STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARROLTON OF DUNN	711 SUSAN TART ROAD DUNN, NC 28335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The surveyor entered the facility on 6/2/25 to conduct a complaint investigation survey. The surveyor was onsite 6/2/25 through 6/5/25 with additional information obtained remotely on 6/6/25. The surveyor returned to the facility on 6/10/25 to validate credible allegations of immediate jeopardy removal. Therefore, the exit date was 6/10/25. Event ID# SEVC11 The following intakes were investigated: NC00228836, NC00228877, NC00229082, NC00230092, and NC00230803. NC00229082 resulted in immediate jeopardy. One of the eight complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag 580 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 3/21/25 and was removed on 6/6/25. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-	F 580		6/22/25

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

Electronically Signed | 06/25/2025

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

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

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F 580	Continued From page 2 locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, therapy staff, and the Physician the facility failed to notify the physician when Resident # 3 experienced a change in status resulting in a decline observed by multiple staff members. Resident # 3 entered the facility for rehabilitation. Therapists and Nurse Aides revealed Resident # 3 was initially making progress in therapy to the degree that she could feed herself, ambulate short distances with therapy in parallel bars or with a quad cane, toilet to the commode, and communicate her needs by gestures. Multiple days prior to a transfer to the hospital, Resident # 3 had declined in functional status and was noted to have symptoms which included dizziness, lightheadedness, nausea, periods of altered responsiveness, change in communication ability, dry mouth, poor oral intake, less urine output, dark stools, and a positive COVID (Coronavirus Disease) test. The physician was not notified of the resident's significant change in status for multiple days although it was documented that therapy had talked with nursing staff about a decline and there was a plan to communicate with the physician or DON to determine why the resident was declining. The physician reported he had not been made aware of the change in condition and decline. If he had been made aware, the physician reported he would have seen the resident, probably ordered stat (right away) blood work, and probably sent her back to the hospital. Resident #3 was transferred to the Emergency Room on 03/25/25. At time of	F 580	Immediate action taken for the resident found to have been affected include: The facility failed to notify the physician when Resident # 3 showed a significant change in condition. Resident #3 was discharged from the facility on 3/25/25. Identification of other residents having the potential to be affected was accomplished by: On 6/4/25 and 6/5/25, twenty-four-hour reports (from the electronic medical record) were printed (for daily meetings 3/25/25 to current) and reviewed by the facility Director of Nursing (DON), Corporate Nurse Consultant, Administrator, and Chief Operations Officer to ensure that the Medical Director (MD)/Attending Physician was notified appropriately of residents who had a decline in condition and that orders from MD visits were implemented appropriately. (The twenty-four report summarizes resident information occurring in the last 24 hours including all progress notes, vital signs, incident reports, physician progress notes, physician order notes, med administration notes, admissions, discharges, and residents on or returning from leave). There were no additional problems	

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hospitalization Resident # 3 was found to be septic (when an individual's body has an extreme reaction to an infection and which can lead to organ failure) due to her COVID infection. The resident was additionally found to have gastrointestinal bleeding, which resulted in a critical hemoglobin of 4.0 and required three units of blood. The resident was hospitalized in the Intensive Care Unit. The resident's 4/8/25 hospital discharge summary noted the resident had sustained heart injury due to the sepsis. This was for 1 of 3 sampled residents reviewed for acute medical conditions (Resident # 3).

Immediate jeopardy began on 3/21/25 when a licensed Physical Therapist identified Resident # 3 had an overall change in status and the physician was not notified. Immediate Jeopardy was removed on 6/6/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective.

The findings included:

Record review revealed Resident # 3 was admitted to the facility on 3/8/25 after being hospitalized on 3/3/25. Review of Resident # 3's 3/3/25 hospital history and physical and the resident's 3/8/25 hospital discharge summary revealed the following information. Prior to hospitalization the resident resided independently at home and presented to the hospital on 3/3/25 with slurred speech. While hospitalized the resident underwent an MRI (Magnetic Resonance Imaging) which revealed multiple acute small infarcts (areas of brain damage from a lack of

identified.

On 6/5/25 meetings were held with the Chief Operating Officer, Chief Clinical Officer, Facility Nurse Consultant, Director of Nursing, and Facility Administrator with staff members including all licensed staff (nurses), therapists, certified nursing assistants, social workers, and facility contractors working at the time of the meeting. Staff members were given the opportunity to identify residents that have experienced a decline in condition from 3/25/25 through 6/5/25. Names were documented by the Chief Clinical Officer and the Chief Operations Officer. Three changes, from earlier in the same day (6/5/25), were brought forward. Immediate medical record review revealed that the three events had been shared with the physician earlier in the day and appropriate actions were taken immediately (including one resident that was sent to the hospital).

The facility has determined that all residents have the potential to be affected when staff members fail to communicate a decline in a residents condition to other team members and the physician.

Actions taken/systems put into place to reduce the risk of future occurrence include:

All staff members (including licensed nurses, therapists, certified nursing assistants, social workers, and facility contractors) were in-serviced on 6/5/25 by

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F 580	Continued From page 4 oxygen). The resident was diagnosed with a stroke with right-sided weakness and slurred speech. The discharging physician further noted Resident # 3 needed to be evaluated as an outpatient for chronic blood loss and further gastrointestinal workup would be deferred to the primary care physician. She was also discharged on anticoagulant medications due to her stroke. The resident's 3/8/25 discharge summary also noted the resident had benign hypertension. Review of the facility record revealed an admission nursing note on 3/8/25 at 3:08 PM which noted the resident had a right sided deficit, was awake, alert, oriented to self, and denied any discomfort. Facility physician orders, dated 3/25/25, revealed Resident # 3 was a full code. Occupational Therapy, Speech Therapy, and Physical Therapy were ordered on 3/10/25. Physical Therapist (PT) # 1's notes revealed on 3/10/25 Resident # 3 actively participated with physical therapy. PT # 1 documented the following information regarding the treatment session on 3/10/25. She (PT # 1) directed Resident # 3 to go from a supine (lying) position to a sitting position. The resident transferred with good balance and with bilateral upper extremities and bilateral lower extremities supported. The resident was able to transfer to the toilet with both PT # 1 and an Occupational Therapist present. PT # 1 helped Resident # 3 with trials of transfers with a quad cane and the future plan was to do a trial with the quad cane or hemiwalker (a mobility device for individuals who have limited use of one of their hands) during transfers and ambulation during the next therapy session.	F 580	the Chief Operating Officer and Chief Clinical Officer regarding the importance of notifying the physician and other team members of decline immediately. The Lead Therapist in serviced all therapy team members on 6/5/25 regarding communicating to the physician and to all other team members of significant change. Agendas for both meetings included the following: Survey findings related to failure to notifying the physician of resident changes; Change identification- all residents with a reported change in condition must be assessed by a nurse immediately. Assessment findings indicating decline or the need for emergent physician intervention will be immediately called to the Physician and documented in the medical record. Other changes identified must be communicated to the physician before the shift ends. Calls to physicians and family members must be documented as notifications are completed. Effective communication among the interdisciplinary team (including 100% of facility team members and contractors). This communication includes but is not limited to: -Nursing assistants and therapists reporting changes to nurses promptly, -Nurses reporting changes in condition to physicians timely	

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F 580	Continued From page 5 According to the record there was one documented visit from the facility physician while the resident resided at the facility on 3/11/25. Within the 3/11/25 physician's progress note, the physician included further diagnoses of thrombocytosis (elevated platelets), cardiomyopathy (disease of the heart muscle), dyslipidemia (elevated cholesterol or fats), and aphasia (loss of ability to express speech clearly or understand). There was no further documentation that the physician saw the resident while she resided at the facility. On 3/11/25 ST (Speech Therapist) # 1 documented the following in a speech therapy progress note, "Pt assessed with her lunch meal. Pt [patient] alert and sitting up in her wheelchair. Pt able to feed herself with her left hand for the most part." ST # 1 further noted Resident # 1 consumed 40 percent of her meal before indicating she did not want any more and that she was able to brush her teeth with intermittent minimal assistance. The ST also noted Resident # 3 was receptive to education. On 3/12/25 Physical Therapy Assistant (PTA) # 1 documented multiple treatment modalities in a physical therapy progress note. One included that gait training was begun in the parallel bars, and the resident was able to complete the length of the parallel bars with minimal assistance two times while resting in between. On 3/14/25 PTA # 1 documented in a therapy progress note for the session of 3/13/25 the following information. She (PTA # 1) instructed Resident # 3 in the use of the hemiwalker and quad cane and the resident required minimal to	F 580	-Apprising the Physician, Director of Nursing, and Administrator of significant changes immediately -Implementation of a STOP & WATCH program for both nursing and therapy teams to communicate identified change. The Director of Nursing continued education every shift until 100% of staff members and contractors were educated. New staff members will be educated by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, or Facility Nurse Consultant during the orientation process. On 6/9/25, Carrolton Facility Management corporate employees, including the Chief Operating Officer, Chief Clinical Officer, and Facility Nurse Consultant, met with therapy leaders, including the Therapy Lead, Clinical Specialists, and the Area Director. The following issues and plans for resolution were discussed during this meeting: The need to see therapy documentation in real-time: -Carrolton Facility management requested an upgrade to allow therapy notes to be visible in the electronic medical records. -Therapy notes will be brought to the morning clinical meeting the day after the care provision and reviewed by the DON and Therapy Lead. Documentation Issues (timeliness and	

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moderate assist due to impulsivity, the need to support her right upper extremity, and balance deficits. The resident was documented as walking 12 feet with both the hemi walker and the quad cane on 3/13/25. The resident was documented as needing minimal assistance for transfers on the session date of 3/13/25. The resident had declined wheelchair mobility because she (the resident) wanted to focus on transfers and gait.

Resident # 3's admission MDS (Minimum Data Set) assessment, dated 3/14/25 coded the resident as having unclear speech and was moderately cognitively impaired. She was assessed to need substantial to maximum assistance with bathing, dressing, and hygiene.

PTA # 1 documented in a therapy progress note for the session of 3/14/25 the following information. She (PTA #1) had instructed the resident on the proper use of the quad cane because she was not using it properly. The resident had also participated in bean bag tossing, transfers from sitting to standing, and ball kicking.

PTA # 1 documented in a therapy progress note for the session of 3/17/25 Resident # 3 needed minimal assistance to transfer to the left and that training was done with a Nurse Aide (NA) to allow for the resident to be toileted by the Nurse Aide.

ST #1 documented in a speech therapy progress note for the session of 3/17/25 the following information. "Pt [patient] participated with expressive language tasks for simple phrase completion and simple responsive naming tasks with improvement noted. Pt completed tasks with 80% accuracy given min to mod [minimal to

accuracy of notes):

-Education plan for clinical staff (licensed nurses and therapists as well as certified nursing assistants).
-Therapy notes will be brought to the morning clinical meeting the day after the care provision and reviewed by the DON and Therapy Lead.

Ways to improve communication:

-Nametags to clearly identify medication aides
-Utilization of the Stop and Watch early warning tool
-Increased interdisciplinary clinical meetings (morning and afternoon)
-Nursing will attend rehabilitation team meetings weekly for the next four (4) weeks.

Following the meeting with therapy, Carrolton Facility Management corporate employees, including the Chief Operating Officer, Chief Clinical Officer, and Facility Nurse Consultant, met with the facility administrator and the DON to discuss issues and corrective action plans.

