STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 06/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 000	INITIAL COMMENTS A complaint survey was conducted from 6/3/24 through 6/19/24. The following intakes were investigated: NC00215780, NC00216087, NC00216376, NC00216563, NC00216579, NC00217169, NC00217722, NC00217345, NC00217512 and NC00217959. 2 of the 32 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 5/28/24 and was removed on 6/13/24. A partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring 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);	F 580		7/8/24

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

Electronically Signed | 07/03/2024

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, Responsible Party (RP) and Physicians the facility failed to immediately notify the responsible party	F 580	F580 - Notify of Changes (Injury/Decline/Room, etc.)	

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F 580	Continued From page 2 when Resident # 6's intravenous fluids (IV) infiltrated (IV fluids going into the surrounding tissue instead of the vein), and the fluids were placed on hold. At the time of infiltration, the resident had already been identified to have new swallowing problems, nausea, and no food intake for multiple consecutive meals. Resident # 6's family reported she would have requested the resident be sent to the hospital if she had known about any delay with the IV fluids. After the IV infiltration, the resident was transferred hours later to the hospital and admitted to the Intensive Care Unit for a principal diagnosis of sepsis. (Sepsis is a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction. The body's reaction causes damage to its own tissues and organs, and it can lead to shock, multiple organ failure and sometimes death). This was for one (Resident # 6) of three residents reviewed for change in condition. Immediate jeopardy began on 5/28/24 when Resident #6's RP agreed to treat the Resident at the facility after a change in condition and was not notified when the IV fluids infiltrated and were placed on hold. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: Resident # 6 was admitted to the facility on 2/28/24. The resident had diagnoses which included occipital stroke, Lewy body dementia, diabetes, hypothyroidism, hypertension,	F 580	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The facility must ensure the family is immediately notified when there is a change in treatment plans for a resident experiencing a change in condition. Resident #6 no longer resides in the facility. 2. On 6/4/2024, current resident□s records were reviewed by the Director of Nursing for the past 30 days for notification to physician and resident/responsible party of change in condition and treatment change during change in condition. Any concerns identified corrected immediately. Audit completed on 6/12/2024. 3. On 6/4/2024, education was initiated to licensed nursing staff by the Director of Nursing/Designee on notification to provider and resident/responsible party for change in treatment during change of condition. Education was completed by 6/8/2024. On 6/4/2024, education was initiated to Certified Nursing Assistants by the Director of Nursing/Designee regarding the ability to identify a change in condition in residents and reporting those changes to the nurse that includes but not limited	

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F 580	Continued From page 3 Parkinson's disease, depression, history of deep vein thrombosis/pulmonary embolism (blood clots). The resident's admission Minimum Data Set assessment, dated 3/5/24, revealed the resident had moderate impairment of her cognitive abilities. Review of orders revealed the resident was a full code while the resident resided at the facility. Review of nursing progress notes and electronic medication administration notes for the dates of 5/27/24 and 5/28/24 revealed the following information: On 5/27/24 at 8:49 AM Nurse # 1 administered Ondansetron (Zofran) 4 mg per a PRN (as needed) order for nausea and vomiting according to a MAR administrative note. On 5/27/24 at 12:38 PM Nurse # 1 documented in a MAR administrative note the Ondansetron (Zofran) had been effective. The following information noting a change in condition appeared in Resident # 6's nursing notes and was entered by Nurse # 1 with an "effective date of 5/28/24 at 9:20 AM." Nurse # 1 had attempted to give morning medications and the resident showed signs of difficulty swallowing. The resident did not want to eat anything. The resident's provider had given orders which included IV fluids to be administered. The following information appeared as "effective date of 5/28/24 at 9:35 AM" in Resident # 6's nursing notes. The Director of Nursing (DON) documented a "Late entry" that she had started	F 580	to having a decreased appetite, consistent refusal of therapeutic diet, nausea, decreased intake of fluids, and/or general malaise, etc. Education for licensed and unlicensed staff was completed by 6/8/2024. The Director of Nursing was responsible for ensuring all licensed and unlicensed staff received the education. Newly hired licensed, unlicensed and agency staff will receive this education during orientation. The Director of Nursing will be responsible for ensuring that this education is completed. An audit will be completed by the Director of Nursing/Designee during Clinical Morning Meeting of the 24/72-hour report x 12 weeks to ensure that notification is complete for all Change in Condition. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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an IV in the resident's arm.

After the DON's nursing note, the following information appeared as "effective date of 5/28/24 at 9:45 AM" in Resident # 6' s electronic record. Nurse # 1 wrote that the DON and another nurse attempted to place a peripheral IV and it was unsuccessful. The facility's IV team was called by the unit manager. The IV team gave a call back with an ETA (estimated arrival time) of 9:00 PM. The provider was called and gave orders to hold the IV.

Following Nurse # 1's entry for 5/28/24 at 9:45 AM the next nursing entry appeared as "effective date of 5/28/24 at 10:39 AM" in the resident's electronic record. It was entered by Unit Manager # 2 and included information that the resident's IV was started and ran about an hour until it infiltrated. The IV team was called and stated they would be in the building around 9:00 PM. The provider had said that waiting on the IV team to start the IV would be fine. There was no documentation that the RP was notified of this change in treatment plan to hold the IV fluids until 9:00 PM.

Following Unit Manager# 2's nursing entry for 5/28/24 at 10:39 AM the next nursing entry appeared as "effective date of 5/28/24 at 1:30 PM" in the resident's electronic record. It was entered by Nurse # 1 and read as a correction to the nurse's previous entry. The nurse noted the IV had been started but had infiltrated and was stopped. The estimated arrival time for the facility's IV team to arrive and start the IV was at 9:00 PM. There was no documentation the RP was notified.

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Nurse # 3 entered a nursing note in the progress notes with an "effective date" of 5/28/24 at 6:39 PM. The note read "Writer walked into the resident's room around 6 PM. Found out resident not responding, sweating all over her extremities, VS (vital signs) taken RR (respiratory rate) elevated Oxygen 2L administered via nasal canula. 6:10 PM writer called on call PA [Name PA # 2}. Order received to send her out via 911. EMS team arrived 1825 (Military time for 6:25 PM). Resident left to the [regional hospital] via stretcher by {name of county] EMS team around 1838 (Military time for 6:38 PM) {RP} present in the room with Emergency Medical Services (EMS) team when they arrived. Nurse Manager notified."

Review of EMS records revealed EMS was called on 5/28/24 at 6:17 PM and arrived at 6:31 PM. EMS noted the following information. The local fire department staff were already on the scene. The resident was receiving oxygen. The resident's eyes were open. She was unconscious and had a right sided gaze. The resident responded to pain. At 6:35 EMS recorded Resident # 6's vital signs as blood pressure 92/68; pulse 96; respirations 28; and oxygen level 77%. She was transported to the hospital. In route to the hospital, EMS documented they were not able to get a continual reading on the resident's oxygen level and they assisted the resident to breathe. The paramedics also placed a saline lock (a portal of entry to the vein) for IV access.

Review of hospital Emergency Department (ED) records and Intensive Care Unit admitting records, dated 5/28/24, revealed upon arrival to the ED, Resident# 6 was emergently intubated (a

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tube is inserted in a resident's throat, and they are placed on a machine to help them breath). She appeared critically ill and would not follow commands. The resident had multiple lab abnormalities which included although were not limited to the following: A potassium level of 7.3 (normal 3.5 to 5.0-- a potassium level of 7.3 is considered dangerously high and can cause heart problems); a white blood count of 27.2 (normal 3.2 to 8.8); a blood urea nitrogen level of 62 (normal 7-20); a creatinine of 4.7 (normal 0.4 to 1.0). She was admitted to the intensive care unit with the principle primary problem documented as Sepsis with acute organ dysfunction. Although not all inclusive, other active problems included hypotension (low blood pressure) related to hypovolemia (abnormally low extracellular fluid in the body which can occur from a loss of both salt and water) and acute kidney injury (sudden loss of the kidneys ability to filter the blood). The resident was given IV fluids in the emergency room.

Nurse # 1 had cared for Resident # 6 on 5/27/24 (Monday) and 5/28/24 (Tuesday) during the 7:00 AM to 3:00 PM shifts. Nurse # 1 was interviewed on 6/7/24 at 10:38 AM and reported the following information. The resident was experiencing a change in condition. She had symptoms of nausea, not eating, and not able to swallow as she usually did. She had spoken to Resident #6's RP on 5/28/24 and the RP wanted the resident sent to the hospital. This was the initial plan. After Unit Manager # 2 talked to the RP and the PA, then the plan was changed to treat the resident in the facility. Part of the treatment plan included orders for the resident to have an IV. She (Nurse # 1) observed the resident "appeared dry" when the DON started the IV. After about one hour, the

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IV infiltrated and it was stopped. She had called the PA and obtained an order to hold the IV. She was aware the IV team was coming to the facility around 9:00 PM to restart the IV. She had not called the RP about the IV infiltrating or about any delay in getting it restarted

Unit Manager # 2 was interviewed on 6/7/24 at 2:01 PM. The Unit Manger reported the following information regarding 5/28/24. She had talked to Resident # 6's RP on the morning of 5/28/24 and made her aware that the facility could provide treatment at the facility. The RP agreed. Orders were obtained for treatment. One of the orders included starting an IV. About an hour after the IV was started the IV was observed to be infiltrated and Nurse # 1 stopped the IV. The facility used a contracted provider to start IVs when needed. At first the IV team indicated they were coming right away and then they called back to say it would be around 9:00 PM. She had not called and talked to the RP about the delay in IV administration before leaving work that day around 3:00 PM. On 5/28/24 her phone showed a text message from 2:37 PM from Resident # 6's RP saying she was checking on the resident and wanting to know if there was anything else that she (the RP) needed to do. She (Unit Manager # 2) saw the text message at 5:35 PM and called the RP back. She informed the RP at that time that the resident's IV had infiltrated and about the delay in the IV fluids. Prior to 5:35 PM, she had not spoken to the RP about the IV infiltrating or about the anticipated delay in getting it restarted.

