STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329

(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
E0000	Initial Comments The survey team entered the facility on 8/4/25 to conduct a recertification and complaint investigation survey. The survey was conducted onsite 8/4/25 through 8/7/25. Additional information was obtained offsite on 8/8/25 through 8/13/25. The survey team returned to the facility on 8/14/25 to validate immediate jeopardy removal. Therefore, the exit date was 8/14/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D2417-H1.	E0000		08/25/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 8/4/25 to conduct a recertification and complaint investigation survey. The survey was conducted onsite on 8/4/25 through 8/7/25. Additional information was obtained offsite on 8/8/25 through 8/13/25. The survey team returned to the facility on 8/14/25 to validate credible allegations of immediate jeopardy removal. Therefore, the exit date was 8/14/25. Event ID# 1D2147-H1. The following intakes were investigated: 795612, 795676, 795678, 795679, 795680. and 795682. 5 of the 8 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR. 483.35 at tag F726 at a scope and severity (J) The tags F600 and F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 2/11/25 and was removed on 8/12/25. An extended survey was conducted.	F0000		08/25/2025
F0550 SS = D	Resident Rights/Exercise of Rights	F0550	F550 Resident Rights/Exercise of Rights	09/01/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews the facility failed to maintain a residents dignity when Nurse Aide #3 placed a meal tray at the bedside of a cognitively impaired resident (Resident #52) who was dependent on staff for feeding assistance and walked away. Nurse Aide #3 did not return to feed	F0550	Continued from page 1 The facility failed to maintain a resident's dignity when Nurse Aide #3 placed a meal tray at the bedside of a cognitively impaired resident (Resident #52) who was dependent on staff for feeding assistance and walked away. Nurse Aide #3 did not return to feed Continued from page 2 Resident #52 for 40 minutes. Nurse Aide #3 then attempted to feed Resident #52 the cold food on the meal tray. This occurred for 1 of 3 residents reviewed for dignity. A reasonable person may feel helpless, forgotten, and become frustrated at not being able to get assistance to eat their meal. 1.Corrective action for resident(s) affected by the alleged deficient practice: On 8/4/2025, Nurse Aide #4 who was in the hallway, was asked to go get a fresh hot meal tray from the kitchen. Resident #52 was pointing at the meal tray while Nurse Aide #3 was sitting there. Nurse Aide #3 went ahead and started feeding her the potato salad which is to be served cold while waiting on another meal tray to come from the kitchen. Nurse Aide #4 returned within 5 minutes with a hot tray. Nurse Aide #3 began feeding Resident #52 at 1:45 PM. Nurse Aide #3 is no longer employed at the facility. 2.Corrective action for residents with the potential to be affected by the alleged deficient practice. On 8/22/2025, an audit was conducted by the Director of Nursing and Nurse management team to identify residents who require dependent dining services by staff to ensure that meals served timely and within appropriate temperatures to promote dignity, nutritional needs and comfort. Results included: 19 of 19 residents received meals timely with no identified concerns. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/27/2025, the Staff Development Coordinator began education will all Full time, Part time, and as needed staff to include agency on Residents Rights; Dignity and Respect. Topics included: Maintaining resident dignity and respect during mealtimes, particularly for dependent residents. Proper food temperature and timely assistance are essential components of quality care and compliance	

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F0550 SS = D	Continued from page 2 Resident #52 for 40 minutes. Nurse Aide #3 then attempted to feed Resident #52 the cold food on the meal tray. This occurred for 1 of 3 residents reviewed for dignity. A reasonable person may feel helpless, forgotten, and become frustrated at not being able to get assistance to eat their meal. Findings included. Resident #52 was admitted to the facility on 10/12/18 with diagnoses including Alzheimer's dementia and dysphagia. A care plan dated 6/13/25 revealed Resident #52 required staff assistance with eating. The goal of care was to receive necessary staff assistance with eating to promote adequate nutrition. Interventions included to provide assistance with meals and promote dignity. The Minimum Data Set (MDS) quarterly assessment dated 6/13/25 revealed Resident #52 was severely cognitively impaired. She required extensive one-person assistance with eating. During dining observations on 8/04/25 at 12:55 PM Resident #52 was observed sitting up in her bed. She was awake, alert, and the head of the bed was elevated in an upright position. Resident #52 was hard of hearing and non-verbal. Nurse Aide #3 entered the room and placed the lunch meal tray on Resident #52's bedside table located on the left side of Resident #52 and within her sight and the bedside table was out of her reach. Nurse Aide #3 did not set up the meal tray and turned and walked away. Resident #52 looked at the meal tray and watched Nurse Aide #3 walk out of the room. A continuous observation was conducted on 8/4/25 from 12:55 PM until 1:35 PM of Room 411 where Resident #52 resided. No staff member entered the room during that time to feed Resident #52. At 1:35 PM Nurse Aide #3 returned to the room to feed Resident #52. Nurse Aide #3 set up the meal tray, sat down at the bedside and attempted to start feeding Resident#52 her meal. The surveyor intervened and asked if the food which consisted of meatballs, green beans, potato salad and bread was cold. Nurse Aide #3 stated the food was cold due to the meal tray sitting in the room for 40 minutes. Nurse Aide #4 who was in the hallway, was asked to go get a fresh hot meal tray from the kitchen. Resident #52 was pointing at the meal tray while Nurse Aide #3 was sitting there. Nurse Aide #3 went ahead and started feeding her the potato salad which is to be served cold while waiting on another meal tray to come	F0550	Continued from page 2 This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/31/2025. 4.Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements The Director of Nurse and/or designee will audit Tray Passes during meal times to ensure timely delivery and assistance for dependent diners. This monitoring will be completed weekly x 4 weeks and then monthly times 2 months or until resolved. Monitoring will begin week of: 8/29/2025. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: ____9/1/2025_____	

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F0550 SS = D	Continued from page 3 from the kitchen. Nurse Aide #3 returned within 5 minutes with a hot tray. Nurse Aide #3 began feeding Resident #52 at 1:45 PM. During an interview on 8/4/25 at 1:40 PM Nurse Aide #3 stated she had three residents on her assignment that needed to be fed by staff. She stated she delivered the meal tray to Resident #52's room then left to go feed the resident in room 415A while Nurse Aide #4 fed the resident in 415 B. She stated it took a while to feed the residents in 415 then she went down to feed Resident #52. She reported that her and Nurse Aide #4 knew who needed to be fed by staff but today they had Nurse Aide #5 on the unit who was agency staff and would not have known to come and assist with feeding the residents. Nurse Aide #3 stated she should have informed the agency nurse aide (Nurse Aide #5) to assist with feeding Resident #52, but she did not think to do that. During an interview on 8/4/25 at 2:10 PM Nurse Aide #4 stated there were three residents on the hall that needed to be fed by staff. She stated typically three nurse aides would feed the three residents during meals but today they had an agency nurse aide that probably was not told to assist with feeding residents their meals. During an interview on 8/4/25 at 2:20 PM Nurse Aide #5 stated she was an agency nurse aide. She stated she was not informed that there were three residents on the hall that needed to be fed by staff or to assist them with their meals. She indicated she was not assigned to Resident #52. She stated she assisted with feeding residents their breakfast this morning without being told to do so, but she was not told to assist with feeding residents their lunch meal. During an interview on 8/4/25 at 2:30 PM the Director of Nursing (DON) stated waiting 40 minutes to feed Resident #52 was too long. The DON stated that Nurse Aide #3 should have informed the agency nurse aide (Nurse Aide #5) to assist her with feeding the residents. She stated Nurse Aide #3 should not have placed the meal tray in front of Resident #52 and not return for 40 minutes to feed her and then attempt to feed her cold food.	F0550		
F0580 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.	F0580	F 580 POC Physician Notification of Change in Condition Corrective Action for Affected Residents The facility failed to ensure physician was notified of a significant change for Resident #119.	09/01/2025

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F0580 SS = J	Continued from page 4 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify	F0580	Continued from page 4 Resident #119's Life Vest shocked her multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and did not notify the physician. The physician was not notified until 2/13/25 when Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the Life Vest's manufacturer that the resident had a severe episode of ventricular tachycardia. Resident #119 did not return to the facility after discharge on 2/13/25. Facility has not been able to contact Nurse #1, and she is no longer working in the facility. The Administrator and Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. On 8/6/25, the facility initiated a comprehensive response to address the identified noncompliance related to failure to notify provider of an acute change in Resident # 119's condition. Corrective action for potentially affected residents. The Direct care nurses conducted an immediate assessment of 100% of current residents to identify any acute changes in condition that had not been communicated to the appropriate medical provider. This included symptoms or signs that were: Acute or sudden in onset Markedly more severe than usual Unrelieved by previously prescribed measures Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) During the audit, it is noted that no residents were found to be using wearable cardiac devices. The audit was completed on 8/11/25. There were 5 residents identified with acute changes in condition. For each of these residents, the provider was notified, and appropriate medical orders were implemented by the direct care staff on 08/11/2025.	

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F0580 SS = J	Continued from page 5 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 staff, Medical Director #1, Cardiologist, LifeVest Resident Representative and LifeVest Technician interviews, the facility failed to consult with Medical Director #1 when Resident #119's LifeVest (an external defibrillator designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) delivered treatment shocks to her multiple times in the early morning hours on 2/11/25. The LifeVest Resident Representative contacted Resident #119's Cardiologist on 2/13/25 about Resident #119's severe episodes of ventricular tachycardia, a life-threatening rapid heart rate. The Cardiologist called the facility and requested to talk to the Medical Director. The Cardiologist recommended that the resident be sent to the hospital for evaluation. The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for notification of change (Resident #119). Immediate jeopardy began on 2/11/25 when Resident #119 received multiple treatment shocks from the external defibrillator device and the facility failed to consult the physician immediately. Immediate Jeopardy was removed on 8/12/25 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings included:	F0580	Continued from page 5 Additionally, on 8/10/25, the Director of Nursing (DON) reviewed the progress notes to include the E -interact transfer and change in condition assessments for all resident transfers to an acute care hospital within the past 30 days to ensure provider notification had occurred for any acute change in condition. The audit confirmed that provider notification was completed timely for 14 out of 14 residents. Systemic Changes To prevent recurrence, the DON began in-servicing all licensed nurses (Register Nurses and Licensed Practical Nurses) and certified nursing assistants (CNAs), including full-time, part-time, PRN (as needed), and agency staff, on 8/6/25. The training emphasized the importance of timely provider notification for any acute change in condition. This included symptoms or signs that were: Acute or sudden in onset Markedly more severe than usual Unrelieved by previously prescribed measures Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) Specific training for a resident with a life vest was if a person's life vest discharges, it means the person may have an unstable arrythmia or that the device is malfunctioning or both, and both of these would require immediate physician notification. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute Life Vest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the Life Vest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for life vest. This training initiative was coordinated by the Director of Nursing. All current staff must complete this training by	

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F0580 SS = J	Continued from page 6 Review of the manufacturer's information and the instructional videos for the LifeVest external defibrillator revealed that the device is prescribed for residents at risk for sudden cardiac death, a condition that occurs without warning with no signs that something is about to happen due to an electrical malfunction of the heart causing a dangerously fast heartbeat with no signs or symptoms. The LifeVest uses electrodes to continuously monitor the heart's electrical activity and detect dangerous heart rhythms, such as ventricular tachycardia and ventricular fibrillation. The device is designed to deliver an electrical shock to the heart when an abnormal rhythm is detected to restore a normal heart rhythm. The manufacturer's instructions indicated that if a treatment shock is delivered, the physician is to be called immediately, and an announcement is made by the device with this instruction. If the vest discharges, it means either the person has an unstable arrythmia (heartbeat) requiring immediate physician attention, or the device is malfunctioning. Both require medical evaluation as soon as possible. An interview with the LifeVest Technician on 8/6/25 at 5:00 PM revealed that the device does not provide continuous real time monitoring by a medical professional. The LifeVest Technician stated that the device was set with parameters and if the heart rate was above the set parameter, the device alarmed. The information from the device went into a server which could be reviewed by the physician. The technician stated that if a shock was delivered, it was recorded on the downloaded information. The technician stated that the information from the device was downloaded into the system every 24 hours, however there were sometimes issues with connectivity. The technician indicated that the blue gel was released prior to a shock being delivered. A button can be pressed to delay the shock from being delivered. 5 shocks are administered, then if more shocks are indicated they will be delivered based on the heart rhythm. The technician stated that if an abnormal heart rhythm was detected, the device emitted a siren alarm which was loud and identifiable. If the device administered a shock, the blue gel was released onto the skin. The technician stated that if the device continuously sounded, the physician and the device manufacturer should have been notified right away to check the equipment. A technician is available 24 hours per day 7 days per week to walk through issues with the device and if the technician is unable to resolve the issue via phone, a technician will come out within 24 hours to fix it or replace the device.	F0580	Continued from page 6 8/11/25 to continue caring for residents with wearable cardiac devices. Staff who do not complete the training by 8/11/25 will not be permitted to work until the training is completed. The Director of Nursing and the Director of Staff Development will do a daily reconciliation of the schedule to ensure all licensed staff have completed the training. This in-service training has been incorporated into the orientation program for all new facility and agency staff. No staff shall work without this training after 8/11/25 Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory Beginning the week of 8/18/25, the Administrator or designee will audit this process using the Quality Assurance Tool for Monitoring Compliance with the notification of change in condition. This audit will be completed weekly x 4 weeks, then monthly x 2 months or until resolved. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager and Dietary Manager. Date of compliance: 9/1/2025	

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F0580 SS = J	Continued from page 7 Resident #119 was admitted on 10/17/24 with diagnosis which included ischemic cardiomyopathy (a condition that occurs when the heart muscle is damaged by lack of blood supply making it difficult for the heart to pump) requiring a LifeVest external defibrillator device, hypertensive heart disease, atrial fibrillation, coronary artery disease, chronic kidney disease with heart failure, acute on chronic systolic heart failure, and diabetes. Review of Resident #119's electronic record revealed a physician order dated 10/17/24 which indicated LifeVest was to be worn at all times every shift. Resident #119 was discharged from the nursing home to the hospital on 1/4/25 with a diagnosis of gastrointestinal hemorrhage and was readmitted on 1/20/25. A physician order revealed an order dated 1/20/25 indicated the LifeVest was to be worn at all times every shift. The order did not contain directives for when to notify the provider. An interview conducted with Nurse Aide (NA) #2 on 8/6/25 at 10:06 AM revealed that she was assigned to Resident #119 on 2/10/25 from 11:00 PM to 7:00 AM. NA #2 stated that Resident #119 had a device that she thought was to "kick start the heart." NA #2 stated that she recalled on the night of 2/10/25 Resident #119's LifeVest device from 11:00 PM to 7:00 AM was "going off all night." NA #2 could not recall if the device was beeping or if it was another sound. NA #2 stated that she let Nurse #1 know that the device was sounding and she did not know what the nurse did about it or if the nurse went in to assess the resident. Attempts were made to interview Nurse #1 were unsuccessful with text messages sent on 8/7/25 at 2:16 PM and 8/8/25 at 12:31 PM with no return call received. Nurse #1 was an agency nurse that worked as needed at the facility and was assigned to Resident #119 on 2/10/25 from 7:00 PM to 7:00 PM. Nurse #1 no longer worked at the facility. A health status note dated 2/11/25 at 8:32 PM written by Nurse #5 revealed that the off going nurse from the 7:00 PM to 7:00 AM shift (Nurse #1) reported that Resident #119's LifeVest was shocking Resident #119 all through the night. The note indicated that Nurse #1 stated that she changed the battery for the LifeVest, and Resident #119 was fine. The note indicated that Nurse #5 immediately went to check Resident #119 and	F0580		