On 6/9/25, the therapy Clinical Specialist in-serviced all therapy teams (company-wide), including the Dunn therapy team (licensed therapists, assistants, and rehabilitation aides), on the following topics:

-Documentation timeliness,
-Documentation accuracy, including the

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F 580	Continued From page 7 moderate] verbal cueing. Pt read simple functional phrases out loud with improved fluency. Pt approximately 75% intelligible when reading simple phrases given moderate cueing [pt wearing glasses for reading task]. Pt alert and up in her wheelchair for po [oral] trials." ST # 1 further noted she educated the resident on swallowing recommendations and the resident was able to participate in solid food trials with minimal improvement in pocketing. Review of weight records revealed on 3/18/25 Resident # 3's weight was documented as 150.3 pounds, which indicated she had gained weight from her documented 3/8/25 admission weight of 147.1. ST # 1 documented in a speech therapy progress note for the session of 3/18/25 the following information. Resident # 3 was dysarthric (difficulty speaking) but she participated with naming common pictured items with 75 % accuracy when given minimal to moderate cueing. Her speech was approximately 75 % intelligible. During the session the resident's right side of her face suddenly started to twitch and Resident # 3 grabbed her face. The physician was notified via nursing. The resident was able to brush her teeth with minimal assistance. The resident was able to drink through a straw without signs of aspiration. ST # 1 was interviewed on 6/3/25 at 3:35 PM and reported the following information. During the first part of Resident # 3's speech therapy she was feeding herself. It was "not perfect but all things considered she was doing good." She also had the will to do good. She started to use a divided plate to help with meals. There was a day when the resident had some facial twitching. The	F 580	importance of including clinically relevant and factual content in daily notes, -Effective communication with nursing staff to ensure immediate physician notification, -Reporting a change in condition, including utilization of the Stop and Watch early warning tool. The Therapy Lead or Clinical Specialist provided in-service training to any staff members who had not received it before they returned to work. The Therapy Lead will educate all new rehabilitation staff members during orientation. The therapy staff began use of the Stop and Watch early warning tool on 6/11/25. On 6/11/25, the facility Stop and Watch form was revised by the Chief Clinical Officer and sent to the print shop for triplicate carbon copies. The facility made copies of the form until the triplicate carbon copy form was available. 6/13/25 through 6/21/25, the facility Director of Nursing /Facility Nurse Consultant in-serviced all certified nursing assistants on the following topics: -Effective communication with nursing staff, -Reporting of changes in condition immediately to nurses, Director of Nursing, and Administrator, -Utilization of the Stop and Watch early warning tool. The DON, ADON, Unit Manager, or	

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F 580	Continued From page 8 resident seemed aware of it and then it went away. The nurse was told about the facial twitching. During the end of therapy, the resident had some general malaise. The date of 3/18/25 was the last date that the resident received speech therapy. ST # 1 reported she was out of work following 3/18/25. On 3/18/25 at 11:20 AM Nurse # 1 completed a SBAR narrative (situation, background, assessment, and recommendation) which noted the following information. Speech therapy had been in with the resident and the resident experiencing twitching to the right side of her face with slower speech than baseline per therapy. Her vitals were within normal limits. The physician was notified and ordered baclofen 10 mg (a muscle relaxer medication) twice per day as needed for spasms. This was the last documented notification to the physician in the narrative nursing notes about a change in the resident's condition prior to 3/25/25. Interview with Nurse # 1 on 6/4/25 at 3:50 PM revealed the only thing she was aware of on 3/18/25 was that the resident had some twitching. She had talked to the physician and the physician thought the twitching was related possibly to residual effects of her stroke. Nurse # 1 reported she did not see any further change in the resident on 3/18/25. On 6/4/25 at 2:00 PM Nurse # 2 entered a late entry into the nursing notes for the date of 3/20/25 at 3:52 PM which read, "Therapist brought resident back to room saying resident unable to participate. No [mechanical lift pad] under resident. Assist X 3 to bed. Assist X 2 to get situated in bed. VS WNL [vital signs within	F 580	Facility Nurse Consultant will educate all new certified nursing assistants during orientation. The Administrator or Director of Nursing will provide in-service training to staff members who have not received the education before returning to work. 6/13/25 through 6/21/25, the facility Director of Nursing /Facility Nurse Consultant in-serviced all licensed nurses on the following topics: -Importance of completing nursing assessments, -Documentation timeliness, -Documentation accuracy, including the importance of including clinically relevant and factual content in daily notes, -Effective communication with nursing assistants and therapy staff, -Utilization of the Stop and Watch early warning tool, -Reporting changes in condition to the physician immediately, -Following physician orders The DON, ADON, Unit Manager, or Facility Nurse Consultant will educate all new nursing staff members during orientation. The Administrator or Director of Nursing will provide in-service training to staff members who have not received it before returning to work. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The DON, or designee, will audit 100% of	

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F 580	Continued From page 9 normal limit] for resident bed low. Call light in reach." PTA # 1 documented in a therapy progress note for the session of 3/20/25 the following information. Resident # 3 was brought to the gym for therapy and while working on transfers, PTA # 1 documented, "With each attempt (2 attempts made) patient required increased assist. When asking patient about what was wrong patient noted to not be attempting to verbalize as per her usual. When asked if she felt bad patient nodded yes. When asked if she was hurting anywhere patient again nodded yes. When asked where she was hurting patient put left had [as written] to her head. Immediately returned patient to her room and informed nursing. Patient became less responsive and was assisted to bed with dependent assist. Patient placed in supine and hall nurse and DON (Director of Nursing) assessed patient. Later in day patient noted to not be in bed and this therapist was informed she was in WC [wheelchair] with activities for bingo. Still later found patient in her room slumped with head back and eyes open, partially responsive. Returned patient to bed with max/dep [maximum dependent] assist and notified nursing. Spoke with activities who stated patient was sitting with head back during activities and said she wanted to go back to bed so she was pushed to her room and call bell activated." PTA # 1 was interviewed on 6/3/25 at 4:22 PM and reported the following information. The first few days when Resident # 3 resided at the facility, she was making progress. She could walk with help and had some "really, really good days." She also could get her point across with gestures and she communicated with staff in that manner.	F 580	the 24-hour reports daily for four (4) weeks to read all progress notes and new orders to ensure that change identification is occurring and is being communicated to all team members and the physician. Any identified adverse findings requiring follow-up will be addressed immediately. The Administrator will monitor the clinical meetings daily for four weeks to ensure that team communication is occurring and to ensure that MD notification is happening immediately. Any identified adverse findings requiring follow-up will be addressed immediately. The Facility Nurse Consultant or Chief Clinical Officer will randomly pull two (2) 24-hour reports weekly for four (4) weeks to audit for change identification and physician notification. Any identified adverse findings requiring follow-up will be addressed immediately. The Facility Nurse Consultant or Chief Clinical Officer will randomly pull (5) Stop and Watch forms weekly for (4) weeks to audit for compliance with follow-up and documentation of identifying and notification of changes in condition. Any identified adverse findings requiring follow-up will be addressed immediately. This correction plan will be monitored at the monthly Quality Assurance Performance Improvement (QAPI) meeting until consistency and substantial compliance are achieved.	

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Then one day she had a big change. She stopped trying to gesture and stopped trying to verbalize. She started to need a lot more assistance in therapy with transfers. She (PTA #1) had reported this to the nursing staff.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse # 2 had cared for Resident # 3 on the day of 3/20/25. Additionally, the file noted Nurse # 2 had cared for Resident # 3 on 3/17/25, 3/19/25, 3/20/25 and 3/24/25. Nurse # 2's signed 3/26/25 statement read in part, "In my opinion [Resident # 3] was a candidate for hospice. [Resident # 3] was unable to speak, she moaned and pointed a lot."

Nurse # 2 was interviewed on 6/4/25 at 3:40 PM and reported the following information. She did not routinely work with Resident # 3 and only recalled working with Resident # 3 twice. The resident always seemed to be in bed and not doing well when she cared for her. Nothing had ever been communicated to her (Nurse # 2) that the resident had been making progress in therapy and had been walking in therapy. She recalled a therapist one day saying the resident could not participate in therapy, and she wondered, given what she knew about the resident, why therapy had the resident out of bed. The nurse reported there had been some communication breakdown because if she had known the resident had in recent weeks been able to walk with a quad cane she would have had her sent out to the hospital. She validated she had not called the physician on 3/20/25.

On 3/21/25 licensed PT # 1 documented the following, "PT [Physical Therapist] completes

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progress note with patient today. Patient found in supine with appearance that she is ready to get up. PT directs patient in rolling L & R [left and right] to finish putting pants on. Patient requires mod A [moderate assist] to roll to L side and CGA cues [contact guard assist cues] for rolling to R side. PT directs patient in 2X supine < >EOB (Edge of Bed) transfers with max A [maximum assistance] and cues with both attempts patient reporting dizziness, lightheadedness, nausea, and overall not feeling well. PT takes BP [blood pressure], during second attempt noting it to be 118/60 in seated from 132/58 in supine at rest. PT notes this to be a mild decrease in BP, however not enough to be considered orthostatic hypotension. PT discusses this change in BP with nurse and overall change in status from admission. Nurse plans to pass the message along to DON and/or doctor for potential further workup on why patient is declining in functional status & overall feeling. Patient is only able to respond to questions with head nocks/shakes [as written] for yes/no questions."

PT # 1 was interviewed on 6/3/25 at 4:10 PM and reported the following information. When Resident # 3 was initially admitted, she and the Occupational Therapist conducted their initial evaluations together. The resident was able to go to the bathroom with moderate assistance. In therapy she began walking with a quad cane. In her progression of therapy, the resident "went up and did really well and then went down." In the beginning of therapy, the resident could shake her head yes and no to communicate. She was doing better with communication near the beginning. Near the end of her stay she was minimally communicating. She went from transferring and walking with the quad cane to

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being totally dependent for transfers near the end of her stay. It had been Nurse # 1 who had been in the room on the day that the resident's blood pressure was taken and dropped.

Nurse # 1 (who was assigned to care for Resident # 3 on 3/21/25) was interviewed on 6/4/25 at 3:50 PM and reported the following information. She knew Resident # 3 had a major stroke when she was admitted to the facility and had always had right sided neglect (where a person's awareness of one side of their body is impaired after a stroke). She seemed to be the same the times she took care of her, and it had never been communicated to her that the resident could stand, pivot, and was progressing with therapy soon after admission. She did not ever witness that herself. She did not recall therapy talking to her about changes or problems. She had not called the physician. If she had known the resident had previously in therapy been doing more for herself to the degree that she could stand and pivot, then she would "have for sure" called the physician. At times therapy also communicated with the Unit Manager about things.

The Unit Manager was interviewed on 6/5/25 at 11:22 AM and reported she was not aware of a change in condition for Resident # 3 and had not notified the physician.

The DON (Director of Nursing) was interviewed on 6/5/25 at 4:00 PM. The DON reported the following. She only recalled one time when a change in condition had been mentioned to her about Resident # 3 and that was regarding the twitching the resident had on 3/18/25. She (the DON) knew physician orders were obtained for

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that and she was not aware of the resident's decline. Therefore, she had not communicated with the physician since it had not been made clear to her.

On 3/22/25 a Point of Care Testing Result for COVID showed Resident # 3 tested positive for a COVID infection. On the form, the resident was checked as having no symptoms.

On 3/22/25 at 11:20 AM Nurse # 1 documented she had called and talked to Resident # 3's responsible party and that the resident's vitals were stable. The resident had left sided neglect, had difficulty swallowing, was pocketing food, and she was receiving therapy services.

On 3/22/25 at 6:02 PM the Unit Manager documented, "Writer called first Emergency contact and informed her of resident testing positive for COVID received verbal consent to start antiviral medication."

Record review revealed no notation in the progress notes or on the COVID test result that the physician was notified of the resident testing positive for COVID on 3/22/25.

On 6/4/25 at 2:15 PM the Administrator, DON, Nurse Consultant, and Chief Clinical Officer were interviewed and reported the following information. The Administrator reported they had an outbreak of COVID on 3/18/25 and Resident # 3 did not test positive until 3/22/25. When residents tested positive, there was a procedure that the Unit Manager was supposed to contact the physician and determine if he wanted them to receive antiviral treatment. They could not find in the record that was done.

