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	345405	A. BUILDING _____ B. WING _____	C 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 12/16/24 through 12/17/24. The corrective action plans were validated on 12/23/24, therefore the exit date was changed to 12/23/24. The following intakes were investigated: NC00225078, NC00224178 and NC00225004. 4 of the 8 complaint allegations resulted in a deficiency. Intake NC00225078 resulted in immediate jeopardy. Past-noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.12 at tag F600 at a scope and severity of J. CFR 483.25 at tag F684 at a scope and severity of J. CFR 483.35 at tag F726 at a scope and severity of J. CFR 483.45 at tag F760 at a scope and severity of J. The tags F600, F684 and F760 constituted Substandard Quality of Care. Immediate jeopardy began on 11/30/24 and was removed 12/10/24. A partial extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in	F 550		1/23/25

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

Electronically Signed | 01/17/2025

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F 550	Continued From page 1 this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to treat a resident in a dignified manner while providing incontinent care	F 550	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility	

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F 550	Continued From page 2 and failed to effectively respond to a call light for 1 of 3 residents reviewed for dignity (Resident #3). Resident #3 stated that she felt "disrespected and upset that she was ignored and made to stay in a soiled brief." The findings included: Resident #3 was admitted to the facility on 4/11/2016 with diagnoses of contracture of left hand, overactive bladder, and chronic obstructive pulmonary disease. The care plan dated 11/12/2024 was reviewed. The problem stated the resident is incontinent of bladder and bowels and is not a candidate for toileting program due to inability to control bowel and bladder due to severe physical impairment. The goal stated that Resident #3 would remain as clean and dry as possible. The interventions included the resident required 2 staff assistance for bed mobility, 1 person assist with toileting, check and change briefs frequently. The quarterly Minimum Data Set (MDS) assessment dated 11/12/2024 revealed that Resident #3 was cognitively intact, required extensive assistance with toileting, and was always incontinent with bowel and bladder. No refusal of care was noted during the assessment reference period. Resident #3 was interviewed on 12/16/2024 at 2:14 PM. During the interview Resident #3 stated that NA #3 had changed her on 12/13/2024 at 4:30 PM. The resident did not state how she knew what time it was, but it was observed that Resident #3 had her cell phone within reach. Resident #3 stated NA #3 "seemed frustrated	F 550	has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F550 Dignity 1. NA #3 was removed from care of Resident #1 on 12/13/2024. NA # 3 was given education on customer service and dignity prior to returning to work. 2. Current Residents are at risk 3. Current nursing staff, including certified nursing assistants (CNAs), will undergo immediate training regarding the facility□s policies on resident dignity, specifically focused on respectful communication, privacy during personal care, and responding promptly to call lights. Education will be completed by the Staff Development Coordinator by 01/20/2025 Any staff not receiving the education will not be allowed to work until education received. New nursing staff will receive education during the orientation process by the Staff Development Coordinator 4. Director of Nursing or designee will conduct rounds to ensure timely responses to call lights and observe interactions during personal care activities to ensure dignity is maintained. This will be completed 5x weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4	

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F 550	Continued From page 3 with her request not to use soap for urinary incontinence due to reoccurring urinary tract infections." Resident #3 stated NA #3 went back in the bathroom to rinse the soap out of the cloth and slammed the bathroom door. Resident #3 voiced when NA #3 came back, NA #3 "rolled her eyes." Resident #3 stated "I felt hurt, because I had done nothing to be treated that way." Resident #3 reported her concerns regarding NA #3's attitude towards her during 4:30 PM incontinence care to Nurse #4 around 8:45 PM. Resident #3 stated she felt confident that Nurse #4 would take care of the situation because the nurses have always resolved issues in past in a timely manner. Resident #3 stated when she placed her call light on around 9:00 PM to receive incontinence care, NA #3 entered the room and Resident #3 stated she needed to be "changed." Resident #3 reported NA #3 did not speak to her, turned the call light off, and exited the room. Resident #3 stated that she felt "disrespected and upset that she was ignored and made to stay in a soiled brief." No one entered the room until NA #4 entered around 10:45 PM. Resident #3 stated the urine in her brief had soaked through her clothing, and she was concerned about her buttocks that was being treated with barrier cream (protective skin cream). On 12/17/2024 an interview was conducted at 9:40 AM with NA #3. NA #3 was assigned to Resident #3 on 12/13/2024 during the 3:00 PM to 11:00 PM shift. NA #3 reported she provided incontinence care for Resident #3 once at the beginning of her shift around 4:45 PM. NA #3 stated that when she returned from her smoke break around 8:45 PM, some of her assigned residents' call lights were on. NA #3 stated she began to answer call lights for the residents;	F 550	weeks. Director of Nursing or designee will perform spot checks to assess if staff are adhering to dignity standards during incontinent care. These audits will be completed 5x weekly x 4 weeks, 3x weekly x 4 weeks, then weekly x 4 weeks. 5. Results will be reported by the Director of Nursing to the quality assurance meeting x1 month for further resolution as needed. Date of completion 1/23/2025	

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however, she did not start with Resident #3. NA #3 reported she entered Resident #3's room around 9:00 PM to answer the call light. NA #3 stated she asked Resident #3 if she needed anything, and Resident #3 did not say anything. NA #3 reported she turned Resident #3's call light off and left the room. NA #3 stated Nurse #4 told her around 9:40 PM not to go back in Resident #3's room and the assignment for the 11:00 PM to 7:00 AM shift would be changed so that NA #3 would not be assigned to Resident #3. NA #3 stated that was her first time caring for Resident #3 and Resident #3 wanted things done a "certain way" that NA #3 was not aware of. NA #3 stated she had not routinely rounded on Resident #3 because Resident #3 was alert enough to call when she needed assistance.

On 12/18/2024 at 9:43 AM an interview was conducted with Nurse #4. Nurse #4 reported when she started her shift on 12/13/2024 at 7:00 PM and completed rounds on the residents around 8:30 PM, Resident #3 reported to Nurse #4 that her brief had not been changed since 4:30 PM and that NA #3 had an attitude and "acting like she didn't want to care for her." Nurse #4 stated that she contacted Unit Manager #2 regarding NA #3 not providing incontinence care to Resident #3. She stated she contacted Unit Manager #2 around 9:30 PM after she observed NA #3 enter Resident #3's room, turning the light out and exiting the room around 9:00pm. Nurse #4 stated Unit Manager #2 requested Nurse #4 change the schedule for the 11:00 PM to 7:00 AM shift and not allow NA #3 back in Resident #3's room. Nurse #4 stated she changed the schedule around 10:00 PM and asked NA #3 around 9:40 PM not to go back in Resident's #3's room. Nurse #4 stated that she and NA #4

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F 550	Continued From page 5 provided incontinence care to Resident #3 at 10:30 PM and Resident #3 was soiled with urine that had leaked through the incontinence brief on to Resident #3's clothing. On 12/17/2024 at 12:00 PM an interview was conducted with NA #4. NA #4 stated that Nurse #4 approached her around 10:30 PM when she arrived for her 11:00 PM to 7:00 AM shift. NA #4 stated she and Nurse #4 provided incontinence care to Resident #3 around 10:45 PM and found Resident #3's clothes were soaked with urine. NA #4 stated Resident #3 said, "I don't know what I did to make her treat me that way." On 12/17/2024 at 10:22 AM an interview was conducted with Unit Manager #2. Unit Manager #2 stated Nurse #4 reported by telephone the behavior of NA #3 as being disrespectful and not providing incontinence care at 9:33 PM. Unit Manager #2 stated he asked Nurse #4 to change assignments and not allow NA #3 back in Residents #3's room. Unit Manager #2 reported that he then sent a text to NA #3 at 9:45 PM, asking NA #3 not to return to Resident #3's room due to her poor treatment towards Resident #3. On 12/17/24 at 8:55 AM an interview was conducted with the Administrator. She stated NA #3 should have provided care when Resident #3 asked. The Administrator stated Resident #3 should never feel disrespected and wait until the next shift for incontinence care.	F 550		
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;	F 580		

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

§483.10(g)(15)
Admission to a composite distinct part. A facility

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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, Nurse Practitioner and Medical Director, the facility failed to immediately consult with the on-call Nurse Practitioner on 11/30/24 when Resident #1 had a significant change in condition. Resident #1 showed signs of restlessness, agitation, crawling onto the floor and verbally expressed to staff that she had experienced difficulty breathing. The facility also failed to notify the provider that Resident #1 had received a medication for anxiety for which she had a documented allergy on 12/01/24 at 7:44 AM. On 12/01/24 at 8:13 AM Resident #1 was found in her room unresponsive with seriously abnormal vital signs. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM on 12/01/24. The deficient practice affected 1 of 3 residents reviewed for physician notification (Resident #1).

The findings included:

Resident #1 was readmitted to the facility on 08/20/24 with diagnoses of chronic obstructive pulmonary disease (COPD) and respiratory failure.

A review of Resident #1's quarterly Minimum Data Set assessment dated 11/29/24 revealed she was cognitively intact. The resident had no behaviors

Past noncompliance: no plan of correction required.

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during the assessment period.

On 12/16/24 at 11:27 AM an interview was conducted with Nurse Aide (NA) #2. NA #2 stated she had cared for Resident #1 on 11/30/24 during the 3:00 PM to 7:00 PM shift. Resident #1 was very anxious when she came on shift at 3:00 PM and did not eat her supper meal. NA #2 recalled Resident #1 had flipped over her bedside table and had thrown her supper meal onto the floor. The interview revealed Resident #1 would not stay in the bed and NA #2 had to keep repositioning the resident so she was sitting up because Resident #1 said to her, "I can't breathe." NA #2 stated, "I sat her up to calm her down, I would give her the call light and she would immediately hit the light again asking me to come back saying she couldn't breathe." The interview revealed she told Nurse #2 and Nurse #1 about the resident's condition; however they just told her the resident was anxious. Resident #1 continued to use her call light throughout the shift and if she did not call out, she would yell out the door stating, "I can't breathe, I can't breathe." NA #2 had not cared for Resident #1 prior to that day and was not familiar with the resident to know if that was typically how Resident #1 acted.

On 12/16/24 at 12:30 PM an interview was conducted with Nurse #2. During the interview she stated she had taken care of Resident #1 on 11/30/24 during the 7:00 AM to 7:00 PM shift. Nurse #2 stated Resident #1 seemed fine during her shift and did not seem anxious or short of breath. She did not recall NA #2 coming to her and stating the resident had not eaten her supper meal or thrown over the bedside table. Nurse #2 did not recall hearing Resident #1 yell out that she could not breathe during the shift. She gave

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report to Nurse #1 and left the facility at 7:00 PM.

On 12/16/24 at 1:20 PM an interview was conducted with NA #5. NA #5 was responsible for Resident #1 on 11/30/24 during the 7:00 PM to 11:00 PM shift. She stated she had a hard time assisting Resident #1 with incontinence care because she needed to sit up and seemed very anxious. NA #5 notified Nurse #1 of the resident's behavior however she stated Nurse #1 was already aware of how the resident was acting. At 11:00 PM she gave report to NA #6 and was assigned another hall. During the night she saw Resident #1's call light on so she went back into the room (but could not recall the time) to assist in changing the resident's brief. Once she lifted the bed up, Resident #1 would not stop moving and trying to get off of the bed. She stated she cleaned the resident as best as she could but Resident #1 would not lay down long enough, so she had a difficult time placing the new brief back onto the resident. NA #5 stated she had taken care of Resident #1 before, and she had never been that way. NA #5 indicated she once again let Nurse #1 know Resident #1 seemed very anxious, wanting to sit up and could not be still. Nurse #1 stated to her she was aware of the resident's condition. NA #5 then went back to her assigned hall.

On 12/18/24 at 9:05 AM an interview was conducted with NA #6. NA #6 was responsible for Resident #1 on 11/30/24 during the 11:00 PM to 7:00 AM shift. She stated at 11:00 PM she received a report that the resident was very anxious. Resident #1 was up and down all night and would not stay in bed. During the shift she would sit in the room with her because if she didn't then Resident #1 would end up lying on the

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floor. Resident #1 was talking but seemed confused. NA #6 stated Resident #1 was having difficulty breathing, was wheezing and did not want to lay down. She would assist the resident to sit up in the bed and sit on the side of the bed during the night. Resident #1 kept saying, "Help me" so she went and got Nurse #1 to go to the room to look at the resident. NA #6 stated at one point Nurse #1 said she was going to notify a physician and send her to the hospital. However, shortly after she changed her mind and said there was nothing the hospital could do for the resident because they were aware of her condition. Resident #1 was constantly moving from the bed to the floor on her fall mat during the shift, sitting up on the fall mat. Nurse #1 did not ask her to obtain vital signs. She stated she had taken care of Resident #1 before and had never seen her in the state she was in. NA #6 stated Resident #1 seemed like she was in distress. At 6:30 AM she gave a report to NA #1 and stated the resident had a change of condition and did not get any sleep during the night. She told NA #1 to keep a close eye on Resident #1 because she did not seem like herself.

