eggs in a plastic storage bag that was undated. An opened 4 pound jar of grape jelly was also observed to be undated. The Dietary Supervisor was present for the observation.	F 812	(4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: Through the utilization of an observation monitoring tool, the Dietary Director or designee will monitor 5x/wk for 4 weeks, 3x/wk for 4 weeks, and 1x/wk for 4 weeks to ensure that facial hair is covered and gloves are warn during food preparation, food service equipment stays clean and free of debris and a clean kitchen environment is maintained, open food is labeled and dated, maintain and monitor the kitchens dish machine to ensure the machines wash cycle and rinse cycle temperature reach a minimum temperature of 120 degrees Fahrenheit, and insulated dome lids and bases are to be dry before they are stacked for use. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	

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An interview with the Dietary Supervisor on 10/22/24 at 4:26 PM revealed she was responsible for completing a walk-through of the cooler each morning and checked that each item in the cooler that was open had a date when it was opened and an expiration date. The Dietary Supervisor did not recall seeing these items in the cooler this morning.

An interview with the Administrator on 10/23/24 at 12:35 PM revealed food items in the walk-in cooler should be properly dated.

4. A continuous observation of the low temperature dish machine in use on 10/23/24 from 9:39 AM to 9:48 AM showed the dish machine temperature gauge reading at 102 degrees Fahrenheit (F) for both the wash and rinse cycle with a load of dishes in the compartment. The dish machine was then observed for three more wash and rinse cycles including one cycle each for 20 plastic drinking cups, 32 fruit bowls and 26 dinner plates with the temperature gauge remaining at 102 degrees F. Dietary Aide #1 was noted to be operating the machine during the observations.

Review of the manufacturers' recommended temperatures affixed to the front of the dish machine for wash specified the dish machine should reach a minimum temperature of 120 degrees F with a recommended temperature of 140 degrees F. The manufacturers recommended temperatures for rinse revealed the dish machine should reach a minimum temperature of 120 degrees F with a recommended temperature of 140 degrees F.

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An interview on 10/23/24 at 9:42 AM with Dietary Aide #1 indicated he spot checked the dish machine temperature at the beginning of his shift prior to starting the dish washing process. He indicated once his initial temperature check was completed, he did not recheck the temperature gauge to make sure the dish machine was maintaining the minimum temperature of 120 degrees F.
An observation and interview were conducted on 10/23/24 at 9:45 AM with the Dietary Supervisor regarding the dish machine which revealed the temperature gauge remaining at 102 degrees F. The Dietary Supervisor stated she would contact the vendor immediately for a service call. The Dietary Supervisor voiced that the Dietary Aides would initially complete several wash and rinse cycles to make sure the dish machine was reaching temperature prior to starting the dish cleaning process. The Dietary Supervisor explained that staff completed the initial check, but the temperature was not checked throughout the dish cleaning process.

An observation and interview were conducted on 10/23/24 at 10:08 AM with the Maintenance Director regarding the dish machine. He stated the dish machine was leased and that he could not complete repairs. The temperature gauge remained at 102 degrees F and he stated the temperature gauge was probably not properly reading the water temperatures cycling through the dish machine.
On 10/23/24 at 10:18 AM a telephone interview was conducted with the Service Manager for the dish machine service company. He stated the dish machine was a low temperature dish machine and water temperature readings for wash and rinse cycle should be a minimum of

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	345070	A. BUILDING _____ B. WING _____	C 11/05/2024

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F 812	Continued From page 69	F 812		

120 degrees F but the recommended temperature should be at least 140 degrees F. The service manager explained the dish machine temperature gauges would become faulty over time and not read the correct water temperature or stay fixed on a certain temperature and need to be replaced. He stated the dish machine at the facility was installed in February of 2023. He further explained the dish machine was last serviced 8 weeks ago (no date given). The Service Manager voiced the service technician was in route to the facility to assess the dish machine.

Review of the dish machine service company service report for the dish machine dated 8/9/24 revealed the dish machine had a water temperature reading of 128 degrees F during this service call. No other concerns or recommendations noted.

Review of the dish machine service company service report for the dish machine dated 10/23/24 revealed the dish machine had a water temperature reading of 115 degrees F. Remarks from the service technician noted the temperature gauge was replaced with a new temperature gauge. No other concerns or recommendations noted.

A continuous observation of the dish machine on 10/23/24 from11:45 AM to 11:51 AM and an interview with the dish machine service company Service Technician was conducted at 11:45 AM. The observation revealed that a new gauge was installed, and the old gauge had been disconnected. The Service Technician stated the old gauge was not working properly and did not show the actual dish machine water temperatures

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F 812	Continued From page 70 for washing and rinsing. The Service Technician completed several wash and rinse cycles and indicated the temperature gauge was working properly at this time with the temperature gauge reading showing above 120 degrees F. The temperature gauge was observed to read 128 degrees F. An interview with the Administrator on 10/23/24 at 12:35 PM revealed when staff notice the temperature gauge not working properly, they should notify the vendor so the issues could be corrected. 5. On 10/23/24 at 10:03 AM an observation of the light brown 4-compartment trolley holding insulated dome lids and bases revealed a stack of wet insulated dome lids and bases in 1 compartment. The compartment held a total of 31 insulated dome lids and bases. During an interview on 10/23/24 at 10:16 AM Dietary Aide #3 stated he forgot to let the insulated dome lids and bases dry prior to placing the items in the 4-compartment trolley. He stated he was rushing. An interview on 10/23/24 at 10:17 AM with the Dietary Supervisor revealed staff should make sure the insulated dome lids and bases are dry before storing them in the trolley. During an interview on 10/23/24 at 12:35 PM with the Administrator he indicated items should be properly dried and then stored.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5)	F 842		11/22/24