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The Unit Manager was interviewed on 6/5/25 at 11:22 AM and reported the following information. There was a lot that happened during the outbreak, and she could not recall for sure whether she had contacted the physician and what he said about Resident # 3 having COVID.

On 3/23/25 OTA# 1 (Occupational Therapist Assistant) documented Resident # 3 was unable to follow commands, utilize utensils, or engage in self-feeding in any manner without total assistance. OTA # 1 further noted, "Pt appeared dehydrated. Pt (patient) able to utilize straw for sucking for brief period and did not react to bringing drink or food to mouth. Collaborated with nursing regarding PO [oral] intake to improve therapeutic potential, however Pt (patient) unable to engage in meal task at this time."

OTA # 1 was interviewed on 6/5/25 at 9:30 AM and reported the following. She could not recall specific details of who she had talked to in nursing or working with Resident # 3 on 3/23/25. She would not have written the resident "appeared dehydrated" unless the resident's mouth was dry or the resident did not pass the "skin pinch test." (A test to assess hydration and skin elasticity by seeing how quickly the skin returns to its normal position when pinched and released)

On 3/23/25 at 3:24 PM Nurse # 1 documented the following in a nursing note. Resident # 3 continued with right-sided neglect and her right side was flaccid. The resident was moving her left side, but without purposeful movements. The resident would look when spoken to and her eyes would drift towards the left side. Her vitals were

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stable and she was not in apparent distress. On 3/23/25 at 8:23 PM Nurse # 1 noted, "correction R sided neglect."

On 3/24/25 COTA # 2 (Certified Occupational Therapist Assistant) wrote, "Pt very lethargic. Required max cues to maintain alertness and participate. Pt was dependent for all tasks."

Licensed Occupational Therapist # 1 was interviewed on 6/3/25 at 3:53 PM and reported the following. The resident could stand and pivot at the start of her therapy treatment. She would make eye contact and try to tell the staff things when she first started therapy. The therapy staff noticed a distinct change a few days before she was discharged from the facility. She was not functioning per her normal and was not as alert. This had been communicated to the nurses, but the licensed OT could not recall which nurses had been told.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse Aide (NA) #1 had cared for Resident # 3 on the dates of 3/10/25, 3/11/25, 3/15/25, 3/16/25, 3/18/25, 3/19/25, 3/24/25, and 3/25/25. Review of NA # 1's signed 3/26/25 statement in the investigative file revealed in part the following information. "When [Resident # 3] first arrived at the facility [Resident # 3] was unable to verbalize her needs; she used her hands and head to communicate. [Resident # 3] needed assistance with feeding. As a few days went by she was getting up in her wheelchair and was able to feed herself. I noticed a change in condition on approximately 3/18/25, [Resident # 3] was acting differently having facial twitching. I noticed [Resident # 3] eating less and [Resident #

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3] was unable to sit up in a wheelchair like she had been doing previously. I notified the hall in the change of condition (as written), not sure which nurse was working that day. The nurse went into the room and assessed [Resident # 3]." NA # 1's statement specifically included information about the date of 3/24/25 which read, "On 3/24/25 I noticed [Resident # 3] was placing her hands in her brief, pulling off her clothes and at lunch, [Resident # 3] had pulled her lunch tray off of the over the bed table into the bed. [Resident # 3] was also staring off into space and moaning, but unable to verbalize if anything was wrong when she was asked. I reported the changes to the hall nurse [Nurse # 2]. [Nurse #2] went into the room and assessed [Resident # 3]."

NA # 1 was interviewed on 6/3/25 at 2:40 PM and reported the following information. When Resident # 1 was admitted the resident worked with therapy and could sit up all day in her wheelchair. She could eat and drink "with her good hand." She could pivot to the toilet and have a bowel movement. She could communicate by motioning for her needs. Prior to Resident # 3 testing positive for COVID there was a day when she (NA # 1) had observed Resident # 3 slumped over in her wheelchair. The resident's head was bent over near her knees, and she was "almost ready to hit the floor." She (NA # 1) recalled she obtained the assistance of NA # 2 and they lifted the resident back to bed. The resident was limp and seemed out of it. At some point after that episode, she (NA #1) recalled Resident # 3 started to twitch. It was not just in her face but at times her shoulder would move up and down with the twitching. The twitching continued but was better some days than other days. The resident would stare off in space and not eat. She seemed

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to have less urine in her brief. She (NA #1) changed her about two times per shift. The resident would put her hand in her brief. Prior to the change that she (NA #1) noticed, the resident seemed to be cold in nature. After the change, Resident # 3 would snatch off her clothes.

NA # 2 was interviewed on 6/3/25 at 2:52 PM and reported the following information. She was the Lead NA and helped everywhere. She did recall there was a day when she had helped NA # 1 get Resident # 3 back to bed because the resident was slouching and it seemed like she could not sit up. That was new for Resident # 3 and she did not seem herself.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 3 had cared for Resident # 3 on the dates of 3/13/25, 3/14/25, 3/17/25, 3/20/25, 3/22/25, and 3/23/25. Review of NA # 3's 3/26/25 signed statement in the investigative file revealed in part the following information. "When [Resident # 3] first arrived at the facility [Resident # 3] would attempt to communicate utilizing paper, [Resident # 3] was unable to communicate verbally. After [Resident # 3] was diagnosed with COVID her condition changed. [Resident # 3] started placing hand in her brief, staring off in to space, taking off her clothes and twisting and turning in the bed." NA # 3 further added in her statement that she had worked the weekend of 3/22/25 and 3/23/25 with Resident # 3. She had not noted a difference in the resident's urination or bowels, but the resident did not eat or drink much either day which NA # 3 noted was a change when compared to before the time the resident had COVID.

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NA # 3 was interviewed on 6/3/25 at 9:22 AM and reported the following information. When Resident # 3 was admitted the resident had worked with therapy and she (NA # #3) had watched the therapist use the gait belt and take Resident # 3 to the bathroom. She (NA # 3) learned to do this from the therapist, and Resident # 3 could stand and pivot to the wheelchair and then stand and pivot to the toilet. The resident made attempts to communicate with paper with her family. The resident would get up for meals and progressed to the point where she could feed herself. After the resident got COVID she did a complete "360" and changed. She would look off into space. When she (NA #3) helped turn the resident in bed, the resident would swing her arms as if falling. She would rip her brief off her body and "dig" in her brief. She had to be fed and did not eat or drink much. Her mouth looked dry as if she had a film over it. She (NA # 3) would tell the nurses she worked with that "this person is not right." She recalled Nurse # 1 saying that Resident # 3 was declining.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 4 had cared for Resident # 3 on the dates of 3/20/25, 3/21/25, and 3/24/25 during the 3:00 PM to 11:00 PM shift. Review of NA # 4's signed 3/25/25 statement in the investigative file revealed in part the following information. "I'm not real familiar with [Resident # 3] due to the fact I only worked with [Resident # 3] on a few occasions. I attempted to feed [Resident # 3] and get [Resident # 3] to drink something the days I was assigned to [Resident # 3] but [Resident # 3] would refuse. I was in the room when a therapist stated they had attempted to get [Resident # 3] to eat and drink but were unable to

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get [Resident # 3] to do either. When I provided incontinent care [Resident # 3] had urinated a small amount. I do recall that [Resident # 3] had a small bowel movement that was noted to be black in color. I do not recall foul odors; I do remember her placing her hands in her brief and picking at the brief. I do recall [Resident # 3] would throw her pillows on the floor consistently. [Resident # 3] would constantly stare at the ceiling. Family member came in on 3/24/25 asking about how much [Resident # 3] was eating. I informed family member that she didn't' eat dinner for you [as written]. Family went to [Nurse # 2] asked [Nurse # 2] about how much [Resident # 3] had eaten on 3/24/25. The family member seemed concerned and confused."

NA # 4 was interviewed on 6/3/25 at 3:06 PM and reported the following information. She did not know how Resident # 3 had been when she first arrived at the facility. When she cared for her, the resident would stare off distantly and seemed fixated on the ceiling. She (NA # 4) could not get her to focus. It was "very noticeable" that she would pick at her brief. There was one day when the therapist was in the room and the resident would not swallow. When the resident had a dark stool, she (NA #4) thought that the resident was possibly on iron and she did not notice blood or a foul odor with the stool.

There was no documentation in the record of the physician being notified the resident was not eating, staring off distantly, would not focus, was having dark bowel movements while also exhibiting these symptoms.

Review of a facility investigative file regarding the care Resident # 3 had received while at the

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facility revealed NA # 5 had cared for Resident # 3 on the 11:00 PM shift to 7:00 AM shift on 3/15/25, 3/16/25, 3/17/25, 3/19/25, 3/20/25, 3/21/25, 3/24/25. Review of NA # 5's signed statement in the investigative file revealed the following information. "I worked 3rd shift I never observed [Resident # 3] eating or drinking but food/snacks were in her room. [Resident # 3] never communicated with me or used her call light while I was working. [Resident # 3] was incontinent and did not urinate or have a lot of bowel movements. [Resident # 3] moved around a lot in bed, moved her legs, removed her bed covers, removed her brief and would throw her pillow on the floor. On 3/24/25, I noticed around [Resident # 3's] mouth that it was dry. During incontinent care [Resident # 3] had a dark, almost black bowel movement on the morning of 3/25/25. At approximately 5:15 AM while providing incontinent care I noticed a rattling sound in her throat, that I had not heard before, I notified [Nurse # 5] and [Nurse #6] ... I witnessed [Nurse # 5] go into [Resident # 3's] room for approximately 2-3 minutes. I did not go back into the room again before the end of my shift."

NA # 5 was interviewed on 6/3/25 at 11:20 PM and reported the following information. When she cared for Resident # 3 the resident would be awake at night. She would move her legs back and forth and she always appeared that way when she had cared for her. On the last night she had cared for Resident # 3, she (NA # 5) had been in the room at 5:15 AM and could hear a rattle in the resident's throat while standing at her bedside. The resident had her eyes open but she would not respond. She saw Nurse # 5 go into the resident's room after she reported the rattle. She (NA # 5) did not go back in the room after the

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nurse went to check on the resident.

Nurse # 5 was interviewed on 6/3/25 at 11:12 PM and reported she had not been assigned to Resident # 3, was not aware of a change in the resident, and did not call the physician.

Nurse # 6 had cared for Resident # 3 on the shift which began at 7:00 PM on 3/24/25 and ended at 7:00 AM on 3/25/25. Nurse # 6 reported the following. She had not called the physician when Resident # 3 was observed rattling on the night shift. She did not recall this being reported to her or any other change that warranted a phone call to the physician prior to the dayshift staff coming on duty on 3/25/25. That was when the dayshift Nurse Aide (NA # 1) reported the resident "was not right" and she had been telling the nurses on dayshift for two days that the resident "was not right."

On 3/25/25 at 8:20 AM Nurse # 3 documented, "Writer made aware by CNA that resident was not acting like herself. Writer upon entrance observed resident to be swinging arm and agitated. Resident did not respond to writer when called by name. Attempted to get oxygen saturation level and pulse and accurate respiratory rate due to resident agitation. Writer left resident room when other nurses entered the room. Writer notifiedDr. [Name of physician] of resident condition. MD ordered writer to send out resident. Writer called in 911. Approximately 10 mins late EMS arrived. Writer then notified [Responsible Party] at 0935 (9:35 AM) of resident condition and transfer out to [Name of Hospital]."

On 3/25/25 at 8:52 AM Nurse # 4 documented, [Resident] presenting with altered mental status,

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will not follow commands or answer questions appropriately, [Resident] would not eat breakfast this morning per CNA staff, [resident] is taking her gown off repeatedly. VS [vital signs] T [temperature] 97.1, P [Pulse] 97, R [respirations] 18, BP 86/56 SPO2, [oxygen level] 100 %." Nurse # 4 further noted the RP was notified and the resident was being sent to the hospital for altered mental status.

