STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VALLEY NURSING AND REHABILITATION CENTER	581 NC HIGHWAY 16 SOUTH TAYLORSVILLE, NC 28681

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/2/2025 to conduct a complaint investigation. The survey team was onsite 1/2/2025. Additional information was obtained offsite on 1/3/2025 and the credible allegation was validated on 01/13/25. Therefore, the exit date was changed to 1/13/2025. Event ID#1TOF11. The following intakes were investigated NC00225094, NC00225334, and NC00225692. 3 of the 12 complaint allegations resulted in deficiency. Intake NC00225334 and NC00225692 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J); the IJ began 12/11/2024 and was removed 1/7/2025 CFR 483.12 at tag F600 at a scope and severity (J); the IJ began 12/11/2024 and was removed 1/7/2025 CFR 483.25 at tag F684 at a scope and severity (J); the IJ began 12/27/2024 and was removed 1/7/2025 CFR 483.30 at tag F714 at a scope and severity (J); the IJ began 12/11/2024 and was removed 1/8/2025 The tags F600 and F684 constituted Substandard Quality of Care. A partial extended survey was conducted.	F 000		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		1/14/25

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

Electronically Signed | 01/23/2025

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F 580 SS=J	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (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	F 580		

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F 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and Resident, Resident Responsible Party (RP), facility staff, Nurse Practitioner (NP), and Medical Director interviews the facility failed to notify the Medical Director of Resident #1's documented allergy to aspirin with a history of a gastrointestinal bleed, recent fall with fracture, and new immobility for further orders regarding anticoagulation. Resident #1's family had expressed concerns to the Director of Nursing (DON) on 12/11/2024 regarding Resident #1 not receiving an anticoagulant after falling at home and sustaining multiple fractures of her pelvis and lumbar spine. Resident #1 had a documented allergy to aspirin and the NP instructed the Assistant Director of Nursing (ADON) to reach out to the MD for further direction. The facility also failed to notify the NP that an ordered venous doppler study (an ultrasound used to diagnose blood clots) on 12/27/2024 could not be completed until the following week. On 12/28/2024, Resident #1 and the RP requested Resident #1 be transferred to the Emergency Department (ED). Upon arrival, Resident #1 was diagnosed with extensive deep vein thrombosis (DVT) of both lower extremities, was placed on a heparin infusion (blood thinning	F 580	F580 On 12/11/2024, the facility failed to notify Medical Director of Resident #1 documented allergy to aspirin based on history of gastrointestinal bleeding, and family□s concern and request for further orders for anticoagulation. The facility also failed to notify the medical provider that Resident #1 swelling and pain was not improving and was getting worse from 12/18/24 to 12/27/24 and that Resident #1 was not as mobile as she had been previously. On 12/27/2024, the facility failed to notify Nurse Practitioner that an ordered venous doppler could not be completed before the next week. On 12/28/2024, Resident #1 and her family insisted on being transferred to the Emergency Department for evaluation and was transferred to hospital for this evaluation. Corrective action taken for residents affected by alleged deficient practice.	

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F 580	Continued From page 3 medication used to prevent or break up blood clots), and admitted. The deficient practice occurred for 1 of 3 residents (Resident #1) reviewed for change in condition. Immediate jeopardy began on 12/11/2024 when the facility failed to notify the Medical Director that Resident #1 had a documented allergy to Aspirin and the Resident's RP was concerned that she was not receiving an anticoagulant. Immediate jeopardy was removed on 1/7/2025 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Hospital records from 11/25/2024 through 12/2/2024 revealed Resident #1 had experienced a fall and was found to have multiple fractures. Orthopedics was consulted while Resident #1 was in the ED. Orthopedics stated they felt none of Resident #1's fractures required surgical intervention and recommended admission for pain control and monitoring of functional status. Resident #1 received subcutaneous heparin injections while in the hospital, prior to her discharge to the facility on 12/2/2024. Resident #1 was discharged to the facility on 12/2/2024 and was not prescribed an anticoagulant upon discharge. Resident #1 was admitted to the facility on 12/2/2024 with diagnoses which included multiple pelvic fractures, fracture of the lumbosacral spine	F 580	12/28/2024 A change in Condition was completed by a Nurse and Resident #1 was transferred to Hospital. Corrective action for residents identified as having the potential to be affected by the same deficient practice: On 01/06/2025, an audit of all residents with significant changes between 11/27/2024 & 12/27/2024 was conducted by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) with no additional failures to notify provider of delayed studies, treatment or transfer identified. Measures put in place or systemic changes made to ensure deficient practice will not recur: 0n 01/06/2025, all licensed nurses, medication aides, and certified nursing assistants were educated by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on requirement to notify physician of all significant changes in condition to ensure timely treatment or transfers. Licensed nurses, medication aides and certified nursing assessments newly hired, including agency, will receive in-service before working their initial shift. Director of Nursing and/or Staff Development coordinator will be responsible for ensuring education is received. Facility administrator communicated this responsibility on 01/06/2025.	

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F 580	Continued From page 4 (lower back and tailbone), and a history of a gastrointestinal bleed (bleeding in the digestive tract). An admission Minimum Data Set (MDS) dated 12/8/2024 revealed Resident #1 was cognitively intact. A nursing note dated 12/11/2024, authored by the Assistant Director of Nursing (ADON), revealed Resident #1's Responsible Party (RP) had requested for Resident #1 to be placed on anticoagulant therapy and the Nurse Practitioner (NP) was notified. An order was received for Aspirin. Resident #1 had an allergy to Aspirin. The order for Aspirin was discontinued. The RP requested anticoagulation due to enoxaparin being given at the hospital. Resident #1 and the RP explained that Resident #1 had a past medical history of gastrointestinal bleeding. Education was provided to Resident #1 and RP, that anticoagulation therapy would put Resident #1 at risk for developing a gastrointestinal bleed. A NP note dated 12/27/2024 revealed Resident #1 was noted to have increased pain and swelling in her left lower extremity. Resident #1 was documented to have 2+ edema, increased pain, and a positive Homan's sign (pain behind the knee when the persons toes are pointed towards their head in her left lower extremity, indicative of a deep vein thrombosis/blood clot). The NP recommended a venous doppler study and for Resident #1 to be non-weight bearing to her left lower extremity. A provider communication form dated 12/27/2024 revealed Resident #1 was ordered an in-house venous doppler study of the left lower extremity	F 580	Indicate how facility plans to monitor its performance to make sure solutions are sustained: Director of Nursing and/or Assistant Director of Nursing to audit Pain scores, using our vital sign report. 5 times per week x 6 weeks, Weekly x 6 weeks, Director of Nursing or designee will audit Notify of Physician for 5 times per week x 6 weeks, Weekly x 6 weeks, using 24-hour report sheet. Director of Nursing or designee will audit Pain Scores 5 times per week x 6 weeks, Weekly x 6 weeks, Director of Nursing or designee will audit intervention for pain for 5 times per week x 6 weeks, Weekly x 6 weeks, using 24 hour report. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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with a diagnosis of edema and pain as well as non-weight bearing on left lower extremity until the doppler studies were available.

A nursing note dated 12/28/2024 at 10:25 am, authored by Nurse #2, revealed Resident #1 requested to go to the ED for left leg pain, swelling, and tenderness. Resident #1 stated she was hurting in the calf, behind the knee, and in her pelvic area. An ultrasound doppler was ordered but the company was not available on 12/27/2024 or over the weekend (12/28/2024-12/29/2024). Resident #1 and the RP were concerned about the pain and swelling, which is why they requested her to be sent to the ED. Nurse #2 spoke with the RP and the RP was going to meet Resident #1 at the hospital. The on-call provider was called prior to calling Emergency Medical Services (EMS) and a message was left for them to call back.

Change of condition documentation dated 12/28/2024, authored by Nurse #2, revealed Resident #1 had requested to go to the ED. Resident #1's left leg was swollen (from hip to toes), painful, and tender to touch. The venous doppler study ordered 12/27/24 was unable to be performed before next week. Resident #1 was documented as having pain of a 4 on scale of 0-10 on the numerical pain scale (indicative of moderate pain) in the left knee, groin, and left lower leg. Nurse #2 attempted to notify the physician, but there was no answer, a message was left.

An ED note dated 12/28/2024 revealed Resident #1 presented to the ED from the facility for evaluation of bilateral lower extremity swelling, which had worsened over the last 2 weeks. A

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bilateral venous doppler study was conducted in the ED which revealed extensive deep vein thrombosis in the left and right leg. A tibia/fibula (bones in the lower leg) x-ray revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant.