Nurse #1 was assigned to Resident #1 on 11/30/24 - 12/1/2024 during the 7:00 PM to 7:00 AM shift. A nursing note written by Nurse #1 as a late entry dated 11/30/24 at 8:30 PM revealed Resident #1 was very restless during the shift and had continued to attempt to place herself onto the floor and pull cords from the wall and wrap them around various body parts. At 10:15 PM Resident #1 was assisted to the chair and stated she wanted to get back into bed. When she was assisted back into bed, she then stated she wanted to get back on the floor. The note revealed at 10:30 PM staff were sitting in the

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room with Resident #1 for a duration of 30 minutes to try and calm her down. At 12:00 AM on 12/01/24, Resident #1 was noted to rest for brief periods of time and then become very restless again. Resident #1 was documented to continue being restless and staff assisted the resident back and forth from the bed to the chair and to the floor per her request at 2:00 AM. At 7:45 AM Resident #1 continued to be restless and a standing order for Ativan was given. At 8:10 AM Resident #1 had respiratory distress and Emergency Medical Services (EMS) was called.

A nursing note written by Nurse #1 as a late entry dated 12/02/24 at 7:48 AM revealed Nurse #1 was made aware by the NA that Resident #1 had attempted to get out of the bed several times and had pulled down multiple items in her room. The resident stated she felt warm and thirsty. Resident #1's temperature decreased, and she was provided with water. Resident #1 continued to thrust herself forward to get out of bed. She was redirected and remained in bed. The incident occurred on 11/30/24 at 9:00 PM.

On 12/17/24 at 3:56 PM an interview was conducted with Nurse #1. Nurse #1 stated when she received a report from Nurse #2 at 7:00 PM the nurse had stated the resident was up and down from the bed to the floor, very anxious and moving around a lot. The anxious behavior continued throughout the night. Nurse #1 said she was not familiar with the resident. Nurse #1 stated she didn't know the process for notification to the physician because she was new to the facility. She stated she assumed since a Nurse Practitioner (NP) was in the building daily that the NP knew what was going on with Resident #1 and would be back in the facility the next day to

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see the resident. Nurse #1 stated because she assumed the Nurse Practitioner was aware of Resident #1's condition and wasn't concerned, then the condition was probably the resident's baseline. She stated, "I would rather talk to the physician in the morning than at 3:00 AM in the middle of the night. It seems like something day shift would tell them."

A nursing note written by Nurse #1 as a late entry dated 12/02/24 at 8:10 AM revealed Nurse #1 was made aware by Nurse #2 that Resident #1 was in possible distress after being discovered by NA #1 after medication administration. Upon entering the room, the resident was faced up and slow to respond. Nurse #1 requested vital signs and to call emergency medical services. Resident #1's vital signs were blood pressure 94/60 (normal blood pressure reading 120/80), pulse 111(normal pulse range 60-100), respiratory rate 4 (normal respiratory rate 12-20) and oxygen saturation level 54% (normal oxygen saturation level greater than 92%), Nurse #1 continued to call Resident #1's name with no response, the nurse requested oxygen saturation levels again with an oxygen saturation reading of 30% with supplemental oxygen (amount unspecified). EMS arrived on scene and were able to take over the resident's care.

On 12/16/24 at 12:53 PM an interview was conducted with Nurse #3. Nurse #3 worked on 11/30/24 -12/02/24 during the 7:00 PM to 7:00 AM shift with Nurse #1 but was not responsible for Resident #1. Nurse #3 stated Nurse #1 asked her what to do regarding the resident because she was very anxious and kept getting in and out of bed. Nurse #1 seemed "overwhelmed" with the situation so Nurse #3 went to the resident's room

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with her to see what she could do. Nurse #3 stated Resident #1 was screaming out, crawling out of the bed and very anxious. At approximately 3:00 AM Nurse #1 again came to her and stated she did not know what to do with Resident #1. Nurse #3 did not instruct Nurse #1 to notify the on-call physician because she felt that Resident #1 had a diagnosis of COPD and was "just excited" like most residents with the diagnosis and the Ativan would help calm her.

A nursing note written by Nurse #2 dated 12/01/24 at 12:14 PM as a late entry revealed she had received report from Nurse #1 who stated Resident #1 was restless all evening and attempted to get out of bed multiple times throughout the night. Nurse Aide #1 alerted Nurse #2 the resident was unresponsive. Upon assessment Resident #1 was noted to be hypoxic (low levels of oxygen) with an oxygen saturation of 60% (normal level greater than 92%) on 4 liters of supplemental oxygen via nasal cannula. Emergency Medical Services (EMS) was notified, Resident #1 was noted to have a do no resuscitate (DNR) order in place. EMS took over in administering life saving measures without success. Resident #1 was pronounced deceased by EMS at 8:30 AM.

On 12/16/24 at 12:30 PM an interview was conducted with Nurse #2. Upon return to the facility on 12/1/24, she came in at 7:00 AM. Nurse #1 was giving her report and stated Resident #1 had been anxious during the night and they had tried to give the resident Ativan but did not have access to the An automated system for medication management, an automated system for medication management. Nurse #2 was getting a report from Nurse #1 when Unit

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Manager #1 arrived at the nurses station. Nurse #3 and Unit Manager #1 then went to pull the Ativan from the An automated system for medication management machine for Resident #1 while Nurse #2 finished getting report and began to start her medication pass. Unit Manager #1 then brought her a cup with a 0.5mg Ativan in it for Resident #1 and stated to her to administer the medication. Nurse #2 stated she did not ask any questions or look at the resident's allergies prior to administering the Ativan 0.5 mg along with the resident of Resident #1's morning medication around 7:44 AM. When she went into the resident's room, she was sitting up on the floor on her fall mat. Nurse #2 and NA #1 assisted the resident to get up to the side of the bed to take her medication. Nurse #2 administered the medication and stated the resident drank water provided and Nurse #2 left the room. She was then alerted by NA#1 approximately 5-10 minutes later that something was wrong with Resident #1. Nurse #2 and Nurse #1 went into the resident's room to find her lying on the bed with her eyes open and fixed, mouth open and a faint pulse. EMS were called and vital signs were obtained. Nurse #2 stated Resident #1 was pronounced deceased by EMS at 8:30 AM.

On 12/16/24 at 12:07 PM an interview was conducted with Nurse Aide (NA) #1. During the interview she stated she came on shift around 6:30 AM on 12/01/24 to find Resident #1 lying on her fall mat in the floor. Resident #1 looked at NA #1 and stated, "I can't take this no more". She went to Nurse #1 who told her not to get the resident off the floor because she had been back and forth from the bed to the floor all night. NA #1 told Nurse #1 she did not feel comfortable leaving

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the resident lying on her fall mat in the floor but since she was wanting to be on the fall mat she proceeded to clean Resident #1 up and change her brief while she was lying on the fall mat. NA #1 then assisted Resident #1 up to the side of her bed and began fixing her oxygen tubing cord which was tangled. NA #1 was in the room with the resident when Nurse #2 entered the room and administered the resident's medication around 7:44 AM. NA #1 said Resident #1 acted like she did not want to take the medication, but she had her back to the resident untangling oxygen tubing. Nurse #2 then left the room as NA #1 continued to untangle the resident's oxygen tubing cord. NA #1 then heard the resident call out her name. When she turned around Resident #1 was lying flat on her back with her eyes fixed up at the ceiling and mouth open. Resident #1 would not respond to her, so she yelled out for Nurse #2 who was in the hallway outside of the resident's room. NA #1 stayed with the resident until Nurse #1 and Nurse #2 entered the room. Nurse #1 was doing a sternal rub on the resident to try and get her to respond however she did not. EMS was called and took over the resident's care once they arrived. She stated she had taken care of Resident #1 the day prior on 11/30/24 during the 7:00 AM to 3:00 PM shift and she was in no distress and was not anxious during the shift.

On 12/16/24 at 10:19 AM an interview was conducted with Unit Manager #1. During the interview she stated she had come in on 12/01/24 as the manager on call to orient Nurse #2 during the 7:00 AM to 7:00 PM shift. The interview revealed she arrived to the facility around 7:12 AM and noticed Resident #1 lying on her fall mat on the floor. She asked Nurse #1 if she was aware the resident was on the fall mat and Nurse

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#1 stated it was the safest place the resident could be. She was told Resident #1 had been very restless, agitated and had been throwing herself out of bed during the night. She was then notified by a Nurse Aide (name she could not recall) that Resident #1 was coding. Resident #1 was a DNR, so she went to the room to find Nurse #1, Nurse #2 and NA #1 in the room with the resident. EMS had already been contacted and were enroute to the facility. She left the room to print the resident's paperwork and gave EMS the resident's DNR paperwork upon their arrival to the facility.

EMS records dated 12/01/24 revealed they were notified at 8:13 AM, dispatched to the facility at 8:18 AM, arrived on scene at 8:29 AM and to the resident at 8:30 AM with a chief complaint of cardiac/ respiratory arrest. Upon EMS arrival Resident #1 was found lying in bed. The resident was apneic (without breathing) and pulseless. Resident #1 had no heart tones with a valid do not resuscitate order (DNR). She was pronounced deceased at 8:30 AM.

On 12/16/24 at 2:24 PM an interview was conducted with the former Director of Nursing (DON). The DON stated Unit Manager #1 called her on 12/01/24 to notify her Resident #1 had expired. The nurses were new to the facility and did not notify the on-call provider that Resident #1 had experienced a change of condition. The DON stated all nurses involved should have followed the facility protocol if a resident had experienced a change of condition and notified the physician.

On 12/16/24 at 11:28 AM an interview was conducted with the Administrator and Regional Nurse Consultant. The interview revealed on

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12/01/24 around 7:30 AM, Nurse #2 administered Ativan 0.5 mg to Resident #1 due to behaviors of restlessness and agitation. Nurse #2 administered Ativan to Resident #1 at 7:44 AM and Resident #1 was then found unresponsive with a low oxygen saturation level. EMS was called to the facility, and the resident was pronounced as deceased. At 11:30 AM the Former Director of Nursing (DON) was reviewing the documentation, and they immediately suspended the nurses involved and completed an investigation into the incident. Nurse #1 was responsible for the resident during the 7:00 PM to 7:00 AM shift and had needed guidance from Nurse #3 who told her about the standing order for Ativan 0.5mg. None of the 4 nurses involved in the incident notified a provider that Resident #1 had experienced difficulty breathing, restlessness or increased anxiety.

On 12/16/24 at 1:34 PM an interview was conducted with the on-call Nurse Practitioner. During the interview she stated she was not contacted on 11/30/24 or 12/01/24 regarding Resident #1. She stated that was unusual because the facility typically would let her know if anything acute happened but if a resident was having trouble breathing, she would have immediately sent the resident to the hospital for an evaluation.

On 12/16/24 at 1:38 PM an interview was conducted with the Medical Director (MD). The MD stated the DON notified him of an incident that happened on 12/01/24 when a nurse administered Ativan to a resident with a documented allergy to the medication. The interview revealed the first time he was contacted was on 12/01/24 at 1:00 PM and told a

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medication error had occurred. He wasn't notified Resident #1 had experienced a change of condition starting at approximately 3:00 PM on 11/30/24. The MD stated the on-call Nurse Practitioner would have been notified if it happened after 5:00 PM. The MD stated the facility should have sent Resident #1 to the hospital for an evaluation because from review of the nursing progress notes she had a respiratory episode and could have had increased carbon dioxide (A waste product produced during metabolism. It is transported through the bloodstream to the lungs, where it is exhaled as a gas.) in the blood. He stated the result of increased CO2 levels would be psychotic behavior such as getting up and down out of bed along with confusion. The MD stated if they had contacted the Nurse Practitioner, she would have sent the resident to the hospital for an evaluation because the resident was likely having an acute exacerbation of COPD as she had experienced in the past and needed to be on a BiPap (non-invasive ventilation therapy).

The Administrator was notified of the immediate jeopardy on 12/17/24 at 6:30 PM.