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§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(h) Medical records.
§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 72 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Physician interviews, the facility failed to maintain an accurate medical record regarding the use of a Continuous Positive Airway Pressure (CPAP) machine for 1 of 1 resident (Resident #1) reviewed for professional standards. The findings included Resident #1 was admitted to the facility on 5/24/22 with multiple diagnoses that included obstructive sleep apnea (a condition that causes	F 842	F-842 (1) How corrective action will be accomplished for resident(s) found to have been affected: Physician #1 no longer provides services to the facility. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed:	

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F 842	Continued From page 73 the upper airway to become blocked during sleep, reducing or stopping airflow). The quarterly Minimum Data Set (MDS) dated 8/8/24 revealed Resident #1 was cognitively intact with no rejection of care. The MDS also documented that Resident #1 did not have a Continuous positive Airway Pressure (CPAP) machine (used to treat sleep apnea by keeping the airways open while sleeping). Review of a Physician note dated 6/19/24 written by Physician #1 revealed documentation to initiate Resident #1 on CPAP 5/10 settings and follow up with outpatient Pulmonology. Also documented was that Resident #1 was "stable" and to continue the use of the CPAP machine at night. A phone interview occurred with Physician #1 on 10/22/24 at 3:52pm. Physician #1 verified he had written the note on 6/19/24. He explained he thought Resident #1 had received her CPAP machine for her obstructive sleep apnea and was not aware Resident #1 did not have the CPAP machine or the inability to follow up with the Pulmonologist. An interview with Resident #1 occurred on 10/22/24 at 12:08pm. Resident #1 stated she never had a CPAP machine since she had been in the facility. She explained that the Physician (Physician #1) had discussed with her needing to see a Pulmonologist "several months ago" and explained to her the appointment was needed so she could obtain a CPAP machine but stated she never saw a Pulmonologist or received a CPAP machine.	F 842	On 11/21/2024 the Director of Nursing audited provider progress notes for the last 7 days to ensure that no other resident was being documented for having a CPAP that did not have one. Audit revealed that no other residents were affected. (3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 11/21/2024, the Director of Nursing re-educated the current attending physician and the nurse practitioners regarding the requirement for maintaining accurate documentation in the medical record. (4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Director of Nursing or designee(s) will audit all provider notes daily 5x/wk for 12 weeks to ensure accuracy. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	

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F 842	Continued From page 74 The Director of Nursing (DON) was interviewed by telephone on 11/1/24 at 9:53am. The DON stated the facility did not review or monitor the Physician's documentation. She confirmed Resident #1 never had a CPAP machine prior to her hospitalization. The DON stated she was unaware Physician #1 was documenting that Resident #1 already had her CPAP machine.	F 842		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean and sanitary environment as evidenced by the presence of a growth buildup in and on 1 of 2 ice machines observed and various colored growths on the floor for 1 of 2 observations that were conducted for clean and sanitary environment. The findings included: On 10/22/24 at 4:11 PM the following observations were made. 1. The ice machine located in a room with electronic equipment on Zone/hall 3 revealed blackish brown spots of matter on the external facing of the ice machine between the top portion of the ice machine and the ice machine door. The inside of the ice machine revealed pinkish/ black colored matter on the internal ceiling of the ice machine and small brownish-black spots on	F 921	F-921 (1) How corrective action will be accomplished for resident(s) found to have been affected: No residents were directly identified as being affected. (2) How corrective action will be accomplished for resident(s) having the potential to be affected by the same issue needing to be addressed: All residents have the potential to be affected. 3) What measure(s) will be put in place or systemic changes made to ensure that the identified issue does not re-occur in the future: On 10/22/2024, the Maintenance Director deep cleaned the affected ice machine	11/22/24

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F 921	Continued From page 75 the internal ceiling front metal lip. 2. The floor and corner molding in the right corner behind the ice machine revealed blackish matter along the molding and underneath the exposed and decayed wood, light beige colored puffy growths among the blackish matter on the floor and corner molding. Yellow matted stringy material was also observed on the floor and among the blackish matter and light beige colored growths. An interview and observation on 10/22/24 at 5:26 PM with the Maintenance Director revealed he was not aware of the ice machine being in this condition. He explained that the ice machine was used by staff, and he had not received any concerns related to mold in the ice machine from staff. The Maintenance Director stated he cleaned the ice machines in the building quarterly. He verbalized he was not certain what the blackish or light beige or yellow colored matter was on the floor or the corner molding. He suspected that it was mold but "not 100% certain." The Maintenance Director explained that he would shut down the ice machine, empty the ice machine out, complete a chemical clean, and repair the flooring around the ice machine. An interview with the Administrator on 10/23/24 at 12:35 PM revealed ice machines were checked weekly by staff and maintenance. The Administrator stated he was not certain of the deep clean schedule for the ice machines.	F 921	and removed any growth buildup. The Maintenance Director also cleaned and removed the various colored growth on the floor around the ice machine. On 11/15/2024 the Administrator re-educated the maintenance department regarding the need to maintain a cleaning schedule for the ice machines to prevent any growth buildup and to ensure the flooring around the ice machine remains free of colored growth to ensure a clean and sanitary environment. 4) Indicate how the facility plans to monitor its performance to make sure that the solutions are achieved and sustained: The Maintenance Director or designee(s) will audit the ice machines and flooring around the ice machines to ensure they remain free of any growth buildup weekly for 12 weeks. The Administrator, Director of Nursing, or designee will report findings of the monitoring process to the facility Quality Assurance and Performance Improvement Committee for any additional monitoring or modification of this plan. The QAPI Committee can modify this plan to ensure the facility remains in substantial compliance. The facility alleges compliance on 11/22/2024.	