An interview was conducted on 1/6/2025 at 11:34 am via telephone with Resident #1's RP. The RP stated she had gone to speak with the Director of Nursing (DON) on 12/11/2024 regarding her concern about Resident #1 not being on an anticoagulant due to her immobility/fractures, swelling in her legs, and a family history of blood clots. The RP stated Resident #1 had received blood thinner shots at the hospital prior to admission to the facility and was concerned that Resident #1 was not currently on an anticoagulant.

An interview was conducted on 1/3/2025 at 4:00 pm with the NP. The NP stated she received notification from the ADON on 12/11/2024 that Resident #1's RP had requested Resident #1 to be placed on an anticoagulant. The NP stated she ordered aspirin to be administered daily and was later the same day contacted by the ADON about Resident #1 having an allergy to aspirin. The NP stated she instructed the ADON to refer to the Medical Director for further direction regarding anticoagulation. The NP verbalized she had not had any follow-up regarding anticoagulation after 12/11/2024. The NP stated the last time she saw Resident #1 was on 12/27/2024 for left leg pain at which time Resident #1 was having increased pain and swelling to her left lower extremity. The NP stated that she had ordered an in-house venous doppler

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study of the left lower extremity and recommended Resident #1 be non-weight bearing to the left leg. The NP stated Resident #1 had swelling and a positive Homan's sign at that time, but did not notice any redness or warmth. The NP stated she was not aware, and was not notified by the DON, the venous doppler study would not be performed until the following week. The NP stated she would have been okay with waiting until Monday for the venous doppler study to be completed but would have wanted to be notified if the venous doppler study could not have been performed until the first of the following week at which point she would have considered sending Resident #1 to the ED.

An interview was conducted on 1/6/2025 at 12:59 pm with the DON. The DON stated she had first spoken to Resident #1's RP on 12/11/24 when the RP was concerned that Resident #1 was not on anticoagulation, was not ambulatory and had redness to her leg. The DON stated she had the NP evaluate Resident #1 on 12/27/2024 and a venous doppler study was ordered. The DON stated she had called the scheduler for the venous doppler study and was told the order would not be looked at until Monday (12/30/24). The DON stated she had told the NP about the delay in obtaining a venous doppler study and verbalized the NP was okay with it.

An interview was conducted on 1/3/2025 at 5:22 pm with the ADON. The ADON stated she was in the DON's office on 12/11/2024 when Resident #1's RP voiced concerns about Resident #1 not being on an anticoagulant. The ADON stated she contacted the NP, at which time aspirin was ordered, and later discontinued after realizing Resident #1 had an allergy to aspirin. The ADON

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stated she did not recall the NP instructing her to reach out to the Medical Director for additional guidance regarding anticoagulation. The ADON stated she cared for Resident #1 on 12/25/2024 and noted swelling to Resident #1's left leg at that time, and stated she assumed it was normal because of the rash. The ADON stated Resident #1's left leg was not red warm to touch at that time. The ADON stated Resident #1 did not complain of pain when she applied the hydrocortisone cream. The ADON stated after she cared for Resident #1, she developed swelling from her hip to her toes on the left side and had pain and tenderness on 12/27/2024. The ADON stated the NP had ordered a venous doppler study on 12/27/24 which could not be conducted until the following week. The ADON stated the company had up to 7 days to complete venous doppler studies at the facility.

An interview was conducted on 1/5/2025 at 4:17 pm with the Medical Director. The Medical Director stated he had seen Resident #1 shortly after admission to the facility but had not seen her since. The Medical Director stated the facility staff, nor the NP had reached out to him with concerns regarding Resident #1. The Medical Director stated if he had been contacted on 12/11/2024 regarding anticoagulation, he would have referred to orthopedics and evaluated whether Resident #1 was ambulatory to see if anticoagulation was needed. The Medical Director stated if Resident #1 had redness and swelling in her leg, he would have ordered a venous doppler study to have been performed on 12/27/2024. The Medical Director stated if he would have known there would have been a delay and Resident #1 had increased pain and swelling, he would have considered sending Resident #1 to

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the ED. The Medical Director did not specify if he wanted to be notified about the anticoagulant and events on 12/27/2024.

An interview was conducted on 1/6/2025 at 5:31 pm with the Assistant Administrator. The Assistant Administrator stated if the NP had concerns that she felt like she could not handled she should consulted the Medical Director.

The Administrator was notified of immediate jeopardy on 1/6/2025 at 6:08 pm.

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

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

On 12/11/2024, facility failed to notify Medical Director of Resident #1's documented allergy to aspirin based on history of gastrointestinal bleeding, and family's concern and request for further orders for anticoagulation. The facility also failed to notify the medical provider that Resident #1's swelling and pain was not improving and was getting worse from 12/18/24 to 12/27/24 and that Resident #1 was not as mobile as she had been previously.

On 12/27/2024, facility failed to notify Nurse Practitioner that an ordered venous doppler could not be completed before the next week.

On 12/28/2024, Resident #1 and her family insisted on being transferred to the Emergency Department for evaluation and was transferred to hospital for this evaluation.

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All other residents with concerns regarding anticoagulation are at risk for this deficient practice.

All other residents with complaints of leg pain and swelling (or signs and symptoms of a blood clot) are at risk for this deficient practice.

On 12/28/2024, Resident #1 discharged from the facility.

On 01/06/2025, an audit of all residents with significant changes between 11/27/2024 & 12/27/2024 was conducted by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) with no additional failures to notify provider of delayed studies, treatment or transfer identified.

On 01/06/2025, the medical director notified by DON of all residents with documented allergy or intolerance to aspirin due to a history of GI bleed and reviewed for any resident needing anticoagulation orders with no additional residents identified. No other residents identified with ordered diagnostic studies that were delayed; no other residents identified with unreported leg pain and swelling or concerns regarding a lack of anticoagulation.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

0n 01/06/2025, all licensed nurses, medication aides, and certified nursing assistants were educated by the Director of Nursing (DON) and

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the Assistant Director of Nursing (ADON) on requirement to notify physician of all significant changes in condition to ensure timely treatment or transfers. Licensed nurses, medication aides and certified nursing assessments who are newly hired, including agency, will receive in-service prior to working their initial shift. Director of Nursing and/or Staff Development coordinator will be responsible to ensure education is received. Facility administrator communicated this responsibility on 01/06/2025.

The education consisted of the following:

-Ordered studies should be scheduled same day of order

-If vendor is unable to perform study on same day of order, provider is to be notified by licensed nurse of expected date of study.

-New orders from medical providers given to address changes in condition should be implemented on day of order, unless otherwise noted by provider. If orders are unable to be implemented timely, provider must be made aware immediately in order to ensure any new intervention or transfer is then implemented timely.

-In this case, licensed nurse is to document notification and any new orders, to include transfer to hospital, deemed necessary by medical provider.

-Physician or physician extender is to be made aware by licensed nurse of all residents with aspirin allergy to determine any needs for anticoagulation. This notification to occur upon

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F 580	Continued From page 12	F 580		

admission or readmission with any newly identified aspirin allergy.

-Certified nursing assistants and medication aides who identify changes in condition should notify licensed nurse.

This removal of immediate jeopardy allegation was reviewed and approved by an ad hoc QAPI meeting on 01/06/2025.

Facility administrator notified DON of responsibility for completion of this immediate jeopardy allegation removal on 01/06/2025.

Alleged date of IJ removal: 01/07/2025.

A validation of immediate jeopardy removal was conducted on 1/13/2025. Initial audits conducted revealed residents with an aspirin allergy were identified and their potential need for anticoagulation was addressed. Audits conducted regarding previous diagnostic studies from 11/27/2024 through 12/27/2024 revealed there were no other delays in obtaining ordered diagnostic testing. Interviews with facility nursing staff (Nurses, Medication Aides, and Nurse Aides) revealed staff had received education on having ordered studies performed on the same day the order was written, if the study is unable to be performed the day it was ordered staff is to notify the provider of the expected date of the study to see if the resident should have a different intervention or should be transferred to the hospital, and the Medical Director is to be made aware of residents with aspirin allergies on admission to determine if there should be any anticoagulation ordered. The immediate jeopardy removal date of 1/7/2025 was validated.