Nurse # 4 was interviewed on 6/4/25 at 3:34 PM and reported the following information. The Nurse Aide came and let her know that she could not get Resident # 3 to eat and the resident would not respond to the NA. When she (Nurse # 4) went into the room the resident had her eyes closed, would shake her head, and was fidgety. That was the first day that she had cared for Resident # 3 and she did not recall any communication in report about something being wrong with the resident or a change prior to that. She had the resident sent out to the hospital.

Nurse # 3 was interviewed on 6/4/25 at 3:24 PM and reported the following information. She had overheard a NA saying the resident was not acting right and went to help. The resident was moving but did not respond to the nurse. She was throwing her hands and the Nurse Aide reported that was not the way she normally was.

Review of Emergency Medical Services (EMS) records for the date of 3/25/25 revealed the following information. EMS received the call on 3/25/25 at 8:30 AM. They were "at the patient" on 3/25/25 at 8:36 AM. The paramedic noted the patient was wildly moving her left arm and groaning. The patient did not respond to verbal stimuli. The patient would groan and pull away

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from painful stimuli.

Review of hospital admission records for the date of 3/25/25 and the hospital discharge summary for the date of 4/8/25 revealed the following information.

- Upon arrival to the ED (Emergency Department) the physician noted "Patient barely responds to painful stimuli, starts moving left upper extremity but does not move the lower extremities and does not withdraw from painful stimuli. Does not move the right side." The resident's hospital admission weight was 140 pounds and 10.5 ounces (which indicated a weight loss from her facility weight on 3/18/25 of 150.3 pounds).

-Labs were completed in the ED and although not all inclusive showed a hemoglobin of 4.0 (normal 12-16); a white blood count of 31.9 (normal 4.5-12.5); sodium level of 153 (normal 136-145). Blood urea nitrogen 115 (normal 7-25); creatinine 3.35 (normal .60 to 1.30) and an elevated troponin level (cardiac enzyme which can be elevated with heart damage).

- The hospital physician noted, "Significant abnormalities seen on labs consistent with dehydration and active COVID infection, hypernatremia [high sodium levels], metabolic acidosis with anion gap [acids build up in the body], AKI [acute kidney injury], elevated troponin, leukocytosis [elevated white blood count]. Significant anemia noted with a hgb [hemoglobin] of 4.0. Stool occult blood was positive [the resident's stool showed blood when tested], and nurse staff reported frank blood [red blood] on exam. Blood transfusion, sepsis bolus [infusion of fluids], and antibiotics ordered by ED."

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The resident was placed on oxygen for her COVID infection and intravenous Decadron (steroid) and albuterol (respiratory medication). The physician also documented upon admission the resident "appeared dry" and her labs were consistent with dehydration.

- The resident was admitted to the Intensive Care Unit. She remained hospitalized until 4/8/25. Review of her discharge summary revealed her primary diagnosis was sepsis secondary to COVID infection. The resident was also noted to have myocardial injury (heart injury) due to sepsis, pneumonia, and COVID. The resident had received a total of 3 units of blood for her low hemoglobin, and found to have a superficial antral ulceration (ulcer in the lower part of the stomach) and duodenitis (inflammation of the first part of the small intestines). An incidental finding was also that the resident had likely uterine sarcoma [a type of cancer] and was to be followed after hospitalization.

The resident's facility physician was interviewed on 6/4/25 at 5:50 PM and the therapy notes were in part reviewed with the physician at this time. The Physician reported the following information. He did not recall if he had been notified of the resident having a positive COVID test. He did know he had not been notified of a change in her medical condition and a decline. He should have been notified days prior to the resident being transferred to the hospital. He was in the facility "all the time" and he would have seen the resident, probably done stat (right away) blood work, and probably sent her back to the hospital. From reviewing the therapy notes, it was evident to the physician that the facility had noted a change in condition on 3/21/25 when there was

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documentation that she was declining in functional status and overall feeling. The physician reported that when a resident experienced a change in condition it was critical that the resident receive treatment in the first two to three days to find the problem and treat the condition, and this had not occurred for Resident # 3. The physician was interviewed regarding whether the resident's heart injury from the sepsis could have been avoided if the resident had had treatment earlier. According to the physician he felt the days she had not had evaluation and treatment had made a change in her outcome. He reported the resident had a "double whammy" in that she had COVID and a gastrointestinal bleed and both had contributed to her decline and severity of illness.

The facility provided a corrective action plan that was not acceptable to the State Agency. The plan included education for nursing staff but did not include education to therapy staff.

On 6/5/25 at 12:19 PM the Administrator was informed of Immediate Jeopardy. The Administrator presented the following Immediate Jeopardy removal plan.

Identify the residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Survey findings on 6-5-25 revealed that the facility failed to notify the physician when Resident #3, a rehabilitation resident, showed a change in functional ability that indicated decline. Chart reviews conducted by the Surveyor revealed that therapy notes from 3-18-25 to 3-25-25 indicated Resident #3 was experiencing

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negative clinical and functional decline. Therapy notes stated that nursing staff members were notified, however, the medical record did not reveal evidence of communicating the decline among nursing staff members or to the physician. Resident #3 also tested positive for COVID and there was no documentation that the physician was made aware.

On 6/4/25 and 6/5/25, twenty-four-hour reports (from the electronic medical record) were printed (for daily meetings 3/25/25 to current) and reviewed by the facility DON, Corporate Nurse Consultant, Administrator, and Chief Operations Officer to ensure that the MD was notified appropriately of residents who had a decline in condition and that orders from MD visits were implemented appropriately. (The twenty-four report summarizes resident information occurring in the last 24 hours including all progress notes, vital signs, incident reports, physician progress notes, physician order notes, med administration notes, admissions, discharges, and residents on or returning from leave). There were no additional problems identified.

The facility has determined that all residents have the potential to be affected when staff members fail to communicate a decline in a resident's condition to other team members and the physician.

On 6/5/25 meetings were held with the Chief Operating Officer, Chief Clinical Officer, Facility Nurse Consultant, Director of Nursing, and Facility Administrator with staff members including all licensed staff (nurses), therapists, certified nursing assistants, social workers, and facility contractors working at the time of the

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meeting. Staff members were given the opportunity to identify residents that have experienced a decline in condition from 3/25/25 through 6/5/25. Names were documented by the Chief Clinical Officer and the Chief Operations Officer. Three changes, from earlier in the same day (6/5/25), were brought forward. Immediate medical record review revealed that the three events had been shared with the physician earlier in the day and appropriate actions were taken immediately (including one resident that was sent to the hospital).

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:

All staff members were in serviced on 6/5/25 by the Chief Operating Officer and Chief Clinical Officer and all therapy team members were in serviced by the Lead Therapist and Chief Clinical Officer regarding decline identification and physician notification of all decline.

The education agenda specifically included the following:
- Survey findings related to failure to notifying the physician of resident changes;
- Effective communication among the interdisciplinary team (including 100% of facility team members and contractors) to include changes identified and processes for notifying Physicians, Nurses, Administrator, and Director of Nursing;
- Processes that ensure nurses document and report all episodes of decline immediately. Nurses communicate with physicians and receive orders for implementation. Other team members have

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access to the physician for information share via secure email, phone, and secure text.
- Change identification with immediate reporting to both nursing team and physician.

Education will continue every shift until 100% of staff members and contractors have been educated. No staff members or contractors will be allowed to work until they have participated in the education sessions. The DON and Administrator, or designee, will ensure that all team members are educated prior to working in the facility. They will utilize one nurse on each shift to assist with education documentation and staff sign in to verify the education was completed.

Alleged date of immediate jeopardy removal: 6/6/25

On 6/10/25 the following was done to validate the facility's removal plan:

The facility presented documentation that they had completed inservice training per their removal plan.
Beginning on 6/10/25 at 9:55 AM multiple interviews were conducted with staff from different shifts. Staff verified they had gone through training per the removal plan and staff were able to verbalize points that were covered. Multiple staff members were interviewed regarding whether they were knowledgeable of any current residents who had experienced a change in condition without the physician being made aware. Staff reported they were not aware of any residents who were experiencing any condition for which the physician was not aware. Licensed nurses verified they had received a

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F 580	Continued From page 29 report regarding the status of their residents at shift change and communication had been clear so they would know if they needed to call the physician. The facility presented evidence that they had reviewed 24 hour reports and therapy notes to ensure the physician had been notified for changes in condition. The facility's immediate jeopardy removal date of 6/6/25 was validated on 6/10/25.	F 580		
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 record review and interviews with staff, responsible party (RP), therapy staff, and the Physician, the facility failed to obtain labs as directed by the physician and ensure staff effectively communicated amongst themselves in order that a change in condition be recognized by the licensed nursing staff and a resident receive evaluation and necessary medical treatment. Resident # 3 entered the facility for rehabilitation. Therapists and Nurse Aides revealed Resident # 3 was initially making progress in therapy to the degree that she could feed herself, ambulate short distances with therapy in parallel bars or	F 684	Immediate action taken for the resident found to have been affected include: The facility failed to implement physician orders and communicate effectively amongst the staff to ensure the seriousness of a change in condition was recognized and necessary medical care was provided to Resident #3. Resident #3 was discharged from the facility on 3/25/25. Identification of other residents having the	6/22/25

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F 684	Continued From page 30 with a quad cane, toilet to the commode, and communicate her needs by gestures. Days prior to a hospital discharge, Resident # 3 had a decline in functional status that included symptoms of dizziness, lightheadedness, nausea, and periods of altered responsiveness. Following this decline, Resident # 3 tested positive for COVID (Coronavirus Disease) on 3/22/25 with no indication of evaluation or treatment for her decline and COVID infection. Following 3/22/25, the resident had a poor appetite, her mouth appeared dry, she would stare off in space, and not focus on staff. The resident did not receive evaluation and medical treatment to treat her change in condition until she was transferred to the hospital on 3/25/25 where she was found to be septic (when an individual's body has an extreme reaction to an infection, and which can lead to organ failure) due to her COVID infection. The resident was additionally found to have gastrointestinal bleeding, which resulted in a critical hemoglobin of 4.0 (normal 12-16) and required three units of blood. The resident was hospitalized in the Intensive Care Unit. The resident's 4/8/25 hospital discharge summary noted the resident had sustained heart injury due to the sepsis. This was for 1 of 3 sampled residents reviewed for professional standards of practice to address a change in medical condition (Resident # 3). Immediate jeopardy began on 3/21/25 when a significant decline in Resident #3's condition was identified and a comprehensive evaluation was not conducted and treatment was not implemented. Immediate Jeopardy was removed on 6/6/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of	F 684	potential to be affected was accomplished by: On 6/5/25, the facility held meetings with the Chief Operating Officer, Chief Clinical Officer, Facility Nurse Consultant, Director of Nursing (DON), Facility Administrator, and staff members, including all licensed nurses, therapists, certified nursing assistants, social workers, and facility contractors working at the time of the meeting. All staff were asked to identify residents with a noted decline in condition. The Chief Clinical Officer and Chief Operations Officer documented identified changes. Three changes from earlier on the same day (6/5/25) were brought forward. Immediate medical record review revealed that the three events had been shared with the physician earlier in the day, and appropriate actions were taken immediately (including one resident who was sent to the hospital). The facility has determined that all residents have the potential to be affected when staff members fail to recognize the seriousness of a change in condition, communicate effectively, provide the necessary medical care, or deviate from the care ordered by the physician. Actions taken/systems put into place to reduce the risk of future occurrence include: All staff members including all licensed	