Resident# 6's RP was interviewed on 6/10/24 at 8:26 AM and reported the following information. When she talked to Unit Manager # 2 on the morning of 5/28/24 the Unit Manager had asked

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her why she would want Resident # 6 sent to the ED (Emergency Department) where the resident would sit for hours when the facility could do tests and treatment there. It was her (the RP's) understanding that Resident # 6 would be seen by the provider, receive IV fluids, diagnostic tests, and monitoring at the facility. That was why she agreed because the Unit Manager had said to trust her that these things could be done. She did not hear about a delay in providing IV fluids until she talked to Unit Manager # 2 at 5:35 PM. If she had known they were having to wait on an IV placement, she would have told the staff to go ahead and send Resident # 6 to the hospital. The RP commented, "Who wouldn't have?"

The chief operating officer of the company which provides IV placement services to the facility was interviewed on 6/10/24 at 1:03 PM and reported the following. They had received the first call from the facility on 5/28/24 at 1:40 PM requesting placement for Resident # 6's IV.

The Emergency Department physician was interviewed on 6/3/24 at 1:00 PM and reported the following. When Resident # 6 had arrived at the hospital she was very septic and had to be emergently intubated. She was hypothermic with unstable vital signs. Even with medical treatment, the resident continued to worsen. It was his opinion that if the resident had been transferred to the hospital even four hours earlier, she would not have been as sick.

The facility's Medical Director was interviewed on 6/10/24 at 4:41 PM and reported the following information. Residents who become septic can become worse very quickly. According to the medical director, retrospectively, sometimes it

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can be seen that a few hours in treatment may have made a difference with a resident but that is not always initially apparent with residents when they first develop symptoms which progress to severe illness.

On 6/14/24 at 11:33 AM the facility Administrator was informed of Immediate Jeopardy.

The facility provided the following credible allegation of immediate jeopardy removal with a completion date of 6/13/24.

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

The facility must ensure the family is immediately notified when there is a change in treatment plans for a resident experiencing a change in condition.
On 5/28/2024
1) staff were aware the resident had experienced two consecutive days in which she had experienced nausea;
2) the resident had not eaten any food for four consecutive meals (all meals on 5/27/24 and breakfast on 5/28/24)
3) The resident had new swallowing problems
4) The staff had been made aware on 5/25/24 the resident's family noticed she would take a few bites and she would throw up
5) the resident's heart rate was on the upper end of normal registering 100 and
6) Resident # 6's family was wanting her sent to the hospital on the morning of 5/28/24.
On the morning of 5/28/24 the PA was in the facility and left orders for the resident to be treated at the facility without physically evaluating the resident. According to the family, the family

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was in agreement with the resident receiving treatment at the facility with the understanding that the resident would be seen by the provider, be monitored and receive diagnostic tests and treatment which included IV fluids.
On 5/28/24 the facility became aware the IV had infiltrated and there would be a delay in starting it again. The family was not notified at that time and reported if they had been notified, they would have wanted the resident sent on to the hospital. The resident was later sent out hours later to the hospital and required assistance breathing by EMS in route to the hospital. She required intubating at the hospital ER. According to the ER physician, it was his opinion that if the resident had been sent out four hours earlier, she would not have been as sick.
On 6/4/2024, current residents records were reviewed by the Director of Nursing for the past 30 days for notification to physician and resident/responsible party of change in condition and treatment change during change in condition. Audit completed on 6/12/2024.
2) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 6/4/2024, education was initiated to licensed nursing staff by the Director of Nursing/designee on notification to provider and resident/responsible party for change in treatment during change of condition. Education was completed by 6/8/2024.
On 6/4/2024, education was initiated to certified nursing assistants by the Director of Nursing/designee regarding the ability to identify a change in condition in residents and reporting those changes to the nurse that includes but not

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F 580	Continued From page 11 limited to having a decreased appetite, consistent refusal of therapeutic diet, nausea, decreased intake of fluids, and/or general malaise, etc. Education for licensed and unlicensed staff was completed by 6/8/2024. The Director of Nursing was responsible for ensuring all licensed and unlicensed staff received the education. Newly hired licensed, unlicensed and agency staff will receive this education during orientation. The Director of Nursing will be responsible for ensuring that this education is completed. Effective 6/8/2024, the Administrator and Director of Nursing will be ultimately responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged Date of Immediate Jeopardy Removal: 6/13/2024 On 6/19/24, the facility's credible allegation for immediate jeopardy was validated. Review of the facility's corrective action plan revealed 100% licensed nursing staff education regarding notification to the provider and resident and/or responsible party (RP) for any changes of condition, as well as 100% unlicensed nursing staff education regarding reporting changes in resident condition to the nurse. Education was completed by 6/12/24. 100% audit of resident medical records was completed to ensure that notification of changes in condition was completed in the past 30 days as applicable. The audits began on 6/4/24 and were ongoing. Staff interviews confirmed education was received on notification of the nurse or provider and resident and/or RP for any changes in condition. The facility's immediate jeopardy removal date of 6/13/24 was validated.	F 580		
F 684 SS=J	Quality of Care	F 684		7/8/24

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F 684	Continued From page 12 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, resident, Responsible Party (RP,) Nurse Practitioner, Physician Assistants, and Physicians the facility failed to effectively communicate amongst their staff and with the medical providers and family and to ensure assessment and treatment occurred for a resident who was showing signs of a change in condition and whose family had initially requested the resident be transferred to the hospital but agreed with facility treatment based on the understanding the resident would receive appropriate evaluation and treatment at the nursing home. The resident's status deteriorated while still at the facility, and she was transferred to the hospital where she was emergently intubated (a tube is placed down an individual's throat, and they are placed on a machine to help them breathe) and admitted to the intensive care unit with a principal problem of sepsis with acute organ dysfunction. (Sepsis is a life-threatening condition that happens when the body's immune system has an extreme response to an infection, causing organ dysfunction. The body's reaction causes damage to its own tissues and organs, and it can lead to shock, multiple organ failure and sometimes death). This was for	F 684	F684 - Quality of Care Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. The facility must ensure it recognizes the need to assess residents and effectively communicate amongst themselves, the provider, and family in order that residents receive treatment and evaluation. Residents that experience a change in condition have the potential to be affected. Resident #6 no longer resides in the facility. 2. On 6/4/2024, current resident records were reviewed by the Director of Nursing for the past 30 days for a change in condition. The audit included 1) Did the resident have a change in condition? 2)	

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F 684	Continued From page 13 one (Resident # 6) of three sampled residents reviewed for professional standards of practice. Immediate jeopardy began on 5/28/24 when due to poor communication over several shifts the facility failed to identify the seriousness of the changes in Resident #6's condition, complete thorough assessments or identify the urgent need for medical attention. Immediate jeopardy was removed on 6/13/24 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective. The findings included: Resident # 6 was admitted to the facility on 2/28/24. The resident had diagnoses which included occipital stroke, lewy body dementia, diabetes, hypothyroidism, hypertension, Parkinson's disease, depression, history of deep vein thrombosis/pulmonary embolism (blood clots). The resident's admission Minimum Data Set assessment, dated 3/5/24, revealed the resident had moderate impairment of her cognitive abilities. Additionally, she was assessed to require set up to eat, needed substantial to maximum assistance with her hygiene and turning in bed, and required total assistance with her toileting and bathing needs. She was also assessed to be totally incontinent of both bowel and bladder.	F 684	Was the change in condition identified and addressed by the staff? 3) Was the provider notified of the signs/symptoms of the change in condition? 4) Were new orders given for the change in condition and followed appropriately and timely? 5) Was the resident□s responsible party notified of the change in condition and provider□s orders? 6) If any, were the providers orders entered into the electronic medical record timely? 7) If the order was to send the resident out, was the resident sent to the ED? No negative findings as a result of the audit. Audit completed on 6/12/2024. 3. On 6/4/2024, education was initiated to licensed nursing staff by the Director of Nursing/Designee on assessments of change in condition. The education included recognizing the clinical changes that warrant a change in condition (including consistent decreased meal intake), perform timely assessment (to include vital signs and pain assessment) of the resident and provide immediate and appropriate interventions. A change in condition evaluation should be completed including a full progress note on the resident□s signs and symptoms, when the change in condition was recognized, interventions performed, notification to the provider and what was relayed in the conversation as appropriate, notification to the family, when EMS was called (if applicable), and that report was given to EMS. On 6/4/2024, education was initiated to	