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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 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Resident, Responsible Party (RP), Nurse Practitioner, and Medical Director interviews, the facility failed to protect a resident's right to be free from neglect when they failed to notify the Medical Director that Resident #1 had a documented allergy to aspirin with a history of gastrointestinal bleed, recent fall with fracture, and new immobility on 12/11/24 when Resident #1's family expressed concerns to the Director of Nursing (DON) that Resident #1 was not receiving anticoagulant. The Nurse Practitioner instructed the Assistant Director of Nursing to reach out the Medical Director for guidance an anticoagulation and failed to communicate or collaborate with the Medical Director herself. The facility further failed to recognize the seriousness of pain and leg swelling that started on 12/11/2024 and neglected to act on the severity of a potential blood clot when a resident (Resident #1) continued to	F 600	F 600 Facility failed to recognize the seriousness of leg swelling and pain manage resident #1 pain notify the medical director of a documented aspirin allergy with a history of GI bleed for further anticoagulation orders the nurse practitioner neglected to communicate with the medical director and ensure the resident received necessary care and services necessary medical evaluation and treatment. Corrective action taken for residents affected by alleged deficient practice 12/28/202 A change in Condition was completed by a Nurse and Resident #1 was transferred to Hospital. Corrective action for residents identified as having the potential to be affected by the same deficient practice:	1/14/25

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F 600	Continued From page 14 experience increased pain and swelling to her left lower extremity. On 12/27/2024, Resident #1 was noted to have increased edema (swelling), a positive Homan's sign (pain behind the knee when the person's toes are pointed towards their head, indicative of a deep vein thrombosis/blood clot), and increased pain to her left lower extremity. The facility failed to seek emergent medical attention when they knew a venous doppler study could not be scheduled for at least three days after it was ordered on 12/27/24. On 12/28/2024, Resident #1 continued to have increased swelling, pain, and redness to her left lower extremity and at her (Resident #1) request, was transferred to the hospital at 10:45 am via Emergency Medical Services (EMS). Resident #1 was diagnosed with extensive deep vein thrombosis (DVT) of both lower extremities, was placed on a heparin infusion (blood thinning medication used to prevent or break up blood clots), and admitted. Resident #1 has remained in the hospital since she was transferred from the facility. Deep vein thrombosis (DVT) can be very dangerous because a blood clot formed in a deep vein can break loose and travel to the lungs, causing a pulmonary embolism which can be life-threatening. The deficient practice occurred for 1 of 3 residents (Resident #1) reviewed for neglect. Immediate jeopardy began on 12/11/24 when the facility failed to notify the Medical Director that Resident #1 had a documented allergy to aspirin and the RP was concerned about Resident #1 not receiving an anticoagulant, had increased edema and pain indicative of deep vein thrombosis. Immediate jeopardy was removed on 1/7/2025 when the facility implemented a credible allegation of immediate jeopardy removal. The	F 600	On 1/6/25 100% audit of all residents had skin and pain assessments conducted and documented in medical record, to include interview questions, for non interviewable residents Observation by Don, ADON or designee with additional findings addressed and provider notified. 100 % education was completed with all staff to include facility policy on abuse, and neglect. Measures put in place or systemic changes made to ensure deficient practice will not recur: 0n 01/06/2025, all licensed nurses, medication aides, and certified nursing assistants were educated by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on requirement to notify physician of all significant changes in condition to ensure timely treatment or transfers. Licensed nurses, medication aides and certified nursing assessments newly hired, including agency, will receive in-service before working their initial shift. Director of Nursing and/or Staff Development coordinator will be responsible for ensuring education is received. Facility administrator communicated this responsibility on 01/06/2025. Indicate how facility plans to monitor its performance to make sure solutions are sustained: On 01/06/2025 Director of Nursing and/or Assistant Director of Nursing to	

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F 600	Continued From page 15 facility will remain out of compliance with a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: This tag is cross-referenced to: F580: Based on record review, and Resident, Resident Responsible Party (RP), facility staff, Nurse Practitioner (NP), and Medical Director interviews the facility failed to notify the Medical Director of Resident #1's documented allergy to aspirin with a history of a gastrointestinal bleed, recent fall with fracture, and new immobility for further orders regarding anticoagulation. Resident #1's family had expressed concerns to the Director of Nursing (DON) on 12/11/2024 regarding Resident #1 not receiving an anticoagulant after falling at home and sustaining multiple fractures of her pelvis and lumbar spine. Resident #1 had a documented allergy to aspirin and the NP instructed the Assistant Director of Nursing (ADON) to reach out to the MD for further direction. The facility also failed to notify the NP that an ordered venous doppler study (an ultrasound used to diagnose blood clots) on 12/27/2024 could not be completed until the following week. On 12/28/2024, Resident #1 and the RP requested Resident #1 be transferred to the Emergency Department (ED). Upon arrival, Resident #1 was diagnosed with extensive deep vein thrombosis (DVT) of both lower extremities, was placed on a heparin infusion (blood thinning medication used to prevent or break up blood clots administer intravenously), and admitted. The deficient practice occurred for 1 of 3 residents	F 600	audit Pain scores, using our 24-hour report sheet. 5 times per week x 6 weeks, Weekly x 6 weeks, Director of Nursing or designee will audit Notify of Physician 5 times per week x 6 weeks, Weekly x 6 weeks, using 24- hour report sheet. Director of Nursing or designee will audit Pain Scores 5 times per week x 6 weeks, Weekly x 6 weeks, using 24- hour report sheet. Director of Nursing or designee will audit intervention for pain. 5 times per week x 6 weeks, Weekly x 6 weeks, using 24- hour report sheet. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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F 600	Continued From page 16 (Resident #1) reviewed for change in condition. F684: Based on record review, and Resident, Resident Responsible Party (RP), facility staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to seek emergent medical attention when Resident #1 who had a recent history of spine and pelvic fractures and anticoagulation therapy prior to admission, experienced increased leg swelling, pain and an ordered venous doppler study (a non-invasive diagnostic procedure that uses sound waves to examine the circulation in the body's veins and arteries) could not be scheduled for at least three days after it was ordered. On 12/27/2024, Resident #1 was noted to have increased edema (swelling), a positive Homan's sign (pain behind the knee when the person's toes are pointed towards their head, indicative of a deep vein thrombosis/blood clot), and pain to her left lower extremity. The facility failed to seek emergent medical attention when they knew a venous doppler study could not be scheduled for at least three days after it was ordered. On 12/28/2024, Resident #1 continued to have increased swelling, pain, and redness to her left lower extremity and was transferred to the hospital at 10:45 am via Emergency Medical Services (EMS). Resident #1 was diagnosed with extensive deep vein thrombosis (DVT) of both lower extremities, was placed on a heparin infusion (blood thinning medication used to prevent or break up blood clots), and admitted. As of 1/6/2025, Resident #1 has remained in the hospital since she was transferred from the facility. Deep vein thrombosis (DVT) can be very dangerous because a blood clot formed in a deep vein can break loose and travel to the lungs, causing a pulmonary embolism which can be	F 600		

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life-threatening. The deficient practice occurred for 1 of 3 residents (Resident #1) reviewed for change in condition.

F714: Based on record review, staff, Resident, Resident Responsible Party (RP), Nurse Practitioner, and Medical Director interview the facility Nurse Practitioner (NP) failed to communicate and collaborate with the Medical Director after Resident #1's RP voiced concerns on 12/11/2024 that Resident #1 was not receiving an anticoagulant (blood thinning medication, used to prevent blood clots) after having a fall at home and sustaining multiple fractures of the pelvis and lumbar (lower back) spine, and was not as mobile as she had been prior to admission to the facility. The Assistant Director of Nursing (ADON) contacted the NP on 12/11/2024 at which time the NP ordered aspirin which was later discontinued due to a listed allergy due to a history of gastrointestinal bleeding. The NP instructed the ADON to consult the Medical Director for further guidance regarding anticoagulation for Resident #1 and failed to reach out to the MD herself. On 12/27/2024 Resident #1 was evaluated by the NP at which time Resident #1 had pain, increased swelling, and a positive Homan's sign (pain behind the knee when the person's toes are pointed towards their head, indicative of a deep vein thrombosis/blood clot) in her left lower extremity. Resident #1 was transferred to the hospital on 12/28/2024 where she was diagnosed with the serious adverse outcome of deep vein thrombi to her bilateral lateral lower extremities, requiring anticoagulation, and hospitalization. The deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for change in condition.

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An interview was conducted on 1/13/2025 at 2:07 pm with the DON. The DON stated examples of neglect would include staff letting someone lay in bed without changing them, not feeding a resident, and not treating pain when a resident reported it. The DON stated she had not felt like Resident #1 experienced neglect because the facility had provided interventions such as having the Nurse Practitioner evaluate Resident #1. The DON stated as soon as Resident #1 requested to go to the Emergency Department on 12/28/2024, she was sent.

The Administrator was notified of immediate jeopardy on 1/6/2025 at 6:08 pm.

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

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

The facility failed to recognize the seriousness of leg swelling and pain, manage Residents #1's pain, notify the medical director of a documented aspirin allergy with a history of a Gastrointestinal (GI) bleed for further anticoagulation orders. The Nurse practitioner neglected to communicate with the medical director and ensure the resident received necessary care and services, necessary medical evaluation and treatment.

On 12/28/2024, Resident #1 discharged from the facility and was admitted to the hospital with blood clots to her bilateral lower extremities and was started on a heparin (used to break up clots) drip.