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F 684	Continued From page 31 compliance at a lower scope and severity D to ensure education is completed and monitoring systems put in place are effective. The findings included: Review of Resident # 3's 3/3/25 hospital history and physical and the resident's 3/8/25 hospital discharge summary revealed the following information. Prior to hospitalization the resident resided independently at home and presented to the hospital on 3/3/25 with slurred speech. While hospitalized the resident underwent an MRI (Magnetic Resonance Imaging) which revealed multiple acute small infarcts (areas of brain damage from a lack of oxygen). The resident was diagnosed with a stroke with right-sided weakness and slurred speech. At the time of the 3/8/25 hospital discharge the resident's physical exam showed left sided facial deviation (drooping), right upper extremity strength of 2 out of 5, right lower extremity strength of 5 out of 5 and left upper and left lower extremity strength of 5 out of 5 (five indicating normal strength against gravity and resistance whereas 2 representing a degree of impairment in muscle strength). Discharge medications included Plavix 75 milligrams (mg) every day for 41 doses (an anticoagulant), Lovenox 40 mg injection for 13 days (an anticoagulant), and Aspirin 81 mg every day for 17 doses. Resident # 3 was also identified to have microcytic, hypochromic anemia (a general term for anemia when the red blood cells are pale) with no evidence of acute blood loss. The resident's Hgb and Hct (hemoglobin and hematocrit) were documented to be stable at time of her 3/8/25 discharge. The discharging physician further noted Resident # 3 needed to be evaluated as an outpatient for chronic blood loss	F 684	nurses, therapists, certified nursing assistants, social workers, and facility contractors were in-serviced on 6/5/25 by the Chief Operating Officer and Chief Clinical Officer, and the training included the following: A review of the survey findings including non-compliance with professional standards (F-684) as evidenced by the facility failing to: -recognize the seriousness of a change in condition, -communicate effectively, -provide the necessary medical care and, -provide care as ordered by the physician. Review of key elements of non-compliance including: -Orders for baseline lab results were missed -Antiviral treatment for COVID was not provided -Lack of communication and coordination amongst the interdisciplinary team -Lack of physician notification of a change in condition. Effective communication among the interdisciplinary team (including 100% of facility team members and contractors). This communication includes but is not limited to: -Nursing assistants and therapists reporting changes to nurses promptly, -Nurses reporting changes in condition to	

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and further gastrointestinal workup would be deferred to the primary care physician. The resident's 3/8/25 discharge summary also noted the resident had benign hypertension.

Resident # 3 was admitted to the facility on 3/8/25 with diagnoses of stroke, anemia, and hypertension.

An admission nursing note on 3/8/25 at 3:08 PM noted the resident had a right sided deficit, was awake, alert, oriented to self, and denied any discomfort.

Physician orders revealed Resident # 3 was a full code. Occupational Therapy, Physical Therapy, and Speech Therapy were ordered on 3/10/25.

Resident # 3's care plan initiated on 3/10/25 indicated the resident had a self-care deficit related to weakness, deconditioning, and mobility limitations related to her stroke. The care plan noted Resident # 3 would receive therapy. There were also directions on the care plan to monitor/document as needed any changes and any potential for improvement, reasons for self-care deficit, expected course and declines in function.

Physical Therapist (PT) # 1's notes revealed on 3/10/25 Resident # 3 actively participated with physical therapy. PT # 1 documented the following information regarding the treatment session on 3/10/25. She (PT # 1) directed Resident # 3 to go from a supine (lying) position to a sitting position. The resident transferred with good balance and with bilateral upper extremities and bilateral lower extremities supported. The resident was able to transfer to the toilet with both

physicians timely,
-All staff keep the Director of Nursing and Administrator or significant changes with residents.

Change identification- all residents with a reported change in condition must be assessed by a nurse immediately. Assessment findings indicating decline or the need for emergent physician intervention will be immediately called to the Physician and documented in the medical record. Other changes identified must be communicated to the physician before the shift ends. Calls to physicians and family members must be documented as notifications are completed.

Education continued every shift (6/5/25-6/13/25) until 100% of staff members and contractors were educated. The Director of Nursing (DON) and Administrator ensured that all team members were educated before working in the facility.

New staff members will be educated by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager, or Facility Nurse Consultant during the orientation process.

On 6/9/25, Carrolton Facility Management corporate employees, including the Chief Operating Officer, Chief Clinical Officer, and Facility Nurse Consultant, met with therapy leaders, including the Therapy Lead, Clinical Specialists, and the Area Director. The following issues and plans

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F 684	Continued From page 33 PT # 1 and an Occupational Therapist present. PT # 1 helped Resident # 3 with trials of transfers with a quad cane and the future plan was to do a trial with the quad cane or hemi-walker (a mobility device for individuals who have limited use of one of their hands) during transfers and ambulation during the next therapy session. According to the record there was one documented visit from the facility physician while the resident resided at the facility on 3/11/25. Within the 3/11/25 physician's progress note, the physician included further diagnoses of thrombocytosis (elevated platelets), cardiomyopathy (disease of the heart muscle), dyslipidemia (elevated cholesterol or fats), and aphasia (loss of ability to express speech clearly or understand). The physician noted the plan was to complete labs which included a complete blood count, a thyroid stimulating hormone, Vitamin B 12 level, Vitamin D level, folate, liver panel, basic metabolic panel, and c-reactive protein. The physician's plan also included therapy and the resident's prognosis was documented as "fair." Review of the facility record revealed no orders for the lab work the physician had documented in the plan in the 3/11/25 progress note were entered into the computer and they were never completed while the resident resided at the facility. Interview with Resident # 3's Physician on 6/4/25 at 5:50 PM revealed he made rounds with the nurses, instructed nurses to read his notes, and follow the directions in his notes. According to the Physician, the labs noted in the 3/11/25 physician note should have been done.	F 684	for resolution were discussed during this meeting: The need to see therapy documentation in real-time: -Carrolton Facility management requested an upgrade to allow therapy notes to be visible in the electronic medical records. -Therapy notes will be brought to the morning clinical meeting the day after the care provision and reviewed by the DON and Therapy Lead. Documentation Issues (timeliness and accuracy of notes): -Education plan for clinical staff (licensed nurses and therapists as well as certified nursing assistants). -Therapy notes will be brought to the morning clinical meeting the day after the care provision and reviewed by the DON and Therapy Lead. Ways to improve communication: -Nametags to clearly identify medication aides -Utilization of the Stop and Watch early warning tool -Increased interdisciplinary clinical meetings (morning and afternoon) -Nursing will attend rehabilitation team meetings weekly for the next four (4) weeks. Following the meeting with therapy, Carrolton Facility Management corporate	

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F 684	Continued From page 34 On 3/11/25 PTA (Physical Therapy Assistant) # 1 documented a care plan was held with the resident, family, social worker, and that the family's plan was that Resident # 3 go home with family after therapy and discharge. On 3/11/25 ST (Speech Therapist) # 1 documented the following in a speech therapy progress note, "Pt [Patient] assessed with her lunch meal. Pt alert and sitting up in her wheelchair. Pt able to feed herself with her left hand for the most part." ST # 1 further noted Resident # 1 consumed 40 percent of her meal before indicating she did not want any more and that she was able to brush her teeth with intermittent minimal assistance. The ST also noted Resident # 3 was receptive to education. On 3/12/25 PTA # 1 documented multiple treatment modalities in a physical therapy progress note. One included that gait training was begun in the parallel bars and the resident was able to complete the length of the parallel bars with minimal assistance two times while resting in between. On 3/14/25 PTA # 1 documented in a therapy progress note for the session of 3/13/25 the following information. She (PTA # 1) instructed Resident # 3 in the use of the hemi-walker and quad cane and the resident required minimal to moderate assist due to impulsivity, the need to support her right upper extremity, and balance deficits. The resident was documented as walking 12 feet with both the hemi-walker and the quad cane on 3/13/25. The resident was documented as needing minimal assistance for transfers on the session date of 3/13/25. The resident had declined wheelchair mobility because she (the	F 684	employees, including the Chief Operating Officer, Chief Clinical Officer, and Facility Nurse Consultant, met with the facility administrator and the DON to discuss issues and corrective action plans. On 6/9/25, the therapy Clinical Specialist in-serviced all therapy teams (company-wide), including the Dunn therapy team (licensed therapists, assistants, and rehabilitation aides), on the following topics: -The Provision of Quality Care -Documentation timeliness, -Documentation accuracy, including the importance of including clinically relevant and factual content in daily notes, -Effective communication with nursing staff, -Reporting a change in condition, including utilization of the Stop and Watch early warning tool. The Therapy Lead or Clinical Specialist provided in-service training to any staff members who had not received it before they returned to work. The Therapy Lead will educate all new rehabilitation staff members during orientation. The therapy staff began use of the Stop and Watch early warning tool on 6/11/25. On 6/11/25, the facility Stop and Watch form was revised by the Chief Clinical Officer and sent to the print shop for triplicate carbon copies. The facility made copies of the form until the triplicate carbon copy form was available.	

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F 684	Continued From page 35 resident) wanted to focus on transfers and gait. Resident # 3's admission MDS (Minimum Data Set) assessment, dated 3/14/25 coded the resident as having unclear speech and was moderately cognitively impaired. She was assessed to need substantial to maximum assistance with bathing, dressing, and hygiene. PTA # 1 documented in a therapy progress note for the session of 3/14/25 the following information. She (PTA #1) had instructed the resident on the proper use of the quad cane because she was not using it properly. The resident had also participated in bean bag tossing, transfers from sitting to standing, and ball kicking. PTA # 1 documented in a therapy progress note for the session of 3/17/25 that Resident # 3 needed minimal assistance to transfer to the left and that training was done with a Nurse Aide (NA) to allow for the resident to be toileted by the Nurse Aide. ST #1 documented in a speech therapy progress note for the session of 3/17/25 the following information. "Pt participated with expressive language tasks for simple phrase completion and simple responsive naming tasks with improvement noted. Pt completed tasks with 80% accuracy given min to mod [minimal to moderate] verbal cueing. Pt read simple functional phrases out loud with improved fluency. Pt approximately 75% intelligible when reading simple phrases given moderate cueing (pt wearing glasses for reading task). Pt alert and up in her wheelchair for po [oral] trials." ST # 1 further noted she educated the resident on swallowing	F 684	6/13/25 through 6/21/25, the facility DON /Facility Nurse Consultant in-serviced all certified nursing assistants on the following topics: -The Provision of Quality Care -Effective communication with nursing staff, -Reporting a change in condition, including utilization of the Stop and Watch early warning tool. The DON, ADON, Unit Manager, or Facility Nurse Consultant will educate all new certified nursing assistants during orientation. The Administrator or Director of Nursing will provide in-service training to staff members who have not received the education before returning to work. 6/13/25 through 6/21/25, the facility DON, Administrator, and Facility Nurse Consultant in-serviced all licensed nurses on the following topics: -The Provision of Quality Care -Importance of completing nursing assessments, -Documentation timeliness, -Documentation accuracy, including the importance of including clinically relevant and factual content in daily notes, -Effective communication with nursing assistants and therapy staff, -Utilization of the Stop and Watch early warning tool, -Reporting changes in condition, -Following physician orders	

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F 684	Continued From page 36 recommendations and the resident participated with eating solid food with minimal improvement in pocketing food. Review of weight records revealed on 3/18/25 Resident # 3's weight was documented as 150.3 pounds, which indicated she had gained weight from her documented 3/8/25 admission weight of 147.1. ST # 1 documented in a speech therapy progress note for the session of 3/18/25 the following information. Resident # 3 was dysarthric (difficulty speaking) but she participated with naming common pictured items with 75% accuracy when given minimal to moderate cueing. Her speech was approximately 75% intelligible. During the session the resident's right side of her face suddenly started to twitch and Resident # 3 grabbed her face. The physician was notified via nursing. The resident was able to brush her teeth with minimal assistance. The resident was able to drink through a straw without signs of aspiration. ST # 1 was interviewed on 6/3/25 at 3:35 PM and reported the following information. During the first part of Resident # 3's speech therapy she was feeding herself. It was "not perfect but all things considered she was doing good." She also had the will to do good. She started to use a divided plate to help with meals. There was a day when the resident had some facial twitching. The resident seemed aware of it and then it went away. The nurse was told about the facial twitching. During the end of therapy, the resident had some general malaise (general feeling of being unwell). The date of 3/18/25 was the last date that the resident received speech therapy. ST # 1 reported she was out of work following	F 684	The DON, ADON, Unit Manager, or Facility Nurse Consultant will educate all new nursing staff members during orientation. The Administrator or Director of Nursing will provide in-service training to staff members who have not received it before returning to work. How the corrective action(s) will be monitored to ensure the practice will not reoccur: The DON, or designee, will audit 100% of the 24-hour reports daily for four (4) weeks to monitor for the provision of quality care, including the following: -Identifying changes in condition, -Notifying the physician of changes in condition, -Provision of medical care, -Implementing new physician orders. Any identified adverse findings requiring follow-up will be addressed immediately. The Facility Nurse Consultant or Chief Clinical Officer will randomly pull two (2) 24-hour reports weekly for four (4) weeks to audit for the provision of quality care, including the following: -Identifying changes in condition, -Notifying the physician of changes in condition, -Provision of medical care, -Implementing new physician orders.	