The facility provided the following corrective action plan with a completion date of 12/07/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to notify the on-call medical provider that Resident #1 had experienced a change of condition. Based on staff interviews on 11/30/24 during the 3:00 PM to 7:00 AM shift, Resident #1 showed signs of restlessness,

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agitation, crawling onto the floor and verbally expressed to staff that she was experiencing difficulty breathing. At 8:13 AM Resident was noted in her room unresponsive with a blood pressure of 94/60, pulse rate of 111, respiratory rate of 4 and oxygen saturation level of 54%. The staff applied a non-rebreather mask then called Emergency Medical Services (EMS). Resident #1 was pronounced deceased by EMS staff at 8:30 AM.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current residents are at risk of this occurring. An audit was completed by the Director of Nursing and designee to review the last 7 days of nursing notes to ensure any noted changes in residents' condition were noted and the physician had been notified. This was completed by the Director of nursing on 12/03/2024. The audit included a review of nursing notes and 24-hour shift to shift reports.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Education started by the Director of Nursing on 12/1/2024 for the change in condition and physician notification related to change in condition to include providing comprehensive assessments, that required medical attention, obtain vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues. Any licensed nurse and medication aides not receiving this education will not be able to work until receiving the education. New licensed

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nurses and medication aides will receive education during the orientation process. Director of Nursing ensured all licensed nurses and medication aides were educated prior to working their next scheduled shift as of 12/6/2024. Director of nursing reeducated all certified nursing assistants on verbally reporting any noted change in condition such as altered mental status, abnormal behaviors, abnormal vital signs, etc. to the nurse for assessment as of 12/6/2024.

All nursing note reviews, and 24-hour reports reviews were completed by the Director of Nursing or designee by 12/06/2024 to ensure noted changes in condition were addressed, vitals taken and physician notified. Nursing note reviews will be completed by the Director of Nursing or Designee on 5 residents weekly x 12 weeks.

New changes in conditions will be reviewed by the nursing clinical team during morning clinical meetings for any noted change in condition and physician notification. This occurs 5 times weekly and is ongoing as of 12/06/2024. New changes in condition from the weekend will be reviewed by the nursing clinical team during the Monday clinical meeting. The nursing team was notified of this responsibility on 12/3/2024 by the facility administrator.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

As of 12/3/2024 the results of the monitoring will be reviewed by the Administrator or Director of Nursing in the weekly Risk meeting and during the monthly Quality Assurance Performance

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F 580	Continued From page 21 Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of compliance and the immediate jeopardy removal date is 12/07/2024. On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on the change in condition and physician notification related to change in condition to include providing comprehensive assessments, that required medical attention, obtain vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues. Nurse Aides were interviewed regarding notification to the nursing staff if they see a resident with a change of condition. The facility's in-service log, monitoring results and training material was reviewed. The immediate jeopardy was removed on 12/07/24. The completion date of 12/07/24 for the corrective action plan was validated.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		

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F 600	Continued From page 22 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and facility staff, Nurse Practitioner (NP), and Medical Director (MD) interviews, the facility failed to protect Resident #1's right to be free of neglect when the facility failed to: 1) immediately consult with the on-call Nurse Practitioner on 11/30/24 when a resident had a significant change in condition during the 3:00 PM to 11:00 PM shift that included signs of restlessness, agitation, crawling onto the floor and verbally expressing to staff that she had difficulty breathing; 2) complete ongoing thorough assessments for the change in condition that continued through the 11:00 PM to 7:00 AM shift; 3) prevent a significant medication error when staff deliberately disregarded an electronic medical record (EMR) system alert when Ativan (a benzodiazepine, used as a sedative medication) was entered into the EMR and administered to a resident who had a documented allergy to the medication; 4) notify the physician that Ativan was administered to a resident with a documented allergy; and 5) recognize the seriousness of a significant change in condition and identify the urgent need for medical attention. On 12/1/24 at 8:13 AM EMS were contacted when Resident #1 was found in her room unresponsive. Upon EMS arrival,	F 600	Past noncompliance: no plan of correction required.	

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Resident #1 was apneic (without breathing) and pulseless and Resident #1 was pronounced deceased at 8:30 AM. This deficient practice affected 1 of 3 sampled residents reviewed for neglect (Resident #1).

The findings included:

This tag is cross referenced to:
F580: Based on record review and interviews with staff, Nurse Practitioner and Medical Director, the facility failed to immediately consult with the on-call Nurse Practitioner on 11/30/24 when Resident #1 had a significant change in condition. Resident #1 showed signs of restlessness, agitation, crawling onto the floor and verbally expressed to staff that she had experienced difficulty breathing. The facility also failed to notify the provider that Resident #1 had received a medication for anxiety for which she had a documented allergy on 12/01/24 at 7:44 AM. On 12/01/24 at 8:13 AM Resident #1 was found in her room unresponsive with seriously abnormal vital signs. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM on 12/01/24. The deficient practice affected 1 of 3 residents reviewed for physician notification (Resident #1).

F684: Based on observations, record review, and resident, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews, the facility failed to identify the seriousness of a significant change in condition, complete ongoing thorough assessment and identify the urgent need for medical attention for a resident with a history of chronic obstructive pulmonary disease who reported she could not breathe. On 11/30/24 during the 3:00 PM to 11:00 PM shift, Resident #1

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was restless, agitated, crawling onto the floor and verbally expressed to staff she could not breathe. During the night shift (11:00 PM to 7:00 AM) the difficulty breathing, anxiety and agitation continued and Resident #1 asked staff repeatedly to help her. On 12/01/24 at 8:13 AM Resident was noted in her room unresponsive with a blood pressure of 94/60, pulse rate of 111, respiratory rate of 4 and oxygen saturation level of 54%. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM. This deficient practice occurred for 1 of 3 sampled residents reviewed for quality of care (Resident #1).

F760: Based on record review, and interviews with staff, Medical Director and Pharmacist, the facility failed to prevent a significant medication error when Resident #1 received a dose of Ativan (a benzodiazepine, used as a sedative medication) as a one-time dose. Resident #1 had an allergy to Ativan documented on the Allergy List in the electronic medical record (EMR) on 08/20/24. The medication order was entered into the electronic health record by Nurse #3. She stated the electronic medical record flagged the order due to the allergy, but she "bypassed" the alert and entered the order in the EMR, which was then pulled from an automated system for medication management. Nurse #2, a nurse who was orienting under the supervision of the Unit Manager, administered the medication on 12/01/24 at 7:44 AM. On 12/01/24 at 8:13 AM Resident #1 became unresponsive with seriously abnormal vital signs. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM. This deficient practice occurred for 1 of 3 sampled residents reviewed for medication errors.

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F 600	Continued From page 25 The Administrator was notified of the immediate jeopardy on 12/17/24 at 6:30 PM. The facility provided the following corrective action plan with a compliance date of 12/07/24. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The facility neglected to act upon the system alert for Resident #1's allergy to Ativan when ordering a one-time dose on 12/01/24. Nurse #3 entered the order for Ativan and when the system flagged the order due to a documented allergy for Resident #1, Nurse #3 "by passed" the alert, continued to enter the order which was then pulled from the Omnicell and given to Resident #1 on 12/01/24 at approximately 7:35 AM. At approximately 8:15 AM Resident #1 was found in her room unresponsive with vital signs: b/p: 94/60, Pulse: 111, Respirations: 4, Oxygen saturation level of 54%. Emergency Medical Services (EMS) was called and pronounced Resident #1 deceased at 8:30 AM. The facility failed to provide comprehensive assessments, failed to identify a significant change in condition that required medical attention, failed to obtain vital signs and ongoing oxygen saturations during the evening and night on 11/30/24 through 12/01/24. On 11/30/24 during the 3:00 PM to 11:00 PM shift, Resident #1 showed signs of restlessness, agitation, crawling onto the floor and verbally expressed to staff that she was experiencing difficulty breathing which continued from 11:00 PM to 7:00 AM. The facility failed to notify the on call medical provider that a resident had experienced a change of condition on	F 600		

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11/30/2024.

On 12/01/2024, the Director of Nursing was notified at 11:13 am by Nurse #1 that Resident #1 had an allergy to Ativan. Nurses involved in the incident were suspended on 12/1/2024 pending investigation. Nurse #1, and Nurse #3 were terminated and reported to the Board of Nursing as of 12/4/2024. Nurse # 2 turned in a resignation letter on 12/7/2024. The Unit Manger was initially terminated and appealed the termination. She was brought back on 12/16 and placed back into the training program. She resigned effective immediately on 12/28. Medical Director was notified of Residents #1 change in condition and medication allergy at around 1:00 pm on 12/01/2024 by the Director of Nursing. The Nurse Practitioner was notified around 8:30 AM of a change in condition and an allergy to Ativan.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current residents are at risk of this occurring.

An audit of medication allergy alerts, change in condition and physician notification in the electronic medical records was completed by the Director of Nursing and designee on 12/03/24 to ensure that medications were not ordered with the listed allergies.

An audit on 12/3/2024 completed by the Director of Nursing and designee to review nursing notes, 24 hour reports, vital sign logs in the electronic healthcare record to ensure any noted changes in residents' condition were noted and physician notified. The audit also included that residents'

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F 600	Continued From page 27 vital signs were taken and noted in the electronic record. Audits included all current residents who could be affected by this deficient practice of neglect were reviewed to ensure any change in condition and physician notification as well as bypassing the allergy alert which would result in neglect were reviewed by the director of nursing. No negative findings noted following the audit on 12/3/2024. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Education started by the Director of Nursing on 12/1/2024 for the process for medication order entry in regard to alerts related to allergies and acknowledgement of alerts. Education also included physician notification of known allergies. Education started by the Director of Nursing on 12/1/2024 for the change in condition and included providing comprehensive assessments that require medical attention, obtaining vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues and notification of physician of change in condition. Education also included the documentation of comprehensive assessment into the electronic medical record. Education also addressed failure to follow above processes results in neglect which is a form of abuse. . Director of nursing educated all certified nursing assistants on reporting any noted change in	F 600		

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condition to the nurse verbally for assessment as of 12/6/2024.

Any licensed nurse and medication aides not receiving this education will not be able to work until receiving the education. Director of Nursing ensured all licensed nurses and medication aides were educated prior to working their next scheduled shift as of 12/6/2024.

New licensed nurses will receive education during the orientation process by the Director of Nursing until a Staff Development Coordinator is hired.

Medication Observations on current licensed nurses and medication aides will be completed by the Director of Nursing or designee by 12/06/2024 to ensure no medications are given related to a resident allergy. Med pass observations will be completed by Director of Nursing or Designee on 5 licensed nurses and/or medication aides weekly x 12 weeks.

New medication alerts will be reviewed by the director of nursing and the clinical team during morning clinical meetings. This occurs 5 times weekly and is ongoing as of 12/06/2024. Any allergy alerts will be addressed at the time.

All nursing notes and 24-hour reports will be reviewed by the nursing clinical team during morning clinical meetings for any noted changes in condition to ensure vital signs and oxygen saturation were done for change in condition. This occurs 5 times weekly and is ongoing as of 12/06/2024. Director of Nursing or designee will review nursing notes over the weekend to ensure any change in condition is addressed. Nursing note reviews will be completed by the Director of

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F 600	Continued From page 29 Nursing or Designee on 5 residents weekly x 12 weeks. As of 12/06/2024 the Director of nursing or designee will interview 5 nurse aides weekly for 12 weeks to ensure they are reporting any change in condition to their charge nurse verbally. Until a Staff Development Coordinator is hired, the Director of Nursing will complete monthly training on abuse and neglect for 3 months and then quarterly ongoing. Education will ensure abuse and neglect is explained to all staff per federal guidelines, "Neglect" as defined at 483.12, "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; As of 12/3/2024 the results of the monitoring will be reviewed by the Administrator or Director of Nursing in the weekly Risk meeting and during the monthly Quality Assurance Performance Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of IJ removal: 12/07/2024	F 600		

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F 600	Continued From page 30 On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on the process for medication order entry in regard to alerts related to allergies and acknowledgement of alerts. Education also included physician notification of known allergies. The education also included change in condition and included providing comprehensive assessments that require medical attention, obtaining vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues. Education also included the documentation of comprehensive assessment into the electronic medical record. Education also addressed failure to follow above processes results in neglect which is a form of abuse. Nurse Aides were interviewed regarding notification to the nursing staff if they see a resident with a change of condition. The facility's in-service log, monitoring results and training material was reviewed. The immediate jeopardy removal date of 12/07/24 and the compliance date of 12/07/24 for the corrective action plan were validated.	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		

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F 684	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, Nurse Practitioner (NP), and Medical Director (MD) interviews, the facility failed to identify the seriousness of a significant change in condition, complete ongoing thorough assessments and identify the urgent need for medical attention for a resident with a history of chronic obstructive pulmonary disease who reported she could not breathe. On 11/30/24 during the 3:00 PM to 11:00 PM shift, Resident #1 was restless, agitated, crawling onto the floor and verbally expressed to staff she could not breathe. During the night shift (11:00 PM to 7:00 AM) the difficulty breathing, anxiety and agitation continued and Resident #1 asked staff repeatedly to help her. On 12/01/24 at 8:13 AM Resident #1 was noted in her room unresponsive with a blood pressure of 94/60 (normal blood pressure reading 120/80), pulse 111(normal pulse range 60-100), respiratory rate 4 (normal respiratory rate 12-20) and oxygen saturation level 54% (normal oxygen saturation level greater than 92%). Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM. This deficient practice occurred for 1 of 3 sampled residents reviewed for quality of care (Resident #1). The findings included: Resident #1 was readmitted to the facility on 08/20/24 with diagnoses of chronic obstructive pulmonary disease (COPD) and respiratory failure. Resident #1 was 67 years old. An allergy list in the electronic medical record (EMR) updated on 08/20/24 included the	F 684	Past noncompliance: no plan of correction required.	