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On 01/06/2025, All residents had skin and pain user defined assessments conducted and documented in the medical record to include interview questions, for all interviewable residents, and observation by Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit manager (UM) or Wound Care Nurse for non-interviewable residents with additional findings addressed and provider notified.

On 01/06/2025, an audit of all residents noted with significant change in condition (changes in status outside of residents baseline) assessments completed from 11/27/2024 to current was conducted by the Director of Nursing (DON) and Assistant Director of Nursing (ADON) to identify any unaddressed new or worsening pain or swelling. Audit of einteract Change in Condition user defined assessments (UDA) revealed no additional concerns noted.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

0n 01/06/2025, the DON, ADON, Staff Development (SDC) and Unit Managers began education for all licensed nurses, medication aides and certified nursing aides on Abuse and Neglect as it is related to not acting or following up on reported and assessed pain or changes in condition. Nursing staff newly hired, including agency, will receive in-service education prior to working their initial shift. Director of Nursing and/or Staff Development coordinator will be responsible to ensure education is received. Facility Administrator communicated this responsibility on 01/06/2025.

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On 1/6/25 Abuse and neglect policy was reviewed by Administrator prior to providing staff education, no changes to policy are required at this time.

The education consisted of the following:
- Identification of pain via verbal and non-verbal cues.
- Pharmacological and non-pharmacological interventions for pain and swelling.
- Failing to act on pain or change in condition is considered neglect.
- Medical provider must be notified of any changes in condition to include acute pain.
- Provider orders and interventions must be implemented timely.
- Changes in condition to include pain should have timely follow up to ensure effectiveness of interventions.

This credible allegation of immediate jeopardy removal plan was reviewed and approved by an ad hoc QAPI meeting on 01/06/2025.

Facility administrator notified DON of responsibility for completion of this credible allegation of immediate jeopardy removal on 01/06/2025.

Alleged IJ removal date is 01/07/2025.

A validation of immediate jeopardy removal was conducted on 1/13/2025. Initial audits conducted on 1/6/2025 revealed residents were assessed for any concerns/new findings, if a provider had been notified of the concern/finding, if a resident was in pain, and if a resident had any new or worsening swelling. Concerns were identified

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F 600	Continued From page 21 and addressed. Interviews with facility staff revealed they had received education on neglect, examples of neglect, addressing pain (bother verbal and non-verbal indicators), administering pharmacological and nonpharmacological interventions for pain and/or swelling, acting on a change in condition, notifying a provider with concerns or a change in condition, and following through on intervention effectiveness. The immediate jeopardy removal date of 1/7/2025 was validated.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		1/14/25

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F 609	Continued From page 22 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to report an allegation of neglect to the state survey agency for 1 of 3 residents reviewed for neglect (Resident #1). The findings included: The Administrator, Assistant Administrator, and Regional Nurse Consultant #1 were notified by a State Surveyor on 1/6/2025 at 6:08 pm of neglect that affected Resident #1. An interview was conducted on 1/13/2025 at 2:00 pm with the Assistant Director of Nursing (ADON). The ADON stated that when anyone reported an allegation of abuse or neglect, the abuse coordinator (the Administrator) was responsible for filing a report with the state survey agency. The ADON stated she was not sure if the Administrator had filed an Initial Allegation Report following the notification of allegation of neglect on 1/6/2025. Verification with the Complaint Intake Unit for the State Survey Agency was conducted on 1/13/2025 at 12:48 pm revealed the facility had not filed a report for an allegation of neglect related to Resident #1. An interview was conducted on 1/13/2025 at 2:07 pm with the Director of Nursing (DON). The DON stated the facility was required file a 2-hour report, 24-hour report, and then a 5-day	F 609	F609 Corrective action taken for residents affected by alleged deficient practice: On 01/13/2025 Administrator reported allegation of neglect. Corrective action for residents identified as having the potential to be affected by the same deficient practice: On 1/13/25 the Administrator audited the last 6 months of Grievance logs and Reportable Logs to ensure no other reportable were missed. No negative findings. Measures put in place or systemic changes made to ensure deficient practice will not recur: On 1/13/25 the RDO in serviced Administrator, Assistant Administrator and Director of Nursing, on timely reporting. Indicate how facility plans to monitor its performance to make sure solutions are sustained: Beginning 1/14/25, The Administrator, Assistant Administrator or DON will review Grievance Log weekly and audit the reports for trends or patterns. The results	

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F 609	Continued From page 23 investigation. The DON stated the abuse coordinator, the Administrator, was responsible for filing reports to the state. The DON stated she did not think that the Administrator had filed a report after being made aware of the allegation of neglect on 1/6/2025 at 6:08 PM and stated there should have been a report made. An interview was conducted on 1/13/2025 at 2:15 pm with the Assistant Administrator. The Assistant Administrator stated when a resident or family member alleged abuse or neglect, the Administrator was responsible for filing a report to the state immediately. The Assistant Administrator verbalized that a report had not been filed after notification of neglect on 1/6/2025 because Resident #1 or Resident #1's Responsible Party (RP) had not voiced concerns of neglect to the facility. An interview was conducted on 1/13/2025 at 3:31 pm with the Director of Clinical Operations. The Director of Clinical Operations stated the facility had not filed a report after the allegation of neglect was made on 1/6/2025. The Director of Clinical Operations stated the facility had written an abatement (plan to correct the immediate problem) for the allegation of neglect and the state was already aware of the allegation and there was no reason to report it to the state. The Administrator was not available for an interview on 1/13/2025.	F 609	of the Administrators audits of the reports will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. All New Administrator and DON will trained during new Hire Orientation on Reporting.	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		1/14/25

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F 684	Continued From page 24 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and Resident, Resident Responsible Party (RP), facility staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to seek emergent medical attention when Resident #1 who had a recent history of spine and pelvic fractures and anticoagulation therapy prior to admission, experienced increased leg swelling, pain and an ordered venous doppler study (a non-invasive diagnostic procedure that uses sound waves to examine the circulation in the body's veins and arteries) could not be scheduled for at least three days after it was ordered. On 12/27/2024, Resident #1 was noted to have increased edema (swelling), a positive Homan's sign (pain behind the knee when the person's toes are pointed towards their head, indicative of a deep vein thrombosis/blood clot), and pain to her left lower extremity. The facility failed to seek emergent medical attention when they knew a venous doppler study could not be scheduled for at least three days after it was ordered. On 12/28/2024, Resident #1 continued to have increased swelling, pain, and redness to her left lower extremity and was transferred to the hospital at 10:45 am via Emergency Medical Services (EMS). Resident #1 was diagnosed with extensive deep vein thrombosis (DVT) of both lower extremities, was placed on a heparin infusion (blood thinning medication used to	F 684	F684 POC Corrective action taken for residents affected by alleged deficient practice: Resident #1 was transferred to the hospital on 12/28/24. Corrective action for residents identified as having the potential to be affected by the same deficient practice: On 1/6/25 the Director of Nursing (DON) and Nursing Leadership team which includes the Assistant Director of Nursing (ADON) and Unit Managers, assessed all current facility residents via a head-to-toe body audit and pain assessment to ensure that no other resident was experiencing pain, leg swelling, or redness with no additional residents identified. Measures put in place or systemic changes made to ensure deficient practice will not recur: On 1/6/25 the DON, ADON, Staff Development (SDC) and Unit Managers	

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F 684	Continued From page 25 prevent or break up blood clots), and admitted. As of 1/6/2025, Resident #1 has remained in the hospital since she was transferred from the facility. Deep vein thrombosis (DVT) can be very dangerous because a blood clot formed in a deep vein can break loose and travel to the lungs, causing a pulmonary embolism which can be life-threatening. The deficient practice occurred for 1 of 3 residents (Resident #1) reviewed for change in condition. Immediate jeopardy began on Friday, 12/27/2024 when Resident #1 had increased edema, pain behind the knee indicative of deep vein thrombosis and the ordered venous doppler study could not be scheduled until Monday, 12/30/24. Immediate jeopardy was removed on 1/7/2025 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance with a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: Hospital records from 11/25/2024 through 12/2/2024 revealed Resident #1 had experienced a fall and was found to have multiple fractures. Orthopedics was consulted while Resident #1 was in the Emergency Department (ED). Orthopedics stated they felt none of Resident #1's fractures required surgical intervention and recommended admission for pain control and monitoring of functional status. Resident #1 received subcutaneous heparin injections (blood thinning shots given through the skin) while in the hospital, prior to her discharge to the facility on	F 684	began education for licensed nurses, medication aides and certified nursing assistants on assessing and responding to pain and signs/symptoms of blood clots. Licensed nurses, medication aides, and certified nursing assistants newly hired, including agency, will receive in-service prior to working their initial shift. Director of Nursing and/or ADON will be responsible to ensure education is received. Facility administrator communicated this responsibility on 01/06/2025. Indicate how facility plans to monitor its performance to make sure solutions are sustained: Beginning 1/14/25 the 24- hour Reports from each unit are being reviewed by the DON, ADON or a unit manager to identify any residents with leg swelling or pain requiring follow-up from provider. These audits will be done 5 times per week for 6 weeks, then weekly for 6 weeks to ensure the provider has been notified and appropriate interventions are in place to address any residents with leg swelling or pain. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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12/2/2024.