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F 684	Continued From page 37 3/18/25. On 3/18/25 at 11:20 AM Nurse # 1 completed a SBAR narrative (situation, background, assessment, and recommendation) which noted the following information. Speech therapy had been in with the resident and the resident experiencing twitching to the right side of her face with slower speech than baseline per therapy. Her vitals were within normal limits. The physician was notified and ordered baclofen 10 mg (a muscle relaxer medication) twice per day as needed for spasms. Interview with Nurse # 1 on 6/4/25 at 3:50 PM revealed the only thing she was aware of on 3/18/25 was that the resident had some twitching. She had talked to the physician and the physician thought the twitching was related possibly to residual effects of her stroke. Nurse # 1 reported she did not see any further change in the resident on 3/18/25. PTA # 1 documented in a therapy progress note for the session of 3/20/25 the following information. Resident # 3 was brought to the gym for therapy and while working on transfers, PTA # 1 documented, "With each attempt (2 attempts made) patient required increased assist. When asking patient about what was wrong patient noted to not be attempting to verbalize as per her usual. When asked if she felt bad patient nodded yes. When asked if she was hurting anywhere patient again nodded yes. When asked where she was hurting patient put left had [as written] to her head. Immediately returned patient to her room and informed nursing. Patient became less responsive and was assisted to bed with dependent assist. Patient placed in supine and	F 684	Any identified adverse findings requiring follow-up will be addressed immediately. The Facility Nurse Consultant or Chief Clinical Officer will randomly pull (5) Stop and Watch forms weekly for (4) weeks to audit for compliance with follow-up and documentation of identifying and notification of changes in condition. Any identified adverse findings requiring follow-up will be addressed immediately. This correction plan will be monitored at the monthly Quality Assurance Performance Improvement (QAPI) meeting until consistency and substantial compliance are achieved. Corrective action completion date: 6/22/25.	

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hall nurse and DON [Director of Nursing] assessed patient. Later in day patient noted to not be in bed and this therapist was informed she was in WC [wheelchair] with activities for bingo. Still later found patient in her room slumped with head back and eyes open, partially responsive. Returned patient to bed with max/dep [maximum dependent] assist and notified nursing. Spoke with activities who stated patient was sitting with head back during activities and said she wanted to go back to bed so she was pushed to her room and call bell activated."

PTA # 1 was interviewed on 6/3/25 at 4:22 PM and reported the following information. The first few days when Resident # 3 resided at the facility, she was making progress. She could walk with help and had some "really, really good days." She also could get her point across with gestures and she communicated with staff in that manner. Then one day she had a big change. She stopped trying to gesture and stopped trying to verbalize. She started to need a lot more assistance in therapy with transfers. She (PTA #1) had reported this to the nursing staff.

On 6/4/25 at 2:00 PM Nurse # 2 entered a late entry into the nursing notes for the date of 3/20/25 at 3:52 PM which read, "Therapist brought resident back to room saying resident unable to participate. No [mechanical lift pad] under resident. Assist X 3 [assistance of 3 persons] to bed. Assist X 2 to get situated in bed. VS WNL [vital signs within normal limits] for resident Bed low. Call light in reach."

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse # 2 had cared for Resident

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3 on the day of 3/20/25. Additionally the file noted Nurse # 2 had cared for Resident # 3 on 3/17/25, 3/19/25, 3/20/25 and 3/24/25. Nurse # 2's 3/26/25 signed statement included, "In my opinion [Resident # 3] was a candidate for hospice. [Resident # 3] was unable to speak, she moaned and pointed a lot."

Nurse # 2 was interviewed on 6/4/25 at 3:40 PM and reported the following information. She did not routinely work with Resident # 3 and only recalled working with Resident # 3 twice. The resident always seemed to be in bed and not doing well when she cared for her. Nothing had ever been communicated to her (Nurse # 2) that the resident had been making progress in therapy and had been walking in therapy. She recalled a therapist one day saying the resident could not participate in therapy, and she wondered, given what she knew about the resident, why therapy had the resident out of bed. The nurse reported there had been some communication breakdown because if she had known the resident had in recent weeks been able to walk with a quad cane she would have had her sent out to the hospital. Nurse #2 indicated she never recalled a nurse aide telling her Resident #3 had a change in condition.

On 3/21/25 there was no narrative nursing progress notes.

On 3/21/25 PT # 1 documented the following, "PT completes progress note with patient today. Patient found in supine with appearance that she is ready to get up. PT directs patient in rolling L & R [left and right] to finish putting pants on. Patient requires mod A (moderate assist) to roll to L side and CGA cues [contact guard assist cues] for

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rolling to R side. PT directs patient in 2 X supine < >EOB (Edge of Bed) transfers with max A [maximum assistance] and cues with both attempts patient reporting dizziness, lightheadedness, nausea, and overall not feeling well. PT takes BP [blood pressure], during second attempt noting it to be 118/60 in seated from 132/58 in supine at rest. PT notes this to be a mild decrease in BP, however, not enough to be considered orthostatic hypotension. PT discusses this change in BP with nurse and overall change in status from admission. Nurse plans to pass the message along to DON and/or doctor for potential further workup on why patient is declining in functional status & overall feeling. Patient is only able to respond to questions with head nocks/shakes [as written] for yes/no questions."

PT # 1 was interviewed on 6/3/25 at 4:10 PM and reported the following information. When Resident # 3 was initially admitted, she and the Occupational Therapist conducted their initial evaluations together. The resident was able to go to the bathroom with moderate assistance. In therapy she began walking with a quad cane. In her progression of therapy, the resident "went up and did really well and then went down." In the beginning of therapy, the resident could shake her head yes and no to communicate. She was doing better with communication near the beginning. Near the end of her stay she was minimally communicating. She went from transferring and walking with the quad cane to being totally dependent for transfers near the end of her stay. It had been Nurse # 1 who had been in the room on the day that the resident's blood pressure was taken and dropped.

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Nurse # 1 (who was assigned to care for Resident # 3 on 3/21/25) was interviewed on 6/4/25 at 3:50 PM and reported the following information. She knew Resident # 3 had a major stroke when she was admitted to the facility and had always had right sided neglect (where a person's awareness of one side of their body is impaired after a stroke). She seemed to be the same the times she took care of her, and it had never been communicated to her that the resident could stand, pivot, and was progressing with therapy soon after admission. She did not ever witness that herself. She did not recall therapy talking to her about changes. At times, therapy talked to the Unit Manager.

The DON was interviewed on 6/5/25 at 4:00 PM. The DON reported the following. She only recalled one time when a change in condition had been mentioned to her about Resident # 3 and that was regarding the twitching the resident had on 3/18/25. She (the DON) knew physician orders were obtained for that and she was not aware of the resident's decline.

On 3/22/25 a Point of Care Testing Result for COVID showed Resident # 3 tested positive for a COVID infection. On the form, the resident was checked as having no symptoms.

On 3/22/25 at 11:20 AM Nurse # 1 documented she had called and talked to Resident # 3's responsible party and that the resident's vitals were stable. The resident had left sided neglect, had difficulty swallowing, was pocketing food, and she was receiving therapy services.

On 3/22/25 at 6:02 PM the Unit Manager documented, "Writer called first Emergency

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contact and informed her of resident testing positive for COVID received verbal consent to start antiviral medication."

Review of the record revealed no medication treatment orders were begun on 3/22/25.

The Unit Manager was interviewed on 6/5/25 at 11:22 AM and reported the following information. She had tested residents during the COVID outbreak. Typically, the symptoms they were seeing with COVID positive residents were a runny nose and/or cough. Resident # 3 did not have those symptoms when Resident # 3 tested positive on 3/22/25. She (the Unit Manager) had called the family and asked for permission about placing the resident on an antiviral if the physician chose to do so when the resident tested positive. There was a lot that happened during the outbreak, and she could not recall for sure whether she had contacted the physician and what he said about Resident # 3 having COVID. At times in general she knew that he was hesitant about antivirals because of kidney function. She had not realized Resident # 3 was having a decline. If it had been communicated to her clearly and she had realized this, then she would have gone into action to make sure she got treatment.

On 6/4/25 at 2:15 PM the Administrator and DON were interviewed with the Nurse Consultant and Chief Clinical Officer also present. The following information was present. The Administrator reported they had an outbreak of COVID on 3/18/25 and Resident # 3 did not test positive until 3/22/25. The DON and Administrator reported the Unit Manager tested the residents. The DON further reported when residents tested positive,

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there was a procedure that the Unit Manager was supposed to contact the physician and determine if he wanted them to receive antiviral treatment. The family would also be notified. Because some of the antivirals could affect kidney function, the use of any ordered antiviral would also be reviewed by the pharmacy in conjunction with a resident's kidney function before starting the medication. They (these administrative staff) had looked at Resident # 3's medical record the previous evening (6/3/25). Excluding the Unit Manager's actions to obtain family consent for an antiviral, they could find no record this procedure had been done for Resident # 3.

On 3/23/25 OTA # 1 (Occupational Therapist Assistant) documented Resident # 3 was unable to follow commands, utilize utensils, or engage in self-feeding in any manner without total assistance. OTA # 1 further noted, "Pt appeared dehydrated. Pt able to utilize straw for sucking for brief period and did not react to bringing drink or food to mouth. Collaborated with nursing regarding PO intake to improve therapeutic potential, however Pt unable to engage in meal task at this time."

OTA # 1 was interviewed on 6/5/25 at 9:30 AM and reported the following. She could not recall specific details of who she had talked to in nursing or working with Resident # 3 on 3/23/25. She would not have written the resident "appeared dehydrated" unless the resident's mouth was dry or the resident did not pass the "skin pinch test" (assesses skin elasticity and potentially indicate dehydration).

On 3/23/25 at 3:24 PM Nurse # 1 documented the following in a nursing note. Resident # 3

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continued with right-sided neglect and her right side was flaccid. The resident was moving her left side, but without purposeful movements. The resident would look when spoken to and her eyes would drift towards the left side. Her vitals were stable and she was not in apparent distress. On 3/23/25 at 8:23 PM Nurse # 1 noted, "correction R sided neglect."

Nurse # 7 had cared for Resident # 3 on the shift which began at 7 PM on 3/23/25 and ended on 3/24/25. Nurse # 7 was interviewed on 6/3/25 at 4:56 PM and reported the following information. She did not recall a big change in Resident # 3. Resident # 3 had always been sluggish and to her knowledge had been admitted that way. She filled in as a nurse at the facility and she had never been told in report that the resident had been up walking or trying to eat on her own. If so, she would have been more concerned about any sluggishness she had noted.