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F 684	Continued From page 14 Review of orders revealed the resident was a full code while the resident resided at the facility. On 3/1/24 Resident # 6 was ordered to receive speech therapy services for cognitive communication deficits. According to a Speech Therapy discharge summary, dated 3/26/24, the resident's swallowing function had also been assessed and she had no signs of esophageal dysphagia (difficulty swallowing). Review of progress notes revealed Resident # 6 was seen on 5/6/24 by Nurse Practitioner (NP) # 1 who noted the visit was per the family/resident requests due to nausea. The NP noted that the resident denied any other issues at the time. The NP further noted she changed the resident's timing of some of her medications, and also prescribed Zofran as needed if further nausea occurred. (Zofran is a medication used to treat nausea). Review of progress notes revealed Resident # 6 was seen again by Nurse Practitioner# 1 on 5/8/24. The Nurse Practitioner noted the resident denied any issues with pain, bowel or bladder or sleep at the current time. Interview with NP # 1 on 6/10/24 at 2:33 PM revealed it was her impression when she saw Resident # 6 on 5/6/24 and 5/8/24 that the resident's nausea was not chronic and could possibly be related to medication timing. She had adjusted the timing of some of the resident's medications. When she saw the resident on 5/8/24 the resident did not complain of further nausea.	F 684	licensed nursing staff by the Director of Nursing/Designee regarding appropriate communication techniques, to include the utilization of the SBAR process during shift-to-shift report. SBAR should be communicated between nurses at bedside during shift change, communicated between nurse and provider to notify of changes from the resident□s baseline or if changes have happened since the last update to the provider. On 6/4/2024, education was initiated to Certified Nursing Assistants by the Director of Nursing/Designee regarding ability to identify a change in condition in residents and the timely reporting of those changes to the nurse that includes but not limited to having a decreased appetite, consistent refusal of therapeutic diet, nausea, decreased intake of fluids, and/or general malaise, etc. Education for licensed and unlicensed staff was completed by 6/8/2024. The Director of Nursing was responsible for ensuring all licensed and unlicensed staff received the education. Newly hired licensed, unlicensed and agency staff will receive this education during orientation. The Director of Nursing will be responsible for ensuring that this education is completed. An audit will be completed by the Director of Nursing/Designee during Clinical Morning Meeting of the 24/72 hour report x 12 weeks to ensure that 1) Did the	

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F 684	Continued From page 15 Review of Resident # 6's May 2024 Medication Administration Record (MAR) revealed between the dates of 5/6/24 and 5/27/24, Resident # 6 received the Zofran once. This was on 5/12/24 at 8:27 PM. Review of nursing progress notes and electronic medication administration (EMAR) notes for the dates of 5/27/24 and 5/28/24 revealed the following information: On 5/27/24 at 8:49 AM Nurse # 1 administered Ondansetron (Zofran) 4 mg per a PRN (as needed) order for nausea and vomiting according to a MAR administrative note. On 5/27/24 at 12:27 PM Nurse # 1 documented in a nursing note Resident # 6's vital signs registered blood pressure 129/72; temperature 98; pulse 93; respirations 16. The nurse further documented the resident had no complaints of pain. On 5/27/24 at 12:38 PM Nurse # 1 documented in a MAR administrative note the Ondansetron (Zofran) had been effective. On 5/27/24 at 8:02 PM Nurse # 5 documented in a nursing note the following vital signs: blood pressure 129/72; temperature 97.8; pulse 93; respirations 16; and the resident was without pain. The following information noting a change in condition appeared in Resident # 6's nursing notes and was entered by Nurse # 1 with an "effective date of 5/28/24 at 9:20 AM." Nurse # 1 had attempted to give morning medications and the resident showed signs of difficulty swallowing. The resident did not want to eat anything. The	F 684	resident have a change in condition? 2) Was the change in condition identified and addressed by the staff. 3) Was the provider notified of the signs/symptoms of the change in condition? 4) Were new orders given for the change in condition and followed appropriately and timely? 5) Was the resident□s responsible party notified of the change in condition and provider□s orders? 6) If any, were the providers orders entered into the electronic medical record timely? 7) If the order was to send the resident out, was the resident sent to the ED. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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resident had no complaints of nausea and no emesis. The resident's provider ordered a KUB (kidney, ureter, and bladder x-ray), IV (intravenous) fluids, CBC (complete blood count) and CMP (complete metabolic panel) to be drawn with a gastrointestinal consult to also be done. Nurse # 1 further recorded Resident # 1's vital signs as blood pressure-131/74 taken at 9:43 AM; pulse100 taken at 9:43 AM; temperature-97.8 taken at 9:44 AM; and respirations 16 taken at 9:43 AM. The resident's oxygen saturation registered 98% on room air.

The following orders were entered into the computer on 5/28/24:
Stat KUB
Stat CBC and CMP
Start peripheral IV of NACL .45% (Sodium Chloride) at 90 cc (cubic centimeters)/ hour for 1000 cc.

The following information appeared as "effective date of 5/28/24 at 9:35 AM" in Resident # 6's nursing notes. The DON (Director of Nursing) documented a "Late entry." She had started an IV in the resident's left arm.

After the DON's nursing note, the following information appeared as "effective date of 5/28/24 at 9:45 AM" in Resident # 6' s electronic record. Nurse # 1 wrote, "Writer received orders to send patient out to the ER from {Name of Physician Assistant #1] Orders were put on hold by DON to do work on patient in house. DON/Unit Manager received new orders from NP. Orders given to writer are place peripheral IV, IV fluids, KUB, CMP and CBC, and GI consultation. Orders followed. DON and another nurse attempted to place peripheral IV and it was unsuccessful. IV

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team called by unit manager. IV team gave a call back with an ETA (estimated arrival time) of 9:00 PM. NP was called and writer was given orders to hold fluids until IV team arrives to place the IV. Stat KUB and stat labs were done around 3:00 PM. Plan of care ongoing."

Following Nurse # 1's entry for 5/28/24 at 9:45 AM the next nursing entry appeared as "effective date of 5/28/24 at 10:39 AM" in the resident's electronic record. It was entered by Unit Manager # 2 and read, "Writer approached by assigned nurse in regard to resident experiencing n/v (nausea/vomiting). Writer approached NP in the building asking her to assess resident, NP gave orders to treat in house due to resident being stable at the time of assessment. Resident able to respond to writer's commands. No pain nor any s/sx (signs/symptoms) of distress at the time. New orders for IV fluids, Stat orders for a KUB, CBC, CMP. Orders were completed. Resident's fluids hanged and ran for about an hour until IV was infiltrated (IV fluids going into the surrounding tissue instead of the vein). IV team was called and stated they would be in the building around 9:00 PM. Assigned nurse asked if we could do a hypodermoclysis (IV fluids are administered underneath the skin). NP stated that waiting for the IV team would be fine."
Following Unit Manager# 2's nursing entry for 5/28/24 at 10:39 AM the next nursing entry appeared as "effective date of 5/28/24 at 1:30 PM" in the resident's electronic record. It was entered by Nurse # 1 and read, "Correction: IV placement on left AC successful, IV fluids given. Order .45 Normal Saline 90 cc/hr (hour) X 1 L bag. IV fluids ran for 1 hr (hour). Writer assessed patient with unit manager. IV infiltration noted. IV fluids stopped. NP notified. IV team called to

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place IV. Unit Manager contacted IV team. IV team called back with an ETA (estimated time of arrival) of 9 PM. NP notified and orders given to hold IV fluids until IV placement. Plan of care ongoing."

An entry in the electronic record appeared as a Medication Administration Record note with an "effective date" of 5/28/24 at 2:34 PM. It was entered by Nurse # 1. Nurse # 1 noted the IV team was being awaited. The NP was notified, and a verbal order was given to hold the IV fluids.

The next nursing entry appeared with an "effective date" of 5/28/24 at 3:35 PM in the resident's electronic record. It was entered by Nurse # 1 and indicated the resident had experienced nausea the morning of 5/28/24. Nurse # 1 wrote, "Writer was doing her walking rounds and patient stated that she was nausea. Patient vital signs was obtained by writer, BS (bowel sounds) present X 4. Patient was given PRN Zofran. Writer assessed patient 30 minutes later. Patient stated that the medication helped. Breakfast was given to the patient and patient stated that she did not want to eat. Patient stated that she no longer felt nausea, but she did not want to eat. NP notified of patients COC (change of condition). Orders given for KUB, peripheral IV fluids, CBC and CMP, and a GI consultation. Orders followed as ordered. IV attempted by [DON] and it was unsuccessful. Attempt was made by another nurse, and it was unsuccessful. IV team has been called with an ETA of 9:00 PM. Hold orders given by NP until peripheral IV is placed. Patient has no c/o pain or discomfort. Plan of care ongoing."

Review of physician orders revealed there was no

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order to hold the IV.

Following Nurse # 1's entry for 5/28/24 at 3:35 PM, the next nursing note in the progress notes were EMAR medication notes entered by Nurse # 3 at 4:24 PM and 5:43 PM noting they were awaiting the IV team and the NP had been notified with orders to hold the fluids.

Following the EMAR medication notes by Nurse # 3, the next note in the progress notes was by Nurse # 3 with an "effective date" of 5/28/24 at 6:39 PM. The note read "Writer walked into the resident's room around 6 PM. Found out resident not responding, sweating all over her extremities, VS taken RR elevated Oxygen 2L administered via nasal canula. 6:10 PM writer called on call PA [Name PA # 2}. Order received to send her out via 911. Emergency Medical Services (EMS) team arrived 1825 (military time for 6:25 PM). Resident left to the [regional hospital] via stretcher by {name of county] EMS team around1838 (military time for 6:38PM). Daughter present in the room with EMS team when they arrived. Nurse Manager notified."

In a change of condition nursing note on 5/28/24 at 6:44 PM, Nurse # 3 also recorded the following vital signs with times the vitals were taken (The blood pressure reading, pulse, and respirations were the first noted in Resident # 6's record since 9:43 AM on 5/28/24).