Resident #1 was admitted to the facility on 12/2/2024 with diagnoses which included multiple pelvic fractures, fracture of the lumbosacral spine (lower back and tailbone), and a history of a gastrointestinal bleed (bleeding in the digestive tract).

Resident #1's medical record revealed Resident #1 had an allergy to aspirin with unknown reactions and severity.

A therapy note dated 12/6/2024 revealed nursing was to address Resident #1's pre-treatment pain. Resident #1 was educated on need for movement in decreasing pain from fracture. Resident #1 performed supine, head of bed elevated, to sitting at the edge of bed transfer with maximum assistance for lower extremity management. Resident #1 required significant increase in time for transfer due to pain.

An admission Minimum Data Set (MDS) dated 12/8/2024 revealed Resident #1 was cognitively intact, had impairment on both sides of her lower extremities, and utilized a wheelchair, received as needed pain medications, had pain frequently during the assessment period and rated pain at a 7 on a scaled of 0 -10.

Pain assessments dated 12/11/2024 revealed Resident #1 had a pain level of 8 out of 10 on the numerical pain scale of 0 to 10 (indicative of severe pain) at 6:20 am and a pain level of 5 out of 10 on the numerical pain scale (indicative of moderate pain) at 3:33 pm.

A nursing note dated 12/11/2024, authored by the

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Assistant Director of Nursing (ADON), revealed Resident #1's Responsible Party (RP) had requested anticoagulant therapy for Resident #1 and the Nurse Practitioner (NP) was notified. An order was received for Aspirin. Resident #1 had an allergy to Aspirin. The order for Aspirin was discontinued. The RP requested anticoagulation due to enoxaparin, an anticoagulant, being given at the hospital. Resident #1 and the RP explained that Resident #1 had a past medical history of gastrointestinal bleeding. The ADON provided education to Resident #1 and RP, that anticoagulation therapy would put Resident #1 at risk for developing a gastrointestinal bleed.

An NP note dated 12/11/2024 revealed Resident #1 was evaluated per staff request due to chest congestion and was noted to have congestion and trace edema in bilateral lower extremities. The NP ordered a chest x-ray, guaifenesin (medication used to break up mucous), and breathing treatments.

A care plan dated 12/13/2024 revealed Resident #1 acute pain related to multiple fractures with interventions which included administering analgesia as ordered and notifying the physician if interventions were unsuccessful or if current complaint is a significant change from residents past experience of pain.

A NP note dated 12/13/2024 revealed Resident #1 was evaluated following an abnormal chest x-ray. Resident #1 was noted to have increased cough, congestion, and trace edema in bilateral lower extremities. Resident #1's chest x-ray revealed central pulmonary venous congestion (when blood pools instead of flowing properly). Resident was ordered furosemide (diuretic, used

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to treat edema and fluid retention) and staff were to monitor for a decrease in symptoms.

A physician's order dated 12/13/2024 revealed Resident #1 was prescribed furosemide 40 milligrams (mg) by mouth once daily for venous congestion for 5 days.

Change in condition documentation dated 12/18/2024, authored by the Director of Nursing (DON), revealed Resident #1 was noted to have a rash on her left lower extremity and was prescribed hydrocortisone cream.

A pain assessment dated 12/18/2024 revealed Resident #1 had a pain level of 7 out of 10 on the numerical pain scale at 9:59 pm.

A provider communication form dated 12/18/2024 revealed Resident #1 had a rash to her left lower extremity and was ordered hydrocortisone cream to be administered twice daily for 5 days.

An NP note dated 12/18/2024 revealed Resident #1 was evaluated for a rash to bilateral lower extremities and a "dry, rough, red rash" to the left lower extremity. Resident #1 complained of mild itching and was noted to have trace edema to bilateral lower extremities. The NP recommended hydrocortisone cream 1% to be applied to the left lower extremity twice daily for 5 days.

An NP note dated 12/27/2024 revealed Resident #1 was noted to have increased pain and swelling in her left lower extremity. Resident #1 was documented to have 2+ edema, increased pain, and a positive Homan's sign in her left lower extremity. The NP recommended a venous

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doppler study and for Resident #1 to be non-weight bearing to her left lower extremity.

A a provider communication form dated 12/27/2024 revealed Resident #1 was ordered an in-house venous doppler study of the left lower extremity with diagnoses of edema and pain as well as non-weight bearing on left lower extremity until the doppler studies were available.

A nursing note dated Friday, 12/27/2024, authored by the DON, revealed Resident #1's RP was notified that a venous doppler study would not be available before Monday. The RP was "fine with that knowledge" and declined to send her to the Emergency Department (ED).

Vital signs dated 12/28/2024 at 7:47 am revealed Resident #1's blood pressure was 128/70, heart rate was 75 beats per minute (normal is between 60 to 100 beats per minute), a respiration rate of 19 (normal is between 12 to 20 breaths per minute), a temperature of 97.4 degrees Fahrenheit, and an oxygen saturation level of 98%.

A nursing note dated 12/28/2024 at 10:25 am, authored by Nurse #2, revealed Resident #1 requested to go to the Emergency Department (ED) for left leg pain, swelling, and tenderness. Resident #1 stated she was hurting in the calf, behind the knee, and in her pelvic area. An ultrasound doppler was ordered but the company was not available on 12/27/2024 or over the weekend (12/28/2024-12/29/2024). Resident #1 and the RP were concerned about the pain and swelling, which is why they requested her to be sent to the ED.

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Change of condition documentation dated 12/28/2024, authored by Nurse #2, revealed Resident #1 had requested to go to the Emergency Department (ED). Resident #1's left leg was swollen (from hip to toes), painful, and tender to touch. The venous doppler study ordered 12/27/24 was unable to be performed before next week. Resident #1 was documented as having pain of a 4 on scale of 0-10 on the numerical pain scale (indicative of moderate pain) in the left knee, groin, and left lower leg. Nurse #2 attempted to notify the physician, but there was no answer, a message was left.

An EMS report dated 12/28/2024 revealed the facility had notified dispatch at 10:18 am regarding a sick person. EMS arrived at Resident #1's room at 10:31 am. Upon arrival to the facility, staff advised EMS that Resident #1 had broken her pelvis on both sides around 11/27/2024, starting 2 weeks ago Resident #1 had noticed her left lower leg was starting to swell, and a week ago began to feel pain in the leg. Facility informed EMS the MD was aware and had ordered a doppler study which would not be available until later the following week which is why they wanted to transfer Resident #1 to the hospital. EMS obtained vital signs at 10:41 am at which time Resident #1 had a blood pressure of 182/74 (normal is 120/80), a heart rate of 90 beats per minute (normal is 60 to 100 beats per minute), a respiration rate of 18 breaths per minute (normal is 12 to 20 breaths per minute), a temperature of 98.8 degrees, and a pain level of 8 out of 10 on the numerical pain scale (indicative of severe pain). Resident #1 was transferred to the hospital at 10:45 am. While enroute to the hospital, EMS administered 4 milligrams of morphine for pain intravenously (through a

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catheter inserted in a vein).

An ED note dated 12/28/2024 revealed Resident #1 presented to the ED from the facility for evaluation of bilateral lower extremity swelling, which had worsened over the last 2 weeks. A bilateral venous doppler study was conducted in the ED which revealed extensive deep vein thrombosis in the left and right leg. A tibia/fibula (bones in the lower leg) x-ray revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant.

An interview was conducted on 1/6/2025 at 11:41 am via telephone with Resident #1. Resident #1 stated while she was at the facility she had experienced left lower leg pain and swelling. Resident #1 stated she noticed increased leg swelling and pain that began on 12/18/2024. Resident #1 stated the swelling and pain continued to get worse, and recalled her leg being so swollen on Christmas (12/25/2024) that she tried to prop her leg up and stated her leg brace was much tighter than normal. Resident #1 stated on 12/27/2024, her left leg was "really swollen." Resident #1 stated she experienced an "achy" pain and rated the pain as an 8-9 out of 10 on the numerical pain scale. Resident #1 stated the NP evaluated her on 12/27/2024 and ordered a test to be done at the facility. Resident #1 stated on 12/28/2024 she called the RP around 8:00 am and informed her that her left leg pain and swelling had gotten worse overnight and that she thought she needed to go to the hospital. Prior to Resident #1's conversation with the RP, Resident #1 recalled two nurse aides (NAs) commented on her leg and how swollen it was.