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F0580 SS = J	Continued from page 8 observed the resident was lying in bed with brown dried emesis on her gown and around her mouth. The note did not indicate that the physician was notified and there were no vital signs recorded. The note stated that Nurse #5 observed that the pads of the electrodes for the LifeVest had leaked gel onto Resident #119's skin and her upper body was covered in gel. Resident #119 was cleaned, and the electrode pads were replaced. LifeVest was placed back on the resident. Resident #119 was alert and responsive but grunting. Nurse #5 notified Support Nurse #1 of the situation. Resident #119 vomited again and did not eat during the shift. The oncoming nurse (Nurse #7) was informed of concerns with the LifeVest and that Resident #119 had vomited. An interview was conducted with Nurse #5 on 8/6/25 at 1:15 PM. Nurse #5 was assigned to Resident #119 frequently and was assigned to her on 2/11/25 from 7:00 AM to 7:00 PM. Nurse #5 indicated that Resident #119 had a LifeVest cardiac defibrillator device. Nurse #5 stated that on the morning of 2/11/25, she received in report from the off going night shift nurse (Nurse #1) that Resident #119's LifeVest device was shocking the resident all night and that the device was sounding all night. Nurse #5 stated she asked the off going nurse (Nurse #1) if she had notified the provider or assessed Resident #119 and was told no, she had not. Nurse #5 stated that Nurse #1 did not indicate why she had not notified the provider or assessed the resident when the shocks occurred. Nurse #5 stated she immediately went to the room and observed Resident #119 was soaked with the blue conducting gel on her chest and upper body from the LifeVest device. Nurse #5 stated she and the Nurse Aide cleaned the resident, obtained vital signs and reapplied the electrodes and the LifeVest device. Nurse #5 indicated she informed Support Nurse #1 what was reported to her regarding Resident #119's condition and being shocked by the LifeVest. A follow up interview with Nurse #5 on 8/7/25 at 2:30 PM revealed that she did not notify the physician on 2/11/25 that Resident #119 was shocked by the LifeVest during the night shift. Nurse #5 stated that she thought Support Nurse #1 was going to notify the provider, and that she did not follow up to ensure that the physician was notified. Voice mail messages and text messages were sent to Nurse #7 on 8/6/25 at 11:25 AM, 8/7/25 at 12:24 PM, and 8/8/25 at 12:35 PM. Nurse #7 was assigned to Resident #119 on 2/11/25 from 7:00 PM to 7:00 AM. Nurse #7 was an agency nurse that was no longer employed at the facility.	F0580		

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F0580 SS = J	Continued from page 9 An interview with Support Nurse #1 on 8/6/25 at 12:05 PM revealed she recalled that Resident #119 had a LifeVest device. Support Nurse #1 stated that if the blue gel was released, a shock was administered. Support Nurse#1 stated that on the morning of 2/11/25, Resident #119 had blue gel on her chest which indicated that she received a shock. Support Nurse #1 stated the provider should have been notified that the LifeVest was sounding and a shock was administered. Support Nurse #1 stated the resident should have been assessed including vital signs and the provider should have been notified immediately when the shock occurred or as soon as possible after it was discovered that it occurred. Support Nurse #1 stated she did not notify a provider on 2/11/25 that Resident #119 received a shock from the LifeVest during the early morning hours and explained that she thought Nurse #5 would have done this. Support Nurse #1 stated she should have followed up with Nurse #5 to be sure that she had notified the provider of the shock from the LifeVest. Support Nurse #1 stated she was responsible for managing the residents on 3 halls, so she thought that the floor nurses were responsible for notifying the provider of changes in condition. An interview conducted with Nurse #8 on 8/7/25 at 11:41 AM indicated that she was assigned to Resident #119 on 2/12/25 from 7:00 AM to 7:00 PM and was assigned to the resident frequently. Nurse #8 stated that she did not recall any significant changes in Resident #119's condition on 2/12/25 from 7:00 AM to 7:00 PM. Nurse #8 stated that she did not think that Resident #119 being slow to respond to verbal stimuli, not eating and not showing interest could have been symptoms of a change in condition that required notifying the provider. An interview with the LifeVest Resident Representative on 8/7/25 at 4:30 PM revealed she had access to her patients' device information and shared alerts and other information with the doctors and cardiologists. She indicated that she called Resident #119's Cardiologist on 2/13/25 and informed him that the resident had a run of ventricular tachycardia (v tach), a dangerous rapid heart rhythm. The Representative stated that if a resident had a run of v tach greater than 1 minute, a shock was delivered. The device can deliver up to 5 shocks. The Representative stated that the data recorded from Resident #119's LifeVest on 2/11/25 just after midnight indicated that v tach was detected. The representative stated that there were multiple episodes of v tach on the night of 2/11/25 and when she received that information, she reached out to the Cardiologist. An interview with the Cardiologist on 8/6/25 at 3:36 PM	F0580		

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F0580 SS = J	Continued from page 10 revealed that the LifeVest device is designed to detect dangerous arrhythmia including ventricular tachycardia and ventricular fibrillation and deliver an electrical shock to restore the heart to a normal rhythm. The Cardiologist stated that the physician should be notified when the device delivered a shock and if unable to contact the physician, the resident should immediately be sent to the hospital for evaluation. The Cardiologist stated that he received a call on 2/13/25 from the LifeVest Resident Representative who stated that Resident #119 was shocked by the device during the early morning hours on 2/11/25 when the abnormal heart rhythm ventricular tachycardia, a dangerous rapid heart rate, was detected. The Cardiologist stated he immediately called the facility on 2/13/25 and recommended that Resident #119 be sent to the hospital for evaluation. A health status note dated 2/13/25 at 5:00 PM written by Support Nurse #1 indicated that the facility received a call from the Cardiologist who stated that a remotely acquired EKG (electrocardiogram) strip received from the LifeVest manufacturing company showed severe episode of ventricular tachycardia (a dangerous rapid heart rhythm). The Cardiologist spoke with Medical Director #1. Upon the Cardiologist's recommendation due to the resident not being stable, Medical Director #1 gave an order to send Resident #119 to the emergency department for further evaluation. Emergency Medical Services was contacted, and Resident #119 was transported to the hospital. Support Nurse #1 was interviewed on 8/6/25 at 12:05 PM. Support Nurse #1 stated the Cardiologist called the facility on 2/13/25 and was adamant that he spoke with Medical Director #1 regarding Resident #119. Support Nurse #1 stated she immediately went and informed Medical Director #1, who was in the building at the time, that the Cardiologist was on the phone and requested to speak with him. After speaking with the Cardiologist, Medical Director #1 gave the order to send Resident #119 to the hospital due to a dangerous heart arrhythmia. An interview with Medical Director #1 on 8/6/25 at 3:52 PM revealed that he had just started in the position at the facility in early February 2025 when the incident with Resident #119 occurred. Medical Director #1 stated he was not notified that Resident #119's LifeVest had alarmed or shocked her due to arrhythmia on 2/11/25. Medical Director #1 stated when the LifeVest alarm sounded due to an arrhythmia, the resident should have been sent to the emergency room, and the provider should have been notified. Medical Director #1 stated	F0580		

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F0580 SS = J	Continued from page 11 that when the device shocked Resident #119, the nurse should have immediately assessed the resident, sent her to the hospital for evaluation and notified the provider. When the LifeVest discharges an electrical shock to the resident, it means the person had an unstable arrythmia requiring immediate physician attention, or the device malfunctioned and administered a shock when it was not required. Both require evaluation. Review of an Emergency Department (ED) report for hospital #1 dated 2/13/25 indicated that Resident #119 presented to the hospital with a LifeVest device on. Resident #119 presented after the LifeVest detected a cardiac arrhythmia and the cardiologist requested evaluation at the nearest emergency room. Resident #119 was somnolent, difficult to understand with closed eyes and was unresponsive on presentation to the ED. Resident #119 was noted to have 4+ pitting edema (a type of swelling where when pressure is applied on the area a temporary indentation or pit remains for a short time after the pressure is released) from toes to abdomen. The impression indicated that Resident #119 was evaluated due to a cardiac arrhythmia and was significantly fluid overloaded with severe congestive heart failure. Resident #119 was transferred to hospital #2 for further evaluation and monitoring. Review of the discharge summary for hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Resident #119's discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. Review of Resident #119's certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock, a life-threatening condition in which the heart suddenly can't pump enough blood characterized by sudden, rapid heartbeat (tachycardia). An interview was conducted on 8/6/25 at 2:20 PM with the Director of Nursing (DON) and the Clinical Services Director. The DON and Clinical Services Director stated that they expected that if something occurred such as the LifeVest delivered a shock, the provider would be notified immediately for further instructions. The DON and Clinical Services Director stated the physician	F0580		

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F0580 SS = J	Continued from page 12 should have been notified immediately when the LifeVest alarmed. The DON was unable to state why the physician was not notified other than that the nurse that worked on the night of 2/10/25 was an agency nurse who no longer worked at the facility. The DON stated that she expected that the nurses recognized and reported changes in condition to the medical provider. The Administrator was notified of immediate jeopardy on 8/11/25 at 12:10 PM. The facility provided the following credible allegation of immediate jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. The facility failed to ensure the physician was notified of a significant change for Resident #119. Resident #119's LifeVest shocked her multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and did not notify the physician. The physician was not notified until 2/13/25 when Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia. Resident #119 did not return to the facility after discharge on 2/13/25. Facility has not been able to contact Nurse #1, and she is no longer working in the facility. The Administrator and Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. On 8/6/25, the facility initiated a comprehensive response to address the identified noncompliance related to failure to notify provider of an acute change in Resident # 119's condition. The Direct care nurses conducted an immediate assessment of 100% of current residents to identify any acute changes in condition that had not been communicated to the appropriate medical provider. This included symptoms or signs that were: - Acute or sudden in onset	F0580		

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F0580 SS = J	Continued from page 13 - Markedly more severe than usual - Unrelieved by previously prescribed measures - Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) During the above audit, it is noted that no residents were found to be using wearable cardiac devices. The audit was completed on 8/11/25. There were 5 residents identified with acute changes in condition. For each of these residents, the provider was notified, and appropriate medical orders were implemented by the direct care staff on 08/11/2025. Additionally, on 8/10/25, the Director of Nursing (DON) reviewed the progress notes to include the E -interact transfer and change in condition assessments for all resident transfers to an acute care hospital within the past 30 days to ensure provider notification had occurred for any acute change in condition. The audit confirmed that provider notification was completed timely for 14 out of 14 residents. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. To prevent recurrence, the DON began in-servicing all licensed nurses (Registered Nurses and Licensed Practical Nurses) and certified Nurse Aides (CNAs), including full-time, part-time, PRN (as needed), and agency staff, on 8/6/25. The training emphasized the importance of timely provider notification for any acute change in condition. This included symptoms or signs that were: - Acute or sudden in onset - Markedly more severe than usual - Unrelieved by previously prescribed measures - Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) Specific training for a resident with a LifeVest was if	F0580		

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F0580 SS = J	Continued from page 14 a person's LifeVest discharges, it means the person may have an unstable arrythmia or that the device is malfunctioning or both, and both of these would require immediate physician notification. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute LifeVest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the LifeVest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for LifeVest. This training initiative was coordinated by the Director of Nursing. All current staff must complete this training by 8/11/25 to care for residents with wearable cardiac devices. Staff who do not complete the training by 8/11/25 will not be permitted to work until the training is completed. The Director of Nursing and the Director of Staff Development will do a daily reconciliation of the schedule to ensure all licensed staff and CNAs have completed the training as indicated above. This in-service training has been incorporated into the orientation program for all new facility and agency staff. No staff shall work without this training after 8/11/25. Alleged date of Immediate Jeopardy removal: 8/12/25 The immediate jeopardy removal plan was validated on 8/14/25. A sample of staff including the Administrator, Director of Nursing, Staff Development Director, nurses, nurse aides and medication aides were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they had received in-service training regarding the LifeVest purpose and function, application and maintenance and emergency response. Validation indicated that licensed nurses had completed a competency checklist regarding the LifeVest device and the indications for when to notify the physician. The nurses that were interviewed	F0580		

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F0580 SS = J	Continued from page 15 indicated that they had received training regarding timely provider notification of acute changes in condition. The immediate jeopardy was removed on 8/12/25.	F0580		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, LifeVest Technician, LifeVest Resident Representative, Medical Director #1 and Cardiologist interviews, the facility failed to protect Resident #119's right to be free from neglect. Resident #119 was admitted on 10/17/24 with a LifeVest (a wearable device designed to detect life-threatening rapid heart rhythm and, if needed, automatically deliver a treatment shock to restore normal heart rhythm). The nurses and nurse aides had no training on how to care for and manage a resident who required a LifeVest and staff neglected to provide necessary care and services after the LifeVest delivered several treatment shocks. Nurse #1 observed the device deliver treatment shocks to the resident in the early morning hours of 2/11/25 and took no action with the exception of notifying the oncoming first shift nurse that the Life Vest was "shocking the resident all through the night". The Physician was not contacted to evaluate Resident #119 after the treatment shocks were delivered as specified in the manufacturer's instructions. Due to ineffective staff communication and lack of comprehensive assessments Resident #119's significant change from her baseline was not recognized or acknowledged by the staff. On 2/13/25, Resident #119's	F0600	F600 Abuse / Neglect Failure to protect Resident #119 from neglect, with cross-references to F580, F684, and F726. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 2/11/25 the facility failed to adhere to its abuse/neglect policy and failed to protect Resident #119 from neglect by not recognizing and responding to a resident's change in condition. Specifically, staff did not notify the Medical Director; did not identify the seriousness of resident's condition and need for a comprehensive medical evaluation; and did not ensure staff were trained and competent to care for a resident who wore a Life Vest, resulting in a failure to provide timely medical intervention. Upon learning of the allegation of neglect on 8/11/25, the Administrator submitted an initial report to the Department of Health and Human Services and report to Adult Protective Services. Resident #119 discharged from the facility on 02/13/25. Nurse #1 no longer works for the facility. The Administrator and the Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. As of 8/8/25, a review conducted by the Director of Nursing confirmed that there have been no residents with a life vest residing in the facility since 03/07/25. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 08/11/25 all current residents were assessed for changes in condition to ensure appropriate care and services were provided. The nurse management team consisting of the Director of Staff Education, Minimum Data Set Nurse Coordinator, and 3 Licensed Practical	09/01/2025

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F0600 SS = SQC-J	Continued from page 16 Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate) on 2/11/25. The emergency department (ED) at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and noted Resident #119 was somnolent, difficult to understand with closed eyes and was unresponsive on presentation to the ED. Resident #119 was transferred to another hospital for further evaluation and monitoring. These failures had a high likelihood of resulting in serious harm or death for Resident #119. Immediate jeopardy began on 2/11/25 when Resident #119 received multiple treatment shocks from the LifeVest and the facility neglected to provide the necessary care and services and consult with the physician about an evaluation for a potential arrhythmia. Immediate jeopardy was removed on 8/12/25 when the facility implemented an acceptable plan of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. The findings included: This is cross-referred to: F580: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest Resident Representative and LifeVest Technician interviews, the facility failed to consult with Medical Director #1 when Resident #119's LifeVest (an external defibrillator designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) delivered treatment shocks to her multiple times in the early morning hours on 2/11/25. The LifeVest Resident Representative contacted Resident #119's Cardiologist on 2/13/25 about Resident #119's severe episodes of ventricular tachycardia, a life-threatening rapid heart rate. The Cardiologist called the facility and requested to talk to the Medical Director. The Cardiologist recommended that the resident be sent to the hospital for evaluation. The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25	F0600	Continued from page 16 Nurse Support Staff conducted comprehensive head-to-toe assessments of all residents with a Brief Interview for Mental Status (BIMS) score of 12 or less to identify any signs of distress or neglect. No concerns were identified. On 08/11/25, residents with a BIMS score of 13 or higher were interviewed by the nurse management team regarding any concerns related to abuse, neglect, or care. All residents denied any such concerns. Additionally, on 08/11/25, the nurse management team completed immediate assessments of 100% of current residents to identify any unreported acute changes in condition. This included symptoms that were: - Acute or sudden in onset - Markedly more severe than usual - Unrelieved by previously prescribed measures - Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) On 08/11/25, corrective actions were completed for 5 out of 116 residents who were identified as having a change in condition. Providers were notified, and orders were carried out by direct care staff. On 08/10/25, the Director of Nursing audited all hospital transfers from the past 30 days to ensure provider notification occurred for any acute changes in condition. The audit confirmed that provider notification was completed for all 14 residents reviewed. No corrective action was required. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 08/08/25, the Administrator and Director of Nursing conducted in-service training for all staff (full-time, part-time, as needed, and agency) on the abuse/neglect policy, including procedures for identifying, reporting, and preventing abuse and neglect. This training was delivered in person and by phone. Staff who did not complete the training by 08/11/25 were restricted from working until completion.	