Blood pressure -92/52 at 6:03 PM
Pulse -94-at 6:03 PM
Respirations-25-at 6:03 PM
Temperature-96.1 -at 6:03 PM
Oxygen level 90% on oxygen- at 6:03 PM
Blood glucose 154-taken at 4:39 PM

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Review of EMS records revealed EMS was called on 5/28/24 at 6:17 PM and arrived at 6:31 PM. EMS noted the following information. The local fire department staff were already on the scene. The resident was receiving oxygen. The resident's eyes were open. She was unconscious and had a right sided gaze. The resident responded to pain. At 6:35 EMS recorded Resident # 6's vital signs as blood pressure 92/68; pulse 96; respirations 28; and oxygen level 77%. She was transported to the hospital. In route to the hospital, EMS documented they were not able to get a continual reading on the resident's oxygen level and they assisted the resident to breathe.

The paramedic, who had responded on 5/28/24, was interviewed on 6/13/24 at 1:20 PM and reported when they arrived the fire department first responders were already on the scene. The resident had oxygen being administered at that time. Her oxygen saturation levels were low. The fire department had the paperwork from staff. He (the paramedic) obtained information from the family. The staff did not give them a report. It would have been helpful to have a report from staff because the paramedics were the ones who were responsible for transferring the resident to the hospital. He had to assist the resident with breathing on the way to the hospital by squeezing a bag that inserts oxygen into the resident's nose and mouth with each squeeze of the bag because her oxygen levels could not be raised and maintained.

Attempts were made to talk to the fire department responders during the complaint survey. As of 6/14/24 at 11:33 AM, the fire department first

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responder could not be interviewed.

Review of hospital Emergency Department (ED) records and Intensive Care Unit admitting records, dated 5/28/24, revealed upon arrival to the ED, Resident# 6 was emergently intubated (a tube is inserted in a resident's throat, and they are placed on a machine to help them breath). She appeared critically ill and would not follow commands. The resident had multiple lab abnormalities which included although were not limited to the following: A potassium level of 7.3 (normal 3.5 to 5.0-- a potassium level of 7.3 is considered dangerously high and can cause heart problems); a white blood count of 27.2 (normal 3.2 to 8.8); a blood urea nitrogen level of 62 (normal 7-20); a creatinine of 4.7 (normal 0.4 to 1.0). She was admitted to the intensive care unit with the principle primary problem documented as Sepsis with acute organ dysfunction. Although not all inclusive, other active problems included hypotension (low blood pressure) related to hypovolemia (abnormally low extracellular fluid in the body which can occur from a loss of both salt and water) and acute kidney injury (sudden loss of the kidneys ability to filter the blood). The resident was given IV fluids in the emergency room.

Unit Manager # 2 was interviewed on 6/7/24 at 2:01 PM and reported the following information. Resident # 6 routinely would say the food was not good and would refuse to eat. On 5/25/24 (Saturday), while not at work she had received a cell phone text message from Resident # 6's RP (Responsible Party) with several questions. One of the questions was, "What is being done about her not eating and if she does take a few bites, she throws up?" The RP had also texted the Unit

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Manager not to respond till after the holiday weekend to her questions. When the Unit Manager received the text, she called the RP on the same day she received it. The RP had indicated there was no urgency to address her concern at that point because of the holiday weekend. The RP had told her it could wait to be discussed until after the holiday weekend and did not elaborate further about the resident not eating and vomiting. She (Unit Manager # 2) tried calling the facility staff on 5/25/24 but none of the nurses were able to pick up when she called. She (Unit Manager # 2) was the on-call Nurse Manager for the facility that weekend and had not received any reports of problems. The nurses were usually very good to call her for acutely ill residents. She planned to follow up when she returned to work on 5/28/24.

Nurse Practitioner # 1 was interviewed on 6/10/24 at 2:33 PM and reported the following information. She was the NP covering the facility's concerns on 5/27/24. She had been in the facility on 5/27/24 and there was nothing in the physician's communication book that indicated Resident #6 needed to be seen. The resident's baseline was that she could answer yes and no questions and nod her head, but she did not normally carry on a full conversation to explain how she was feeling when the NP had previously visited her.

NA (Nurse Aide # 10) had cared for Resident # 6 from 7:00 AM to 3:00 PM on 5/27/24 (Monday). NA # 10 was interviewed on 6/10/24 at 1:40 PM and reported the following information. Resident # 6 did not eat her food for breakfast or lunch on 5/27/24 (Monday). She did drink "a little" milk for breakfast and drank some tea for lunch. She did

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not recall further problems.

NA # 11 had cared for Resident # 6 from 3 PM to 7 PM on 5/27/24 (Monday). NA # 11 was interviewed on 6/7/24 at 4:56 PM and reported the following information. The resident did not eat any of her food for the evening dinner meal on 5/27/24 (Monday). She drank about 120 cc of fluids (cubic centimeters). NA # 11 reported the resident did not like the food and she did not recall any further problems with the resident.

Nurse # 5 had cared for Resident # 6 from 3:00 to 11:00 PM on 5/27/24 (Monday). Nurse # 5 was interviewed on 6/7/24 at 1:33 PM and reported the following information. "Nothing out of the ordinary" occurred that shift that the Nurse could recall. She did not recall the resident having problems with swallowing.

Nurse # 9 had cared for Resident # 6 from 11 PM on 5/27/24 until 7:00 AM on 5/28/24 (Tuesday). Nurse #9 was interviewed on 6/8/24 at 1:06 PM and reported the following. She (Nurse #9) recalled the 3:00 to 11:00 PM nurse (Nurse #5) had difficulty getting Resident # 6 to swallow her medications. The 3:00 to 11:00 PM nurse still had the medications when she (Nurse # 9) arrived to work at 11:00 PM on 5/27/24. The 3:00 to 11:00 PM nurse decided to crush the medications in order to get the resident to swallow them. Nurse # 9 reported she did not recall Resident # 6 having problems on her shift.

Nurse # 1 had cared for Resident # 6 on 5/27/24 (Monday) and 5/28/24(Tuesday) during the 7:00 AM to 3:00 PM shifts. Nurse # 1 was interviewed on 6/7/24 at 10:38 AM and reported the following information. On 5/27/24 (Monday) the resident

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had not eaten her breakfast or lunch. She had also been nauseated. She (Nurse # 1) administered Zofran (Ondansetron) per a PRN order to do so. The Zofran was effective and the resident never vomited. She was only nauseated. The resident never ate 100% so that was not new for the resident, but the nausea was new on 5/27/24. On 5/28/24 (Tuesday), she noted further differences in the resident. On 5/28/24 (Tuesday), before the night shift nurse (Nurse #9) left, the night shift nurse told her (Nurse # 1) that Resident # 6 had trouble swallowing her pills during the night. The night shift nurse had to administer them in applesauce. This was a change for the resident. She (Nurse # 1) also noticed a change in Resident # 6's swallowing. The resident could not swallow her pills on the morning of 5/28/24. She swallowed liquid but the pills would not go down her throat. Resident # 6 also had been nauseated again on the morning of 5/28/24. She again gave the resident PRN Zofran on 5/28/24. The resident did not vomit. She called the resident's RP (Responsible Party) and informed her of the new swallowing problem and not eating. The RP indicated the resident had problems over the weekend but did not explain what problems the RP had noticed. Nurse # 1 did not know about problems over the weekend. The RP wanted the resident sent to the ER for evaluation. After talking to the RP, Nurse # 1 called the PA (PA # 1) and obtained an order to send the resident to the hospital. She started to prepare the paperwork before entering the order into the computer because she knew she could do the order entry after calling 911 and having EMS papers ready. The DON (Director of Nursing) passed by her while she was preparing to send Resident # 6 to the hospital, and she (Nurse # 1) informed the DON that Resident # 6

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was being sent to the hospital. The DON asked if she had educated the family about services they could provide in the facility. The DON wanted Unit Manager # 2 to communicate with the family and ask if the resident's RP would be agreeable to letting them try to treat the resident in the facility. Therefore, Nurse # 1 continued to do her med pass. She did not call the RP back. As she was doing the medication pass, Unit Manager # 2 approached her and let her know that she had obtained orders for Resident # 6 which included stat labs, a KUB, and an IV. Unit Manger # 2 told her (Nurse # 1) that the PA wanted the orders done. She (Nurse # 1) started processing the orders. She accompanied the DON and another nurse to start the IV. The resident "looked dry" and they had a hard time finding a vein to start the IV. One unsuccessful attempt was made and then the DON was able to place the IV. This was around 12:00 PM when the IV was started. Also, during the day, she (Nurse # 1) assisted Nurse Aide # 2 to turn and position the resident. The resident had complained of back pain and wanted to be only on her right side. She would not lay on her left. Positioning seemed to help this, and she did not require pain medication. Therefore, she (Nurse # 1) thought the pain had originated from how the resident was lying in bed. In approximately an hour after the IV was started, the IV had infiltrated. Unit Manager # 2 called the IV team, and the facility was notified that it would be around 9 PM before they could be at the facility. She (Nurse # 1) called the PA to update her about the delay in the IV and asked if they could hold the IV order due to the infiltration until the IV team could arrive. The PA agreed. She did not know how much the resident had drunk that day and she did not recall if she had mentioned to the PA that the resident had not eaten that day

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when she asked for the hold order. She also did not tell the PA that the resident was hurting in her back. After she had obtained the order to hold the IV, Unit Manger # 2 told her (Nurse # 1) that the DON wanted them to ask the PA if they could do hypodermoclysis (the administration of IV fluids beneath the skin). She (Nurse # 1) informed Unit Manger # 2 she had already called the PA, and the PA said it was okay to hold the IV until the IV team came to start it. The nurse further reported that during the day the resident would respond to questions. It was her baseline not to volunteer information. The staff had to ask her questions in order to determine how she was doing. During the day, the resident had no garbled speech and when asked if she was okay, she would say "yes." She had taken the resident's vital signs in the morning and knew Resident #6's heart rate was 100. She had not taken a complete set of vital signs before leaving at the end of her shift. When she left at the end of the 7:00 AM to 3:00 PM shift, she had not noted any further changes. Nurse # 1 was further interviewed about the two differences in the medical record written by her; one indicating the resident did not have nausea on 5/28/24 and the other note indicating the resident did. Nurse # 1 validated the resident had nausea both days. She had written a second note to clarify the events that had happened and the entry noting she had nausea on 5/28/24 was correct. Nurse # 1 indicated it had been a very busy day and that may have contributed to some of the differences in the charting about the nausea.