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medication Ativan. Resident #1's allergy reaction was documented as unspecified.

A physician order dated 08/20/24 revealed Resident #1 required continuous supplemental oxygen via 2 liters/minute to maintain oxygen saturation levels greater than 92 %.

A physician order dated 11/22/24 revealed Resident #1 was prescribed formoterol fumarate inhalation nebulization solution (breathing treatment) to inhale orally via nebulizer two times a day related to COPD with acute exacerbation.

A review of Resident #1's quarterly Minimum Data Set assessment dated 11/29/24 revealed she was cognitively intact. The resident had no behaviors during the assessment period. Resident #1 received antianxiety medication during the assessment period and continuous oxygen therapy.

On 12/16/24 at 11:27 AM a telephone interview was conducted with Nurse Aide (NA) #2. NA #2 stated she had cared for Resident #1 on 11/30/24 during the 3:00 PM to 7:00 PM shift. Resident #1 was very anxious when she came on shift at 3:00 PM and did not eat her supper meal. NA #2 recalled Resident #1 had flipped over her bedside table and had thrown her supper meal onto the floor. The interview revealed Resident #1 would not stay in the bed and NA #2 had to keep repositioning the resident so she was sitting up because Resident #1 said to her, "I can't breathe." NA #2 stated, "I sat her up to calm her down, I would give her the call light and she would immediately hit the light again asking me to come back saying she couldn't breathe." NA #2 recalled she told Nurse #2 and Nurse #1 about

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the resident's condition; however they just told her the resident was anxious. Resident #1 continued to use her call light throughout the shift and if she did not call out, she would yell out the door stating, "I can't breathe, I can't breathe." NA #2 had not cared for Resident #1 prior to that day and was not familiar with the resident to know if that was typically how Resident #1 acted. Resident #1 was wearing supplemental oxygen during the shift. NA #2 stated Resident #1 continued to be anxious and have behaviors throughout her shift and reported the behaviors to the oncoming NA (NA#5).

A nursing note dated 11/30/24 at 6:39 PM documented by Nurse #2 revealed Resident #1's vital signs taken on 11/27/24 with readings of blood pressure 135/72, temperature 97.6, pulse 67, respiratory rate 14 and O2 96%. Resident #1 was receiving oxygen therapy at 2 liters per minute. No signs or symptoms of distress were noted.

On 12/16/24 at 12:30 PM a telephone interview was conducted with Nurse #2. During the interview she stated she had taken care of Resident #1 on 11/30/24 during the 7:00 AM to 7:00 PM shift. Nurse #2 stated Resident #1 seemed fine during her shift and did not seem anxious or short of breath. She did not recall NA #2 coming to her and stating the resident had not eaten her supper meal or thrown over the bedside table. Nurse #2 did not recall hearing Resident #1 yell out that she could not breathe during the shift. Nurse #2 stated she had administered Resident #1's medication around 5:00 PM and she was able to swallow her medication and did not seem to be in any distress. She gave report to Nurse #1 that

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Resident #1 was using her call light repeatedly, but the nurses said that was normal for the resident. Nurse #2 indicated she left the facility at 7:00 PM. Nurse #2 stated she was new to the facility and was not very familiar with Resident #1.

Review of Resident #1's medical record revealed no vital signs were documented for Resident #1 on 11/30/24 during the 7:00 AM to 7:00 PM shift.

On 12/16/24 at 1:20 PM a telephone interview was conducted with NA #5. NA #5 stated she was responsible for Resident #1 on 11/30/24 during the 7:00 PM to 11:00 PM shift. NA #5 indicated she received report from NA #2 who had stated Resident #1 was very anxious and having difficulty breathing. NA #5 stated she had a hard time assisting Resident #1 with incontinence care because she needed to sit up and seemed very anxious. NA #5 notified Nurse #1 of the resident's behavior around 10:00 PM however she stated Nurse #1 was already aware of how the resident was acting because she had been in and out of the room during the shift. NA #5 revealed she gave report to NA #6 at 11:00 PM and she (NA #5) was assigned to another hall. During the night (could not recall what time) she saw Resident #1's call light on so she went back into the room to assist NA #6 with changing the resident's brief. Once she raised the bed up, Resident #1 would not stop moving and trying to get off the bed. She stated she cleaned the resident as best as she could, but Resident #1 would not lay down long enough, so she had a difficult time placing the new brief back onto the resident. NA #5 stated she had taken care of Resident #1 before, and she had never been that way. Resident #1 was wearing supplemental oxygen during the shift. NA #5 indicated she once again let Nurse #1 know

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Resident #1 seemed very anxious, wanting to sit up and could not be still. Nurse #1 stated to her she was aware of the resident's condition. NA #5 then went back to her assigned hall.

On 12/18/24 at 9:05 AM a telephone interview was conducted with NA #6 who was responsible for Resident #1 on 11/30/24 during the 11:00 PM to 7:00 AM shift. She stated at 11:00 PM she received a report NA #5 that the resident was very anxious. Resident #1 was up and down all night and would not stay in bed. NA #6 recalled she sat in the room with Resident #1 during the shift because if she didn't then Resident #1 would end up lying on the floor. Resident #1 was talking but seemed confused. NA #6 stated Resident #1 was having difficulty breathing, was wheezing and did not want to lay down. She assisted the resident to sit up in the bed and sit on the side of the bed during the night. Resident #1 kept saying, "Help me" so she went and got Nurse #1 to go to the room to look at the resident (could not recall what time). Nurse #1 went into the room and looked at Resident #1 and said she was going to notify a physician and send her to the hospital. However, shortly after Nurse #1 changed her mind and said there was nothing the hospital could do for the resident because they were aware of her condition. Resident #1 was constantly moving from the bed to the floor on her fall mat during the shift, sitting up on the fall mat. Resident #1 was wearing supplemental oxygen during the shift. Nurse #1 did not ask her to obtain vital signs, so she did not get them. She stated she had taken care of Resident #1 before and had never seen her in the state she was in, and it seemed like she was in distress. At 6:30 AM she gave a report to NA #1 and stated the resident had a change of condition and did not

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get any sleep during the night. She told NA #1 to keep a close eye on Resident #1 because she did not seem like herself.

Review of Resident #1's Medication Administration Record dated November 2024 revealed an order for nebulization solution (breathing treatment) to inhale orally via nebulizer at bedtime related to Chronic Obstructive Pulmonary Disease with Acute Exacerbation. On 11/30/24 the medication was scheduled for 9:00 PM. Nurse #1 documented a (2) for the 11/30/24 9:00 PM dose. Review of the legend located at the bottom of the MAR dated November 2024 revealed documentation of a (2) meant the medication was refused.

A statement written and signed by Nurse #1 on 12/02/24 obtained by the facility revealed she was assigned Resident #1 during the 7:00 PM to 7:00 AM shift on 11/30/24 through 12/01/2024. The statement revealed Resident #1 kept getting out of the bed and laying on the floor during the shift. Nurse #3 asked her if the resident had any Ativan available and Nurse #1 stated she wasn't sure. Nurse #3 then told her the facility had standing orders for Ativan, and it could be pulled from the automated medication dispensing system. Nurse #1 was unable to access the automated medication dispensing system. and had to wait until the next shift to be able to obtain the Ativan. When the next shift arrived at 7:00 AM Nurse #1 gave report to Nurse #2. NA #1 came to the office after Nurse #3's medication pass and stated something was wrong with Resident #1. Nurse #3 asked if she would go to the resident's room for support, so Nurse #1 did. Upon arrival to the resident's room Resident #1 was face up, lying in bed with a slow response to communicate. She

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asked for vital signs and for someone to call EMS after feeling a weak pulse on the resident. Nurse #1 continued to do a sternal rub on the resident until EMS arrived. After EMS arrived, she was told Resident #1 had expired. Nurse #1 was later told Resident #1 had received by mouth Ativan and that she had an allergy to the medication. Nurse #1 noted in her statement she did not administer the medication but had signed off on the resident's MAR because she was the nurse responsible for the resident and had initiated the process of Resident #1's need for the medication.

Nurse #1 was assigned to Resident #1 on 11/30/24 at 7:00 PM through 12/1/2024 at 7:00 AM. A nursing note written by Nurse #1 as a late entry dated 11/30/24 at 8:30 PM revealed Resident #1 was very restless during the shift and had continued to attempt to place herself onto the floor and pull cords from the wall and wrap them around various body parts. At 10:15 PM Resident #1 was assisted to the chair and stated she wanted to get back into bed. The note read, "vital signs completed WNL (within normal limits)". When she was assisted back into bed, she then stated she wanted to get back on the floor. The note revealed at 10:30 PM staff were sitting in the room with Resident #1 for a duration of 30 minutes to try and calm her down. At 12:00 AM on 12/01/24, Resident #1 was noted to rest for brief periods of time and then become very restless again. Resident #1 was documented to continue being restless and staff assisted the resident back and forth from the bed to the chair and to the floor per her request at 2:00 AM. At 7:45 AM (12/01/24) Resident #1 continued to be restless and a standing order for Ativan was given. At 8:10 AM Resident #1 had respiratory distress and Emergency Medical Services (EMS)

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was called.

A nursing note written by Nurse #1 as a late entry dated 12/02/24 at 7:48 AM revealed Nurse #1 was made aware by the NA that Resident #1 had attempted to get out of bed several times and had pulled down multiple items in her room. The resident stated she felt warm and thirsty. Resident #1's temperature decreased, and she was provided with water. Resident #1 continued to thrust herself forward to get out of bed. She was redirected and remained in bed. The incident occurred on 11/30/24 at 9:00 PM.

A nursing note written by Nurse #1 as a late entry for 12/01/24 dated 12/02/24 at 8:10 AM revealed Nurse #1 was made aware by Nurse #2 that Resident #1 was in possible distress after being discovered by NA #1 after medication administration. Upon entering the room, the resident was face up and slow to respond. Nurse #1 requested vital signs and to call emergency medical services. Resident #1's vital signs were blood pressure 94/60 (normal blood pressure reading 120/80), pulse 111(normal pulse range 60-100), respiratory rate 4 (normal respiratory rate 12-20) and oxygen saturation level 54% (normal oxygen saturation level greater than 92%), Nurse #1 continued to call Resident #1's name with no response, the nurse requested oxygen saturation levels again with an oxygen saturation reading of 30% with supplemental oxygen (amount unspecified). EMS arrived on scene and were able to take over the resident's care.

On 12/17/24 at 3:56 PM a telephone interview was conducted with Nurse #1. She confirmed she was responsible for Resident #1 on 11/30/24

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through 12/01/24 for the 7:00 PM to 7:00 AM shift. Nurse #1 stated when she received a report from Nurse #2 at 7:00 PM on 11/30/24 the nurse had stated the resident was up and down from the bed to the floor, very anxious and moving around a lot. Nurse #1 recalled the anxious behavior continued throughout the night for her entire shift. Nurse #1 said she was not familiar with the resident. Nurse #1 stated she didn't know the process for notification to the physician because she was new to the facility. She stated she assumed since a Nurse Practitioner (NP) was in the building daily that the NP knew what was going on with Resident #1 and would be back in the facility the next day to see the resident. Nurse #1 stated because she assumed the Nurse Practitioner was aware of Resident #1's condition and wasn't concerned, then the condition was probably the resident's baseline. Nurse #1, who was no longer employed by the facility, stated she wanted to use her initial statement to the facility as a response to any more questions asked.