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F0600 SS = SQC-J	Continued from page 17 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for notification of change (Resident #119). F684: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest technician and LifeVest patient representative interviews, the facility failed to obtain physician directives for staff about what to do when the LifeVest delivered a shock, identify the seriousness of Resident #119's cardiac status and the need for a comprehensive medical evaluation when a LifeVest (an external defibrillator device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) shocked the resident multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and took no action with the exception of notifying the oncoming first shift nurse that the LifeVest was "shocking the resident all through the night". From 2/11/25 through 2/13/25 the facility failed to consult with the physician regarding the LifeVest having delivered treatment shocks to the resident and provide ongoing nursing assessment. According to the manufacturer's instructions, a resident with a LifeVest is to be evaluated by a physician for potential arrhythmia once the vest delivers a treatment shock. On 2/13/25, Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute	F0600	Continued from page 17 On 08/06/25, the Director of Nursing began targeted education for all licensed nurses (Registered Nurses, Licensed Practical Nurses), and certified nursing assistants on the importance of notifying providers of any acute change in condition. Training included emphasis on timely care and services, and the definition of neglect as failure to act during a medical emergency. The training also included: Recognizing types of changes in condition Appropriate response protocols Notification procedures When to initiate Emergency Medical Services Additionally, beginning 8/8/25, all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are required to complete education and competency validation prior to providing care to any resident with a wearable cardiac device. This will be completed by the Director of Nursing, Minimal Data Set Nurse and Director of Staff Education. Specific training for a resident with a life vest was if a person's life vest discharges, it means the person may have an unstable arrythmia or that the device is malfunctioning or both, and both of these would require immediate physician notification. Nurses received training to complete a comprehensive assessment and notify the medical provider of findings and concerns. On 8/6/2025 Nurses were trained on the emergency response to include areas of: if the life vest delivers a shock, when to notify the physician and document the event and understanding of when to remove the life vest. On 8/6/2025 the Administrative nursing team to include the Director of Nursing, the Director of Staff Education, the 3 licensed practical nurse support nurses and the Minimum Data Set nurses were educated by the Regional Nurse Consultant to ensure that orders directing care for residents with life vests are obtained from the physician and entered into the medical record to include: maintenance and emergency response. On 8/11/2025 the Minimum Data Set Nurse was educated by Regional Nurse Consultant to ensure that all residents with a life vest have a care plan moving forward that will include directives of what to do in the event the vest delivers a shock.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0600 SS = SQC-J	Continued from page 18 hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for professional standards (#119). F726: Based on record review and staff, Medical Director #1, Cardiologist, Resident Representative, LifeVest technician, and LifeVest patient representative interviews the facility failed to ensure staff were trained and competent to care for a resident who wore a LifeVest (a device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm). Resident #119 received a treatment shock multiple times by the LifeVest she was wearing in the early morning hours (beginning shortly after midnight) on 2/11/25. Nurse #1, an agency nurse assigned to Resident #119, observed the device deliver the treatment shocks to Resident #119 and took no action with the exception of notifying the oncoming first shift nurse (Nurse #5) that the LifeVest was “shocking the resident all through the night”. The 7 of 7 staff members that cared for Resident #119 from 02/11/25 through 02/13/25 that included Nurse #1, Nurse #5, Nurse #6, Nurse #8, Nurse Aide (NA) #2, NA #6, and NA #7 had not been trained on how to respond if the LifeVest alarmed or sounded or how to respond if the LifeVest delivered a treatment shock. Per the manufacture instructions, if a treatment shock was delivered, the physician was to be called immediately, and an announcement was made by the device with this instruction. Resident #119’s Cardiologist contacted the facility on 2/13/25 and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest’s manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of	F0600	Continued from page 18 On 8/7/25, the Director of Admissions was instructed by the Administrator that any prospective resident with a wearable cardiac device must undergo a clinical review to ensure staff competency before acceptance. On 8/8/25, a life vest manufacturer representative came to the facility to complete a hands-on review of the care and function of the life vest, utilizing a demo vest, with the Director of Nursing and the Director of Staff Education. Instruction manual with several resource documents were provided. On 8/10/25, the Director of Nursing created a life-vest quick reference guide for each nursing station. Contents of the manual included a patient checklist, a quick reference guide for trouble shooting, an educational overview for patients and families on use of the life vest, and the manufacturers manual for the life vest. The 24- hour help line number is also located on the outside and inside of the manual. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute Life Vest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the Life Vest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for life vest. On 08/06/25, all Certified Nursing Assistants received education from the Director of Nurses, Director of Staff Education, and the Minimum Data Set Nurse Coordinator on the need to immediately report to the staff nurse when a resident utilizing a life vest receives a shock treatment or expresses any other concerns. The Interdisciplinary Team—including the Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, and Pharmacist—was informed of the neglect allegation on 08/11/25 and actively participated in the removal plan. The Director of Nursing and the Director of Staff Education along with the individual department managers	

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F0600 SS = SQC-J	Continued from page 19 death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock (medical emergency resulting from inadequate blood flow to the body's organ due to dysfunction of the heart). The Administrator was notified of immediate jeopardy on 8/11/25 at 12:10 PM. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Failure to protect Resident #119 from neglect, with cross-references to F580, F684, and F726. On 2/11/25 the facility failed to adhere to its abuse/neglect policy and failed to protect Resident #119 from neglect by not recognizing and responding to a resident's change in condition. Specifically, staff did not notify the Medical Director; did not identify the seriousness of resident's condition and need for a comprehensive medical evaluation; and did not ensure staff were trained and competent to care for a resident who wore a Life Vest, resulting in a failure to provide timely medical intervention. Upon learning of the allegation of neglect on 8/11/25, the Administrator submitted an initial report to the Department of Health and Human Services and report to Adult Protective Services. Resident #119 discharged from the facility on 02/13/25. Nurse #1 no longer works for the facility. The Administrator and the Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. As of 8/8/25, a review conducted by the Director of Nursing confirmed that there have been no residents with a Life Vest residing in the facility since 03/07/25. On 08/11/25 all current residents were assessed for changes in condition to ensure appropriate care and services were provided. The nurse management team consisting of the Director of Staff Education, Minimum Data Set Nurse Coordinator, and 3 Licensed Practical	F0600	Continued from page 19 will do a daily reconciliation of the schedule to ensure all staff have completed the training and education as indicated above. This training has been incorporated into the orientation process for all new employees and agency staff. All licensed nurse new hires, including agency staff, must complete mandatory training and competency checks before being assigned to residents using these devices. The Administrator and Director of Nursing will ensure that any staff member who did not complete the required training by 08/11/25 will not be able to work until training is completed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; Quality Assurance Beginning the week of 8/18/2025, The Administrator or designee will monitor the abuse/neglect process to ensure residents are free from neglect and any neglect identified reported and addressed according to facility policy using the QA Tool for Recognizing and Reporting Abuse/Neglect. The Administrator or designee will interview 5 staff members to monitor if staff know the procedure for reporting alleged abuse/neglect and when and who to report to and 5 residents related to abuse/neglect concerns. Also, the Administrator or designee will review allegation reports submitted to State Survey Agencies to ensure reports submitted per facility policy. The monitoring will be completed weekly for 4 weeks and then monthly for 2 months or until resolved. Reports will be presented to the weekly Quality Assurance Committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Support nurse, Therapy Director Social Worker, Maintenance Director, Health Information Management and Dietary Manager.	

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F0600 SS = SQC-J	Continued from page 20 Nurse Support Staff conducted comprehensive head-to-toe assessments of all residents with a Brief Interview for Mental Status (BIMS) score of 12 or less to identify any signs of distress or neglect. No concerns were identified. On 08/11/25, residents with a BIMS score of 13 or higher were interviewed by the nurse management team regarding any concerns related to abuse, neglect, or care. All residents denied any such concerns. Additionally, on 08/11/25, the nurse management team completed immediate assessments of 100% of current residents to identify any unreported acute changes in condition. This included symptoms that were: - Acute or sudden in onset - Markedly more severe than usual - Unrelieved by previously prescribed measures - Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) On 08/11/25, corrective actions were completed for 5 out of 116 residents who were identified as having a change in condition. Providers were notified, and orders were carried out by direct care staff. On 08/10/25, the Director of Nursing audited all hospital transfers from the past 30 days to ensure provider notification occurred for any acute changes in condition. The audit confirmed that provider notification was completed for all 14 residents reviewed. No corrective action was required. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. On 08/08/25, the Administrator and Director of Nursing conducted in-service training for all staff (full-time, part-time, as needed, and agency) on the abuse/neglect policy, including procedures for identifying, reporting, and preventing abuse and neglect. This training was delivered in person and by phone. Staff who did not complete the training by 08/11/25 were restricted from working until completion.	F0600	Continued from page 20 Date of Compliance: 9/1/2025	

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F0600 SS = SQC-J	Continued from page 21 On 08/06/25, the Director of Nursing began targeted education for all licensed nurses (Registered Nurses, Licensed Practical Nurses), and certified nursing assistants on the importance of notifying providers of any acute change in condition. Training included emphasis on timely care and services, and the definition of neglect as failure to act during a medical emergency. The training also included: - Recognizing types of changes in condition - Appropriate response protocols - Notification procedures - When to initiate Emergency Medical Services Additionally, beginning 8/8/25, all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are required to complete education and competency validation prior to providing care to any resident with a wearable cardiac device. This will be completed by the Director of Nursing, Minimum Data Set Nurse and Director of Staff Education. Specific training for a resident with a Life Vest was if a person's Life Vest discharges, it means the person may have an unstable arrythmia or that the device is malfunctioning or both, and both of these would require immediate physician notification. Nurses received training to complete a comprehensive assessment and notify the medical provider of findings and concerns. On 8/6/2025 Nurses were trained on the emergency response to include areas of: if the Life Vest delivers a shock, when to notify the physician and document the event and understanding of when to remove the Life Vest. On 8/6/2025 the Administrative nursing team to include the Director of Nursing, the Director of Staff Education, the 3 licensed practical nurse support nurses and the Minimum Data Set nurses were educated by the Regional Nurse Consultant to ensure that orders directing care for residents with Life Vests are obtained from the physician and entered into the medical record to include: maintenance and emergency response. On 8/11/2025 the Minimum Data Set Nurse was educated by Regional Nurse Consultant to ensure that all residents with a Life Vest have a care plan moving forward that will include directives of what to do in the event the vest delivers a shock.	F0600		

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F0600 SS = SQC-J	Continued from page 22 On 8/7/25, the Director of Admissions was instructed by the Administrator that any prospective resident with a wearable cardiac device must undergo a clinical review to ensure staff competency before acceptance. On 8/8/25, a Life Vest manufacturer representative came to the facility to complete a hands-on review of the care and function of the Life Vest, utilizing a demo vest, with the Director of Nursing and the Director of Staff Education. Instruction manual with several resource documents were provided. On 8/10/25, the Director of Nursing created a life-vest quick reference guide for each nursing station. Contents of the manual included a patient checklist, a quick reference guide for trouble shooting, an educational overview for patients and families on use of the Life Vest, and the manufacturers manual for the Life Vest. The 24- hour help line number is also located on the outside and inside of the manual. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute Life Vest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the Life Vest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for Life Vest. On 08/06/25, all Certified Nursing Assistants received education from the Director of Nurses, Director of Staff Education, and the Minimum Data Set Nurse Coordinator on the need to immediately report to the staff nurse when a resident utilizing a Life Vest receives a shock treatment or expresses any other concerns. The Interdisciplinary Team—including the Administrator, Director of Nursing, Nurse Managers, Minimum Data Set Coordinators, Unit Manager, Support Nurse, Therapy, Health Information Management, Dietary Manager, Medical Director, and Pharmacist—was informed of the neglect allegation on 08/11/25 and actively participated in the removal plan. The Director of Nursing and the Director of Staff Education along with the individual department managers will do a daily reconciliation of the schedule to	F0600		

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F0600 SS = SQC-J	Continued from page 23 ensure all staff have completed the training and education as indicated above. This training has been incorporated into the orientation process for all new employees and agency staff. All licensed nurse new hires, including agency staff, must complete mandatory training and competency checks before being assigned to residents using these devices. The Administrator and Director of Nursing will ensure that any staff member who did not complete the required training by 08/11/25 will not be able to work until training is completed. The Administrator is responsible for ensuring full implementation of the removal plan. Alleged date of Immediate Jeopardy removal: 08/12/25 The removal plan of the Immediate Jeopardy was validated on 8/14/25. A sample of staff including the Administrator, Director of Nursing, Support Nurse #1, nurses, nurse aides and medication aides were interviewed regarding in-service training received related to the deficient practice. All staff interviewed stated they had been in serviced regarding the importance of staff understanding that all residents have a right to be free of neglect and they indicated that they understood that failing to provide the necessary care and services to residents constituted neglect. The staff interviewed indicated that the in-service training they received stated that failure to notify the physician of significant changes including receiving shocks from a wearable defibrillator device constituted neglect. The removal date of 8/12/25 was validated.	F0600		
F0684 SS = SQC-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	F0684	F684 POC: Quality of Care Corrective Action for Affected Residents Resident #119 was placed at serious risk due to the facility's failure to recognize and respond appropriately to a critical change in condition. The resident wore a Life Vest, an external defibrillator prescribed due to a severely reduced left ventricular ejection fraction. This device is intended to detect and treat life-threatening arrhythmias.	09/01/2025

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F0684 SS = SQC-J	Continued from page 24 person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest technician and LifeVest patient representative interviews, the facility failed to obtain physician directives for staff about what to do when the LifeVest delivered a shock, identify the seriousness of Resident #119's cardiac status and the need for a comprehensive medical evaluation when a LifeVest (an external defibrillator device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) shocked the resident multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and took no action with the exception of notifying the oncoming first shift nurse that the LifeVest was "shocking the resident all through the night". From 2/11/25 through 2/13/25 the facility failed to consult with the physician regarding the LifeVest having delivered treatment shocks to the resident and provide ongoing nursing assessment. According to the manufacturer's instructions, a resident with a LifeVest is to be evaluated by a physician for potential arrhythmia once the vest delivers a treatment shock. On 2/13/25, Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for professional standards (#119). Immediate jeopardy began on 2/11/25 when Resident #119	F0684	Continued from page 24 This failure in clinical judgment and timely notification to the physician, so that a comprehensive medical evaluation necessity determination could be made, created a high likelihood of serious harm or death, as the Life Vest's discharge indicates either an unstable arrhythmia or device malfunction, both requiring immediate medical evaluation. On 2/11/25, the Life Vest delivered multiple shocks beginning shortly after midnight. Nurse #1 witnessed these events but failed to assess the resident and to notify a physician, instead only informing the incoming shift nurse. No physician directives were in place regarding staff response to Life Vest discharges. The cardiologist was only informed on 2/13/25 after the Life Vest manufacturer reported a severe episode of ventricular tachycardia, at which point the resident was sent to the hospital and did not return to the facility. Facility has not been able to contact Nurse #1, and she is no longer working in the facility. The Administrator and Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. Corrective action for potentially affected residents On 8/6/25, the facility initiated a comprehensive response to address the facility's failure to recognize and respond appropriately to a critical change in condition for Resident #119. The Director of Staff Education, Minimum Data Set Nurse and 3 licensed support nurses conducted an immediate assessment of 100% of current residents to identify any acute changes in condition that had not been communicated to the appropriate medical provider. This included symptoms or signs that were: Acute or sudden in onset Markedly more severe than usual Unrelieved by previously prescribed measures Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) During the audit, it is noted that no residents were found to be using wearable cardiac devices. The Director of Nursing verified on 8/8/25 that there had been no residents with a life vest residing in the facility since 03/07/25.	