NA # 2 had cared for Resident # 6 on 5/28/24 (Tuesday) from 7 AM to 3 PM. NA # 2 was interviewed on 6/7/24 at 12:42 PM and reported the following information. On Tuesday (5/28/24)

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the resident did not eat any food for breakfast or lunch. For breakfast she drank her orange juice. For lunch she drank 1 ½ glasses of lemonade. She just did not want to eat. They kept water by her bedside. When she (NA # 2) turned the resident, the resident complained of pain in her back. She did not want to be on her right side.

During the interview with Unit Manager # 2 on 6/7/24 at 2:01 PM the Unit Manger further reported the following information regarding 5/28/24. On Tuesday (5/28/24) she returned to work for the first time after having received the RP's text message on 5/25/24. The DON mentioned to her that Resident # 6's RP wanted her sent out to the hospital. She had talked to Nurse # 1 and Nurse # 1 did not mention to her that the resident's heart rate was 100 or that the resident had trouble swallowing. Nurse # 1 did tell her (Unit Manager # 2) that the resident had some nausea and vomiting that morning but did not mention her having any problems with nausea the previous day which required medication. She (Unit Manager # 2) and the DON went to see the resident on Tuesday morning (5/28/24). They did not do a hands-on physical assessment of the resident. By looking at her, the resident appeared alert, she was not sluggish, nor in pain. Her breathing was not labored. She called and talked to the RP around 10:10 AM per her cell phone records. The RP conveyed she was worried about the resident. Unit Manager # 2 made her aware the facility could do labs, IV fluids, and tests and asked if she would want her treated at the facility instead of sending her to the hospital. She made it clear it was the RP's decision. The RP did not mention any problems the resident had over the weekend during the phone call. The RP was agreeable to have the resident treated at the

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facility. She (Unit Manager # 2) went to talk to PA # 1 who was in the facility at that point. Orders were given for stat labs, a KUB, and an IV to be started. She talked to Nurse # 1, gave Nurse# 1 the orders, and helped call and arrange for the lab/tests to be done. The DON went with Nurse # 1 to start the IV. She (Unit Manager # 2) thought this was before lunch when the IV was started. About an hour after the IV was started the IV was observed to be infiltrated and Nurse # 1 stopped the IV. The facility used a contracted provider to start IVs when needed. The DON texted Unit Manager # 2 to contact the IV team for Resident # 6. At first the IV team indicated they were coming right away and then they called back to say it would be around 9 PM. The DON asked Unit Manager # 2 to ask the provider if they could do hypodermoclysis. She told Nurse # 1 to ask the provider this question. Nurse # 1 said she had already spoken to the provider and obtained an order to hold the IV until the IV team arrived. She left work that day around 3:00 PM, checked on the resident before leaving, and the resident was still the same. On 5/28/24 her phone showed a text message at 2:37 PM from Resident # 6's RP saying she was checking on the resident and wanting to know if there was anything else that she (the RP) needed to do. She (Unit Manager # 2) saw the text message at 5:35 PM and called the RP back. She informed the RP at that time that the resident's IV had infiltrated. Prior to 5:35 PM, she had not spoken to the RP about the IV infiltrating or about the anticipated delay in getting it restarted. When she spoke to the RP, the RP indicated another family member (Family member # 1) had already been to see the resident that afternoon, the resident was not doing well, and she was headed to the facility at that time. According to her phone records, she (Unit

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Manager # 2) received a text from Resident # 6's RP at 6:18 PM saying that the resident looked terrible, and they were calling 911.

The DON was interviewed on 6/7/24 at 4:22 PM and reported the following information. Prior to Resident # 6 being sent out to the hospital she had been aware the resident did not like the facility's food and did not want to eat. On the morning of 5/28/24, Nurse # 1 was wanting the resident sent out to the hospital. At the time, the DON had not been aware the resident had not eaten any food on 5/27/24 (Monday). She had asked Nurse # 1 if there was any other acute symptoms, and Nurse # 1 had indicated there was not. She had asked Unit Manager # 2 to call Resident # 6's RP about in house treatment. At the time she had requested Unit Manager to do this, she (the DON) was not under the impression there was anything further wrong with the resident other than her not eating much. She had started the IV on Resident # 6 and the resident did not look like she was in distress. She looked in on the resident around 1:00 PM and the resident appeared fine. When the IV infiltrated, she had asked Unit Manager # 2 to call the IV team. She also asked the Unit Manager to find out if the provider would want them to do hypodermoclysis and she was told by her staff that the provider said it was okay to wait until the IV team arrived. After leaving work, she received a call from Unit Manager # 2 saying that they had sent the resident to the hospital.

NA # 1 had cared for Resident # 6 on 5/28/24 (Tuesday) from 3:00 PM to 11:00 PM. NA # 1 was interviewed on 6/7/24 at 3:41 PM and reported the following information. She had cared for Resident # 6 another time previously but did not

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routinely care for her. When she arrived on 5/28/24 (Tuesday) for her evening shift, Resident # 6 was having a test completed. The resident did not seem "off" compared to how she had been the other time she had cared for her. The resident responded when she first checked on her. After the test, she provided incontinent care for the resident. Her urine had a strong odor and seemed "off settling." The resident did not complain of pain. She responded during the incontinent care. Prior to the evening dinner time meal, she had checked on Resident # 6 again and her head was tilted back. Her eyes appeared "dazed" as she focused on the Nurse Aide and the resident was not responding the same. Her speech was slurred when the Nurse Aide tried to talk to the resident, and it was not clear what the resident was saying. She had talked to Nurse # 3 about this, and he acknowledged he knew the resident was not feeling well and she "was off that day." This was around "4 something" when she talked to Nurse # 3. The dinner trays came out around 5:30 to 6 PM. Another Nurse Aide took the tray in the room. She (NA # 1) knew the resident was not going to be able to eat. She went back to Nurse # 3 who at that time was on his way to call 911 and was focused on sending her out.

Resident # 6's former roommate (Resident # 12) was interviewed on 6/7/24 at 5:40 PM. (A review of Resident #12's Quarterly MDS assessment, dated 5/13/24, revealed the resident was cognitively intact). During the interview, Resident # 12 recalled rooming with her former roommate for about a week and being concerned that Resident # 6 did not eat many meals in a row. Resident # 12 reported the following information. On the last day Resident # 6 had been at the

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facility, one of Resident# 6's family members visited in the afternoon. It was at that time that she (Resident # 12) noticed a difference in Resident # 6. Normally Resident # 6 would not initiate conversation on her own accord but she would respond when someone spoke to her. When the family member entered on the afternoon of 5/28/24, Resident # 6 spoke when the family member first came into the room and then stopped speaking to him. The family member was concerned and called the RP asking her to come to the facility. Resident # 12 reported she recalled the family member stating he had an appointment at 4:30 PM to attend and she thought the timing of the family member's visit would have been before that time.

The phlebotomist, who drew Resident # 6's blood work on 5/28/24, was interviewed on 6/10/24 at 12:49 PM and reported she had drawn Resident # 6's blood work at 4:15 PM. The phlebotomist further reported the resident was able to state her name and date of birth at the time the blood was drawn. The phlebotomist reported that if she had observed that the resident seemed in some sort of medical distress, she would have gotten a facility staff member when she drew the blood.

NA # 12 was the Nurse Aide who took Resident # 6's evening dinner tray to her room on 5/28/24. NA # 12 was interviewed on 6/7/24 at 4:02 PM and reported the following information. She had cared for the resident in the past on night shift. The resident usually did not talk much and would nod her head to questions. On Tuesday (5/28/24) when she took the evening dinner tray to her room, the resident was not responding. Her eyes were ½ way open and her eyes were ½ rolled back. She asked the assigned Nurse Aide if she

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had been like that, and the Nurse Aide went to the nurse. NA # 12 reported she usually did not work second shift and she did not know all the second shift names, but she knew she had reported what she saw to whoever was assigned to the resident and that the assigned nurse aide had gone to the assigned nurse.