On 12/16/24 at 12:07 PM an interview was conducted with Nurse Aide (NA) #1. During the interview she stated she came on shift around 6:30 AM on 12/01/24 to find Resident #1 lying on her fall mat in the floor with supplemental oxygen on via nasal cannula. Resident #1 looked at NA #1 and stated, "I can't take this no more". She went to Nurse #1 who told her not to get the resident off the floor because she had been back and forth from the bed to the floor all night. NA #1 told Nurse #1 she did not feel comfortable leaving the resident lying on her fall mat on the floor but since she was wanting to be on the fall mat she proceeded to clean Resident #1 up and change her brief while she was lying on the fall mat. NA

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#1 then assisted Resident #1 up to the side of her bed and began fixing her oxygen tubing cord which was tangled. NA #1 was in the room with the resident when Nurse #2 entered the room and administered the resident's medication. NA #1 then heard the resident call out her name. When she turned around Resident #1 was lying flat on her back with her eyes fixed up at the ceiling and with her mouth open. Resident #1 would not respond to her, so she yelled out for Nurse #2 who was in the hallway outside of the resident's room. NA #1 stayed with the resident until Nurse #1 and Nurse #2 entered the room. Nurse #1 was doing a sternal rub on the resident to try and get her to respond, however she did not. EMS was called and took over the resident's care once they arrived. She stated she had taken care of Resident #1 the day prior on 11/30/24 during the 7:00 AM to 3:00 PM shift and she was in no distress and was not anxious during the shift.

An undated After-Hours Standing Physician Orders revealed for aggression or agitated behavior the nurse may administer Ativan 0.5 milligram (mg) by mouth. The nurse could repeat the action in 20 minutes if the resident did not respond to the medication. The orders read to notify the primary care physician in the AM for further orders.

A medication administration note in the electronic medical record dated 12/01/24 at 7:43 AM revealed Nurse #3 entered an order for Ativan oral tablet 0.5 mg. Give 0.5 mg by mouth one time only related to COPD with acute exacerbation. The medication order triggered an alert for a system identified drug allergy.

Resident #1's Medication Administration Record

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(MAR) for December 2024 revealed an order for Ativan oral tablet 0.5 mg by mouth on time only related to COPD with acute exacerbation. The medication was administered on 12/01/24 at 7:44 AM and signed off by Nurse #1.

A nursing note written by Nurse #2 dated 12/01/24 at 12:14 PM as a late entry revealed she had received report from Nurse #1 who stated Resident #1 was restless all evening and attempted to get out of bed multiple times throughout the night. Nurse Aide #1 alerted Nurse #2 the resident was unresponsive. Upon assessment Resident #1 was noted to be hypoxic (low levels of oxygen) with an oxygen saturation of 60% (normal level greater than 92%) on 4 liters of supplemental oxygen via nasal cannula. Emergency Medical Services (EMS) was notified, Resident #1 was noted to have a do no resuscitate (DNR) order in place. EMS took over in administering life saving measures without success. Resident #1 was pronounced deceased by EMS at 8:30 AM.

On 12/16/24 at 12:30 PM a telephone interview was conducted with Nurse #2. Nurse #2 stated she returned to the facility on 12/01/24 at 7:00 AM and Nurse #1 gave her report and stated Resident #1 had been anxious during the night and they had tried to give the resident Ativan but did not have access to the automated medication dispensing system. Nurse #2 recalled she was getting a report from Nurse #1 when Unit Manager #1 arrived at the nurse's station. Nurse #3 and Unit Manager #1 then went to pull the Ativan for Resident #1 while she (Nurse #2) finished getting report and began to start her medication pass. Unit Manager #1 brought her a cup with a 0.5mg Ativan in it for Resident #1 and

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stated to her to administer the medication. Nurse #2 stated she did not ask any questions or look at the resident's allergies prior to administering the Ativan 0.5 mg along with Resident #1's morning medication. When she went into the resident's room, Resident #1 was sitting up on the floor on her fall mat. Nurse #2 and NA #1 assisted the resident to get up to the side of the bed to take her medication. Nurse #2 administered the medication and stated the resident drank water provided and Nurse #2 left the room. She was then alerted by NA#1 approximately 5-10 minutes later that something was wrong with Resident #1. Nurse #2 and Nurse #1 went into the resident's room to find her lying on the bed with her eyes open and fixed, mouth open and a faint pulse. EMS were called and vital signs were obtained. Nurse #2 stated Resident #1 was pronounced deceased by EMS at 8:30 AM.

On 12/16/24 at 12:53 PM a telephone interview was conducted with Nurse #3. Nurse #3 worked on 11/30/24 through 12/1/2024 during the 7:00 PM to 7:00 AM shift with Nurse #1 but was not responsible for Resident #1. Nurse #3 stated Nurse #1 asked her what to do regarding the resident because she was very anxious and kept getting in/ out of bed. Nurse #1 seemed "overwhelmed" with the situation so Nurse #3 went to the resident's room with her to see what she could do. Nurse #3 stated Resident #1 was screaming out, crawling out of bed and very anxious. At approximately 3:00 AM on 12/1/2024, Nurse #1 again came to her and stated she did not know what to do with Resident #1. Nurse #3 then told her the facility had standing orders for Ativan, she stated she told her it was okay to give the resident Ativan because the resident was "all over the place" by screaming, pulling on her

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oxygen tubing and crawling out of bed. The interview revealed Nurse #3 had access to the automated medication dispensing system. but Nurse #1 did not. The two nurses waited until the day shift arrived and asked Unit Manager #1 to be a second witness to pull the Ativan out of the automated medication dispensing system. machine. Nurse #3 and Unit Manager #1 then pulled Ativan 0.5 mg from the automated medication dispensing system for Resident #1 and Unit Manager #1 took the medication and gave it to Nurse #2 to administer. The interview revealed there were no alerts that popped up in the automated medication dispensing system. machine. However, when Nurse #3 put the Ativan order in the electronic charting system an allergy alert did pop up and she bypassed the alert in the system. At that time Nurse #3 did not know if they had administered the medication or not and left the facility after entering the medication order. Nurse #3 recalled she received a call after leaving the facility from the DON that Resident #1 had an allergy to the medication, and Nurse #3 had put the standing order into the Medication Administration Record (MAR). Nurse #3 stated she knew she should not have bypassed the allergy alerts in the system but was not thinking clearly about the situation and just clicked the button. She stated she felt that Resident #1 had a diagnosis of COPD and was "just excited" like most residents with the diagnosis and the Ativan would help calm her. Nurse #3 stated she did not review the resident's allergy list. The interview revealed looking back on the situation, the nurses should have contacted the on-call Nurse Practitioner regarding Resident #1's change in behavior.

On 12/16/24 at 10:19 AM an interview was

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conducted with Unit Manager #1. During the interview she stated she had come in on 12/01/24 as the manager on call to orient Nurse #2 during the 7:00 AM to 7:00 PM shift. The interview revealed she arrived at the facility around 7:12 AM and noticed Resident #1 lying on her fall mat on the floor. She asked Nurse #1 if she was aware the resident was on the fall mat and Nurse #1 stated it was the safest place the resident could be. The interview revealed she was touching base with Nurse #2 when Nurse #3 asked her to be a second witness to remove Ativan 0.5mg from the automated medication dispensing system. for Resident #1 due to agitation. She was told Resident #1 had been very restless, agitated and had been throwing herself out of bed during the night and Nurse #1 did not have access to the automated medication dispensing system. to pull the medication. Unit Manager #1 indicated she went with Nurse #3 and removed the medication from the automated medication dispensing system. as the second witness. She took the medication and gave it to Nurse #2 and instructed her to administer the medication to Resident #1. She was then notified by a nurse aide (name she could not recall) that Resident #1 was coding. Resident #1 was a DNR, so she went to the room to find Nurse #1, Nurse #2 and NA #1 in the room with the resident. EMS had already been contacted and were enroute to the facility. The interview further revealed Unit Manager #1 was new to the facility and was not familiar with Resident #1. Unit Manager #1 stated if Resident #1 had a change of condition and experienced difficulty breathing the nurses on duty should have notified the on-call Nurse Practitioner of the resident's condition.

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EMS records dated 12/01/24 revealed they were notified at 8:13 AM, dispatched to the facility at 8:18 AM, arrived on scene at 8:29 AM and to the resident at 8:30 AM with a chief complaint of cardiac/ respiratory arrest. Upon EMS arrival Resident #1 was found lying in bed. The resident was apneic (without breathing) and pulseless. Resident #1 had no heart tones with a valid do not resuscitate order (DNR). She was pronounced deceased at 8:30 AM.

On 12/16/24 at 2:24 PM a telephone interview was conducted with the former Director of Nursing (DON). The DON stated Unit Manager #1 called her on 12/01/24 to notify her Resident #1 had expired. The DON indicated nurses were new to the facility and did not notify the on-call provider that Resident #1 had experienced a change of condition, and the nurses should have completed an assessment on the resident. The interview revealed she instructed Nurse #1 to go back into the system and document nursing notes for the night of 11/30/24 through 12/01/24 because the nurse had not originally documented the resident's change of condition. The DON stated all nurses involved should have followed the facility protocol if a resident had experienced a change of condition and notified the physician. The DON revealed looking through documentation she saw Resident #1 had a documented allergy to the medication Ativan she was administered at 7:44 AM on 12/01/24. The DON stated it was around 11:00 AM on 12/01/24 when she was notified of Resident #1 being administered a medication she had a documented allergy to and she immediately suspended the nurses involved. She notified the Medical Director on 12/01/24 at 1:00 PM Resident #1 had received the medication Ativan

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with a documented allergy. The interview revealed the facility had standing orders to use Ativan if a resident was having agitation which was to administer 0.5mg of Ativan as a one-time dose. The nurses were new to the facility and the nurse who administered the medication (Nurse #2) was still in orientation and did not ask any questions prior to giving it to the resident because she was told to do so by Unit Manager #1, who was her preceptor. The DON stated all nurses involved should have followed the facility protocol for administration of medication which included review of the resident's allergies. She stated Nurse #3 should have never bypassed the allergy alerts in the EMR system. All nurses were suspended pending the investigation.

On 12/16/24 at 11:28 AM an interview was conducted with the Administrator and Regional Nurse Consultant. The interview revealed on 12/01/24 around 7:30 AM, Nurse #2 administered Ativan 0.5 mg to Resident #1 due to behaviors of restlessness and agitation based off of standing physician orders the facility had in place. The Regional Nurse Consultant stated Nurse #2 administered Ativan to Resident #1 at 7:44 AM and Resident #1 was then found unresponsive with a low oxygen saturation level. EMS was called to the facility, and the resident was pronounced as deceased. At 11:30 AM the Former Director of Nursing (DON) was reviewing the documentation, and they immediately suspended the nurses involved and completed an investigation into the incident. Nurse #1 was responsible for the resident during the 7:00 PM to 7:00 AM shift on 11/30/24 through 12/01/24 and needed guidance from Nurse #3 who told her about the standing order for Ativan 0.5mg. The

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Administrator stated none of the four nurses involved in the incident notified a provider or documented assessments when Resident #1 had experienced difficulty breathing, restlessness or increased anxiety and should have identified Resident #1 had experienced a change of condition during the night. Resident #1 was noted to have a documented allergy to the medication Ativan administered at 7:44 AM. None of the four nurses involved in the incident verified Resident #1 had no allergies to the medication. Nurse #3 bypassed the alerts in the electronic medical record when entering the medication order into the resident's MAR. The Administrator stated the nurses were responsible for verifying that the resident did not have an allergy to the medication, and they did not. The Regional Nurse Consultant stated nurses should be documenting the resident assessments and vital signs throughout the shift especially if there were changes to the resident's condition.

On 12/16/24 at 1:34 PM a telephone interview was conducted with the on-call Nurse Practitioner. During the interview she stated she was not contacted on 11/30/24 or 12/01/24 regarding Resident #1. She stated that it was unusual because the facility typically would let her know if anything acute happened but if a resident was having trouble breathing, she would have immediately sent the resident to the hospital for an evaluation.

On 12/16/24 at 1:38 PM a telephone interview was conducted with the Medical Director (MD). The MD stated the DON notified him of an incident that happened on 12/01/24 when a nurse administered Ativan to a resident with a

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documented allergy to the medication. The interview revealed the first time he was contacted was on 12/01/24 at 1:00 PM and told a medication error had occurred. He wasn't notified Resident #1 had experienced a change of condition starting at approximately 3:00 PM on 11/30/24. The MD stated the on-call Nurse Practitioner would have been notified if it happened after 5:00 PM. The MD stated the facility should have sent Resident #1 to the hospital for an evaluation because from review of the nursing progress notes she had a respiratory episode and could have had increased carbon dioxide (A waste product produced during metabolism. It is transported through the bloodstream to the lungs, where it is exhaled as a gas.) in the blood. He stated the result of increased CO2 levels would be psychotic behavior such as getting up and down out of bed along with confusion. The MD stated if they had contacted the Nurse Practitioner, she would have sent the resident to the hospital for an evaluation because the resident was likely having an acute exacerbation of COPD as she had experienced in the past and needed to be on a BiPap (non-invasive ventilation therapy).