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F0684 SS = SQC-J	Continued from page 25 received multiple treatment shocks from the external defibrillator device which meant the resident possibly had an unstable arrythmia (irregular heart rhythm that means the heart is not effectively pumping enough blood to the body's vital organs increasing the risk of complications like heart failure, stroke, or even sudden cardiac arrest) and staff failed to identify the seriousness of Resident #119's cardiac status which required immediate evaluation by a medical provider. Immediate jeopardy was removed on 8/12/25 when the facility implemented an acceptable plan of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings included: Review of the manufacturer's information and the instructional videos for the LifeVest external defibrillator revealed that the device is prescribed for residents at risk for sudden cardiac death, a condition that occurs without warning with no signs that something is about to happen due to an electrical malfunction of the heart causing a dangerously fast heartbeat with no signs or symptoms. The LifeVest uses electrodes to continuously monitor the heart's electrical activity and detect dangerous heart rhythms, such as ventricular tachycardia and ventricular fibrillation. The device is designed to deliver an electrical shock to the heart when an abnormal rhythm is detected to restore a normal heart rhythm. The manufacturer's instructions indicated that if a treatment shock is delivered, the physician is to be called immediately, and an announcement is made by the device with this instruction. If the vest discharges, it means either the person has an unstable arrythmia (heartbeat) requiring immediate physician attention, or the device is malfunctioning. Both must have medical evaluations as soon as possible. The LifeVest device should be removed to bathe, shower or change the garment. The device comes with 2 batteries, and 1 battery is always to be charged while using the other. Changing and charging the batteries was to occur at the same time each day. The monitor, electrode belt or charger is not to be put in water and should not get wet. The data from the device is to be downloaded as directed by the device or at least weekly. If data is not sent in for greater than 7 days, a prompt appears on the monitor which states "time to send data." An interview with the LifeVest Manufacturer Technician on 8/6/25 at 5:00 PM revealed that the device does not	F0684	Continued from page 25 The audit was completed on 8/11/25. There were 5 residents identified with acute changes in condition. For each of these residents, the provider was notified, and appropriate medical orders were implemented by the direct care staff on 08/11/2025. Additionally, on 8/10/25, the Director of Nursing (DON) reviewed the progress notes to include the E -interact transfer and change in condition assessments for all resident transfers to an acute care hospital within the past 30 days to ensure provider notification had occurred for any acute change in condition. The audit confirmed that provider notification was completed timely for 14 out of 14 residents. Systemic Changes To prevent recurrence, the Director of Nursing began in-servicing all Registered Nurses and Licensed Practical Nurses and certified nursing assistants, including full-time, part-time, PRN (as needed), and agency staff, on 8/6/25. The training emphasized the importance of timely provider notification for any acute change in condition. This included symptoms or signs that were: Acute or sudden in onset Markedly more severe than usual Unrelieved by previously prescribed measures Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) Specific training for a resident with a life vest was if a person's life vest discharges, it means the person may have an unstable arrythmia or that the device is malfunctioning or both, and both of these would require immediate physician notification. Nurses received training to complete a comprehensive assessment and notify the medical provider of findings and concerns. On 8/6/2025 Nurses were trained on the emergency response to include areas of: if the life vest delivers a shock, when to notify the physician and document the event and understanding of when to remove the life vest. On 8/6/2025 the Administrative nursing team to	

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F0684 SS = SQC-J	Continued from page 26 provide continuous monitoring. The LifeVest Manufacturer Technician stated that the device was set with parameters and if the heart rate was above the set parameter, the device alarms. The information from the device goes into a server which can be reviewed by the physician. The technician stated that if a shock was delivered, it was recorded on the downloaded information. The technician stated that the information from the device was downloaded into the system every 24 hours, however there are sometimes issues with connectivity. The technician indicated that the gel was released prior to a shock being delivered. A button can be pressed to delay the shock from being delivered. Five shocks are administered, then if more shocks are indicated they will be delivered based on the heart rhythm. The technician stated that if an abnormal heart rhythm was detected, the device emits a siren alarm which was loud and identifiable. If the device administered a shock, the blue gel was released onto the skin. The technician stated that if the device continuously sounded, the physician and the device manufacturer should be notified to check the equipment. A technician was available 24 hours per day 7 days per week to walk through issues with the device and if the technician was unable to resolve the issue via phone, a technician will come out within 24 hours to fix it or replace the device. Resident #119 was admitted on 10/17/24 with diagnosis which included ischemic cardiomyopathy (a condition that occurs when the heart muscle is damaged by lack of blood supply making it difficult for the heart to pump) requiring a LifeVest external defibrillator device, hypertensive heart disease, atrial fibrillation, coronary artery disease, chronic kidney disease with heart failure, acute on chronic systolic heart failure, and diabetes. Resident #119's electronic record revealed a physician order dated 10/17/24 which indicated LifeVest was to be worn at all times every shift. Resident #119's care plan dated 10/18/24 indicated that the resident had altered cardiovascular status related to cardiomyopathy and coronary artery disease and wore a LifeVest. The goal indicated that Resident #119 would be free from signs or symptoms of complications of cardiac problems through the next review date. Interventions included assess for chest pain every shift, enforce the need to call for assistance if pain starts, assess for shortness of breath and cyanosis every shift, monitor/document/report to MD changes in lung sounds, edema (swelling) and changes in weight, monitor/document/report to the physician as needed any	F0684	Continued from page 26 include the Director of Nursing, the Director of staff education, the 3 licensed practical nurse support nurses and the Minimum set data nurses were educated by the Regional Nurse Consultant to ensure that orders directing care for residents with life vests are obtained from the physician and entered into the medical record to include: maintenance and emergency response. On 8/11/2025 the Minimum Data Set Nurse was educated by Regional Nurse Consultant to ensure that all residents with a life vest have a care plan moving forward that will include directives of what to do in the event the vest delivers a shock. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute Life Vest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the Life Vest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for life vest. This training initiative was coordinated by the Director of Nursing. On 08/06/25, all Certified Nursing Assistants received education from the Director of Nurses, Director of Staff Education, and the Minimum Data Set Nurse Coordinator on the need to immediately report to the staff nurse when a resident utilizing a life vest receives a shock treatment or expresses any other concerns. The Director of Nursing and the Director of Staff Development will do a daily reconciliation of the schedule to ensure all licensed staff have completed the training and competency validation and all Certified Nursing Assistants received education as indicated above. This in-service training indicated above in addition to the competency validation for licensed staff has been incorporated into the orientation program for all new facility and agency staff. The in-service training indicated above for the Certified Nursing Assistants has been incorporated into the orientation program for all new facility and agency staff.	

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F0684 SS = SQC-J	Continued from page 27 signs or symptoms of coronary artery disease: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in capillary refill, color or warmth of extremities. An additional care plan problem indicated that Resident #119 had a problem of atrial fibrillation (abnormal heart rhythm) with increased risk of stroke and or heart failure. Interventions stated that Resident #119 was to be assessed for chest pain or discomfort every shift and vital signs were to be obtained weekly per protocol. There were no interventions listed in the care plan for management of the LifeVest device, indications when the resident required medical attention or what to do after a treatment shock was delivered. Resident #119 was discharged from the nursing home to the hospital on 1/4/25. Resident #119 was diagnosed with lower gastrointestinal bleed and was readmitted on 1/20/25. Resident #119's physician order revealed an order dated 1/20/25 that indicated the LifeVest was to be worn at all times every shift. Resident #119's January and February 2025 Medication Administration Records (MAR) revealed the entry for the LifeVest to be worn at all times every shift was electronically signed for each shift. The MAR lacked directives for the LifeVest, including instructions to call the provider if the alarm sounded, remove the LifeVest for showers or baths, change and charge the battery every 24 hours, change and wash the garment every 1-2 days, manage post-treatment shocks, and download data weekly. Resident #119's quarterly Minimum Data Set (MDS) assessment dated 1/23/25 indicated resident was cognitively intact, had no behavior, and the presence of a heart assistive device. Resident #119 was dependent on staff for toileting, transfers and wheelchair mobility, required moderate assistance with bed mobility and was non ambulatory. A physician progress note dated 1/27/25 by Medical Director #3 indicated Resident #119 was recently readmitted to the facility following hospitalization due to gastrointestinal bleed. The progress note indicated Resident #119 was full code status, had a LifeVest in place, was to be monitored closely and facility staff were to alert the medical staff with changes in condition. Vital signs were recorded in Resident #119's record on	F0684	Continued from page 27 No staff shall work without this training after 8/11/25. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory Beginning the week of 8/18/25, the Administrator or designee will audit this process using the Quality Assurance Tool for Monitoring Compliance with the notification of change in condition and to ensure physician directives in place regarding staff response to Life Vest discharges and routine care. The Director of Nursing will also monitor that any prospective resident with a wearable cardiac device must undergo a clinical review to ensure staff competency before acceptance This audit will be completed weekly x 4 weeks, then monthly x 2 months or until resolved. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager and Dietary Manager. Date of Compliance: 9/1/2025	

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F0684 SS = SQC-J	Continued from page 28 2/10/25 at 3:36 PM as blood pressure 108/65, pulse 87 beats per minute, respirations 18 breaths per minute, and temperature 97.0. An interview was conducted with Nurse Aide (NA) #2 on 8/6/25 at 10:06 AM. It revealed that she was assigned to Resident #119 on 2/10/25 from 11:00 PM to 7:00 AM. NA #2 stated that Resident #119 had a device that she thought was to “kick start the heart.” NA #2 stated that she recalled on the night of 2/10/25 Resident #119’s LifeVest device from 11:00 PM to 7:00 AM was “going off all night.” NA #2 could not recall if the device was beeping or if it was another sound. NA #2 stated that she let Nurse #1 know that the device was sounding and she did not know what the nurse did about it or if the nurse went in to assess the resident. Attempts were made to interview Nurse #1 were unsuccessful with text messages sent on 8/7/25 at 2:16 PM and 8/8/25 at 12:31 PM with no return call received. Nurse #1 was an agency nurse who worked as needed at the facility and was assigned to Resident #119 on 2/10/25 from 7:00 PM to 7:00 PM. Nurse #1 no longer worked at the facility. An interview conducted with NA #4 on 8/6/25 at 2:45 PM revealed that she was assigned to Resident #119 on 2/11/25 from 7:00 AM to 3:00 PM. NA #4 stated that Nurse #5 asked her to assist with cleaning Resident #119 on the morning of 2/11/25. NA #4 stated she observed blue gel from the LifeVest all over Resident #119’s upper body. NA #4 stated she and Nurse #5 cleaned Resident #119 and reapplied the LifeVest. A health status note dated 2/11/25 at 8:32 PM written by Nurse #5 was a summary note that described the events during the 7:00 AM to 7:00 PM shift. Nurse #5 stated in morning report that day, the off going nurse from the 7:00 PM to 7:00 AM shift (Nurse #1) reported that Resident #119's LifeVest was shocking Resident #119 all through the night. The note indicated that Nurse #1 stated that she changed the battery for the LifeVest, and Resident #119 was fine. The note indicated that Nurse #5 immediately went to check Resident #119 and observed the resident was lying in bed with brown dried emesis on her gown and around her mouth. The note did not indicate that the physician was notified and there were no vital signs recorded. The note stated that Nurse #5 observed that the pads of the electrodes for the LifeVest had leaked gel onto Resident #119's skin and her upper body was covered in gel. Resident #119 was cleaned, and the electrode pads were replaced. LifeVest was placed back on the resident. Resident #119 was alert, responsive but	F0684		

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F0684 SS = SQC-J	Continued from page 29 grunting. The note indicated that the LifeVest monitor was beeping with a message which stated to replenish the gel. Nurse #5 notified Support Nurse #1 of the situation. The note stated that the LifeVest support technician was notified of the issues with the LifeVest and the technician attempted to do a system check without success because of internet connection issues. The technician informed Nurse #5 that a technician would come to the facility to check the LifeVest equipment later that day or the next day. Resident #119 vomited again and did not eat during the shift. The oncoming nurse (Nurse #7) was informed of concerns with the LifeVest and that Resident #119 had vomited. On 2/11/25 at 12:29 PM Resident #119's vital signs were, blood pressure 123/78, pulse 94 beats per minute, respirations 18 breaths per minute, and temperature 97.0. An interview was conducted with Nurse #5 on 8/6/25 at 1:15 PM. Nurse #5 was assigned to Resident #119 frequently and was assigned to her on 2/11/25 from 7:00 AM to 7:00 PM. Nurse #5 indicated that Resident #119 had a LifeVest cardiac defibrillator device. Nurse #5 stated that she was familiar with the LifeVest device as she had worked with one at another facility in the past. Nurse #5 indicated that the LifeVest device provided an alert if an irregular heart rate was detected and the screen on the device indicated what to do. Nurse #5 stated that electrodes are applied and attached to the vest that the resident wears at all times. Nurse #5 stated that on the morning of 2/11/25, she received in report from the off going night shift nurse (Nurse #1) that Resident #119's LifeVest device was shocking the resident all night and that the device was sounding all night. Nurse #5 stated she asked the off going nurse (Nurse #1) if she had notified the provider or assessed Resident #119 and was told no, she had not. Nurse #5 stated she immediately went to the room and observed Resident #119 was soaked, her LifeVest device was soaked with the blue conducting gel that was released when a shock was received. Nurse #5 stated she and the Nurse Aide cleaned the resident, obtained vital signs and reapplied the electrodes and the LifeVest device. Nurse #5 stated that there was a message on the device that indicated that shocks were delivered. Nurse #5 indicated she informed Support Nurse #1 what was reported to her regarding Resident #119's condition and being shocked by the LifeVest. Nurse #5 indicated that the gel was all over the resident and that the gel released when the device delivered a shock. A follow up interview with Nurse #5 on 8/7/25 at 2:30	F0684		