Nurse # 3 had cared for Resident # 6 from 3:00 PM until her discharge on 5/28/24. Nurse # 3 was interviewed on 6/7/24 at 3:02 PM and reported the following information. He did not routinely care for Resident # 6. At the first of the 5/28/24 evening shift in report, he was told the provider had been called and there was an IV order. It had been started, but infiltrated, and it had been arranged for the IV team to come. He may have been told further symptoms, but he did not recall all of them. He did know that it had not been reported to him that Resident # 6 had not eaten any of her food the previous day of 5/27/24 nor that she had some back pain. If he had known this, then it would have alerted him more to her condition. After report, he checked on the resident around 3:30 PM. Her eyes were closed, and she appeared to be sleeping. She did not awaken to her name, but her breathing was not labored. He did not disturb her to take a full set of vitals. Around dinner the Nurse Aide (Nurse Aide # 1) alerted him that she did not look good. He went to check on her and checked her vitals at that time. Her skin had sweat on it. She was looking up, and her breathing was different. There had been a definite change compared to when he had looked at her around 3:30 PM. He went to get oxygen for her, placed it on her, and listened to her lungs. This took about 10 to 15 minutes. He then called the on- call provider, notified the provider of the change, and asked to

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send her out. He then called 911 to transport the resident.

Nurse # 3 was interviewed again on 6/10/24 at 12:38 PM and interviewed regarding if he recalled NA # 1 coming to him "around 4 something" when she had noted the resident's speech was slurred and her eyes dazed. Nurse # 3 reported he did not recall a definite change being reported to him until around dinner time and he and the staff speak all the time throughout the shift about residents. He did recall that he gave the resident her medications at the time he did her blood sugar check. Her eyes were open at that time. She did not talk but she swallowed her medications crushed. (According to the electronic record, a blood sugar check was performed by Nurse # 3 at 4:40 PM).

During the interview with Unit Manager # 2 on 6/7/24 at 2:01 PM Unit Manager # 2 also reported the following information. When she received the text message from Resident # 6's RP at 6:18 PM that the resident looked terrible, she had called the facility to check on the resident and to talk to Nurse # 3. Nurse # 3 reported they had already called 911 for the resident to be transported to the hospital.

During an interview with Resident # 6's RP on 6/3/24 at 8:07 PM the RP reported she arrived at the facility on the evening of 5/28/24 to find Resident # 6 with labored breathing. The RP further reported the resident's color was gray, her eyes rolled back, and her mouth was hanging open. She was not being monitored by staff.

Resident # 6's RP was interviewed on 6/10/24 at 8:26 AM and reported the following information.

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When she talked to Unit Manager # 2 on the morning of 5/28/24 the Unit Manager had informed her the facility could provide treatment at the facility and asked if she would want to do that rather than send the resident to the hospital. From her conversation with Unit Manager # 2, it was her (the RP's) understanding that Resident # 6 would be seen by the provider, receive IV fluids, diagnostic tests, and monitoring at the facility. That was why she agreed because the Unit Manager had said to trust her that these things could be done. Later in the afternoon, another family member had gone to see Resident # 6 and had reported to her (the RP) that something was not right with Resident # 6. The resident was having trouble breathing. She had not heard from the facility staff that there had been any change. She did not hear about a delay in providing IV fluids until she talked to Unit Manager # 2 at 5:35 PM. If she had known they were having to wait on an IV placement, she would have told the staff to go ahead and send Resident # 6 to the hospital. The RP commented, "Who wouldn't have?"

The chief operating officer of the company which provides IV placement services to the facility was interviewed on 6/10/24 at 1:03 PM and reported the following. They had received the first call from the facility on 5/28/24 at 1:40 PM requesting placement for Resident # 6's IV.

During the interview with Nurse # 5 on 6/7/24 at 1:33 PM, Nurse # 5 further reported the following information. She had been working on the 3 PM to 11 PM shift on 5/28/24 although she was not assigned to Resident # 6. She recalled receiving a phone call from Unit Manager # 2 that evening and Unit Manager # 2 wanted her (Nurse # 5) to take the phone to Nurse # 3 so the Unit Manger

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could speak to him. She (Nurse # 5) took the phone to Nurse # 3. He was about two doors down from Resident # 6's room coming out of another resident's room. She (Nurse # 5) could hear Nurse# 3 as he talked to the Unit Manager and heard that he said he had already called 911. She whispered to him, "Who did you call 911 for?" and while Nurse # 3 was talking to the Unit Manager he pointed to Resident # 6's room. She (Nurse # 5) went to Resident # 6's room. The resident had a pulse, but her breathing was labored, and she was not responding. The resident's RP was in the room. She (Nurse # 5) went to check the resident's code status. She informed Nurse # 10 that Resident # 6 did not look good and asked her to come also. She placed the code cart outside Resident # 6's door in case it was needed. Within a few minutes of this, the paramedics were onsite and attended to the resident.

Nurse # 10 was interviewed on 6/11/24 at 3:37 PM and reported the following information. She had worked on the evening of 5/28/24. Nurse # 5 had asked her to come with her because they might have to do a code. She followed Nurse # 5 to Resident # 6's room. Nurse # 3 was in the room at that time checking on the resident's pulse, checking oxygen levels, and asking the resident "can you hear me?" At that time the resident's eyes were open, but she was not responding to him. Within just a minute or two the fire department first responders came, and the paramedics were right behind them.

PA # 1 was interviewed on 6/10/24 at 4:03 PM and reported the following information. She did not usually cover Resident # 6 for care. She had gotten a call from a facility staff member when

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she was on the way to the facility on the morning of 5/28/24. The staff member had not shared anything that was super alarming. From what was conveyed to her, the resident did not seem very sick. The staff member let her know the family was asking if the resident could go to the hospital and typically if a family wanted a resident evaluated at the hospital, she would agree. Once at the facility a staff member approached her and asked if they could start IV fluids at the facility since the resident had not been eating much and so she agreed and gave orders. She was on call until 5:00 PM that day and also typically answered her phone if staff called after 5:00 PM. She recalled she thought it was around 5:00 PM and someone let her know the IV team was still not there and could they just go ahead and send the resident to the hospital. She told them to go ahead and send the resident out to the hospital. PA # 1 was informed by the surveyor during the interview that the facility staff interviews indicated 1) the resident had not eaten any food for five consecutive meals by lunch time on 5/28/24 and 2) they reported they had called earlier in the day to obtain a hold order for the IV when it infiltrated and 3) that family interview with the surveyor revealed they would have wanted the resident sent to the hospital when the IV could not be restarted right away. PA # 1 was interviewed regarding whether she would have sent the resident out earlier if she had been told all of this information in addition to information about an IV infiltration. PA # 1 responded she got so many phone calls from facilities it would be hard to tell about specific phone calls coming through to her. She did recall the one around 5:00 PM and also speaking to the staff in the morning when they did not convey Resident #6 was very sick. If they had called earlier about an IV infiltration and also let

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her know that the family wanted the resident sent on to the hospital, and that the resident had not eaten any food at all for five consecutive meals, then she would have probably gone ahead and sent the resident to the hospital. The PA commented that not eating any food at all is different than when a resident does eat a few bites.

PA # 2 was interviewed on 6/17/24 at 10:43 AM and reported she took call from multiple facilities, and she could not recall if she got a phone call from the facility staff on 5/28/24 during the evening.

Interview with the facility's corporate regional clinical director on 6/12/24 at 1:21 PM revealed the following information. She felt as if Resident # 6's former roommate (Resident # 12) had the ability to recall events correctly. Prior to Resident # 6 being sent to the hospital on 5/28/24 she (the corporate regional clinical director) had already been working on educational training with facility nurses about assessment. The staff nurses had been in serviced that when they noticed a difference in a resident to try to determine the cause. If a resident missed multiple consecutive meals, then the regional clinical director felt this would indicate to nurses the resident needed to be assessed further.

The Emergency Department Physician was interviewed on 6/3/24 at 1:00 PM and reported the following. When Resident # 6 had arrived at the hospital she was very septic and had to be emergently intubated. She was hypothermic with unstable vital signs. Even with medical treatment, the resident continued to worsen. It was his opinion that if the resident had been transferred

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to the hospital even four hours earlier, she would not have been as sick.

The facility's Medical Director was interviewed on 6/10/24 at 4:41 PM and reported the following information. Residents who become septic can become worse very quickly and within a matter of minutes changes can occur. According to the medical director, retrospectively, sometimes it can be seen that a few hours in treatment may have made a difference with a resident but that is not always apparent initially with residents when they first develop symptoms which progress to severe illness. The Medical Director felt that based on what PA # 1 was told, the PA was trying to provide care in place in the facility and at the time it seemed appropriate. He did not think that was wrong or there had been anything wrong in the timeline of events. He felt the nurses had been attentive and were trying to give good care to the resident. He also felt the resident's Lewy body dementia could have been contributing to poor oral intake.

On 6/14/24 at 11:33 AM the Administrator was notified of immediate jeopardy.

The facility provided the following credible allegation of immediate jeopardy removal with a completion date of 6/13/24.
1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility must ensure it recognizes the need to assess residents and effectively communicate amongst themselves, the provider, and family in order that residents receive treatment and evaluation. Residents that experience a change

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in condition have the potential to be affected.

On 5/28/2024
1) staff were aware the resident had experienced two consecutive days in which she had experienced nausea;
2) the resident had not eaten any food for four consecutive meals (all meals on 5/27/24 and breakfast on 5/28/24)
3) The resident had new swallowing problems
4) The staff had been made aware on 5/25/24 the resident's family noticed she would take a few bites and she would throw up
5) the resident's heart rate was on the upper end of normal registering 100 and
6) Resident # 6's family was wanting her sent to the hospital on the morning of 5/28/24.

On the morning of 5/28/24 the PA was in the facility and left orders for the resident to be treated at the facility without physically evaluating the resident. According to the family, the family was in agreement with the resident receiving treatment at the facility with the understanding that the resident would be seen by the provider, be monitored and receive diagnostic tests and treatment which included IV fluids.