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An interview was conducted on 1/6/2025 at 11:34 am via telephone with Resident #1's RP. The RP stated she had gone to speak with the Director of Nursing (DON) on 12/11/2024 regarding her concern about Resident #1 not being on an anticoagulant due to her immobility/fractures, swelling in her legs, and a family history of blood clots. The RP stated Resident #1 had received blood thinner shots at the hospital prior to admission to the facility. The RP stated Resident #1 was seen by the NP on 12/18/2024 at which time she had discoloration to her left leg as well as swelling and was diagnosed with a "rash." The RP stated the facility contacted her on 12/25/2024 about a planned discharge and insurance denial, at which time she expressed her concern over Resident #1's swollen left leg. The RP stated she spoke with the DON again on 12/27/2024, at which time she expressed concern about Resident #1 continuing to have swelling and pain in her left leg. The RP stated the DON had the NP evaluate Resident #1 at which time they ordered a venous doppler study. The RP stated neither the DON nor any facility staff offered to have Resident #1 sent to the hospital on 12/27/2024 for further evaluation. The RP stated she received a call on 12/28/2024 at 8:08 am (per her cell phone call log) from Resident #1 stating that her leg was hurting/more swollen and thought she needed to go to the hospital. The RP stated she called the facility at 10:08 am and insisted that the facility call EMS to have Resident #1 transferred to the hospital for further evaluation. The RP stated she received a phone call from a facility staff member at 10:21 am, at which time they reported EMS had been called. The RP stated when Resident #1 arrived at the hospital, a doppler study was performed in the ED, and Resident #1 was diagnosed with blood

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clots in her bilateral lower extremities and started on heparin.

An interview was conducted on 1/5/2025 at 12:55 pm with Nurse Aide (NA) #1. NA #1 stated she worked on night shift (7:00 pm to 7:00 am) at the facility and stated the last night that she worked with Resident #1 was on 12/26/2024 at which time she noticed Resident #1's left leg was "a little red" and swollen, "nothing too serious." NA #1 stated Resident #1 expressed she was in pain at which time she notified Nurse #1.

Nurse #1 was unavailable for interview.

An interview was conducted on 1/5/2025 at 1:24 pm with NA #3. NA #3 stated she worked dayshift (7:00 am to 7:00 pm) on 12/27/2024 and was assigned Resident #1. NA #3 stated Resident #1's left leg was more swollen than the other leg and stated Nurse #3 was aware of the swelling and Resident #1 was evaluated by the NP on 12/27/2024.

An interview was conducted on 1/3/2025 at 4:09 pm with Nurse #3. Nurse #3 stated she worked dayshift (7:00 am to 7:00 pm) and had been assigned Resident #1 on multiple occasions, including 12/27/2024. Nurse #3 stated Resident #1's legs started swelling before Christmas, 12/25/2024. Nurse #3 stated she the NP had evaluated her (unsure of date) and ordered cream to be administered. Nurse #3 stated the swelling in Resident #1's left leg had worsened and when she was assigned Resident #1 on 12/27/2024 and had the DON come assess Resident #1's leg with her. Nurse #3 was unable to recall if Resident #1 was in pain.

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An interview was conducted on 1/5/2025 at 1:51 pm with Nurse #4. Nurse #4 stated she worked nightshift and had been assigned Resident #1 on 12/25/2024. Nurse #4 stated Resident #1 was not able to ambulate, required full assist, and was bedbound mostly. Nurse #4 stated Resident #1 had been admitted to the facility with an injury to her hip and always had a lot of pain. Nurse #4 was unable to recall Resident #1 having any swelling to her left or right leg.

An interview was conducted on 1/6/2025 at 10:30 am with NA #2. NA #2 stated she worked dayshift and was assigned Resident #1 on 12/28/2024. NA #2 stated when she rounded on Resident #1 between 7:30 am and 8:00 am, she noticed Resident #1 she had noticeable swelling of her left leg, redness near the ankle, and warmness to the touch. NA #2 stated Resident #1 had also expressed pain in her left leg. NA #2 stated she immediately notified Nurse #2 and stated Resident #1 was transferred to the hospital later that morning on 12/28/2024.

An interview was conducted on 1/5/2025 at 4:48 pm with NA #4. NA #4 stated she worked dayshift and assisted with caring for Resident #1 on 12/28/2024. NA #4 stated when she went in Resident #1's room at the beginning of the shift (between 7:00 am and 8:00 am) Resident #1 was complaining about her left leg being swollen. NA #4 stated Resident #1 had swelling from her left hip down to her toes. NA #4 stated there was redness towards the bottom of Resident #1's left lower leg, and stated Resident #1 was in a lot of pain. NA #4 stated she reported the concerns to Nurse #2.

An interview was conducted on 1/5/2025 at 12:48

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pm with Nurse #2. Nurse #2 stated she worked dayshift and 12/28/2024 she was assigned Resident #1 for the first time. Nurse #2 stated Medication Aide (MA) #1 was also assigned Resident #1. Nurse #2 stated she was approached by a staff member (unable to remember who) about Resident #1's left leg being swollen. Nurse #2 stated she assessed Resident #1's left leg was significantly more swollen than the right leg, had redness from the knee to the ankle, was warm to the touch, and painful (from behind the knee, the calve, and the pelvic area). Nurse #2 stated Resident #1's RP called her and asked to have Resident #1 sent to the hospital for evaluation. Nurse #2 stated she tried to call the on-call provider and there was no answer, so she left a message for a return call. Nurse #2 stated she then decided to call EMS.

An interview was conducted on 1/5/2025 at 3:16 pm with the Rehabilitation Director. The Rehabilitation Director stated Resident #1 was seen by both Occupational Therapy (OT) and Physical Therapy (PT). The Rehabilitation Director stated Resident #1 was originally assessed by OT on 12/4/2024 at which time she required moderate assistance and was unable to stand. The Rehabilitation Director stated Resident #1 was initially assessed by PT on 12/6/2024 at which time she was unable to do much due to pain and required maximum assistance with transfers and bed mobility. The Rehabilitation Director stated Resident #1 had left foot drop and required a brace from a previous injury. The Rehabilitation Director stated he worked with Resident #1 on 12/24/2024, at which time he was able to apply the brace to the left leg. The Rehabilitation Director stated he noticed minor signs of swelling, but no discoloration. The

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Rehabilitation Director stated he reported the minor swelling to nursing staff. The Rehabilitation Director stated the RP reached out to him on 12/27/2024 over concerns regarding Resident #1 having leg swelling and overall concern about Resident #1 not being ready for discharge. The Rehabilitation Director stated he reported the RP's concerns to nursing staff (unable to recall who).

An interview was conducted on 1/3/2025 at 4:00 pm with the NP. The NP stated she received notification from the ADON on 12/11/2024 that Resident #1's RP had requested Resident #1 to be placed on an anticoagulant. The NP stated she ordered aspirin to be administered daily and was later contacted by the ADON about Resident #1 having an allergy to aspirin. The NP stated she instructed the ADON to refer to the MD for further direction regarding anticoagulation. The NP stated she had evaluated Resident #1 on 12/11/2024 per staff request for chest congestion at which time Resident #1 had trace edema to bilateral lower extremities and a congested cough and stated she ordered a chest x-ray, guaifenesin, and breathing treatments. The NP stated she evaluated Resident #1 on 12/13/14 following an abnormal chest x-ray which revealed central pulmonary venous congestion and stated she ordered furosemide, a diuretic, to be administered daily for 5 days. The NP stated she evaluated Resident #1 on 12/18/2024 due to a rash to her left lower extremity, trace edema in bilateral lower extremities, and stated she ordered hydrocortisone cream 1% to be administered to the left lower extremity twice a day for 5 days. The NP stated the last time she saw Resident #1 was on 12/27/2024 for left leg pain at which time Resident #1 was having

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increased pain and swelling to her left lower extremity. The NP stated that she had ordered an in-house venous doppler study of the left lower extremity and recommended Resident #1 be non-weight bearing to the left leg. The NP stated Resident #1 had swelling and a positive Homan's sign at that time, but did not notice any redness or warmth. The NP stated she was not aware the venous doppler study would not be performed until the following week. The NP stated she would have been okay with waiting until Monday for the venous doppler study to be completed but would have considered sending Resident #1 to the ED if it could not have been obtained until after Monday. The NP stated she had seen Resident #1 on multiple occasions since she was admitted to the facility and was familiar with Resident #1's history.