The Administrator was notified of the immediate jeopardy on 12/17/24 at 6:30 PM.

The facility provided the following corrective action plan with a compliance dated of 12/07/24.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to provide comprehensive

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assessments, failed to identify a significant change in condition that required medical attention, failed to obtain vital signs and ongoing oxygen saturations during the evening and night on 11/30/24 through 12/01/24. On 11/30/24 during the 3:00 PM to 11:00 PM shift, Resident #1 showed signs of restlessness, agitation, crawling onto the floor and verbally expressed to staff that she was experiencing difficulty breathing which continued from 11:00 PM to 7:00 AM. At 8:13 AM Resident was noted in her room unresponsive with a blood pressure of 94/60, pulse rate of 111, respiratory rate of 4 and oxygen saturation level of 54%. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM.

On the evening of 11/30/2024, Resident #1 showed signs of restlessness and agitation according to the licensed nurses' statements. Licensed nurses made multiple attempts to make resident #1 comfortable. Nurse #2 continued to assist Resident #1 throughout the night moving her from bed to chair to help the resident to become more comfortable. Nurse #2 obtained Resident #1's oxygen saturations at 98% at approximately 2:00 AM. Resident #1 needed one on one supervision periodically during the night by nursing staff for safety. Nurse #2 failed to properly assess the resident.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current residents are at risk of this occurring. As of 12/3/2024 an audit was completed by the Director of Nursing and designee to review nursing notes, 24-hour reports, and vital sign logs

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in the electronic healthcare record to ensure any noted changes in residents' condition were noted and the physician notified from 11/23/2024 forward. The audit also included a review to ensure that residents' vital signs were taken and noted in the electronic record. This was completed by the Director of nursing and designees on 12/03/2024

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Education started by the Director of Nursing on 12/1/2024 for the change in condition and included providing comprehensive assessments that require medical attention, obtaining vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues. Education also included the documentation of comprehensive assessment into the electronic medical record. All education was completed by the Director of Nursing and/or designee as of 12/06/2024. All licensed nurses and medication aides not receiving this education will not be able to work until receiving the education. New licensed nurses and medication aides will receive education during the orientation process by the Director of Nursing until a Staff Development Coordinator is hired. The facility Administrator made the Director of Nursing aware of this responsibility on 12/2/2024 and will educated the Staff Development Coordinator once that position is filled. Director of Nursing ensured all licensed nurses and medication aides were educated prior to working their next scheduled shift as of 12/6/2024. Director of nursing educated all certified nursing assistants on reporting any noted change in condition to the nurse for assessment

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in writing as of 12/6/2024. Example of change in conditions included but not limited to, difficulty breathing and change in mental status. Vitals are to be taken as per policy to include with acute changes, weekly and every shift for skilled residents.

All nursing notes and 24-hour reports will be reviewed by the nursing clinical team during morning clinical meetings for any noted changes in condition to ensure vital signs and oxygen saturations were done for changes in condition. This occurs 5 times weekly and is ongoing as of 12/06/2024. Director of Nursing or designee will review nursing notes over the weekend to ensure any change in condition is addressed. Nursing note reviews will be completed by the Director of Nursing or Designee on 5 residents weekly x 12 weeks.

As of 12/06/2024 the Director of nursing or designee will interview 5 nurse aides weekly for 12 weeks to ensure they are reporting any change in condition to their charge nurse verbally.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

As of 12/3/2024 the results of the monitoring will be reviewed by the Administrator or Director of Nursing in the weekly Risk meeting and during the monthly Quality Assurance Performance Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024 for 3 months. Changes will be made to the plan as necessary to maintain compliance with resident safety. The IDT team will consist of the Administrator, Director of Nursing, Medical

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F 684	Continued From page 52 Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. Alleged date of IJ removal: 12/07/2024. On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews. The interviews revealed all nursing staff had received education on change in condition and included providing comprehensive assessments that require medical attention, obtaining vital signs, signs of restlessness, agitation, oxygen saturations, and any breathing issues. Education also included the documentation of comprehensive assessment into the electronic medical record. Nurse Aides were interviewed regarding notification to the nursing staff if they see a resident with a change of condition. The facility's in-service log, monitoring results and training material was reviewed. The IJ removal date of 12/07/24 and completion date for the corrective action plan of 12/07/24 was validated.	F 684		
F 726 SS=J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		

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F 726	Continued From page 53 at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, Medical Director and Pharmacist, the facility failed to provide effective training and orientation for new hires including preceptorship, skills validations and specific training related to pharmacy services and resident allergies in the electronic medical record (EMR) system alerts. On 12/1/24 Unit Manager #1, who had not received a complete orientation, was scheduled to precept Nurse #2. Under Unit Manager #1's direction Nurse #2 administered Ativan to Resident #1 who had a documented allergy to Ativan. At 8:13 AM Resident #1 was noted in her room unresponsive and vital signs were blood pressure 94/60 (normal blood pressure reading 120/80), pulse 111(normal pulse range 60-100), respiratory rate 4 (normal respiratory rate 12-20) and oxygen saturation level 54% (normal oxygen	F 726	Past noncompliance: no plan of correction required.	

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saturation level greater than 92%). Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM. The incomplete orientation and training for Unit Manager #1 put all residents at risk for a serious adverse outcome.

For example b. the facility failed to provide complete orientation and training for Nurse #1 before she worked independently. This is cited at "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy).

The deficient practice occurred for 2 of 4 nurses reviewed for competencies.

The findings included:

This tag is cross-referred to:

F760: Based on record review, and interviews with staff, Medical Director and Pharmacist, the facility failed to prevent a significant medication error when Resident #1 received a dose of Ativan (a benzodiazepine, used as a sedative medication) as a one-time dose. Resident #1 had an allergy to Ativan documented on the Allergy List in the electronic medical record (EMR) on 08/20/24. The medication order was entered into the electronic health record by Nurse #3. She stated the electronic medical record flagged the order due to the allergy, but she "bypassed" the alert and entered the order in the EMR, which was then pulled from an automated system for medication management. Nurse #2, a nurse who was orienting under the supervision of the Unit Manager, administered the medication on 12/01/24 at 7:44 AM. On 12/01/24 at 8:13 AM Resident #1 became unresponsive with seriously

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abnormal vital signs. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM. This deficient practice occurred for 1 of 3 sampled residents reviewed for medication errors.

a. Review of Unit Manager #1's employee file revealed she had been hired on 10/15/24. An undated, incomplete skills validation record titled, "Unit Manager" revealed Unit Manager #1 had not received training on facility equipment, supervising Nurse Aides (NA), clinical processes, pharmacy services, EMR documentation, or clinical skills competencies. She also had not completed nursing competencies under the heading, "Unit Manager Responsibilities".

On 12/17/24 at 10:19 AM an interview was conducted with Unit Manager #1. Unit Manger #1 stated she was hired on 10/15/24 and received three days of class orientation with the facility Scheduler. The training included introducing her to the company, discussing the schedule, discussing the facility policy regarding attendance and paid time off. On the second day she met with the Staff Development Coordinator (SDC) going over infection control, contact isolation, enhanced barrier precautions and watching informative videos. Unit Manager #1 was given a skills validation packet and told she would be placed with a preceptor and the preceptor would assist her in completing the nursing competencies. Unit Manager #1 stated nothing else happened after that, she was never placed with a preceptor or received any more training after the in-class training. She stated she asked the Former Director of Nursing about receiving education or training and she would say okay, but never followed back up with Unit Manager #1.

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When Nurse #1 and Nurse #2 were hired the facility did not have a SDC and their orientation wasn't even half of what she had received. Nurse #3 would state to her that she hadn't received any on-the-floor training. Unit Manager #1 stated on 12/01/24 she was scheduled to precept Nurse #2. However, she had not even received orientation herself but was told by the Scheduler that Nurse #2 just needed support because she really did not need orientation. Unit Manager#1 stated she had her skills validation sheet however it wasn't completed other than the three days of classroom orientation. Unit Manager #1 stated no one from the facility had gone over verifying residents allergies prior to administration of medication or system alerts related to resident allergies. She stated she knew she should have verified the residents' allergies but thought Nurse #1 had already done so. She was not the primary nurse and was just signing as a witness. The interview revealed no one from the facility had gone over medication rights or change of condition with her until after the incident on 12/01/24.

On 12/17/24 at 10:56 AM an interview was conducted with the Scheduler. The interview revealed she assisted during the orientation process and provided each newly hired Nurse Aide or Nurse with a skills check off sheet. She stated the newly hired staff received an orientation lasting three days and then were placed with a preceptor on the units that would sign off the newly hired staff member was competent in the area on the checklist. The interview revealed once the checklist was completed it would be returned to herself or the Staff Development Coordinator who placed it into the employee's file. The Scheduler stated the facility had a period of time with no SDC in the

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building from October 2024 until 12/16/24 and the Former Director of Nursing had been responsible for gathering the completed checklist and oversight of newly hired staff. The Scheduler stated she had not seen a completed skills checklist from Nurse #1 and Unit Manager #1. She stated Nurse #2 was still in orientation and Nurse #3 had a completed skills checklist.

On 12/17/24 at 9:24 AM an interview was conducted with the Staff Development Coordinator (SDC). She stated she had left the facility at the end of October and not returned until 12/16/24. The SDC stated the Former DON was responsible for all nursing orientation during that time. Orientation in the facility consists of 3-4 days in person class time for the Nurses and Nurse Aides (NA). After the class orientation nurses were typically placed with a preceptor for at least a week or two after the in-class orientation. The interview revealed Nurses received access to the automated medication dispensing system during the class orientation. The SDC stated she was unaware if Nurse #1, and Unit Manager #1 had completed their skills validation record or received a precepted orientation because she had only been back into the building for one day. The SDC verified that part of the orientation training included reviewing residents allergies prior to administration of medication.

An interview conducted on 12/16/24 at 2:24 PM with the Former Director of Nursing (DON) revealed Unit Manager #1 called her on 12/01/24 to notify her Resident #1 had expired. After looking through documentation she saw Resident #1 had a documented allergy to the medication Ativan she was administered at 7:44 AM. The

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DON stated it was around 11:00 AM when she was notified, and she immediately suspended the nurses involved. She notified the Medical Director at 1:00 PM. The interview revealed the facility had standing orders to use Ativan if a resident was having agitation which was to administer 0.5mg of Ativan as a one-time dose. The nurses were new to the facility and the nurse who administered the medication (Nurse #2) was still in orientation and did not ask any questions prior to giving it to the resident because she was told to do so by Unit Manager #1 who was her preceptor. The DON stated all nurses involved should have followed the facility protocol for administration of medication which included review of the resident's allergies. She stated Nurse #3 should have never bypassed the allergy alerts in the EMR system. The Former DON stated verifying resident's allergies and acknowledging system alerts were covered during orientation to the facility by the Staff Development Coordinator (SDC) or nursing preceptor assigned to newly hired employees.

On 12/17/24 at 11:23 AM an interview was conducted with the Administrator. During the interview she stated immediately following the incident on 11/30/24 through 12/01/24 the facility put a plan of correction in place regarding orientation. The facility realized the biggest mistake was during the orientation process and their Corporate Clinical Educator put together a structured orientation process of what the facility should be doing for newly hired staff. Education was completed for every staff member that was still in the orientation process. The Administrator stated the staff members had not received the clinical preceptorship to meet her expectations, and each staff member had voiced they felt they

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were not properly trained by the facility.

The Administrator was notified of the immediate jeopardy on 01/07/25 at 4:15 PM.

b. Review of Nurse #1's employee file revealed she had been hired on 11/12/24. An undated, incomplete skills validation record titled, "Charge Nurse" revealed Nurse #1 did not receive training on Pharmacy Services, Electronic Medical Record (EMR) clinical documentation for allergies or clinical skills competencies.

An interview conducted on 12/17/24 at 3:56 PM with Nurse #1 revealed she was hired by the facility on 11/12/24 and received an in-person class training for 2 days. She stated following the class training she was assigned with a nurse that was "as needed" (PRN) in the facility and was only with her for a duration of two days before being placed on her own because the staff member wasn't working in the facility. Nurse #1 stated she had come from a hospital setting where she had received 8 weeks' training, and she felt like the long-term care training was not adequate. The interview revealed the training was incomplete because she had not received an actual precepted orientation and no one from the facility had provided training on resident allergies or EMR system alerts.