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F0684 SS = SQC-J	Continued from page 30 PM revealed that she did not notify the physician on 2/11/25 that Resident #119 was shocked by the LifeVest during the night shift. Nurse #5 stated that she reported to Support Nurse #1 that the off going nurse (Nurse #1) stated Resident #119 was shocked by the device, and she thought Support Nurse #1 was going to notify the physician. Nurse #5 stated that she did follow up with Support Nurse #1 to ensure that the physician was notified that Resident #119 was shocked. An interview with Nurse Aide (NA) #7 on 8/8/25 at 1:20 PM revealed that she was assigned to Resident #119 regularly on the 3:00 PM to 11:00 PM shift and that she was assigned to her (Resident #119) on 2/11/25, 2/12/25 and 2/13/25. NA #7 indicated that Resident #119 was alert at first when she was admitted but she had become increasingly weak. NA #7 stated that Resident #119 had stopped feeding herself, required 2-person assistance with bed mobility, and was bed bound. NA #7 stated Resident #119 was unable to manage the LifeVest device. NA #7 indicated that she did not know anything about the LifeVest or what it did until the night of 2/11/25 when the technician came to the facility to change out the equipment. NA #7 stated that the technician informed her on 2/11/25, that the LifeVest device was a defibrillator that shocked the resident's heart if an abnormal heart rate was detected. NA #7 stated she was surprised when she found out this information as she had no idea about the seriousness of this device. Until 2/11/25, NA stated she just knew that Resident #119 was to always wear the LifeVest. An interview with the Staff Development Director (SDD) on 8/7/25 at 3:00 PM revealed that she was informed on 2/11/25 that Resident #119 was noted with blue gel on her LifeVest indicating that a shock was delivered. The SDD stated that she was present on the evening of 2/11/25 when the representative from the manufacturer arrived. The SDD indicated that she did not conduct any orientation or any training regarding the LifeVest device with Nurse #1 who was an agency nurse who worked at the facility as needed. The SDD stated she was not aware of the directives for managing the LifeVest and was unable to explain why she had not provided education to the staff regarding the device. Voice mail messages and text messages were sent to Nurse #7 on 8/6/25 at 11:25 AM, 8/7/25 at 12:24 PM, 8/8/25 at 12:35 PM. Nurse #7 was assigned to Resident #119 on 2/11/25 from 7:00 PM to 7:00 AM. Nurse #7 was an agency nurse who was no longer employed at the facility. A review of the facility staffing assignment sheet	F0684		

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F0684 SS = SQC-J	Continued from page 31 revealed that the on-call nurse, an administrative nurse designated to be called for any emergency situations for 2/10/25-2/11/25, was Support Nurse #1. An alert note (a note designation in a resident chart that includes important information and is used to notify care team members about the need for follow up) dated 2/12/25 at 8:16 AM written by the Support Nurse #1 indicated that Resident #119 refused meal. The note did not indicate a comprehensive assessment was completed, did not indicate that the physician was notified and did not include vital signs. An interview with Support Nurse #1 on 8/6/25 at 12:05 PM revealed she recalled that Resident #119 had a LifeVest device. Support Nurse #1 stated that the LifeVest device had a transmitter box that sounded a “gong” noise if it detected an abnormal rhythm. If a button was not pressed, a shock was administered. Support Nurse #1 stated that she talked to the technician at the manufacturer regarding the device on 2/11/25 and was informed that if the gel was released, a shock was administered. Support Nurse #1 stated that on 2/11/25, Resident #119 had gel on her chest which indicated that she received a shock. Support Nurse #1 stated the provider should have been notified that the LifeVest was sounding and a shock was administered. Support Nurse #1 stated that Resident #119 should have been assessed immediately including vital signs and monitored closely and stated that she thought that the floor nurse (Nurse #5 would have done this. Support Nurse #1 stated she did not notify a provider on 2/11/25 that Resident #119 received a shock from the LifeVest and explained that she thought Nurse #5 would have done this. Support Nurse #1 stated she should have followed up with Nurse #5 to be sure that she had assessed Resident #5 and notified the provider of the shock from the LifeVest. Support Nurse #1 stated the Cardiologist called the facility on 2/13/25 and was adamant that he speak with Medical Director #1 regarding Resident #119. A health status note dated 2/12/25 at 7:07 PM written by Nurse #8 indicated Resident #119 had been in bed resting with eyes closed most of the shift. The note indicated that Resident #119 had difficulty feeding herself, showed no interest in food when staff attempted to assist with feeding and was slow to respond to verbal stimuli. Staff attempted to keep Resident #119 engaged, but she showed no interest. Resident #119’s urinary catheter was patent draining yellow urine with sediment. Resident #119 showed a lack of interest in any activities. The note did not indicate a comprehensive assessment was completed, did	F0684		

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F0684 SS = SQC-J	Continued from page 32 not indicate that the physician was notified and did not include vital signs. Review of Resident #119's medical record revealed no documentation of vital signs on 2/12/25. An interview conducted with Nurse #8 on 8/7/25 at 11:41 AM indicated that she was assigned to Resident #119 on 2/12/25 from 7:00 AM to 7:00 PM and was assigned to the resident frequently. Nurse #8 stated that she was familiar with the LifeVest device as she had personal experience with it. Nurse #8 stated she did not recall receiving in service education at the facility regarding the device. Nurse #8 stated that Resident #119 was unable to manage the device herself and that there were no directives for how to manage the device. Nurse #8 stated that she did not recall whether Resident #119 had any significant changes on 2/12/25 from 7:00 AM to 7:00 PM and stated that the resident had been demonstrating a gradual, slow decline. Nurse #8 was unable to explain why she did not complete a full assessment of Resident #119. An interview was conducted on 8/6/25 at 1:45 PM with the Nurse Aide (NA) #6 who stated she was assigned to Resident #119 on 2/11/25 and 2/12/25 from 11:00 PM to 7:00 AM. NA #6 stated Resident #119 had "some type of LifeVest that she wore" and she did not recall any issues with it. NA #6 stated she did not know much about the device but knew that it had something to do with resident's heart and if it beeped, she notified the nurse. NA #6 stated she had not received any instructions about the device. An interview with Nurse #6 on 8/7/25 at 2:20 PM indicated that she was assigned to Resident #119 on 2/12/25 from 7:00 PM to 7:00 AM. Nurse #6 stated she was familiar with the LifeVest device from working with residents at other facilities with this device. Nurse #6 stated there were no issues with Resident #119 on the night of 2/12/25. If the device had alarmed, she would have called for assistance, called Emergency Medical Services, the provider and the responsible party. An interview with the Resident Representative for the LifeVest manufacturer on 8/7/25 at 4:30 PM revealed she worked with the physician and shared information with the doctors and cardiologists. She indicated that she called the Cardiologist on 2/13/25 and informed him that Resident #119 had a sustained run of ventricular tachycardia (v tach) on 2/11/25. The representative indicated that if a resident had a run of v tach greater than 1 minute, a shock was delivered. The	F0684		

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F0684 SS = SQC-J	Continued from page 33 device can deliver up to five shocks. The representative stated that the LifeVest device does not provide continuous real time monitoring of the resident's heart rhythm meaning that there was not a medical professional viewing the information for each resident wearing a LifeVest, therefore if an alarm sounds on the device, it was imperative to respond to that alarm and inform the medical provider. If the monitor was not plugged in, then the information was stored and was downloaded when it was plugged in again. The representative stated that when the technician for the manufacturer came to the facility on 2/11/25 and serviced the equipment, then the monitor generated the stored information from the device. The representative stated that the strip from 2/11/25 just after midnight indicated that v tach was detected. The representative stated that there were multiple episodes of v tach from the night of 2/11/25 and when she received that information, she reached out to the Cardiologist. An interview with the Cardiologist on 8/6/25 at 3:36 PM revealed that the LifeVest device is designed to detect dangerous arrhythmias including ventricular tachycardia and ventricular fibrillation. The Cardiologist stated that the device can be disarmed to prevent a shock from being administered. If the resident is unable to disarm the device, a shock is delivered. The Cardiologist stated that the physician should be notified when the device delivered a shock and if unable to contact the physician, the resident should be sent to the hospital for evaluation. Following an electrical shock from the LifeVest device, evaluation is required to determine if the heart has returned to a regular rate and rhythm. The cardiologist stated that he received a call on 2/13/25 from the representative for the LifeVest manufacturer who stated that Resident #119 was shocked by the device due to the abnormal heart rhythm ventricular tachycardia. The Cardiologist stated he called the facility and recommended that Resident #119 be sent to the hospital for evaluation. A health status note dated 2/13/25 at 5:00 PM written by Support Nurse #1 indicated that the facility received a call from the cardiologist who stated that a remotely acquired EKG (electrocardiogram) strip received from the LifeVest manufacturing company showed severe episode of ventricular tachycardia (a dangerous rapid heart rhythm). The Cardiologist spoke with Medical Director #1 and upon cardiologist's recommendation due to the resident not being stable, an order was received to send Resident #119 to the emergency department for further evaluation. Emergency Medical Services was contacted, and Resident #119 was transported to the hospital.	F0684		

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F0684 SS = SQC-J	Continued from page 34 An interview was conducted with Support Nurse #1 on 8/6/25 at 12:05 PM. She said the Cardiologist was on the phone and requested to speak with the Medical Director. She immediately went and informed Medical Director #1, who was in the building at the time. After speaking with the Cardiologist, Medical Director #1 gave the order to send Resident #119 to the hospital due to a dangerous heart arrhythmia. An interview with Medical Director #1 on 8/6/25 at 3:52 PM revealed that he had started in the facility in early February 2025. Medical Director #1 stated he was not notified that Resident #119's LifeVest had alarmed or shocked her due to arrhythmia. Medical Director #1 stated if the LifeVest alarm sounded due to arrhythmia, the resident should be sent to the emergency room and then the provider should be notified. Medical Director #1 stated that if the device shocked the resident, the nurse should have immediately assessed the resident and sent her to the hospital for evaluation. When the LifeVest discharges an electrical shock to the resident, it means the person had an unstable arrythmia requiring immediate physician attention, or the device malfunctioned and administered a shock when it was not required. Both require evaluation. An Emergency Department (ED) report from hospital #1 dated 2/13/25 indicated that Resident #119 presented to the hospital with a LifeVest device on. Resident #119 presented after the LifeVest detected a cardiac arrhythmia and the cardiologist requested evaluation at the nearest emergency room. Resident #119 was somnolent, difficult to understand with closed eyes and was unresponsive on presentation to the ED. Resident #119 was noted to have 4+ pitting edema from toes to abdomen. The impression indicated that Resident #119 was evaluated due to a cardiac arrhythmia and was significantly fluid overloaded with severe congestive heart failure. Due to her severe and acute condition, Resident #119 was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic	F0684		

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F0684 SS = SQC-J	Continued from page 35 congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. An interview was conducted on 8/6/25 at 2:20 PM with the Director of Nursing (DON) and the Clinical Services Director. The DON stated that the facility had residents with a LifeVest in the past, and they usually came in with a booklet that provided instructions about the device and managed their own device. The DON did not recall if Resident #119 came in with a booklet about her device or if she was able to manage her own LifeVest when she was admitted. The DON and Clinical Services Director stated that they expected that if something occurred such as the LifeVest delivered a shock, the provider would be notified immediately for further instructions. The DON and Clinical Services Director stated that Resident #119 should have had a full assessment completed including vital signs and the physician should have been notified immediately for further instructions when the LifeVest alarmed during the night on 2/11/25. The DON stated that when the alarm on the device sounded, it indicated an abnormal heart rate was detected and this required notification of the physician. The DON was unable to state why the physician was not notified other than that the nurse who worked on the night of 2/10/25 was an agency nurse who is no longer working at the facility. The DON further stated that when Resident #119 had a change in condition with emesis twice and lack of appetite the resident should have been assessed, and the provider should have been notified. The DON stated that the manufacturer provided an in-service to the administrative nursing staff following this incident, but it was not part of a plan of correction. The DON did not provide a plan of correction and stated a plan of correction was not implemented nor was an investigation of the incident completed. An interview with the Administrator on 8/7/25 at 4:00 PM revealed that when the facility admitted Resident #119 with the LifeVest device, the facility was responsible for managing the device. The Administrator stated that the facility staff as well as agency staff that were assigned to Resident #119 should have been aware of the seriousness of the LifeVest device and the directives for managing it. The Administrator was notified of immediate jeopardy on 8/11/25 at 12:10 PM. The facility provided the following credible allegation of Immediate Jeopardy removal:	F0684		

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F0684 SS = SQC-J	Continued from page 36 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #119 was placed at serious risk due to the facility's failure to recognize and respond appropriately to a critical change in condition. The resident wore a LifeVest, an external defibrillator prescribed due to a severely reduced left ventricular ejection fraction. This device is intended to detect and treat life-threatening arrhythmias. This failure in clinical judgment and timely notification to the physician, so that a comprehensive medical evaluation necessity determination could be made, created a high likelihood of serious harm or death, as the LifeVest's discharge indicates either an unstable arrhythmia or device malfunction, both requiring immediate medical evaluation. On 2/11/25, the LifeVest delivered multiple shocks beginning shortly after midnight. Nurse #1 witnessed these events but failed to assess the resident and to notify a physician, instead only informing the incoming shift nurse. No physician directives were in place regarding staff response to LifeVest discharges. The Cardiologist was only informed on 2/13/25 after the LifeVest manufacturer reported a severe episode of ventricular tachycardia, at which point the resident was sent to the hospital and did not return to the facility. The facility has not been able to contact Nurse #1, and she is no longer working in the facility. The Administrator and Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. On 8/6/25, the facility initiated a comprehensive response to address the facility's failure to recognize and respond appropriately to a critical change in condition for Resident #119. The Director of Staff Education, Minimum Data Set Nurse and 3 licensed support nurses conducted an immediate assessment of 100% of current residents to identify any acute changes in condition that had not been communicated to the appropriate medical provider. This included symptoms or signs that were: - Acute or sudden in onset	F0684		

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F0684 SS = SQC-J	Continued from page 37 - Markedly more severe than usual - Unrelieved by previously prescribed measures - Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) During the audit, it is noted that no residents were found to be using wearable cardiac devices. The Director of Nursing verified on 8/8/25 that there had been no residents with a LifeVest residing in the facility since 03/07/25. The audit was completed on 8/11/25. There were 5 residents identified with acute changes in condition. For each of these residents, the provider was notified, and appropriate medical orders were implemented by the direct care staff on 08/11/2025. Additionally, on 8/10/25, the Director of Nursing (DON) reviewed the progress notes to include the E -interact transfer and change in condition assessments for all resident transfers to an acute care hospital within the past 30 days to ensure provider notification had occurred for any acute change in condition. The audit confirmed that provider notification was completed timely for 14 out of 14 residents. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed. To prevent recurrence, the Director of Nursing began in-servicing all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) and certified nursing assistants (CNAs), including full-time, part-time, PRN (as needed), and agency staff, on 8/6/25. The training emphasized the importance of timely provider notification for any acute change in condition. This included symptoms or signs that were: - Acute or sudden in onset - Markedly more severe than usual - Unrelieved by previously prescribed measures - Indicative of respiratory distress (e.g., difficulty breathing, low oxygen saturation, new onset cough or congestion, decreased appetite) Specific training for a resident with a LifeVest was if a person's LifeVest discharges, it means the person may	F0684		