Review of narrative nursing progress notes revealed no notation for the date of 3/24/25.

On 3/24/25 COTA # 2 (Certified Occupational Therapist Assistant) wrote, "Pt very lethargic. Required max cues to maintain alertness and participate. Pt was dependent for all tasks."

Occupational Therapist # 1 was interviewed on 6/3/25 at 3:53 PM and reported the following. The resident could stand and pivot at the start of her therapy treatment. She would make eye contact and try to tell the staff things when she first started therapy. The therapy staff noticed a distinct change a few days before she was discharged from the facility. She was not functioning per her normal and was not as alert.

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This had been communicated to the nurses, but OT # 1 could not recall which nurses had been told.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse Aide (NA) #1 had cared for Resident # 3 on the dates of 3/10/25, 3/11/25, 3/15/25, 3/16/25, 3/18/25, 3/19/25, 3/24/25, and 3/25/25. Review of NA # 1's 3/26/25 signed statement in the investigative file revealed the following information. "When [Resident # 3] first arrived at the facility [Resident # 3] was unable to verbalize her needs; she used her hands and head to communicate. [Resident # 3] needed assistance with feeding. As a few days went by she was getting up in her wheelchair and was able to feed herself. I noticed a change in condition on approximately 3/18/25, [Resident # 3] was acting differently having facial twitching. I noticed [Resident # 3] eating less and [Resident # 3] was unable to sit up in a wheelchair like she had been doing previously. I notified the hall in the change of condition [as written], not sure which nurse was working that day. The nurse went into the room and assessed [Resident # 3]." NA # 1's statement specifically included information about the date of 3/24/25 which read, "On 3/24/25 I noticed [Resident # 3] was placing her hands in her brief, pulling off her clothes and at lunch, [Resident # 3] had pulled her lunch tray off of the over the bed table into the bed. [Resident # 3] was also staring off into space and moaning, but unable to verbalize if anything was wrong when she was asked. I reported the changes to the hall nurse [Nurse # 2]. [Nurse #2] went into the room and assessed [Resident # 3]."

Nurse Aide (NA) # 1 was interviewed on 6/3/25 at

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2:40 PM and reported the following information. When Resident # 3 was admitted the resident worked with therapy and could sit up all day in her wheelchair. She could eat and drink "with her good hand." She could pivot to the toilet and have a bowel movement. She could communicate by motioning for her needs. Prior to Resident # 3 testing positive for COVID there was a day when she (NA # 1) had observed Resident # 3 slumped over in her wheelchair. The resident's head was bent over near her knees and she was "almost ready to hit the floor." She (NA # 1) recalled she obtained the assistance of NA # 2 and they lifted the resident back to bed. The resident was limp and seemed out of it. At some point after that episode, she (NA #1) recalled Resident # 3 started to twitch. It was not just in her face but at times her shoulder would move up and down with the twitching. The twitching continued but was better some days than other days. The resident would stare off in space and not eat. She seemed to have less urine in her brief. She (NA #1) changed her about two times per shift. The resident would put her hand in her brief. Prior to the change that she (NA #1) noticed, the resident seemed to be cold in nature. After the change, Resident # 3 would snatch off her clothes.

NA # 2 was interviewed on 6/3/25 at 2:52 PM and reported the following information. She was the Lead NA and helped everywhere. She did recall there was a day when she had helped NA # 1 get Resident # 3 back to bed because the resident was slouching and it seemed like she could not sit up. That was new for Resident # 3 and she did not seem herself.

Review of a facility investigative file regarding the care Resident # 3 had received while at the

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facility revealed NA # 3 had cared for Resident # 3 on the dates of 3/13/25, 3/14/25, 3/17/25, 3/20/25, 3/22/25, and 3/23/25. Review of NA # 3's signed 3/26/25 statement in the investigative file revealed in part the following information. "When [Resident # 3] first arrived at the facility [Resident # 3] would attempt to communicate utilizing paper, [Resident # 3] was unable to communicate verbally. After [Resident # 3] was diagnosed with COVID her condition changed. [Resident # 3] started placing hand in her brief, staring off in to space, taking off her clothes and twisting and turning in the bed." NA # 3 further added in her statement that she had worked the weekend of 3/22/25 and 3/23/25 with Resident # 3. She had not noted a difference in the resident's urination or bowels but the resident did not eat or drink much either day which NA # 3 noted was a change when compared to before the time the resident had COVID.

NA # 3 was interviewed on 6/3/25 at 9:22 AM and reported the following information. When Resident # 3 was admitted the resident had worked with therapy and she (NA # #3) had watched the therapist use the gait belt and take Resident # 3 to the bathroom. She (NA # 3) learned to do this from the therapist, and Resident # 3 could stand and pivot to the wheelchair and then stand and pivot to the toilet. The resident made attempts to communicate with paper with her family. The resident would get up for meals and progressed to the point where she could feed herself. After the resident got COVID she did a complete "360" and changed. She would look off into space. When she (NA #3) helped turn the resident in bed, the resident would swing her arms as if falling. She would rip her brief off her body and "dig" in her brief. She

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had to be fed and did not eat or drink much. Her mouth looked dry as if she had a film over it. She (NA # 3) would tell the nurses she worked with that "this person is not right." She recalled Nurse # 1 saying that Resident # 3 was declining.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 4 had cared for Resident # 3 on the dates of 3/20/25, 3/21/25, and 3/24/25 during the 3:00 PM to 11:00 PM shift. Review of NA # 4's signed 3/25/25 statement in the investigative file revealed the following information. "I'm not real familiar with [Resident # 3] due to the fact I only worked with [Resident # 3] on a few occasions. I attempted to feed [Resident # 3] and get [Resident # 3] to drink something the days I was assigned to [Resident # 3] but [Resident # 3] would refuse. I was in the room when a therapist stated they had attempted to get [Resident # 3] to eat and drink but were unable to get [Resident # 3] to do either. When I provided incontinent care [Resident # 3] had urinated a small amount. I do recall that [Resident # 3] had a small bowel movement that was noted to be black in color. I do not recall foul odors; I do remember her placing her hands in her brief and picking at the brief. I do recall [Resident # 3] would throw her pillows on the floor consistently. [Resident # 3] would constantly stare at the ceiling. Family member came in on 3/24/25 asking about how much [Resident # 3] was eating. I informed family member that she didn't' eat dinner for you [as written]. Family went to [Nurse # 2] asked [Nurse # 2] about how much [Resident # 3] had eaten on 3/24/25. The family member seemed concerned and confused."

NA # 4 was interviewed on 6/3/25 at 3:06 PM and

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reported the following information. She did not know how Resident # 3 had been when she first arrived at the facility. When she cared for her, the resident would stare off distantly and seemed fixated on the ceiling. She (NA # 4) could not get her to focus. It was "very noticeable" that she would pick at her brief. There was one day when the therapist was in the room and the resident would not swallow. When the resident had a dark stool, she (NA #4) thought that the resident was possibly on iron and she did not notice blood or a foul odor with the stool.

A review of Nurse # 2's 3/26/25 statement in the facility's investigative file which included specific information about the date of 3/24/25 read, "On 3/24/25 I was informed by [NA # 4] that [Resident # 3] did not eat her dinner. I never recall seeing the call light on for [Resident # 3's] room. No [NAs] reported any change of conditions other than her lack of eating on 3/24/25."

Resident # 3's RP was interviewed on 6/2/25 at 12:07 PM and reported the following information. When Resident # 3 was initially admitted to the facility she seemed to be doing well and was eating and going to the bathroom. She then seemed to "go downhill." She (the RP) came on the evening of 3/24/25 around 7:00 PM and the resident "looked bad." She talked to the nurse (did not recall which nurse) and asked if Resident # 3 was eating. She was told she had eaten 25% that day (3/24/25), nothing the day prior and 25% the day prior to that. She could not understand why the resident had changed so much.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed NA # 5 had cared for Resident #

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3 on the 11:00 PM shift to 7:00 AM shift on 3/15/25, 3/16/25, 3/17/25, 3/19/25, 3/20/25, 3/21/25, 3/24/25. Review of NA # 5's signed statement, which was undated, in the investigative file revealed in part the following information. "I worked 3rd shift I never observed [Resident # 3] eating or drinking but food/snacks were in her room. [Resident # 3] never communicated with me or used her call light while I was working. [Resident # 3] was incontinent and did not urinate or have a lot of bowel movements. [Resident # 3] moved around a lot in bed, moved her legs, removed her bed covers, removed her brief and would throw her pillow on the floor. On 3/24/25, I noticed around [Resident # 3's] mouth that it was dry. During incontinent care [Resident # 3] had a dark, almost black bowel movement on the morning of 3/25/25. At approximately 515 AM while providing incontinent care I noticed a rattling sound in her throat, that I had not heard before, I notified [Nurse # 5] and [Nurse #6] ... I witnessed [Nurse # 5] go into [Resident # 3's] room for approximately 2-3 minutes. I did not go back into the room again before the end of my shift."

NA # 5 was interviewed on 6/3/25 at 11:20 PM and reported the following information. When she cared for Resident # 3 the resident would be awake at night. She would move her legs back and forth and she always appeared that way when she had cared for her. On the last night she had cared for Resident # 3, she (NA # 5) had been in the room at 5:15 AM and could hear a rattle in the resident's throat while standing at her bedside. The resident had her eyes open but she would not respond. She saw Nurse # 5 go into the resident's room after she reported the rattle. She (NA # 5) did not go back in the room after the nurse went to check on the resident.

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Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse # 5 had given a statement, which was not dated, noting she had not gone into Resident # 3's room or provided any type of care while the resident resided at the facility.

Nurse # 5 was interviewed on 6/3/25 at 11:12 PM and reported the following information. She was not assigned to Resident # 3 on the night shift which began at 7PM on 3/24/25 and ended at 7:00 AM on 3/25/25. She (Nurse # 5) did recall a Nurse Aide coming up to both her and Nurse # 6 while they were together and reporting something, but did not recall what was said. She (Nurse # 5) never went into the room because it was not her resident. Resident # 3 was assigned to Nurse # 6.

Review of a facility investigative file regarding the care Resident # 3 had received while at the facility revealed Nurse # 6 had cared for Resident # 3 on 3/14/25, 3/20/25, and 3/24/25 on the 7:00 PM to 7:00 AM shifts. Nurse # 6's 3/25/25 statement read, "[Resident # 3] only receives 1 medication during my shift and was able to take medication without difficulty. [Resident # 3] is in bed resting with eyes closed during my shift, with no signs of distress, discomfort or pain. On 3/25/25, I was approached by [NA # 1] who informed me that [Resident # 3] was not acting right. I went into [Resident # 3's] room along with [Nurse # 4] and [Nurse # 3] to assess [Resident # 3]. As far as my experience with [Resident # 3] is concerned, she was at her base line the morning of 3/25/25.

Nurse # 6 was interviewed on 6/3/25 at 12:45 PM

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and reported the following information. There had been nothing communicated in report during the times she had taken care of Resident # 3 that the resident was not eating or having a change. The resident only got one medication and was always able to swallow it during her 12 hour 7:00 PM to 7:00 AM shifts. Therefore, after she gave the resident medication, she would peek in on the resident during the nights she cared for her and the resident appeared to be sleeping. She did not recall problems reported by the Nurse Aides and did not recall NA # 5 reporting Resident # 3 was rattling to her. If "rattling" had been reported to her then that would have been a "huge concern." The first she recalled anyone communicating a change in condition was when the day shift NA (NA # 1) came on duty at the change of shift during the morning of 3/25/25. NA # 1 reported the resident "was not right" and she had been telling the nurses on dayshift for two days that the resident "was not right." She (Nurse # 6) got Nurse # 4 and Nurse # 3 to go with her. Nurse # 4 thought the resident was a little off but that was the way she was.