The facility submitted the following corrective action plan:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

While interviewing 4 nurses involved in the

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incident occurring on 12/1/2024, It was mentioned that they did not feel as if they received proper orientation from the facility. The facilities failure to have a proper orientation and training program in place, led to an undesirable resident outcome.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

On 12/4/2024 the Administrator identified that current clinical staff hired on or after 10/15/2024 were not properly orientated, onboarded, and thoroughly trained to completely fulfill their role.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

As of 12/4/24 it was decided by the Administrator to have identified employees return for a corrected orientation, onboarding, and training process beginning on 12/09/2024. Licensed Nurses completed Medication Pass Observations with the Director of Nursing starting on 12/3/2024 after medication error on 12/1/2024. Nurses who did not complete this Medication Pass Observation before their next scheduled shift, were not allowed to work until it was completed. Skills Validations were started on 12/3/2024 for Licensed Nurses by the Director of Nursing or designee after incident on 12/1/2024. All Licensed Nurses hired on 10/15/2024 or after participated in the training program on 12/9/2024. Those who did not attend were not allowed to return until they went through the training program. Nurses involved in the incident were suspended on 12/1/2024 pending investigation. Nurse #1, and Nurse #3 were terminated and

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reported to the Board of Nursing as of 12/4/2024. Nurse # 2 turned in a resignation letter on 12/7/2024. The Unit Manger was initially terminated and appealed the termination. She was brought back on 12/16 and placed back into the training program. She resigned effective immediately on 12/28. This training program was held by the Administrator, Director of Nursing and Human Resources Director. Training included prior to accepting responsibility for an assignment without preceptor supervision, the Director of Nursing or designee must validate successful completion of the Skills Validation Record, Medication Pass Observation, and Treatment Observation. Skills Validation Record, Medication Pass Observation, and Treatment Observation was completed by designated preceptor or supervisor.

The Director of Clinical Education and Regional Director of Clinical Services provided detailed training on company expectations in the area of appropriate orientation, onboarding, and thorough training on Wednesday, 12/4/2024 to the Administrator, Director of Nursing, and Human Resources Director. Once a Staff Development Coordinator is hired, they will be educated by the administrator on the expected orientation process.

The Administrator, Director of Nursing or designee, and Human Resources Director will ensure that company expectations for appropriate orientation, onboarding, and thorough training for newly hired clinicians are implemented beginning 12/9/2024. The Director of Nursing will complete this training until an SDC is hired.

Company expectations are as follows: 5 days of

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classroom orientation adhering to the company-specific orientation agenda, followed by no less than 2 weeks of on-the-floor 1:1 onboarding and training with a center-designated clinical preceptor.

Prior to accepting responsibility for an assignment without preceptor supervision, the Director of Nursing or designee must validate successful completion of the Skills Validation Record, Medication Pass Observation, and Treatment Observation. Skills Validation Record, Medication Pass Observation, and Treatment Observation will be completed by designated preceptor or supervisor. Effective 12/04/2024, the Administrator will be ultimately responsible for ensuring implementation of this corrective action plan.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

As of 12/9/2024, HR will interview new hire employees weekly x 12 weeks to ensure that they are receiving proper orientation and feel comfortable with the training that is being provided.

As of 12/3/2024 Medication pass observations will be completed by the Director of Nursing or Designee on 5 licensed nurses weekly x 12 weeks to ensure residents do not receive medications with listed allergies on the EMAR. Allergies are listed on the EMAR and show up when the EMAR is pulled up or displayed in the electronic health record.

As of 12/9/2024 The results of the monitoring will

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F 726	Continued From page 63 be discussed by the Administrator during the monthly QAPI meeting with the Interdisciplinary Team. Changes will be made to the plan as necessary to maintain compliance with resident safety. IJ removal date: 12/10/2024 On 12/17/24, the corrective action plan was validated by onsite verification through facility staff interviews. The interviews revealed the facility staff were provided with company expectations of the following: 5 days of classroom orientation adhering to the company-specific orientation agenda, followed by no less than 2 weeks of on-the-floor 1:1 onboarding and training with a center-designated clinical preceptor. Prior to accepting responsibility for an assignment without preceptor supervision. The facility's in-service log, monitoring results and training material was reviewed. The IJ removal date of 12/10/24 and the compliance date of 12/10/24 for the corrective action plan were validated.	F 726		
F 760 SS=J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with staff, Medical Director and Pharmacist, the facility failed to prevent a significant medication error when Resident #1 received a dose of Ativan (a benzodiazepine, used as a sedative medication) as a one-time dose. Resident #1 had an allergy to Ativan documented on the Allergy List in the	F 760	Past noncompliance: no plan of correction required.	

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electronic medical record (EMR) on 08/20/24. The medication order was entered into the electronic health record by Nurse #3. She stated the electronic medical record flagged the order due to the allergy, but she "bypassed" the alert and entered the order in the EMR, which was then pulled from the automated system for medication management. Nurse #2, a nurse who was orienting under the supervision of the Unit Manager, administered the medication on 12/01/24 at 7:44 AM. On 12/01/24 at 8:13 AM Resident #1 became unresponsive with seriously abnormal vital signs. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM. This deficient practice occurred for 1 of 3 sampled residents reviewed for medication errors.

The findings included:

An undated "After-Hours Standing Physician Orders" revealed for aggression or agitated behavior the nurse may administer Ativan 0.5 milligram (mg) by mouth. The nurse could repeat the action in 20 minutes if the resident did not respond to the medication. The order read to notify the primary care physician in the AM for further orders.

Resident #1 was readmitted to the facility on 08/20/24 with diagnoses of chronic obstructive pulmonary disease (COPD) and respiratory failure.

An allergy list in the electronic medical record updated on 08/20/24 included the medication Ativan. Resident #1's allergy reaction was documented as unspecified.

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A review of Resident #1's quarterly Minimum Data Set assessment dated 11/29/24 revealed she was cognitively intact.

A review of the facility's medication error report dated 12/01/24 at 11:20 AM by the Director of Nursing (DON) revealed Resident #1 was ordered and administered Ativan 0.5 mg for a one-time dose with a documented allergy to the medication by Nurse #2. The result of the incident was documented as Resident #1 experienced an unresponsive event. The medication error was reported to the Medical Director.

A medication administration note in the electronic medical record dated 12/01/24 at 7:43 AM revealed Nurse #3 entered an order for Ativan oral tablet 0.5 mg. Give 0.5 mg by mouth one time only related to Chronic Obstructive Pulmonary Disease with Acute Exacerbation until 12/01/24 at 9:00 AM. The medication order triggered an alert for a system identified drug allergy.

Resident #1's Medication Administration Record (MAR) for December 2024 revealed an order for Ativan oral tablet 0.5 mg by mouth on time only related to COPD with acute exacerbation. The medication was administered on 12/01/24 at 7:44 AM and signed off by Nurse #1.

On 12/17/24 at 3:56 PM an interview was conducted with Nurse #1, who was no longer employed by the facility. During the interview she stated she wanted to use her initial statement to the facility as a response to questions asked.

A statement written and signed by Nurse #1 on 12/02/24 obtained by the facility revealed she was

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assigned Resident #1 during the 7:00 PM to 7:00 AM shift on 11/30/24 - 12/1/2024. The statement revealed Resident #1 kept getting out of the bed and laying on the floor during the shift. Nurse #3 asked her if the resident had any Ativan available and Nurse #1 stated she wasn't sure. Nurse #3 then told her the facility had standing orders for Ativan, and it could be pulled from the automated system for medication management. Nurse #1 was unable to access the automated system for medication management and had to wait until the next shift to be able to obtain the Ativan. When the next shift arrived at 7:00 AM Nurse #1 gave a report to Nurse #2. NA #1 came to the office after Nurse #3's medication pass and stated something was wrong with Resident #1. Nurse #3 asked if she would go to the resident's room for support, so Nurse #1 did. Upon arrival to the resident's room Resident #1 was face up, lying in bed with a slow response to communicate. She asked for vital signs and for someone to call EMS after feeling a weak pulse on the resident. Nurse #1 continued to do a sternal rub on the resident until EMS arrived. After EMS arrived, she was told Resident #1 had expired. Nurse #1 was later told Resident #1 had received by mouth Ativan and that she had an allergy to the medication. Nurse #1 noted in her statement she did not administer the medication but had signed off on the resident's MAR because she was the nurse responsible for the resident and had initiated the process of Resident #1's need for the medication.

On 12/16/24 at 12:53 PM an interview was conducted with Nurse #3. Nurse #3 worked on 11/30/24 - 12/1/2024. during the 7:00 PM to 7:00 AM shift with Nurse #1 but was not responsible for Resident #1. Nurse #3 stated Nurse #1 asked her what to do regarding the resident because

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she was very anxious and kept getting in/ out of bed. Nurse #1 seemed "overwhelmed" with the situation so Nurse #3 went to the resident's room with her to see what she could do. Nurse #3 stated Resident #1 was screaming out, crawling out of the bed and very anxious. At approximately 3:00 AM on 12/1/2024, Nurse #1 again came to her and stated she did not know what to do with Resident #1. Nurse #3 then told her the facility had standing orders for Ativan, she stated she told her it was okay to give the resident Ativan because the resident was "all over the place" by screaming, pulling on her oxygen tubing and crawling out of bed. The interview revealed Nurse #3 had access to the automated system for medication management, but Nurse #1 did not. The two nurses waited until the day shift arrived and asked Unit Manager #1 to be a second witness to pull the Ativan out of the automated system for medication management. Nurse #3 and Unit Manager #1 then pulled Ativan 0.5 mg for Resident #1 and Unit Manager #1 took the medication and gave it to Nurse #2 to administer. The interview revealed there were no alerts that popped up in the automated system for medication management. However, when Nurse #3 put the Ativan order in the electronic charting system an allergy alert did pop up and she bypassed the alert in the system. At that time Nurse #3 did not know if they had administered the medication or not and left the facility after entering the medication order. She then received a call after leaving the facility from the DON that Resident #1 had an allergy to the medication, and Nurse #3 had put the standing order into the Medication Administration Record (MAR). Nurse #3 stated she knew she should not have bypassed the allergy alerts in the system but was not thinking clearly about the situation and just

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clicked the button. She stated she felt that Resident #1 had a diagnosis of COPD and was "just excited" like most residents with the diagnosis and the Ativan would help calm her. Nurse #3 stated she did not review the resident's allergy list.

On 12/16/24 at 10:19 AM an interview was conducted with Unit Manager #1. During the interview she stated she had come in on 12/01/24 as the manager on call to orient Nurse #2 during the 7:00 AM to 7:00 PM shift. The interview revealed she arrived at the facility around 7:12 AM and was touching base with Nurse #2 when Nurse #3 asked her to be a second witness to remove Ativan 0.5mg from the automated system for medication management for Resident #1 due to agitation. She was told Resident #1 had been very restless, agitated and had been throwing herself out of bed during the night and Nurse #1 did not have access to the automated system for medication management to pull the medication. Unit Manager #1 went with Nurse #3 and removed the medication from the as the second witness. After, she took the medication and gave it to Nurse #2 whom she was orienting and instructed her to administer the medication to Resident #1.

On 12/16/24 at 12:07 PM an interview was conducted with Nurse Aide (NA) #1. During the interview she stated she came on shift around 6:30 AM on 12/01/24 to find Resident #1 lying on her fall mat on the floor. She went to Nurse #1 who told her not to get the resident off the floor because she had been back and forth from the bed to the floor all night. NA #1 was in the room with the resident when Nurse #2 entered the room and administered the resident's medication

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around 7:44 AM. NA #1 said Resident #1 acted like she did not want to take the medication, but she had her back to the resident untangling oxygen tubing. Nurse #2 then left the room as NA #1 continued to untangle the resident's oxygen tubing cord. NA #1 then heard the resident call out her name. When she turned around Resident #1 was lying flat on her back with her eyes fixed up at the ceiling and mouth open. Resident #1 would not respond to her, so she yelled out for Nurse #2 who was in the hallway outside of the resident's room. NA #1 stayed with the resident until Nurse #1 and Nurse #2 entered the room. Nurse #1 was doing a sternal rub on the resident to try and get her to respond, however she did not. EMS was called and took over the resident's care once they arrived.