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F0684 SS = SQC-J	Continued from page 38 have an unstable arrythmia or that the device is malfunctioning or both, and both of these would require immediate physician notification. Nurses received training to complete a comprehensive assessment and notify the medical provider of findings and concerns. On 8/6/2025 Nurses were trained on the emergency response to include areas of: if the LifeVest delivers a shock, when to notify the physician and document the event and understanding of when to remove the LifeVest. On 8/6/2025 the Administrative nursing team to include the Director of Nursing, the Director of Staff Education, the 3 LPN support nurses and the Minimum Data Set Nurse were educated by the Regional Nurse Consultant to ensure that orders directing care for residents with LifeVests are obtained from the physician and entered into the medical record to include: maintenance and emergency response. On 8/11/2025 the Minimum Data Set Nurse was educated by Regional Nurse Consultant to ensure that all residents with a LifeVest have a care plan moving forward that will include directives of what to do in the event the vest delivers a shock. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute LifeVest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the LifeVest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for LifeVest. This training initiative was coordinated by the Director of Nursing. On 08/06/25, all Certified Nursing Assistants received education from the Director of Nurses, Director of Staff Education, and the Minimum Data Set Nurse Coordinator on the need to immediately report to the staff nurse when a resident utilizing a LifeVest receives a shock treatment or expresses any other concerns. The Director of Nursing and the Director of Staff Development will do a daily reconciliation of the schedule to ensure all licensed staff have completed the training and competency validation and all Certified Nursing Assistants received education as indicated above. This in-service training indicated above in addition to	F0684		

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F0684 SS = SQC-J	Continued from page 39 the competency validation for licensed staff has been incorporated into the orientation program for all new facility and agency staff. The in-service training indicated above for the Certified Nursing Assistants has been incorporated into the orientation program for all new facility and agency staff. No staff shall work without this training after 8/11/25 Alleged Date of Immediate Jeopardy Removal: 8/12/25 The removal plan of the Immediate Jeopardy was validated on 8/14/25. A sample of staff including the Administrator, Unit Manager, nurses, nurse aides and medication aides were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they had been in-serviced regarding the LifeVest purpose and function, application and maintenance and emergency response. Validation indicated that licensed nurses had completed a competency checklist regarding the LifeVest device and the indications to notify the physician. A LifeVest reference manual was observed at the nurses' station. The immediate jeopardy removal date of 8/12/25 was validated.	F0684		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and resident, staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to lock the left brake on Resident #3's wheelchair during a one person stand-pivot transfer on 3/14/25. The left wheelchair brake mechanism was worn	F0689	F0689: Free of Accident Hazards/Supervision/Devices The facility failed to lock the left brake on Resident #3's wheelchair during a one-person stand-pivot transfer on 3/14/25. The left wheelchair brake mechanism was worn and did not engage with the rubber on the tire. 1.Corrective action for resident(s) affected by the alleged deficient practice: On 3/14/2025, Nurse #3 assessed Resident #3 who denied pain and wanted to go to a scheduled dialysis appointment. During the dialysis appointment, Resident #3 experienced left knee pain. A portable x-ray taken at the facility was negative. Resident #3 continued to have pain and was sent to an orthopedic clinic where he had another x-ray with a negative result. He was treated with a left knee steroid injection for pain. Pain continued after the injection. On 3/28/25 Resident #3 was sent to the hospital for further evaluation. Resident #3 was diagnosed with a left femoral fracture and had an open reduction and internal fixation (ORIF)	09/01/2025

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F0689 SS = G	Continued from page 40 and did not engage with the rubber on the tire. The resident could not stand independently or stop the wheelchair when it started to roll. Nurse Aide (NA) #1 lowered Resident #3 to the floor. Both Resident #3 and NA#1 heard a pop. Nurse #3 assessed Resident #3 who denied pain and wanted to go to a scheduled dialysis appointment. During the dialysis appointment, Resident #3 experienced left knee pain. A portable x-ray taken at the facility was negative. Resident #3 continued to have pain and was sent to an orthopedic clinic where he had another x-ray with a negative result. He was treated with a left knee steroid injection for pain. Pain continued after the injection. On 3/28/25 Resident #3 was sent to the hospital for further evaluation. Resident #3 was diagnosed with a left femoral fracture and had an open reduction and internal fixation (ORIF) surgery to repair a bone fracture of his left femur. This deficient practice occurred for 1 of 5 residents (Resident #3) sampled for supervision to prevent accidents. The findings included: Resident #3 was admitted to the facility on 01/07/25. His diagnosis included end stage renal disease stage 4 with dialysis, history of falls, anxiety, weakness, osteopenia, and peripheral vascular disease. A review of Resident #3's annual Minimum Data Set dated 01/14/25 indicated Resident #3 had no cognitive impairment and required supervision to one-person assistance for activities for daily living (ADL) and one-person extensive assistance with transfers. The care plan last reviewed on 01/08/25 showed Resident #3 was care planned for falls and required assistance with activities of daily living due to chronic health conditions and weakness in extremities. The intervention included the use of a manual wheelchair for mobility, and extensive assistance with transfers using stand pivot method. The January 2025 physician orders showed that Resident #3 was not on any blood thinner medications and had scheduled dialysis on Mondays, Wednesday and Fridays. Nurse #3 completed an incident report dated Friday, 03/14/25 at 5:00 AM. The nurse stated Resident #3 reported pain upon return from dialysis at 8:30 AM. A report from dialysis of resident signing off machine early due to pain described from fall at the facility prior to transport to dialysis. Resident #3 stated, "The Nursing Aide (NA #1) who had me went to get me up into the wheelchair and when she went to put me down in	F0689	Continued from page 40 surgery to repair a bone fracture of his left femur. On 08/05/25, Director of Nursing removed old wheelchair with proper disposal. Resident was immediately provided with a replacement wheelchair with proper functioning brake mechanism. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 8/5/2025, All resident wheelchairs were inspected to ensure proper brake functionality and to evaluate the condition of tires for signs of damage or deterioration. The results included: 7 out of 80 wheelchairs with required corrective action. Corrective action was immediately implemented to include: Any defective equipment was repaired or replaced. A preventive maintenance schedule was implemented for monthly inspection of all mobility devices, including brake testing. On 8/8/2025, the Director of Nursing (DON) and Nurse Manager conducted a 30-day retrospective audit of incident reports to identify any additional occurrences involving malfunctioning equipment, including but not limited to improper wheelchair brake function. The audit findings revealed no identified concerns related to non-functioning equipment 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 8/8/2025, the Staff Development Coordinator began in servicing of all nursing staff (including agency) on Fall prevention, post fall care and Equipment Safety process. This training will include all current staff including agency. The training included: What are the common causes of falls? Identifying Falls Risk and potential negative effects General Falls Prevention Strategies and staff reminders to include: Review Kardex Reporting concerns during any Transfer to supervisor Residents must receive adequate supervision to prevent avoidable accidents. Assistive devices to include wheelchairs must be	

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F0689 SS = G	Continued from page 41 the wheelchair, it started to roll away, so I told her to sit me down on the floor. When she did, I heard something go 'pop'. I didn't think anything of it until I was at dialysis, and they wanted to move me, and it hurt like you know what." Facility's immediate action: Nurse #3 assessed resident with noted generalized edema to the left knee. Resident #3 described pain as 8 out of 10 and voiced inability to move due to pain. The Nurse Practitioner (NP) was notified of concern with orders given for x-ray of left knee and orthopedic consultation. No injuries were observed at the time of incident. Resident #3's wheelchair rolled away with break levers in place to lock. Resident's family members and physicians were notified on the morning of 03/14/25. Root cause of fall was determined by facility to be wheelchair malfunction, with intervention for maintenance to repair the wheelchair for safety, care plan reviewed and updated, with physician and Responsible Party (RP) aware and agreed with intervention. An interview and observation were conducted on 08/04/25 at 11:10 AM with Resident #3 revealed the resident sitting up in bed, fully dressed, alert and oriented, TV on, room clean, had bilateral bed rails for positioning, his wheelchair was next to the bed on right side. Resident stated he had dialysis that morning and was just resting up in bed. His wheelchair was checked. It had bald, worn wheels with rubber peeling off. The right brake functioned well and locked. The left wheel brake was not functioning and did not lock. Resident #3 stated on the morning of 03/14/25, Nurse Aide #1 was helping him transfer from the side of his bed, with assist to stand, and pivot to his wheelchair. The wheelchair started to slide back on the left side, when NA #1 started to lower him onto the wheelchair seat. Resident #3 stated he told NA not to lift him up, but to lower him to the floor, which she did. When he was on the floor, they both heard a pop from his left knee. He said a nurse looked at his knee, which did not hurt at all until the dialysis staff used a mechanical lift, and straightened his leg to put him into their dialysis lift, and it was then that he said his knee started to hurt. He stated he had two knee x-rays, which were negative for knee injury, and had doctor visits and an orthopedic visit and they thought his knee was the issue and the reason for his pain, which the facility was medicating him for. During a follow-up orthopedic visit, the orthopedic nurse observed that his left foot was turned inward, and they sent him to the hospital for further testing and evaluation on 03/27/25. It was at that time that the x-rays revealed a fractured femur, not a dislocated hip or injured left knee. Resident #3 said he then had	F0689	Continued from page 41 properly maintained and used appropriately. Malfunctioning equipment (e.g., wheelchairs) must be immediately removed from use. This information has been integrated into the standard orientation training and agency orientation for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 8/31/2025 will not be allowed to work until the training is completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 8/25/2025, the Director of Nursing and the Maintenance Director (or designee) will conduct audits to monitor fall prevention efforts and ensure the functionality of resident equipment. This will include reviewing five residents with documented falls to verify that appropriate interventions were initiated in a timely manner and that all equipment involved was functioning properly. Reports will be presented to the QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the QA Meeting. The QA Meeting is attended by the Administrator, DON, MDS Coordinator, Therapy, HIM, and the Dietary Manager. Date of Compliance: 9/1/2025	

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F0689 SS = G	Continued from page 42 surgery and was doing fine now. He said when NA #1 lowered him to the floor on 3/14/25 his left leg must have bent at a strange angle. An interview was conducted on 08/05/25 at 8:15 AM with NA #1. She said on 03/14/25 around 5:00 AM she was helping Resident #3 pivot from his bed to the wheelchair for his dialysis appointment and when she was lowering him onto his wheelchair, she noted his wheelchair started to slide back some on the left side, even though she thought he had both wheels locked. She said she was going to lift him back onto his bed, but the resident said he did not want to see her hurt her back, and asked that she lower him to the floor, which she did without incident. She said she heard resident's knee pop, but he denied any injury or pain, and wanted to go to his dialysis appointment, which he did. The NA stated she told Nurse #3 about the incident, and the nurse immediately assessed Resident #3's left knee, which was not painful or swollen, so the resident stated he still wanted to go on to his dialysis appointment, which he did. A nursing note written by Nurse #3, dated 03/14/25 at 7:10 AM for Resident #3 revealed the resident returned to facility from dialysis in wheelchair. The resident was alert and oriented upon return and answered writer's questions appropriately. The resident said, "When the girl got me up this morning around 5:00 AM to put me in my chair, the chair kept moving back, and instead of her struggling, I told her to sit me down on the floor and I guess my leg twisted and I heard a pop in my knee and I was fine it didn't hurt, but when I got to dialysis and they put me in the mechanical lift I was very uncomfortable and it took everything in me to not scream because my knee hurt so bad and I just could not take it so I had to come back." The resident's vital signs were obtained and documented. The resident requested and received as needed pain medication. The resident stated he was unable to straighten his leg without pain. Nurse Practitioner #1 was notified and stated she had already spoken to Nurse #3 and given orders for Resident #3 to obtain a left knee x-ray. This writer has put in order with portable x-ray and notified resident and resident's Responsible Party (RP) via voicemail. An interview was conducted on 08/05/25 at 1:20 PM with Nurse #3 who stated Resident #3 returned from dialysis around 8:30 AM on 03/14/25 and told her that his left knee started to hurt at dialysis. The resident told her that earlier when NA #1 was helping him into his	F0689		

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F0689 SS = G	Continued from page 43 wheelchair to go to dialysis, the wheelchair moved, so the NA #1 lowered him to the floor, and he heard his left knee pop. Resident #3 stated his knee did not hurt at that time, so he went to his dialysis appointment, where his left knee started to hurt. Nurse #3 stated she went and got NP #1 to come and assess the resident's knee and she ordered a portable x-ray and set up an orthopedic consult visit. They also asked for maintenance to change out resident's wheelchair. The nurse said if Resident #3's wheelchair had locked properly and did not slide backwards on the left side during his pivot transfer, NA #1 would not have had to lower the resident to the floor, and Resident #3's left knee would not have popped, resulting in further pain and treatment. A written statement from the Maintenance Director revealed, "On 03/14/25 he received a request to check Resident #3's wheelchair for brakes locking properly. When checked it was noticed that the rubber piece on the wheelchair had worn down and the brake was not engaging properly. Resident #3 was in bed at the time, and the wheelchair was replaced. I removed the chair with the wheel issue from the room and took it to the storage area." An interview was conducted on 08/05/25 at 1:30 PM with the Maintenance Director. He stated he checked Resident #3's wheelchair on 03/14/25, after returning from dialysis. He observed the wheelchair tire rubber did not contact the brake on the left side and could easily slide back on the left side. He stated he removed the wheelchair from the room and brought in another one. He stated he and his assistant did monthly wheelchair checks on all facility wheelchairs. He said he might have missed checking Resident #3's if he was out of facility. The Maintenance Director did not know how Resident #3's old wheelchair got back into his room. An interview was conducted on 08/07/25 at 3:45 PM with Nurse Practitioner (NP) #1. The NP stated on 03/14/25 she assessed Resident #3 after his fall and return from dialysis. She said after his dialysis appointment, he was complaining of left knee pain, so she ordered an x-ray. The NP stated when she assessed his left knee, there was no swelling, no hip pain, or injury of any kind observed. She said his left knee x-ray was negative, and still he was complaining of left knee pain, so she obtained an order to send him to orthopedics for a second x-ray, evaluation and treatment. NA #1 said the second left knee x-ray from orthopedics was also negative for fracture, so they	F0689		