An interview was conducted on 1/3/2025 at 5:22 pm with the ADON. The ADON stated she was in the DON's office on 12/11/2024 when Resident #1's RP voiced concerns about Resident #1 not being on an anticoagulant. The ADON stated she contacted the NP, at which time aspirin was ordered, and later discontinued after realizing Resident #1 had an allergy to aspirin. The ADON stated she did not recall the NP instructing her to reach out to the MD for additional guidance regarding anticoagulation. The ADON stated Resident #1 was seen by the NP on 12/18/2024 due to a rash on her left lower leg at which time hydrocortisone cream was ordered. The ADON stated she cared for Resident #1 on 12/25/2024 and noted swelling to Resident #1's left leg at that time, and stated she assumed it was normal because of the rash. The ADON stated Resident #1's left leg was not red or warm to touch at that time. The ADON stated Resident #1 did not

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complain of pain when she applied the hydrocortisone cream. The ADON stated after she cared for Resident #1, she developed swelling from her hip to her toes on the left side and had pain and tenderness. The ADON stated the NP had ordered a venous doppler study which could not be conducted until the following week. The ADON stated that per documentation the RP had declined to send Resident #1 to the ED on 12/27/2024. The ADON stated Resident #1 was sent to the ED on 12/28/2024 and did not return to the facility.

An interview was conducted on 1/6/2025 at 12:59 pm with the DON. The DON stated she had first spoken to Resident #1's RP after Resident #1 had been prescribed hydrocortisone cream for a rash when she was concerned it had not been applied. The DON stated she received a call from the RP on 12/27/2024 at which time the RP was upset about an insurance denial, Resident #1 not being able to ambulate, and about Resident #1's left leg being red. The DON stated she had the NP evaluate Resident #1 on 12/27/2024 and a venous doppler study was ordered. The DON stated she had called the scheduler for the venous doppler study and was told the order would not be looked at until Monday. The DON stated she had told the NP about the delay in obtaining a venous doppler study and verbalized the NP was okay with it. The DON stated she told the RP about the delay of the venous doppler study and offered to send Resident #1 to the hospital at which time the RP declined.

An interview was conducted on 1/5/2025 at 4:17 pm with the Medical Director. The Medical Director stated he had seen Resident #1 shortly

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after admission to the facility but had not seen her since. The Medical Director stated the facility staff, nor the NP had reached out to him with concerns regarding Resident #1. The Medical Director stated if he had been contacted on 12/11/2024 regarding anticoagulation, he would have referred to orthopedics and evaluated whether Resident #1 was ambulatory to see if anticoagulation was needed. The Medical Director stated if Resident #1 had redness and swelling in her leg, he would have ordered a venous doppler study to have been performed on 12/27/2024. The Medical Director stated if he would have known there would have been a delay and Resident #1 had increased pain and swelling, he would have considered sending Resident #1 to the ED.

The Administrator was notified of immediate jeopardy on 1/6/2025 at 6:08 pm.

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

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

The facility failed to recognize the severity or seriousness of bilateral leg swelling and pain for resident #1. Resident #1 had a recent history of fall with fractures in her lumbar spine and pelvis and was not as mobile as she had been previously and was not on an anticoagulant (to prevent blood clot) medication. The facility failed to seek necessary medical attention.

On 12/28/24 resident#1 was discharged to the hospital where she was admitted with bilateral

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blood clots and placed on a heparin (used to break up blood clots) drip.

On 1/6/25 the Director of Nursing (DON) and Nursing Leadership team which includes the Assistant Director of Nursing (ADON) and Unit Managers, assessed all current facility residents via a head-to-toe body audit and pain assessment to ensure that no other resident was experiencing pain, leg swelling or redness with no additional residents identified.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 1/6/25 the DON, ADON, Staff Development (SDC) and Unit Managers began education for licensed nurses, medication aides and certified nursing assistants on assessing and responding to pain and signs/symptoms of blood clots. Licensed nurses, medication aides, and certified nursing assistants newly hired, including agency, will receive in-service prior to working their initial shift. Director of Nursing and/or Staff Development coordinator will be responsible to ensure education is received. Facility administrator communicated this responsibility on 01/06/2025.

Education included:

-How to recognize deep vein thrombosis (DVT) is a blood clot
-Symptoms: Pain, Swelling, Discoloration, Warmth, Positive Homan's sign
-Explaining the seriousness of DVT and how they can be life threatening to Responsible Party's or

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F 684	Continued From page 41 families so they can make informed decisions. As of 01/06 /2025, 24-hour report will be reviewed at least five days weekly by the DON, ADON or a unit manager to identify any residents with leg swelling or pain requiring follow-up from provider. The Administrator communicated the responsibility of reviewing 24-hour reports to the DON, ADON and Unit Managers on 01/06/2025. This credible allegation of immediate jeopardy removal plan was reviewed and approved by an ad hoc QAPI meeting on 01/06/2025. Facility administrator notified DON of responsibility for completion of this credible allegation of immediate jeopardy removal plan on 01/06/2025. Alleged date of IJ removal: 01/07/2025. A validation of immediate jeopardy removal was conducted on 1/13/2025. Initial audits conducted revealed residents were evaluated for the presense of pain, if a provider had been notified, and for new/worsening leg swelling. Interviews with facility nursing staff (Nurses, Medication Aides, Nurse Aides) revealed staff had received education regarding pain assessment, change in condition, and how to report changes in condition to a medical provider without delay. Facility nursing staff were also educated about recognizing the signs and symptoms of a deep vein thrombosis and recognizing the seriousness of the development of a deep vein thrombosis. Facility nursing staff verbalized they were to explain the seriousness of a deep vein thrombosis to the resident and/or responsible party so they could make informed decisions	F 684		

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F 684	Continued From page 42 involving care and treatment. The immediate jeopardy removal date of 1/7/2025 was validated.	F 684		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, Nurse Practitioner (NP), Resident, Resident Responsible Party (RP), and staff interviews, the facility failed to manage a resident's pain (Resident #1) when she experienced increased pain combined with swelling and redness on 12/18/2024 in her left lower extremity. Resident #1 reported she had experienced pain to her left leg on 12/18/2024 and it got worse until she called her family and requested to go the hospital on 12/28/2024. Resident #1's RP called the facility on 12/28/2024 and requested that Resident #1 be sent to the hospital due to increased pain and swelling in her left leg. Emergency Medical Services (EMS) were called to the facility and noted Resident #1 to have an elevated blood pressure of 182/74 (normal is 120/80) and pain of 8 out of 10 on a numerical pain scale (indicative of severe pain). EMS administered morphine (narcotic pain medication) 4 milligrams (mgs) to Resident #1 before arriving at the hospital. Resident #1 experienced pain at 8-9 out of 10 on the numerical pain scale. The deficient practice was identified for one of three residents reviewed for pain management (Resident #1).	F 697	POC for F697 Corrective action taken for residents affected by alleged deficient practice: Resident #1 was discharged to the hospital on 12/28/24. Corrective action for residents identified as having the potential to be affected by the same deficient practice: On 01/06/2025, all residents had skin and pain assessments conducted and documented in the medical record. The assessments included pain interview questions for all interviewable residents, and physical head-to-toe observations of all non-interviewable residents. These assessments were conducted by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager and Wound Nurse. All findings were addressed, and provider was notified. No care plan updates were required. Assessments were documented in	1/14/25

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F 697	Continued From page 43 The findings included: Resident #1 was admitted to the facility on 12/2/2024 with diagnoses which included multiple pelvic fractures, fracture of the lumbosacral spine (lower back and tailbone), and a history of a gastrointestinal bleed (bleeding in the digestive tract). A care plan dated 12/2/2024 revealed Resident #1 had acute pain related to multiple fractures with interventions which included for staff to administer analgesia per order, observe/report changes in usual routine, sleep patterns, decrease in functional abilities, decreased range of motion, withdrawal or resistance to care, and to notify the physician if interventions were not successful or if the current complaint is a significant change from Resident #1's past experience of pain. A physician's order dated 12/3/2024 revealed Resident #1 was ordered oxycodone-acetaminophen 5-325 milligrams (mg) every 4 hours as needed for pain. The December 2024 Medication Administration Record (MAR), from 12/3/2024 through 12/8/2024, revealed Resident #1 had received as needed (PRN) pain medication, oxycodone-acetaminophen 5-325 mg and it was effective. An admission Minimum Data Set (MDS) dated 12/8/2024 revealed Resident #1 was cognitively intact, had impairment on both sides of her lower extremities, utilized a wheelchair, received as needed pain medications, received scheduled	F 697	electronic Medical Records. Measures put in place or systemic changes made to ensure deficient practice will not recur: 0n 01/06/2025, all licensed nurses and medication aides were educated by the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on effective assessment of pain, documentation of assessment and administration of appropriate interventions including physician notification when a change occurs outside of the prescribed plan of care, to effectively manage pain. Nursing Assistants were educated on identifying and reporting signs/symptoms of pain to the nurse. Licensed nurses, medication aides, nursing assistants newly hired, including agency nurses, will receive in-service education prior to working their initial shift, with administrator and DON to ensure this occurs. Pain is assessed as ordered and as needed. Director of Nursing and Assistant Director of Nursing will track employee□s education. Indicate how facility plans to monitor its performance to make sure solutions are sustained: The Director of Nursing and Assistant Director implemented audits of all documented pain levels to ensure pain control interventions are effective beginning 01/14/25. These audits will be conducted 5 times weekly for 6 weeks,	