On 3/25/25 at 8:20 AM Nurse # 3 documented, "Writer made aware by [NA] that resident was not acting like herself. Writer upon entrance observed resident to be swinging arm and agitated. Resident did not respond to writer when called by name. Attempted to get oxygen saturation level and pulse and accurate respiratory rate due to resident agitation. Writer left resident room when other nurses entered the room. Writer notified Dr. [Name of physician] of resident condition. [The Physician] ordered writer to send out resident. Writer called in 911. Approximately 10 mins later EMS [Emergency Medical Services] arrived. Writer then notified [Responsible Party] at 0935

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(9:35 AM) of resident condition and transfer out to [Name of Hospital].

On 3/25/25 at 8:52 AM Nurse # 4 documented, "[Resident] presenting with altered mental status, will not follow commands or answer questions appropriately, [resident] would not eat breakfast this morning per [NA] staff, [resident] is taking her gown off repeatedly. VS T [temperature] 97.1, P [Pulse] 97, R [respirations] 18, BP 86/56, SPO2 [oxygen level] 100 %." Nurse # 4 further noted the RP was notified and the resident was being sent to the hospital for altered mental status.

Nurse # 4 was interviewed on 6/4/25 at 3:34 PM and reported the following information. The Nurse Aide came and let her know that she could not get Resident # 3 to eat and the resident would not respond to the NA. When she (Nurse # 4) went into the room the resident had her eyes closed, would shake her head, and was fidgety. That was the first day that she had cared for Resident # 3 and she did not recall any communication in report about something being wrong with the resident or a change prior to that. She had the resident sent out to the hospital.

Nurse # 3 was interviewed on 6/4/25 at 3:24 PM and reported the following information. She had overheard a NA saying the resident was not acting right on 3/25/25 and went to help. The resident was moving but did not respond to the nurse. She was throwing her hands and the Nurse Aide reported that was not the way she normally was.

Review of EMS records for the date of 3/25/25 revealed the following information. EMS received the call on 3/25/25 at 8:30 AM. They were "at the

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patient" on 3/25/25 at 8:36 AM. The paramedic noted. "UOA [upon arrival] we were greeted by facility staff at the patient's room. Facility staff reported that they did not know the patient and that the patient was not normally under their care, but that the patient's normal [NA] reported that the patient was altered from her normal. EMS was provided facility paperwork. EMS noted a Hx (history) of [cerebrovascular accident] with right-sided deficits." The paramedic also noted Resident # 3 was "laying supine on her bed within her room. The patient was wildly moving her left arm and groaning. The patient did not respond to verbal stimuli. The patient would groan and pull away from painful stimuli. The patient would lean to the right throughout the call. The patient did not use or react to stimuli on her right arm or use either leg. The patient was placed on the monitor via 12-lead, NIBP [noninvasive blood pressure] cuff, and pulse ox. [oximetry]. Patient axillary temp and BGL [blood glucose] checked. EMS had some difficulty attaining consistent, high quality pulse oximetry due to patient movement and nail polish and long nail length. Facility nursing staff returned and informed EMS that the patient had been undergoing a progressive decline in LOC [level of consciousness] and mental status for approx [approximately] 1 week, but did not know an exact last known well [as written]." The paramedic noted the resident was transferred to the stretcher and taken to the hospital.

Review of hospital admission records for the date of 3/25/25 and the hospital discharge summary for the date of 4/8/25 revealed the following information.

- Upon arrival to the ED (Emergency Department)

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the physician noted "Patient barely responds to painful stimuli, starts moving left upper extremity but does not move the lower extremities and does not withdraw from painful stimuli. Does not move the right side." The resident's hospital admission weight was 140 pounds and 10.5 ounces (which indicated a weight loss from her facility weight on 3/18/25 of 150.3 pounds).

-Labs were completed in the ED and although not all inclusive showed a hemoglobin of 4.0 (normal 12-16); a white blood count of 31.9 (normal 4.5-12.5); sodium level of 153 (normal 136-145). Blood urea nitrogen 115 (normal 7-25); creatinine 3.35 (normal .60 to 1.30) and an elevated troponin level (cardiac enzyme which can be elevated with heart damage).

- The hospital physician noted, "Significant abnormalities seen on labs consistent with dehydration and active COVID infection, hypernatremia [high sodium levels], metabolic acidosis with anion gap [acids build up in the body], AKI [acute kidney injury], elevated troponin, leukocytosis [elevated white blood count]. Significant anemia noted with a hgb [hemoglobin] of 4.0. Stool occult blood was positive [the resident's stool showed blood when tested], and nurse staff reported frank blood [red blood] on exam. Blood transfusion, sepsis bolus [infusion of fluids], and antibiotics ordered by ED." The resident was placed on oxygen for her COVID infection and intravenous Decadron (steroid) and albuterol (respiratory medication). The physician also documented upon admission the resident "appeared dry" and her labs were consistent with dehydration.

- The resident was admitted to the Intensive Care

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Unit. She remained hospitalized until 4/8/25. Review of her discharge summary revealed her primary diagnosis was sepsis secondary to COVID infection. The resident was also noted to have myocardial injury (heart injury) due to sepsis, pneumonia, and covid. The resident had received a total of 3 units of blood for her low hemoglobin, and found to have a superficial antral ulceration (ulcer in the lower part of the stomach) and duodenitis (inflammation of the first part of the small intestines). An incidental finding was also that the resident had likely uterine sarcoma [a type of cancer] and was to be followed after hospitalization.

The resident's facility physician was interviewed on 6/4/25 at 5:50 PM and the therapy notes were in part reviewed with the physician at this time. The Physician reported the following information. When a resident experienced a change in condition it was critical that the resident receive treatment in the first two to three days to find the problem and treat the condition. From reviewing the therapy notes, it was evident to the Physician that the facility had noted a change in condition on 3/21/25 when there was documentation that she was declining in functional status and overall feeling. He did not know why he had not been made aware and reported he was in the facility "all the time." The Physician was interviewed regarding whether the resident's heart injury from the sepsis could have been avoided if the resident had had treatment earlier. According to the Physician he felt the days she had not had evaluation and treatment had made a change in her outcome. He reported the resident had a "double whammy" in that she had COVID and a gastrointestinal bleed and both had contributed to her decline and severity of illness.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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The facility provided a corrective action plan that was not acceptable to the State Agency. The plan included education for nursing staff but did not include education to therapy staff.

On 6/5/25 at 12:19 PM the Administrator was informed of Immediate Jeopardy.

The Administrator presented the following Immediate Jeopardy removal plan.
Identify the residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:
Survey findings on 6/5/25 revealed that the facility failed to recognize the seriousness of a change in condition, communicate effectively, provide the necessary medical care, and provide care as ordered by the physician.

Resident #3 was admitted to the facility for short-term rehabilitation and resided in the facility for 23 days. No baseline lab work was obtained as ordered by the physician on 3/11/25.

Chart reviews conducted by the Surveyor revealed that therapy notes from 3/18/25 to 3/25/25 indicated Resident #3 was experiencing negative clinical and functional decline.

During interviews conducted by the Surveyor (6/3/25 and 6/4/25) with nurse aides and therapists, it was noted that a decline in the resident's condition occurred from 3/18/25 to 3/25/25 that included decreased functional abilities. Interviews revealed that the decline was reported to licensed nursing staff.

Interviews by the Surveyor (6/3/25 and 6/4/25)

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with nurses indicated that this decline and decrease in functional ability from 3/18/25 to 3/25/25 had not been recognized or reported to the physician.

On 3/22/25, Resident #3 was diagnosed with COVID, and the family gave consent for antiviral treatment. Antiviral treatment was not initiated. Resident #3 was sent to the hospital on 3/25/25, where she was diagnosed with Sepsis secondary to COVID infection and a gastrointestinal ulceration. Resident #3 did not return to the building.

On 6/4/25 and 6/5/25 twenty-four-hour reports from the electronic medical record (dated from 3/25/25 through 6/5/25) were printed and reviewed by the Director of Nursing to confirm that appropriate follow-up had occurred for any resident decline. (The twenty-four report summarizes resident information occurring in the last 24 hours, including all progress notes, vital signs, incident reports, physician progress notes, physician order notes, med administration notes, admissions, discharges, and residents on or returning from leave). All identified concerns were immediately addressed.

On 6/5/25, during meetings with the Chief Operating Officer, Chief Clinical Officer, Facility Nurse Consultant, Director of Nursing, and Facility Administrator, staff members included all licensed staff (nurses), therapists, certified nursing assistants, social workers, and facility contractors working at the time of the meeting. All staff were asked to identify residents with a noted decline in condition. Identified changes were documented by the Chief Clinical Officer and Chief Operations Officer. Three changes,

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from earlier in the same day (6/5/25), were brought forward. Immediate medical record review revealed that the three events had been shared with the physician earlier in the day and appropriate actions were taken immediately (including one resident that was sent to the hospital.

The facility has determined that all residents have the potential to be affected when staff members fail to recognize the seriousness of a change in condition, communicate effectively, provide the necessary medical care or deviate from the care ordered by the physician.

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:

All staff members were in-serviced on 6/5/25 by the Chief Operating Officer and Chief Clinical Officer, and the training included the following:

A review of the survey findings including non-compliance with professional standards (F-684) as evidenced by the facility failing to:
- recognize the seriousness of a change in condition,
- communicate effectively,
- provide the necessary medical care and,
- provide care as ordered by the physician.

Review of key elements of non-compliance including:
- Orders for baseline lab results were missed
- Antiviral treatment for COVID was not provided
- Lack of communication and coordination

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amongst the interdisciplinary team
- Lack of physician notification of change in condition.

Effective communication among the interdisciplinary team (including 100% of facility team members and contractors). This communication includes but is not limited to:
- Nursing assistants and therapists reporting changes to nurses timely,
- Nurses reporting changes in condition to physicians timely,
- All staff keep the Director of Nursing and Administrator or significant changes with residents.

Change identification- all residents with a reported change in condition must be assessed by a nurse immediately. Assessment findings indicating decline or the need for emergent physician intervention will be called to the Physician immediately and documented in the medical record immediately. Other changes identified must be communicated to the physician before shift end. Calls to physicians and family members must be documented as notifications are completed.

Education will continue every shift until 100% of staff members and contractors have been educated. The Director of Nursing and Administrator will ensure that all team members are educated prior to working in the facility. They will utilize one nurse on each shift to assist with education documentation and staff sign in to verify the education was completed. New staff members will be educated during the orientation process by the Director of Nursing, Assistant

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Director of Nursing, Unit Manager or the Facility Nurse Consultant.

Alleged date of immediate jeopardy removal: 6/6/25

On 6/10/25 the following was done to validate the facility's removal plan:
The facility presented documentation that they had completed inservice training per their removal plan.

Beginning on 6/10/25 at 9:55 AM multiple interviews were conducted with staff from different shifts. Staff verified they had gone through training per the removal plan and staff were able to verbalize points that were covered. Multiple staff members were interviewed regarding whether they were knowledgeable of any current residents who had experienced a change in condition and who were not receiving medical treatment. Staff reported they were not aware of any residents who were not receiving medical treatment. Licensed nurses verified they had received a report regarding the status of their residents at shift change and communication had been clear.

The facility presented evidence they had reviewed 24 hour reports and therapy notes to ensure current residents were receiving appropriate medical care and status changes had been communicated and were being addressed per their removal plan. Multiple 24 hour reports were reviewed by the surveyor and the DON was interviewed about any documentation of status change or medical need. The DON was knowledgeable about any status change in the 24 hour reports and it was validated that residents

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F 684	Continued From page 62 who had a medical need were receiving care. The facility's immediate jeopardy removal date of 6/6/25 was validated.	F 684		