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F0689 SS = G	Continued from page 44 gave him a cortisone steroid injection to see if that would stop his left knee from pain. NP stated after the steroid injection, Resident #3 was still complaining of left knee pain. Orthopedics thought he might then have a dislocated left hip, so they ordered him to go to the hospital for further work-up and treatment. She stated the hospital's hip x-rays revealed the resident had a femur fracture. The NP #1 stated throughout time Resident #3 only complained of left knee pain. NP said nursing staff did what they were trained to do, step by step. She voiced no staffing concerns. A nursing note dated 03/20/25 at 05:10 PM for Resident #3 revealed the resident was out of facility for orthopedic appointment. The resident returned to facility with paperwork stating left knee pain with decreased range of motion and decreased strength. The resident was given cortisone injection in left knee at appointment, for left knee pain to rule out left knee ligament tear, with additional knee x-rays ordered to be obtained at orthopedics and resident to follow up with orthopedics after x-rays obtained. A physician note dated 03/27/25 by the Medical Director #1 for Resident #3 revealed resident complaints about his left hip and knee pain for the past 6 days. He was transitioning into his wheelchair and inadvertently placed weight on that left knee which caused him to lose balance and then the wheelchair moved away from him, and he was lowered to the floor. He complains of pain in the lateral left hip radiating down the lateral thigh to the left knee. He was unable to sustain any weight on his left lower extremity or turn or move the left hip without pain. His left lower extremity is internally rotated with trace lower extremity edema specifically in ankles, unable to place weight upon the left lower extremity due to pain, left hip with significant decreased range of motion due to pain, left lower extremity internally rotated and foreshortened consistent with a dislocation. Emergency Medical Services (EMS) transported Resident #3 to the hospital for possible left hip dislocation or fracture. He was taken to orthopedics where he was evaluated. He was treated with a left knee injection of lidocaine and triamcinolone (a common medical procedure used to treat various conditions involving inflammation and pain). He was subsequently diagnosed with left femoral fracture and underwent surgery of left femur on 03/28/25, with a closed fracture of shaft of left femur. An interview was conducted on 08/07/25 at 3:30 PM with	F0689		

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F0689 SS = G	Continued from page 45 the Medical Director #1. The Medical Director stated when Resident #3 was lowered onto the floor on 03/14/25, he initially had no pain or swelling and went on to dialysis and there he first complained of left knee pain. Upon his return from dialysis the facility obtained a portable x-ray of his left knee, which was negative for fracture. The Medical Director stated the resident was still complaining of pain after the initial x-ray, so a second x-ray was taken, and it also was negative for left knee fracture. The Medical Director stated Resident #3's fall on 03/14/25 initially had no pain from being lowered to the floor and later complained of left knee pain, which was possibly nerve pain that radiated to his left knee, due to a hairline fracture in his left femur that completed the non-displaced fracture days later. The Medical Director stated after the second negative knee x-ray orthopedics gave him a steroid knee injection, which helped some, but his left knee was still hurting after the injection, so they sent him to the hospital for further evaluation and treatment for possible hip dislocation. The hospital's hip x-ray did not show a dislocated hip, but a non-displaced femur fracture, which was treated with ORIF surgery. Medical Director #1 stated all of this might have been prevented if the facility had thrown out the resident's worn-out wheelchair in the first place and provided him with a new one with good wheel tread. The Administrator presented a timeline of Resident #3's fall dated 03/14/25. It revealed during a one-person stand-pivot transfer, Resident #3 requested for the staff member (NA#1) to lower him to the floor when the wheelchair moved backward during the transfer. The resident denied immediate pain, refused assessment and proceeded to dialysis as scheduled. The resident returned from dialysis with complaints of left knee pain, with the resident being immediately assessed by Nurse #3 with notification to the medical provider, with order received for left knee x-ray, and pain management given per regimen and effective. The resident's wheelchair was removed by maintenance with replacement chair provided. The Nurse Practitioner (NP #1) assessed the resident with orders to include x-ray and orthopedic referral. Mobile x-ray on 03/14/25 of resident's left knee revealed knee without fractures or dislocations identified. On 03/17/25 the NP follow-up assessment noted positive bursa effusion (accumulation of fluid in the sacs that cushion joints), and updated resident that the knee x-ray results were without fracture with recommendation to continue with orthopedic consult. On 03/20/25 Resident #3 was sent to orthopedics, with treatment regimen of steroid	F0689		

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F0689 SS = G	Continued from page 46 injection to the left knee, with order to repeat x-ray at local diagnostic center. On 03/20/25 Resident #3 was assessed by the facility medical director with further review of the 03/15/25 x-ray results with notation of results to include: no fracture or dislocation. On 03/21/25 the NP follow-up with notation resident moves all extremities, left knee flexed position and complains of pain at whole knee, with no discoloration and minimum swelling. On 03/24/25 NP #1 evaluated resident with continuation in current plan of treatment. On 03/25/25 the resident was sent out to outpatient diagnostic center for left knee -ray with results to include no fracture or dislocation noted. On 03/27/25 Resident #3 complained of pain to left hip area, not previously identified by resident during prior assessments. Nurse #3 notified NP #1 with new orders of two view x-ray of left hip. On 03/27/25 Medical Director #1 completed a physical assessment on Resident #3 with new orders given to send Resident #3 to local emergency department for further evaluation and treatment. On 03/27/25 hospital records indicated Resident #3 had a left hip fracture of the proximal femoral shaft. On 03/28/25 Resident #3 underwent open reduction internal fixation (ORIF) of his left femur. An observation was conducted on 08/05/25 at 12:20 PM of Resident #3's wheelchair located next to his bed. Resident #3 confirmed the wheelchair next to his bed was his. The wheelchair's two large back tires were worn flat and peeling black rubber tread. The right brake worked well, but the left tire brake did not lock on tire allowing the tire to slide backwards when in the locked position. The resident stated he could not remember if they gave him a different one or not after the 03/27/25 fall. An interview was conducted on 08/04/25 at 3:00 PM with the Director of Nursing (DON). The DON stated that the root cause for Resident #3's fall on 03/14/25 was a faulty wheelchair where the left brake didn't lock due to the worn tire tread, causing the wheelchair to slide back resulting in NA #1 having to lower the resident to the floor. An interview and follow-up wheelchair observation with the Administrator and Director of Nursing were conducted on 08/05/25 at 12:45 PM. They confirmed that on 03/14/25 Resident #3 was lowered to the floor because his wheelchair slid back, due to worn tires, and the left brake lock did not grab the bald tire, which was a wheelchair equipment failure. The DON	F0689		

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F0689 SS = G	Continued from page 47 stated Resident #3's old wheelchair should not have been in his room to use on 08/05/25, and should have been discarded, and a properly functioning wheelchair put in its place. The DON and Administrator expected Resident #3's wheelchair to have been replaced, and all wheelchairs in facility checked monthly and for brakes and tires to function properly, which in Resident #3's case, they missed. The Administrator and DON said they immediately removed Resident #3's wheelchair from his room after the 03/14/25 fall and replaced it with a new one. They both stated they had no idea how Resident #3's old wheelchair showed up in his room on 08/05/25.	F0689		
F0726 SS = J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F0726	F726 Corrective action for resident Resident #119 was admitted on 10/17/2024 with a physician-prescribed life vest. The clinical staff did not receive adequate training or demonstrate competency in the operation, monitoring, and emergency response procedures associated with the device. This lack of preparedness created a significant risk for serious adverse outcomes for Resident #119. Resident #119 was shocked by her Life Vest multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and took no action with the exception of notifying the oncoming first shift nurse that the Life Vest was “shocking the resident all through the night”. On 2/13/25 Resident #119’s Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the Life Vest’s manufacturer that the resident had a severe episode of ventricular tachycardia. Nurse #1 no longer works for the facility. The Administrator and the Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. Resident #119 did not return to the facility after discharge on 2/13/25. Corrective action for residents with the potential to be affected by the alleged deficient practice As of 8/8/25, a review conducted by the Director of Nursing confirmed that there have been no residents with a life vest residing in the facility since	09/01/2025

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F0726 SS = J	Continued from page 48 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Medical Director #1, Cardiologist, Resident Representative, LifeVest technician, and LifeVest patient representative interviews, the facility failed to ensure staff were trained and competent to care for a resident who wore a LifeVest (a device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm). Resident #119 received a treatment shock multiple times by the LifeVest she was wearing in the early morning hours (beginning shortly after midnight) on 2/11/25. Nurse #1, an agency nurse assigned to Resident #119, observed the device deliver the treatment shocks to Resident #119 and took no action with the exception of notifying the oncoming first shift nurse (Nurse #5) that the LifeVest was "shocking the resident all through the night". The 7 of 7 staff members that cared for Resident #119 from 02/11/25 through 02/13/25 that included Nurse #1, Nurse #5, Nurse #6, Nurse #8, Nurse Aide (NA) #2, NA #6, and NA #7 had not been trained on how to respond if the LifeVest alarmed or sounded or how to respond if the LifeVest delivered a treatment shock. Per the manufacturer instructions, if a treatment shock was delivered, the physician was to be called immediately, and an announcement was made by the device with this instruction. Resident #119's Cardiologist contacted the facility on 2/13/25 and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock (medical emergency resulting from inadequate blood flow to the body's organ due to dysfunction of the heart).	F0726	Continued from page 48 03/07/25. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice To prevent recurrence, a new protocol has been established requiring documented training and competency validation for any wearable cardiac device (e.g., cardioverter defibrillator) prior to resident admission. On 8/7/25, the Director of Admissions was instructed by the Administrator that any prospective resident with a wearable cardiac device must undergo a clinical review to ensure staff competency before acceptance. On 8/8/25, a life vest manufacturer representative came to the facility to complete a hands-on review of the care and function of the life vest, utilizing a demo vest, with the Director of Nursing and the Director of Staff Education. Instruction manual with several resource documents were provided. On 8/10/25, the Director of Nursing created a life-vest quick reference guide for each nursing station. Contents of the manual included a patient checklist, a quick reference guide for trouble shooting, an educational overview for patients and families on use of the life vest, and the manufacturers manual for the life vest. The 24- hour help line number is also located on the outside and inside of the manual. Beginning 8/8/25, all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are required to complete education and competency validation prior to providing care to any resident with a wearable cardiac device. All licensed nurse new hires, including agency staff, must complete mandatory training and competency checks before being assigned to residents using these devices. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute Life Vest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the	

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F0726 SS = J	Continued from page 49 Immediate Jeopardy began for Resident #119 on 2/11/25 when Resident #119 received a treatment shock from LifeVest and the staff did not demonstrate competency for delivering care according to the manufacturer's instructions. Immediate Jeopardy was removed on 8/12/25 when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings: This tag is cross referred to: F580: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest Resident Representative and LifeVest Technician interviews, the facility failed to consult with Medical Director #1 when Resident #119's LifeVest (an external defibrillator designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) delivered treatment shocks to her multiple times in the early morning hours on 2/11/25. The LifeVest Resident Representative contacted Resident #119's Cardiologist on 2/13/25 about Resident #119's severe episodes of ventricular tachycardia, a life-threatening rapid heart rate. The Cardiologist called the facility and requested to talk to the Medical Director. The Cardiologist recommended that the resident be sent to the hospital for evaluation. The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for notification of change (Resident #119).	F0726	Continued from page 49 Life Vest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for life vest. On 08/06/25, all Certified Nursing Assistants received education from the Director of Nurses, Director of Staff Education, and the Minimum Data Set Nurse Coordinator on the need to immediately report to the staff nurse when a resident utilizing a life vest receives a shock treatment or expresses any other concerns. Staff who do not complete the training by 8/11/25 will not be permitted to work until the training is completed. The Director of Nursing and the Director of Staff Development will do a daily reconciliation of the schedule to ensure all licensed staff have completed the training and competency validation and all Certified Nursing Assistants received education as indicated above. This in-service training indicated above in addition to the competency validation for licensed staff has been incorporated into the orientation program for all new facility and agency staff. The in-service training indicated above for the Certified Nursing Assistants has been incorporated into the orientation program for all new facility and agency staff. No staff shall work without this training after 8/11/25 Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements Beginning the week of 8/18/25, the Director of Nursing will monitor that any prospective resident with a wearable cardiac device must undergo a clinical review to ensure staff competency before acceptance. This audit will be completed weekly x 4 weeks, then monthly x 2 months or until resolved. Reports will be presented to the Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The monthly Quality Assurance	

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F0726 SS = J	Continued from page 50 F684: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest technician and LifeVest patient representative interviews, the facility failed to obtain physician directives for staff about what to do when the LifeVest delivered a shock, identify the seriousness of Resident #119's cardiac status and the need for a comprehensive medical evaluation when a LifeVest (an external defibrillator device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) shocked the resident multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and took no action with the exception of notifying the oncoming first shift nurse that the LifeVest was "shocking the resident all through the night". From 2/11/25 through 2/13/25 the facility failed to consult with the physician regarding the LifeVest having delivered treatment shocks to the resident and provide ongoing nursing assessment. According to the manufacturer's instructions, a resident with a LifeVest is to be evaluated by a physician for potential arrhythmia once the vest delivers a treatment shock. On 2/13/25, Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for professional standards (#119). An interview with Resident #119's Resident Representative on 8/7/25 at 9:02 AM revealed that Resident #119 was not cognitively intact, was unable to	F0726	Continued from page 50 Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager and Dietary Manager. Date of Compliance: Date of compliance: 09/01/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329

(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
F0726 SS = J	Continued from page 51 manage the LifeVest device and was dependent on staff for all care. Resident Representative stated that when she visited Resident #119, she was unable to recall the exact dates, she observed that the extra battery for the LifeVest device was in a drawer or in a bag and was not charged and the transmitter (router) device was not plugged in. Resident Representative stated that when she asked the staff assigned to Resident #119 questions, she was unable to recall which staff members specifically, about the Life Vest device, the staff stated they did not know about it and to ask someone else. An interview was conducted with staff nurse Nurse #5 on 8/6/25 at 1:15 PM. Nurse #5 was assigned to Resident #119 frequently and was assigned to her on 2/11/25 from 7:00 AM to 7:00 PM. Nurse #5 indicated that Resident #119 had a LifeVest cardiac defibrillator device. Nurse #5 stated she had not received any training regarding the LifeVest device and there were no instructions for management or when to notify the provider regarding the device on Resident #119's Medication Administration Record (MAR). Nurse #5 stated that she had some knowledge of the LifeVest and how it functioned from working with one at another facility. Nurse #5 indicated she had not asked for training regarding the LifeVest device. Attempts were made to interview Nurse #1 were unsuccessful with text messages sent on 8/7/25 at 2:16 PM and 8/8/25 at 12:31 PM with no return call received. Nurse #1 was an agency nurse that worked as needed at the facility and was assigned to Resident #119 on 2/10/25 from 7:00 PM to 7:00 PM. Nurse #1 no longer worked at the facility. An interview with Support Nurse #1 (who was assigned as the on-call administrative nurse designated to be called for emergencies on 2/10/25-2/11/25) on 8/6/25 at 12:05 PM revealed she did not know anything about the device prior to Resident #119 being admitted with a LifeVest device and had received no training regarding the device. Support Nurse #1 indicated that she had not asked for training or information regarding the LifeVest. Support Nurse #1 stated that the facility had admitted residents with LifeVest devices in the past, but the residents had managed the device themselves, so she had not learned about the device or the management of it. Support Nurse #1 stated Nurse #5 informed her on 2/11/25 that Resident #119's LifeVest device had a message on the monitor that stated the gel was depleted. Nurse #5 requested that Support Nurse #1 call the LifeVest support help line. Support Nurse #1 stated that after speaking with the LifeVest technician on	F0726		