On 5/28/24 the facility became aware the IV had infiltrated and there would be a delay in starting it again. The family was not notified at that time and reported if they had been notified, they would have wanted the resident sent on to the hospital. The resident was later sent out hours later to the hospital and required assistance breathing by EMS in route to the hospital. She required intubating at the hospital ER. According to the ER physician, it was his opinion that if the resident had been sent out four hours earlier, she would

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not have been as sick.

On 5/28/2024, 3-11 nurse failed to respond to a change in condition report when it was brought to his attention by the certified nursing assistant.

On 6/4/2024, current resident records were reviewed by the Director of Nursing for the past 30 days for change in condition. The audit included 1) Did the resident have a change in condition? 2) Was the change in condition identified and addressed by the staff. 3) Was the provider notified of the signs/symptoms of the change in condition? 4) Were new orders given for the change in condition and followed appropriately and timely? 5) Was the resident's responsible party notified of the change in condition and provider's orders? 6) If any, were the providers orders entered into the electronic medical record timely? 7) If the order was to send the resident out, was the resident sent to the ED? No negative findings as a result of the audit. Audit completed on 6/12/2024.

2) Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:
On 6/4/2024, education was initiated to licensed nursing staff by the Director of Nursing/designee on assessments of change in condition. The education included recognizing the clinical changes that warrant a change in condition (including consistent decreased meal intake), perform timely assessment (to include vital signs and pain assessment) of the resident and provide immediate and appropriate interventions. A change in condition evaluation should be completed including a full progress note on the

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resident's signs and symptoms, when the change in condition was recognized, interventions performed, notification to the provider and what was relayed in the conversation as appropriate, notification to the family, when EMS was called (if applicable), and that report was given to EMS.

On 6/4/2024, education was initiated to licensed nursing staff by the Director of Nursing/designee regarding appropriate communication techniques, to include the utilization of the SBAR process during shift-to-shift report. SBAR should be communicated between nurses at bedside during shift change, communicated between nurse and provider to notify of changes from the resident's baseline or if changes have happened since the last update to the provider.

On 6/4/2024, education was initiated to certified nursing assistants by the Director of Nursing/designee regarding ability to identify a change in condition in residents and the timely reporting of those changes to the nurse that includes but not limited to having a decreased appetite, consistent refusal of therapeutic diet, nausea, decreased intake of fluids, and/or general malaise, etc.

Education for licensed and unlicensed staff was completed by 6/8/2024. The Director of Nursing was responsible for ensuring all licensed and unlicensed staff received the education.

Newly hired licensed, unlicensed and agency staff will receive this education during orientation. The Director of Nursing will be responsible for ensuring that this education is completed.

Effective 6/8/2024, the Administrator and Director

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F 684	Continued From page 42 of Nursing will be ultimately responsible for ensuring implementation of this immediate jeopardy removal for this alleged noncompliance. Alleged Date of Immediate Jeopardy Removal: 6/13/2024 On 6/19/24, the facility's credible allegation for immediate jeopardy was validated. Review of the facility's corrective action plan revealed 100% licensed nursing staff education regarding assessing a change in condition and providing immediate and appropriate interventions to include notification of the provider and responsible party (RP). In addition, 100% unlicensed nursing staff education was completed regarding the ability to identify a change in resident condition and the timely reporting of those changes to the nurse. All education was completed by 6/12/24. 100% audit of resident medical records began on 6/4/24 to ensure that any change in condition was identified, addressed by the staff, notification to the provider and RP and orders were entered promptly. The audits were ongoing. Staff interviews confirmed education was received on recognizing a change in resident condition and how to promptly address and notify the provider and RP. The facility's immediate jeopardy removal date of 6/13/24 was validated.	F 684		
F 689 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	F 689		7/8/24

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F 689	Continued From page 43 §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 staff interviews, the facility failed to investigate the root cause of the repeated falls and provide supervision to prevent more falls from occurring. One of these falls required hospital intervention with sutures for lacerations to the nose and forehead and another fall the same day required hospital intervention with additional sutures to the back of the head. This resident did not return to the facility after the last fall with injury. This deficient practice was identified for 1 of 3 residents reviewed for accidents (Resident #8). The findings included: Resident #8 was admitted 4/4/24 with metabolic encephalopathy(any brain disturbance of the brain's function), history of multiple falls at home, osteoarthritis of the knees, intervertebral disc degeneration and macular degeneration. Review of Resident #8's comprehensive care plan included a care area risk for falls with an initiation date of 4/5/24. The admission Minimum Data Set (MDS) dated 4/11/24 indicated Resident #8 had moderate cognitive impairment, required supervision with transfers and bed mobility, was continent of bladder and bowel and coded for falls prior to admission. Review of an incident report dated 4/14/23 at 9:15 PM read Resident #8 was found with her left knee on the floor. She stated she was trying to transfer to her chair and lost her balance. She	F 689	F689 - Free of Accident Hazards/Supervision/Devices Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Center failed to investigate the root cause of repeated falls and provide supervision to prevent additional falls for Resident #8. Resident #8 discharged from Center on 4/19/24. 2. On 6/21/24, Director of Nursing/designee reviewed the prior 30 days of falls to ensure that all had interventions in place. Any concerns identified corrected immediately. An additional review of progress notes was completed on 6/24/24, by the Clinical Leadership team to include Director of Nursing and Unit Managers of the prior 30 days to ensure that all falls had appropriate documentation, interventions, and notifications to provider and resident representative(s). No additional concerns noted. 3. Clinical Leadership was reeducated by	

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F 689	Continued From page 44 denied pain of discomfort. The intervention was frequent rounding. Nurse #8 completed this report. Review of an interdisciplinary team (IDT) note dated 4/18/24 at 11:09 AM read Resident #8 was discussed in the weekly IDT meeting because she triggered for falls. Resident #8 had a fall on 4/14/24. She was observed on floor in room on her left knee. Resident stated she was trying to sit in her chair and lost her balance. There were no injuries noted. The intervention in place was for frequent rounding at night. The Physician and Responsible Party were aware, the care plan was updated and continued with the current plan of care. Unit Manager (UM) #1 completed this note. Review of an incident report dated 4/18/24 at 10:21 AM read Resident #8's spouse came out of the room yelling for help. Resident #8 was found on the floor trying to get up. She stated she was trying to go to the bathroom when she lost her balance and fell. There were no injuries. The spouse stated he was assisting her when she fell. Resident #8 was reminded to use her call bell and her spouse was reminded to let staff assist Resident #8. Nurse #7 completed this report. A telephone interview was completed on 6/4/24 at 3:07 PM with Nursing Assistant (NA) #7 who was assigned Resident #8 on 4/18/24 at the time of her fall at 10:21 AM. She stated Resident #8 was her usual self. She did not display any increase in restlessness or agitation. NA #7 stated her spouse stayed with her most of the day every day and he was assisting her to the bathroom when she lost her balance and fell.	F 689	the Regional Clinical Director on 6/26/24 for falls management to include thorough investigation of falls with root cause analysis to ensure appropriate interventions. Licensed Nurses will be reeducated on the falls management process to include appropriate documentation, interventions, and notifications to provider and resident representative(s). Education to be completed by 7/7/24. Newly hired Licensed Nurses will be educated during department orientation on falls management. An audit of the 24/72-hour report and Risk Management will be completed during clinical morning meeting (Monday-Friday) by the Director of Nursing/Designee x 12 weeks to ensure that falls have appropriate documentation, investigation, intervention and notifications. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	

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Review of another incident report dated 4/18/24 at 9:30 PM read Resident #8 was found sitting on the floor in front of the bed. There were no injuries. She stated she was trying to sit on her bed and missed the bed. The intervention was to offer out of the room activities when she appeared restless. Nurse #8 completed this report.

A telephone interview was completed on 6/12/24 at 1:20 PM with Nurse #8. She recalled Resident #8 and stated she did not appear restless or agitated on second shift on 4/18/24. She stated Resident #8 was in her room watching television and while she went to administer some medications, she returned and noted Resident #8 sitting on the floor beside her bed. Nurse #8 stated she had to get a close eye on Resident #8 because she was difficult to redirect. She stated there were two aides working with her that evening which was the normal assignment.

A telephone call was attempted on 6/4/24 at 2:50 PM with Nursing Assistant (NA) #4 assigned Resident #8 on 4/18/24 at the time of the fall at 9:30 PM Her cell phone mailbox was full. There were no additional contact numbers per the facility.

A telephone interview was completed on 6/12/24 at 11:25 AM with NA #9 who also worked second shift on 4/18/24. She stated she started working at the facility the second week of April and only did a couple of shifts on the rehabilitation hall. She stated she did not recall Resident #8.

Review of Resident #8's electronic medical record included a situation, background, assessment and recommendation (SBAR) note

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dated 4/19/24 at 2:55 AM read Resident #8 was found on the floor on the 100 hallway. She sustained lacerations to her face and the bridge of her nose. She was transferred to the hospital for sutures. There was also an electronic transfer form completed that read she was transferred to the emergency department at 3:22 AM. Nurse #6 completed this SBAR and transfer form. This fall did not appear on the facility's incident list for resident falls in April 2024.

A telephone interview was completed on 6/4/24 at 11:11 AM with Nurse #6. She stated she had been working at the facility for approximately a month and was still in orientation. She stated she was working with Resident #8 on the night of 4/19/24 when she fell in the hallway. Nurse #6 stated Nurse #8 reported to her that Resident #8 had been restless and was found sitting on the floor bedside her bed on her shift. Nurse #6 stated the night of 4/19/24, Resident #8 was up in a wheelchair self-propelling up and down the halls looking for her spouse when she observed Resident #8 on the floor. Nurse #6 stated there were two aides that night. She stated one aide may have been in a resident room and the other aide may have taken her lunch break. When questioned about the lack of an incident report completion, she stated she must have forgotten to complete it but Nurse #7 was her relief and she made him aware that she had sent Resident #8 out to the hospital due to a fall earlier on her shift.