On 12/16/24 at 12:30 PM an interview was conducted with Nurse #2. During the interview she stated she worked the 7:00 AM to 7:00 PM shift on 12/01/24. The interview revealed when she came in at 7:00 AM Nurse #1 was giving her report and stated Resident #1 had been anxious during the night and they had tried to give the resident Ativan but did not have access to the automated system for medication management. Nurse #2 was getting a report from Nurse #1 when Unit Manager #1 arrived at the nurses station. Nurse #3 and Unit Manager #1 then went to pull the Ativan for Resident #1 while Nurse #2 finished getting report and began to start her medication pass. Unit Manager #1 then brought her a cup with a 0.5mg Ativan in it for Resident #1 and stated to her to administer the medication. Nurse #2 stated she did not ask any questions or look at the resident's allergies prior to administering the Ativan 0.5 mg along with the resident of Resident #1's morning medication

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around 7:44 AM. When she went into the resident's room, she was sitting up on the floor on her fall mat. Nurse #2 and NA #1 assisted the resident to get up to the side of the bed to take her medication. Nurse #2 administered the medication and stated the resident drank water provided and Nurse #2 left the room. She was then alerted by NA #1 approximately five to ten minutes later that something was wrong with Resident #1. Nurse #2 and Nurse #1 went into the resident's room to find her lying on the bed with her eyes open and fixed, mouth open and a faint pulse. EMS were called and vital signs were obtained. Nurse #2 stated Resident #1 was pronounced deceased by EMS at 8:30 AM.

A nursing note written by Nurse #1 dated 12/02/24 at 8:10 AM as a late entry revealed she was made aware by Nurse #2 that Resident #1 was in possible distress after being discovered by NA #1 after the morning medication pass. Upon entering the room, the resident was slow to respond. Nurse #1 requested vital signs to be obtained and to call EMS. Resident #1's blood pressure was 94/60 (normal blood pressure reading 120/80), pulse 111 (normal pulse range 60-100), respiratory rate 4 (normal respiratory rate 12-20) and oxygen saturation level 54% (normal oxygen saturation level greater than 92%), she was noted to be receiving an undocumented amount of supplemental oxygen via nasal cannula. Nurse #1 continued to call the resident's name without a response. Resident #1's oxygen saturation was checked for a second time with a reading of 30%. EMS then arrived on scene and were able to take over the resident's care.

EMS records dated 12/01/24 revealed they were

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notified at 8:13 AM, dispatched to the facility at 8:18 AM, arrived on scene at 8:29 AM and to the resident at 8:30 AM with a chief complaint of cardiac/ respiratory arrest. Upon EMS arrival Resident #1 was found lying in bed. The resident was apneic (without breathing) and pulseless. Resident #1 had no heart tones with a valid do not resuscitate order (DNR). She was pronounced deceased at 8:30 AM. Allergies listed on the EMS report for Resident #1 included Ativan.

On 12/16/24 at 2:24 PM an interview was conducted with the former Director of Nursing (DON). The DON stated Unit Manager #1 called her on 12/01/24 to notify her Resident #1 had expired. After looking through documentation she saw Resident #1 had a documented allergy to the medication Ativan she was administered at 7:44 AM. The DON stated it was around 11:00 AM when she was notified, and she immediately suspended the nurses involved. She notified the Medical Director at 1:00 PM. The interview revealed the facility had standing orders to use Ativan if a resident was having agitation which was to administer 0.5mg of Ativan as a one-time dose. The nurses were new to the facility and the nurse who administered the medication (Nurse #2) was still in orientation and did not ask any questions prior to giving it to the resident because she was told to do so by Unit Manager #1 who was her preceptor. The DON stated all nurses involved should have followed the facility protocol for administration of medication which included review of the resident's allergies. She stated Nurse #3 should have never bypassed the allergy alerts in the EMR system.

On 12/16/24 at 11:28 AM an interview was

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conducted with the Administrator and Regional Nurse Consultant. The interview revealed on 12/01/24 around 7:30 AM Nurse #2 administered Ativan 0.5 mg to Resident #1 due to behaviors of restlessness and agitation. At 7:30 AM Nurse #3 and Unit Manager #1 pulled Ativan 0.5 mg out of the automated system for medication management based on standing orders the facility had. The facility had a standing order to give Ativan 0.5 mg as needed for agitation. Nurse #2 administered Ativan to Resident #1 at 7:44 AM and Resident #1 was then found unresponsive with a low oxygen saturation level. EMS was called to the facility, and the resident was pronounced as deceased. At 11:30 AM the Former Director of Nursing (DON) was reviewing the documentation and noted the resident had a allergy to the medication and notified the Regional Nurse Consultant who then called the Administrator. The interview revealed they immediately suspended the nurses involved and completed an investigation into the incident. Nurse #1 was responsible for the resident during the 7:00 PM to 7:00 AM shift and had needed guidance from Nurse #3 who told her about the standing order for Ativan 0.5mg however they did not have access to the automated system for medication management to pull the medication. They waited until the next shift arrived at 7:00 AM on 12/01/24 and had Unit Manager #1 be the second witness to pull the medication with Nurse #3. Nurse #2 was working the day shift on 12/01/24 and was asked to administer the medication to Resident #1 in which she did and did not ask any questions. None of the 4 nurses involved in the incident verified Resident #1 had no allergies to the medication. Nurse #3 bypassed the alerts in the electronic medical record when entering the medication order into

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the resident's MAR. The Administrator stated the nurses were responsible for verifying that the resident did not have an allergy to the medication and they did not.

On 12/16/24 at 1:38 PM an interview was conducted with the Medical Director (MD). The MD stated the DON notified him of an incident that happened on 12/01/24 when a nurse administered Ativan to a resident with a documented allergy to the medication. He stated it happened because the facility had standing orders for the medication for agitation as needed. The nurse involved did not check the resident's allergies and just gave the medication. The interview revealed he was contacted around 1:00 PM on 12/1/2024 and the medication error occurred earlier in the morning. The MD stated he knew the resident had expired but it did not sound like she had an anaphylactic reaction to the medication, however, would not know unless an autopsy was performed, and to his knowledge it had not been done. Resident #1 was not noted to have any rash or hives by the nursing staff. The MD stated there was no justification for the staff members to administer Ativan to the resident with a documented allergy.

On 12/16/24 at 2:18 PM an interview was conducted with the Pharmacist. During the interview he stated a true medication allergy would result in anaphylaxis (severe, life-threatening allergic reaction that can occur within minutes of exposure to an allergen) and a rash. After reviewing Resident #1's medication orders he stated there were no active physician orders for Ativan 0.5mg from the pharmacy for the resident but he did see an allergy listed for Ativan. The interview revealed if the facility

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initiated a standing order for the medication, it would not have come from the pharmacy, but they would have pulled it from the automated system for medication management located at the facility. The staff would not have been alerted to the resident's allergy in the sytem when pulling the medication. He stated he completed a system report that showed on 12/01/24 the medication Ativan 0.5mg was removed from the machine under Resident #1's name. The Pharmacist stated the allergy error would have shown when the nurses were putting the order into the electronic medical record and the nurses would have had to click off on the allergy alert to get the error screen to remove and move forward in the system. The interview revealed the nurse would have to bypass the alert. The pharmacist stated no resident should receive medication with a documented allergy. That is why alerts were put in place for staff to recognize prior to administration of the medication.

The Administrator was notified of the immediate jeopardy on 12/17/24 at 12:31 PM.

The facility provided the following corrective action plan.

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

The facility failed to prevent a significant medication error when Resident #1 received a dose of Ativan 0.5 milligram (mg) as a one-time dose. Resident #1 had a documented allergy to Ativan on 08/20/24. The medication order was entered into the electronic health record by Nurse #3 who said that the Electronic Health record

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electronic order entry flagged the order due to the allergy but she "bypassed" the alert and entered the order which was then pulled from the automated system for medication management. Nurse #2 Administered the medication on 12/01/24 at 7:44 AM. At 8:13 AM Resident #1 was noted in her room unresponsive with a blood pressure of 94/60, pulse rate of 111, respiratory rate of 4 and oxygen saturation level of 54%. Resident #1 was pronounced deceased by Emergency Medical Services (EMS) staff at 8:30 AM.

On the evening of 11/30/2024, Resident #1 showed signs of restlessness and agitation according to the licensed nurses' statements. Licensed nurses made multiple attempts to make Resident #1 comfortable. Licensed nurses repositioned residents many times, changed the room temperature, and offered fluids and snacks. Resident #1 tried to crawl onto the floor and roll around in the bed. Staff provided Resident #1 with one on one supervision periodically throughout the night, due to Resident #1 trying to crawl out of the bed related to agitation and restlessness. The morning of 12/01/2024, at approximately 7:00 am, the day shift nursing staff came on duty. At about 7:15 am, the standing order for Ativan 0.5 mg tablet was pulled from the automated system for medication management. The medication was provided to Nurse #2 to give to Resident #1. Ativan 0.5 mg was given by mouth to Resident #1 at approximately 7:35 am. The medication order was placed into the electronic health record system at 7:43 am by Nurse #3. The electronic medication administration record (EMAR) was signed off as medication given at 7: 44 am by Nurse #3. This information was obtained through interviews with

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the above-mentioned nurses.

On 12/02/2024, after the occurrence, all licensed nurses were given access to the automated system for medication management by the Director of Nursing.

At 8:13 am Resident # 1 was in her room and unresponsive with Vital Signs as follows: BP 94/60, Pulse 111, Resp 4, Oxygen sat level 54. EMS was called for transport. Resident #1 was Do Not Resuscitate. EMS arrived on scene and resident #1 was pronounced deceased at approximately 8:30am.

Upon review of the chart by the Director of Nursing on 12/01/2024, it was noted that Resident #1 had an allergy to Ativan. The severity of the allergy was unknown. The Medical Director was notified that Resident #1 expired and Ativan was given with a documented allergy on 12/1/2024.

Nurse #3 and Nurse #1 were terminated 12/03/24 by the facility Administrator.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Current residents are at risk of this occurring.

An audit of current resident's allergy listing and current medication list was completed by the Director of Nursing and designee to ensure that medications were not ordered or given with the listed allergies. This was completed by the Director of nursing on 12/03/2024.

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Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

On 12/01/2024, Director of Nursing was notified at 11:13 am by Nurse #1 that Resident #1 had an allergy to Ativan. The Director of Nursing started an investigation.

Education started 12/02/2024 by the Director of Nursing for all licensed nurses and medication aides on alerts in the electronic health record order entry in the MAR. Education was also conducted for pulling medications from the automated system for medication management to ensure there is order in place and allergies are checked prior to withdrawing medication. All flagged notifications will be reviewed when flagged as an alert when entering the order in the electronic health record by the nurse, and the nurse will notify the physician for direction. Any licensed nurse not receiving this education will not be able to work until receiving the education. New licensed nurses will receive education during the orientation process. Director of Nursing ensured all licensed nurses and medication aides were educated prior to working their next scheduled shift as of 12/6/2024.

Medication observations on current licensed nurses and medication aides will be completed by the Director of Nursing or designee to ensure residents are not receiving medication with listed allergies on their EMAR by 12/06/2024. Allergies are listed on the EMAR and show up when the EMAR is pulled up or displayed in the electronic health record.

Medication pass observations will be completed

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by the Director of Nursing or Designee on 5 licensed nurses weekly x 12 weeks to ensure residents do not receive medications with listed allergies on the EMAR. Audits begin as of 12/6/2024. Allergies are listed on the EMAR and show up when the EMAR is pulled up or displayed in the electronic health record.

Education was provided to all licensed nurses that before activating a standing order, allergies must be reviewed to ensure the resident does not have a listed allergy for the medication by the Director of Nursing on 12/06/2024.

All new orders are reviewed during the morning clinical meeting by the nursing clinical team to ensure no new medications are ordered that residents have an allergy too. This will be completed in 5x weeks x 12 weeks.

As of 12/06/2024, Regional Clinical Nurse or designee will review medication allergy alerts in the electronic health record by reviewing the progress notes for allergy alerts weekly to ensure no allergy alerts were bypassed. These audits will be completed weekly x 12 weeks.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

As of 12/3/2024 the results of the monitoring will be reviewed by the Administrator or Director of Nursing in the weekly Risk meeting and during the monthly Quality Assurance Performance Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) as of 12/03/2024. Changes will be made to the plan as necessary to maintain compliance with resident safety. The

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IDT team will consist of the Administrator, Director of Nursing, Medical Director, Social Worker, Activities Director and Minimum Data Set (MDS) nurse. This meeting lasted for 1 hour.

IJ removal date: 12/07/2024.

On 12/23/24, the corrective action plan was validated by onsite verification through facility staff interviews and record review. The interviews revealed all nursing staff had received education on alerts in the electronic health record order entry in the MAR. Education was also conducted for pulling medications from the automated system for medication management to ensure there was an order in place and allergies were checked prior to withdrawing medication. All flagged notifications will be reviewed when flagged as an alert when entering the order in the electronic health record by the nurse, and the nurse will notify the physician for direction. Education was provided to all licensed nurses that before activating a standing order, allergies must be reviewed to ensure the resident does not have a listed allergy for the medication. The facility's in-service log, audits and training material were reviewed.

The immediate jeopardy removal date of 12/07/24 and the compliance date of 12/07/24 for the corrective action plan were validated.