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F0726 SS = J	Continued from page 52 2/11/25, she learned that the blue gel observed on Resident #119's chest and upper body indicated that an electrical shock was administered due to an abnormal heart rhythm. An interview conducted with Nurse Aide (NA) #2 on 8/6/25 at 10:06 AM revealed that she was assigned to Resident #119 on 2/10/25 from 11:00 PM to 7:00 AM. NA #2 stated she had not received any training regarding the LifeVest device. An interview with Nurse #6, an agency nurse that worked at the facility as needed, was conducted on 8/7/25 at 2:20 PM. Nurse #6 indicated that she was assigned to Resident #119 on 2/12/25 from 7:00 PM to 7:00 AM. Nurse #6 stated she knew what a LifeVest device was from working with residents at other facilities with this device. Nurse #6 stated that she did not receive any training regarding the LifeVest device or how to manage it. Nurse #6 stated that she did not ask for training regarding the device since she only worked at the facility as needed and she worked the 7:00 PM to 7:00 AM shift when there was no administrative staff available. An interview with the Staff Development Director (SDD) on 8/6/25 at 12:25 PM revealed that she did not know much about the LifeVest Device when Resident #119 was admitted with the device in October 2024. The SDD stated that she researched the device to find out more about it. The SDD stated she briefly reviewed some of the things to know about the device with a few of the nurses and nursing assistants, she could not recall which ones. The SDD stated that information regarding managing the device should have been entered on the Medication Administration Record (MAR) by the admitting nurse so that all nurses were aware of the management of the device. The SDD stated she did not know how an agency nurse or facility nurse would know how to manage the LifeVest device or the response to an alarm. The SDD stated she did not complete any training on the LifeVest or orientation to the facility or procedures with agency Nurse #1 that was assigned to Resident #119 on the night of 2/10/25. The SDD was unable to explain why she had not conducted any training regarding the LifeVest device with the staff. The SDD stated she had not consulted with the physician regarding management of the LifeVest device. An interview with Medical Director #1 on 8/6/25 at 3:52 PM revealed that he had just started in the position at the facility in early February 2025 and prior to the incident with Resident #119's LifeVest on 2/11/25, he was not aware that the facility had an external	F0726		

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F0726 SS = J	Continued from page 53 defibrillator device in the facility. Medical Director #1 stated that the nursing staff should have been trained in the management of the LifeVest device due to the seriousness of the device and the potential for complications. An interview was conducted on 8/6/25 at 2:20 PM with the Director of Nursing (DON) and the Clinical Services Director. The DON stated that the facility had residents with a LifeVest in the past, and they usually had a booklet about the device and managed their own device. The DON did not recall if Resident #119 had a booklet or if she was able to manage her own LifeVest when she was admitted. The DON revealed that staff training about the LifeVest was not completed prior to Resident #119's admission in October 2024 with the physician order for the LifeVest device nor was staff training completed upon Resident #119's readmission in January 2025. The DON stated that training regarding the LifeVest was not provided at any time during Resident #119's stay at the facility. The DON did not provide a plan of correction and stated a plan of correction was not implemented nor was an investigation of the incident completed. The DON indicated that the staff should have been trained in management of the LifeVest and emergency procedures. There were no other residents at this time that had LifeVest in the facility. An interview with the Administrator on 8/7/25 at 4:00 PM revealed that when the facility admitted Resident #119 with the LifeVest device, the facility was responsible for managing the device. The Administrator stated that the facility staff as well as agency staff that were assigned to Resident #119 should have been trained regarding the seriousness of the LifeVest device and the directives for managing it. The Administrator did not recall if she was aware that Resident #119 had the LifeVest device prior to the incident on 2/11/25. The Administrator revealed that the DON and SDD were responsible for ensuring that staff were trained on medical devices or equipment prior to the resident's admission. The Administrator was notified of Immediate Jeopardy on 8/11/25 at 12:10 PM. The facility provided the following credible allegation of Immediate Jeopardy removal: Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.	F0726		

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F0726 SS = J	Continued from page 54 Resident #119 was admitted on 10/17/2024 with a physician-prescribed LifeVest. The clinical staff did not receive adequate training or demonstrate competency in the operation, monitoring, and emergency response procedures associated with the device. This lack of preparedness created a significant risk for serious adverse outcomes for Resident #119. Resident #119 was shocked by her LifeVest multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and took no action with the exception of notifying the oncoming first shift nurse that the LifeVest was “shocking the resident all through the night”. On 2/13/25 Resident #119’s Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest’ s manufacturer that the resident had a severe episode of ventricular tachycardia. Nurse #1 no longer works for the facility. The Administrator and the Director of Nursing attempted to contact Nurse #1 on 8/6/25, but the number was not operational. Resident #119 did not return to the facility after discharge on 2/13/25. As of 8/8/25, a review conducted by the Director of Nursing confirmed that there have been no residents with a LifeVest residing in the facility since 03/07/25. 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. To prevent recurrence, a new protocol has been established requiring documented training and competency validation for any wearable cardiac device (e.g., cardioverter defibrillator) prior to resident admission. On 8/7/25, the Director of Admissions was instructed by the Administrator that any prospective resident with a wearable cardiac device must undergo a clinical review to ensure staff competency before acceptance. On 8/8/25, a LifeVest manufacturer representative came to the facility to complete a hands-on review of the	F0726		

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F0726 SS = J	Continued from page 55 care and function of the LifeVest, utilizing a demo vest, with the Director of Nursing and the Director of Staff Education. Instruction manual with several resource documents were provided. On 8/10/25, the Director of Nursing created a LifeVest quick reference guide for each nursing station. Contents of the manual included a patient checklist, a quick reference guide for trouble shooting, an educational overview for patients and families on use of the LifeVest, and the manufacturers manual for the LifeVest. The 24- hour help line number is also located on the outside and inside of the manual. Beginning 8/8/25, all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) are required to complete education and competency validation prior to providing care to any resident with a wearable cardiac device. All licensed nurse new hires, including agency staff, must complete mandatory training and competency checks before being assigned to residents using these devices. Training for licensed nursing staff began on 8/8/25 and includes viewing the 26-minute LifeVest instructional video designed for both patients and caregivers. Following the video, the Director of Staff Education utilized a competency checklist to validate staff understanding. This competency checklist includes verbalization of understanding of the knowledge of the LifeVest purpose and function, application and maintenance, emergency response, communication and education as well as the location and contents of the quick reference guide for LifeVest. On 08/06/25, all Certified Nursing Assistants received education from the Director of Nurses, Director of Staff Education, and the Minimum Data Set Nurse Coordinator on the need to immediately report to the staff nurse when a resident utilizing a LifeVest receives a shock treatment or expresses any other concerns. Staff who do not complete the training by 8/11/25 will not be permitted to work until the training is completed. The Director of Nursing and the Director of Staff Development will do a daily reconciliation of the schedule to ensure all licensed staff have completed the training and competency validation and all Certified Nursing Assistants received education as indicated above.	F0726		

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F0726 SS = J	Continued from page 56 This in-service training indicated above in addition to the competency validation for licensed staff has been incorporated into the orientation program for all new facility and agency staff. The in-service training indicated above for the Certified Nursing Assistants has been incorporated into the orientation program for all new facility and agency staff. No staff shall work without this training after 8/11/25. Alleged date of Immediate Jeopardy removal: 8/12/25 The removal plan of the Immediate Jeopardy was validated on 8/14/25. A sample of staff including the Administrator, the DON, Support Nurse #1, SDD, nurses, and nurse aides were interviewed regarding in-services they received related to the deficient practice. All staff interviewed stated they received in-service training regarding the LifeVest purpose and function, application, maintenance and emergency response. Validation indicated that licensed nurses had completed a competency checklist regarding the LifeVest device and the indications to notify the physician. A LifeVest reference manual was created and was observed at the nurses' station. The immediate jeopardy removal date of 8/12/25 was validated.	F0726		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature	F0761	F761: Label/Store Drugs and Biologicals The facility failed to remove 1 opened multi-dose insulin injector pen that was expired on the (200-hall medication cart). 1. Corrective action for resident(s) affected by the alleged deficient practice: On 8/6/2025, Nurse #5 removed and discarded the expired multi-dose insulin injector pen from the cart. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected.	09/01/2025

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F0761 SS = D	Continued from page 57 controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on manufacturer directions, observations, and staff interviews, the facility failed to remove 1 opened multi-dose insulin injector pen that was expired in 1 of 3 medication carts (200-hall medication cart), reviewed for medication storage and labeling. The findings included: The manufacturer's directions for insulin glargine injector pen stated once opened, the product is good for 28-days. Discard after 28 days: Even if there's insulin left in the pen after 28-days, discard it. The insulin may have lost potency after this time. An observation of the 200-hall medication cart and interview with Nurse #5 were conducted on 08/06/25 at 8:45 AM. An opened insulin glargine injector pen dated 07/02/25 was found in the cart. The insulin glargine pen had a label on it which stated the insulin pen was to be discarded 28 days after opening. Nurse #5 stated the expired insulin glargine pen dated 07/02/25 should have been removed after 28-days by the night nurse on the 200-hall medication cart and was not. An interview was conducted with the Interview with the Director of Nursing (DON) after the medication storage observation on 08/06/25 at 3:30 PM. The DON stated the insulin glargine pen that was opened and dated 07/02/25 should have been discarded by the night nursing staff after 28-days from 07/02/25 and was not. An interview was conducted with the Administrator on 08/07/25 at 4:00 PM. She stated the nursing staff were responsible for dating the insulin pen injector when it was opened and discarding it 28 days after opening. The Administrator further stated the nursing staff were responsible for checking and removing any expired medication from the medication carts.	F0761	Continued from page 57 Beginning on 8/15/2025, The Director of Nurses, Staff Development Coordinator (SDC), Nurse Supervisor, and the Unit Support Nurses audited all medication carts, treatment carts, and medication rooms to identify any expired or undated medications. Corrections were made immediately where indicated to include discarding of any expired medications. This was completed on 8/15/2025. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 8/27/2025, the Staff Development Coordinator began educating all full time, part time, and PRN Licensed Nurses, Registered Nurses (RNs), Licensed Practical Nurses (LPN), and Medication Aides including agency staff on the following topics: Checking medications for expiration date prior to administering the medication. Labeling medications when opened with date open as indicated. McNeill's Pharmacy recommended storage for selected items. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/31/2025. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Beginning the week of 8/25/2025, The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tool weekly x 4 weeks then monthly x 2 months. The DON or designee will monitor	

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F0761 SS = D		F0761	Continued from page 58 for compliance with labeling medications with a date when opened and ensuring the medication and treatment carts and the medication room is free of expired medications. Reports will be presented to the Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 9/1/2025	
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to: a) label and date opened packages of food for 1 of 1 walk in freezers, b) label and date items in the large walk-in refrigerator and a smaller refrigerator for 2 of 2 refrigerators in the kitchen and c) discard expired items in 2 of 2 refrigerators in	F0812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F812 For dietary services, a corrective action was obtained on 8/04/2025. Based on initial tour of kitchen, nourishment room observations, and interviews; it was noted the facility had failed to store food properly in 2 of 2 nourishment rooms as well in the main kitchen in walk-in fridge, walk-in freezer, and reach-in fridge. On 8/04/2025 expired and improperly labeled items thrown out from kitchen areas and nourishment rooms. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 8/06/2025 the Dietary Service Director and Dietitian completed a walk-through of the kitchen and nourishment rooms to ensure all areas met standards to store, prepare, and serve sanitary food/beverages.	09/01/2025

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F0812 SS = E	Continued from page 59 2 of 2 nutrition rooms. This deficient practice had the potential to affect the food served to the residents. Findings included: An initial tour of the kitchen was conducted on 8/4/25 at 11:00 AM in the presence of the Dietary Manager. a) Observation of the walk-in freezer revealed the following: An open cardboard box containing an opened plastic bag of hamburger meat with no opened date, an opened plastic bag of tater tots with no opened dated and an opened plastic bag of diced potatoes with no opened date. The following were also observed in the walk-in freezer: An opened bag of chicken tenders with no opened date. An opened bag of frozen cookie dough with no opened date. An opened bag of garlic bread with no opened date. An interview with the Dietary Manager was completed on 8/4/25 at 11:05 AM. The Dietary Manager stated that all opened foods stored in the walk-in freezer should be labeled and dated with the date it was opened and the expiration date. b) Observation of the large walk-in refrigerator in the kitchen revealed the following: A tray with 7 individual salads with no prepared date and 1 of the salads had brown lettuce. An opened package of sliced deli ham with no opened date Observation of the small refrigerator in the kitchen revealed the following: An opened box of thawed sausage patties with an opened date of 7/2/25. The outside of the box stated the product was to be kept frozen. An opened box of thawed sausage links with an opened date of 7/2/25. The outside of the box stated the	F0812	Continued from page 59 Systemic changes In-service education was provided to Dietary Staff, Nursing Staff, and Environmental Service Staff on 8/26/2025. Topics included: Procedures and policies for handling personal food. Labeling and Dating policies and procedures This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Quality Assurance monitoring procedure. Beginning the week of 8/25/25 Dietary Service Director or assignee will monitor procedures for proper food storage in kitchen and nourishment rooms daily x 2 weeks then weekly x 4 weeks using the Food Dating/Labeling QA Tool which will observe that all supplements are labeled, dated, within proper dates, and stored properly. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of Compliance : 9/1/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329

(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
F0812 SS = E	Continued from page 60 product was to be kept frozen. An opened box of thawed bacon with no opened date. A list of Use By Dates for Refrigerator Items taped to the refrigerator stated thawed meats can be stored for 3 days. An interview was completed with the Dietary Manager on 8/4/25 at 11:30 AM. The Dietary Manager stated there was not supposed to be any expired food in the freezer or refrigerators. The Dietary Manager indicated there was not a consistent system to ensure that all foods were labeled, dated and discarded when the items expired. c-1) An observation of the refrigerator in the nutrition room on 700 and 800 Hall was conducted with the Dietary Manager on 8/5/25 at 3:00 PM. The following items were observed: An opened container of nectar thick sweet tea with an opened date of 4/3. An opened container of nectar thick water with an opened date of 3/3. The label on the containers of nectar thick liquids stated that after opening, the items may be kept up to 7 days under refrigeration. An opened bottle of prune juice with a date of 3/24. An opened carton of orange juice with no opened date. A plastic bag of fast food fried chicken with no name or date. An opened carton of apple juice with no opened date. A notice taped to the front of the refrigerator indicated juice in a carton was expired 7 days after being opened. c-2) An observation of the refrigerator in the nutrition room that is utilized for 100, 200, 300, 400, 500 and 600 halls was conducted with the Dietary Manager present on 8/5/25 at 3:10 PM and revealed the following: An opened bottle of prune juice dated 1/18.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/14/2025

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F0812 SS = E	Continued from page 61 An opened bottle of prune juice dated 3/29. An unopened half gallon bottle of milk with a sell by date of 7/19/25. An opened carton of medication pass supplement with a date of 7/19/25. The label on the medication pass supplement stated consume within 4 days of opening. An opened carton of nectar thick tea dated 4/3. An opened carton of nectar thick apple juice dated 4/16. A disposable take-out container of food with a resident name and no date. An interview with the Dietary Manager on 8/5/25 at 3:15 PM revealed that she expected that all refrigerated foods, liquids and supplements would be labeled and dated properly and that expired items would be discarded. An interview with the Administrator on 8/7/25 at 4:45 PM revealed she expected all foods, liquids, and supplements would be labeled and dated and that expired items would be discarded. The Administrator further stated she expected the kitchen staff would check the dates on foods, liquids, and supplements in the freezer and the refrigerators in the kitchen and nourishment rooms and discard expired items.	F0812		