A telephone call was attempted on 6/4/24 at 2:52 PM with NA #5 assigned Resident #8 on 4/19/24 at the time of the fall at 2:55 AM. Her cell phone mailbox was full. There were no additional contact numbers per the facility.

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A telephone interview was completed on 6/12/24 at 3:20 PM with NA #8 who worked third shift on 4/19/24. She stated she started out helping at station 1 where Resident #8's room was but she was moved to station 2 to work shortly after coming into work. She stated she did recall Nurse #8 talking about Resident #8 requiring close observation at the beginning of the shift.

Review of Resident #8's progress notes did not include a nursing note regarding her return to the facility from the hospital department on 4/19/24 after receiving sutures to her nose and forehead however, emergency department records indicated she was discharged back to the facility at approximately 8:00 AM.

Review of the electronic medical record included another transfer form dated 4/19/24 at 11:40 AM that read Resident #8 was transferred back to the hospital for another fall. Nurse #7 completed the transfer form. This fall did not appear in the progress notes or on the facility's incident list for resident falls in April 2024.

An interview was completed on 6/4/24 at 11:30 AM with Nurse #7. He confirmed he was assigned Resident #8 on 4/19/24 when she fell again at approximately 11:00 AM-12:00 PM. Nurse #7 stated when he came in at the beginning of his shift on 4/19/24, Nurse #6 reported that she was out at the hospital for treatment due to a fall she sustained at 2:55 AM. Nurse #7 recalled Resident #8 returning from the hospital early on 4/19/24 with sutures to her forehead and the bridge of her nose. He stated he was passing medications on the 100 hall with his medication cart positioned in between rooms 101 and 103 since Resident #8. He stated he did

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this so he could keep a close watch on her. He stated he left his medication cart to administer some medications when Resident #8 apparently got her walker and walked into the hallway and apparently fell backwards striking the back of her head at approximately 11:00 AM. Nurse #7 stated he applied pressure to the back of her head and emergency medical services (EMS) was notified. He stated it was a really busy day so he did not have time to complete a note or incident report.

An observation with Nurse #7 of the 100 hall was completed on 6/5/24 at 11:04 AM. Rooms 101 and 103 were on the left side of the hall and room 102 was on the right side of the hall. Nurse #7 stated he placed the medication cart in between rooms 101 and 103 with his back to room 102. He stated he had to keep his medication cart parked there because he needed the outlet for his laptop on the medication cart. He stated he was still able to keep a close eye on Resident #8 but she was able to get up and ambulate into the hall so quickly, that he did not see her actually fall.

A telephone interview was completed on 6/4/24 at 2:55 PM with NA #6 who was assigned Resident #8 on 4/19/24 at the time of the fall around 11:00 AM. She stated she was unable to recall Resident #8 or anything about her falls.

Review of emergency department records dated 4/19/24 at 1:45 PM read Resident #8 sustained another unwitnessed fall at the facility where she fell backwards striking the back of her head. There was no loss of consciousness. A cervical collar was put in place. There was a new laceration to the back of her head requiring sutures and a renal mass suspicious of cancer was identified on the scans. She was discharged

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F 689	Continued From page 49 to a memory care unit. A telephone interview was attempted with the Medical Director on 6/3/24 at 1:10 PM. He stated he did not recall Resident #8. An interview was completed on 6/4/24 at 11:25 AM with UM #1. She stated the facility had a weekly IDT meeting usually led by the Director of Nursing (DON). She stated all unit managers, the dietary manager, therapy director and the MDS Nurse all attend the weekly meetings. She stated all falls were discussed daily from the day before in each morning clinical meeting to ensure an effective intervention was put in place. She stated Resident #8's two falls on 4/18/24 would have been discussed in the morning clinical meeting on 4/19/24 but stated she was not certain if the clinical team would have discussed Resident #8's two falls with injuries that occurred on 4/19/24 since there was no incident report generated. An interview was completed on 6/5/24 at 9:50 AM with the DON. She stated she started at the facility in January of 2024. She stated she worked with the staff on documentation but offered no explanation for the lack of information documented on Resident #8. She also stated Resident #8 needed close supervision but the facility could not provide one-on-one supervision. The DON stated the facility needed to improve on their investigative process to determine any patterns or root cause behind reported falls.	F 689		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is	F 842		7/8/24

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

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

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

§483.70(i)(3) The facility must safeguard medical

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F 842	Continued From page 51 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a complete and accurate medical record by not obtaining a Physician order to hold Intravenous fluids, incomplete oral intake records and inaccurate medication administration times on 5/28/24 that did not match the times Nurse #8 reported administering the medications for Resident #6. This was for 1 of 12 residents reviewed for complete and accurate medical records. The findings included: Based on record review and staff interviews, the facility failed to maintain a complete and accurate medical record by not obtaining a	F 842	F842 - Resident Records □ Identifiable Information Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Center failed to maintain a complete and accurate medical record for Resident	

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F 842	Continued From page 52 Physician order to hold Intravenous fluids, incomplete oral intake records and inaccurate medication administration times on 5/28/24 that did not match the times Nurse #8 reported administering the medications for Resident #6. This was for of 1 of 12 residents reviewed for complete and accurate medical records. The findings included: 1a. Resident # 6 was admitted to the facility on 2/28/24. Nurse # 1 documented a nursing note on 5/28/24 at 1:30 PM noting Resident # 6's IV (intravenous) fluids had infiltrated, and the Nurse Practitioner was notified and gave an order for the IV fluids to be placed on hold until IV placement was obtained. A review of Resident # 6's electronic record on 6/7/24 revealed the record was incomplete. There was no order entered into the resident's record to hold the IV. It was confirmed with the regional clinical director on 6/7/24 at 7:00 PM that there was no order in Resident # 6's record to hold the IV. 1b. A review of Resident # 6's electronic record on 6/7/24 revealed Resident # 6's meal consumption sheets were incomplete. Although not all inclusive, some examples included no meal intake recorded for the supper meal for the dates of 5/18/24, 5/19/24, and 5/26/24. Additionally, the meal consumption sheet showed that Resident # 6 consumed 51 to 75 % of her supper meal on 5/27/24. During an interview with Nurse Aide # 11, who cared for Resident # 6 on the evening of 5/27/24, NA # 11 reported the resident had not eaten any of her supper meal. The area on the meal consumption sheet which would have accurately reflected this was blank. 1c. Review of a medication administration audit	F 842	#6. Resident #6 discharged from the Center on 5/28/24. 2. All residents have the potential to be affected by the deficient practice. 3. Certified Nursing Assistants were reeducated by the Director of Nursing/Designee to accurately and completely document meal consumptions. Education to be completed by 7/7/24. Licensed Nurses were reeducated by the Director of Nursing/Designee on ensuring that orders obtained from Provider are entered into Resident□s electronic medical record. Education to be completed by 7/7/24. Licensed Nurses were reeducated by the Director of Nursing/Designee on ensuring that medications are documented at time of administration. Education to be completed by 7/7/24. Newly hired Licensed Nurses and Certified Nursing Assistants will be educated during department orientation on accurate documentation in the Medical Record. An audit of the Clinical Alerts for meal consumption will be reviewed in Clinical Morning Meeting by the Director of Nursing/Designee x 12 weeks to ensure that all alerts pertaining to meal consumption are addressed. Additionally, the Director of Nursing/Designee will complete 5 observations of meal intake vs	

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F 842	Continued From page 53 report, which was generated from Resident # 6's electronic record on the date of 6/7/24 at 9:31 AM, revealed the report included scheduled medications and orders for Resident # 6 for the date of 5/28/24. The report also included the documented administration times which had been entered into Resident # 6's electronic record for medications and her blood sugar check on 5/28/24. According to the report, Nurse # 3 had documented on 5/28/24 at 4:40 PM he had completed a blood sugar check on Resident # 6. Further review of the report revealed Nurse # 3 documented he administered multiple medications to Resident # 6 over an hour after he had performed the resident's blood sugar check. Although not all inclusive, some examples are as follows. Nurse # 3 documented that he administered carbidopa-levodopa, atorvastatin, metformin, and duloxetine at 5:45 PM on 5/28/24. Nurse # 3 was interviewed on 6/10/24 at 12:38 PM and reported he gave medications to Resident # 6 at the same time he did the resident's blood sugar reading on 5/28/24. He did not know why the administration times in Resident # 6's record reflected her medications were given over an hour later, and the administration times should have been closer or at the time he did her blood sugar check. According to the nurse, that would have been an accurate reflection of what he had done.	F 842	documentation per week x 4 weeks, then 3 observations of meal intake vs documentation per week x 4 weeks, then 1 observation of meal intake vs documentation per week x 4 weeks to ensure meal intake is accurately documented. An audit of the 24/72-hour report will be conducted in Clinical Morning Meeting by the Director of Nursing/Designee x 12 weeks to ensure that physician orders are entered into the Medical record. An audit by the Director of Nursing/Designee will be completed of 5 Med pass observations per week x 4 weeks, then 3 Med pass observations per week x 4 weeks, then 1 Med pass observations per week x 4 weeks to ensure that Licensed Nurse document medication administration at time of administration. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. 5. Person Responsible: Director of Nursing	