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F 697	Continued From page 44 pain medication regimen in the last 5 days, had pain frequently during the assessment period and rated pain at a 7 on a scaled of 0 -10. The December 2024 MAR, from 12/9/2024 through 12/11/2024, revealed Resident #1 had received as needed (PRN) pain medication, oxycodone-acetaminophen 5-325 mg, and it was effective. A physician's order dated 12/11/2024 revealed Resident #1 was ordered acetaminophen 650 mg three times a day for pain (9:00 am, 2:00 pm, and 9:00 pm) for pain in addition to the as needed oxycodone-acetaminophen. The December 2024 MAR, from 12/12/2024 through 12/17/2024, revealed Resident #1 had received as needed (PRN) pain medication, oxycodone-acetaminophen 5-325 mg. and it was effective. An interview was conducted on 1/6/2025 at 11:41 am via telephone with Resident #1. Resident #1 stated while she was at the facility she had experienced left lower leg pain and swelling around 12/18/2024. Resident #1 stated she noticed worsened leg swelling and pain that began on 12/18/2024. A change in condition evaluation dated 12/18/2024 at 11:45 am, completed by the Director of Nursing (DON), revealed Resident #1 had edema and "redness" to her left lower leg. There was no pain status evaluation performed at that time. A pain assessment conducted on 12/18/2024 at 9:59 pm, by Nurse #4, revealed Resident #1	F 697	then 3 times weekly for 6 weeks, then once weekly for 6 weeks to ensure that pain control interventions are effective. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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rated her pain as a 7 out of 10 on the numerical pain scale and was documented as having received oxycodone 5-325 mg. On 12/18/2024 at 9:59 pm there was a documented pain level of 7 out of 10. There was no source of pain identified. The medication administration was documented as effective.

The December 2024 MAR, from 12/22/2024 through 12/25/2024, revealed Resident #1 had received as needed (PRN) pain medication, oxycodone-acetaminophen 5-325 mg on 12/22/2024 at 9:28 pm for a documented pain level of 3 out of 10. There was no source of pain identified. The medication administration was documented as effective.

An interview was conducted on 1/6/2025 at 11:41 am via telephone with Resident #1. Resident #1 stated the swelling and pain continued to get worse, and recalled her leg being so swollen on Christmas (12/25/2024) that she tried to prop her leg up and stated her leg brace was much tighter than normal.

An interview was conducted on 1/5/2025 at 1:51 pm with Nurse #4. Nurse #4 stated she worked nightshift and had been assigned Resident #1 on 12/25/2024. Nurse #4 was unable to recall Resident #1 having any swelling to her left or right leg. Nurse #4 stated she administered pain medication when she assessed Resident #1 to have pain.

According to the December 2024 MAR, there was a documented pain level of 7 out of 10 on 12/26/2024 at 4:48 pm. There was no source of pain identified. The medication administration was documented as effective. There was no

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administration of PRN medications given after 4:48 pm on 12/26/2024.

An interview was conducted on 1/5/2025 at 12:55 pm with Nurse Aide (NA) #1. NA #1 stated she worked on night shift (7:00 pm to 7:00 am) at the facility and stated the last night that she worked with Resident #1 was on 12/26/2024 at which time she noticed Resident #1's left leg was "a little red" and swollen, "nothing too serious." NA #1 stated Resident #1 expressed she was in pain at which time she notified Nurse #1. NA #1 was unable to recall if Nurse #1 administered any medication for pain.

Nurse #1 was unavailable for interview.

An interview was conducted on 1/6/2025 at 11:41 am via telephone with Resident #1. Resident #1 stated on 12/27/2024, her left leg was "really swollen." Resident #1 stated she experienced an "achy" pain and rated the pain as an 8-9 out of 10 on the numerical pain scale. Resident #1 stated the NP evaluated her on 12/27/2024 and ordered a test to be done at the facility.

An interview was conducted on 1/6/2025 at 11:34 am via telephone with Resident #1's RP. The RP stated she spoke with the DON on 12/27/2024, at which time she expressed concern about Resident #1 continuing to have swelling and pain in her left leg. The RP stated the DON had the NP evaluate Resident #1 at which time they ordered a venous doppler study. The RP stated neither the DON nor any facility staff offered to have Resident #1 sent to the hospital on 12/27/2024 for further evaluation.

A pain assessment conducted on 12/27/2024, by

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Medication Aide (MA) #2, between 7:00 am and 7:00 pm, revealed Resident #1 had a pain level of 8 out of 10 on the numerical pain scale (indicative of severe pain). There were no documented administrations of as needed oxycodone-acetaminophen 5-325 mg on 12/27/2024.

An interview was conducted on 1/5/2025 at 3:27 pm with MA #2. MA #2 stated she worked on 12/27/2024. MA #2 stated she was unable to recall Resident #1.

An interview was conducted on 1/5/2025 at 1:24 pm with NA #3. NA #3 stated she worked dayshift (7:00 am to 7:00 pm) on 12/27/2024 and was assigned Resident #1. NA #3 stated Resident #1's left leg was more swollen than the other leg and stated Nurse #3 was aware of the swelling and Resident #1 was evaluated by the NP on 12/27/2024. NA #3 was unable to recall if Resident #1 was in any pain.

An interview was conducted on 1/3/2025 at 4:09 pm with Nurse #3. Nurse #3 stated she worked dayshift (7:00 am to 7:00 pm) and had been assigned Resident #1 on multiple occasions, including 12/27/2024. Nurse #3 stated Resident #1's legs started swelling before Christmas, 12/25/2024. Nurse #3 stated the NP had previously evaluated Resident #1 and ordered cream to be administered. Nurse #3 stated the swelling in Resident #1's left leg had worsened and when she was assigned Resident #1 on 12/27/2024 she had the DON come assess Resident #1's leg with her. Nurse #3 stated on 12/27/2024 Resident #1's left leg was swollen; she was unable to recall the leg being hot and was unable to recall if Resident #1 was in pain on

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12/27/2024. Nurse #3 stated the DON had the NP come back to evaluate Resident #1 at which time a venous doppler study was ordered.

An interview was conducted on 1/3/2025 at 4:00 pm with the NP. The NP stated the last time she saw Resident #1 was on 12/27/2024 for left leg pain at which time Resident #1 was having increased pain and swelling to her left lower extremity. The NP stated that she had ordered an in-house venous doppler study of the left lower extremity and recommended Resident #1 be non-weight bearing to the left leg. The NP stated Resident #1 had swelling and a positive Homan's sign (pain behind the knee when the persons toes are pointed towards their head in her left lower extremity, indicative of a deep vein thrombosis/blood clot) at that time. The NP stated Resident #1 did complain of pain at the time of the visit.

A follow up interview was conducted on 1/13/2025 at 12:43 pm with the NP. The NP stated she had no further comments about Resident #1's pain and stated to refer to her notes.

An interview was conducted on 1/6/2025 at 11:41 am via telephone with Resident #1. Resident #1 stated on 12/28/2024 she called the RP around 8:00 am and informed her that her left leg pain and swelling had gotten worse overnight and that she thought she needed to go to the hospital. Prior to Resident #1's conversation with the RP, Resident #1 stated there were two NAs that commented on her leg and how swollen it was.

The December 2024 MAR revealed Resident #1 was documented as having received acetaminophen 650 mg as scheduled daily

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except for 12/28/2024 at which time Resident #1 was documented as hospitalized for the 9:00 am dose of acetaminophen 650 mg by Medication Aide (MA) #1.

An interview was conducted on 1/6/2025 at 11:34 am via telephone with Resident #1's RP. The RP stated she received a call on 12/28/2024 at 8:08 am (per her cell phone call log) from Resident #1 stating that her leg was hurting/more swollen and thought she needed to go to the hospital. The RP stated she called the facility at 10:08 am and insisted that the facility call EMS to have Resident #1 transferred to the hospital for further evaluation.

An interview was conducted on 1/6/2025 at 10:30 am with NA #2. NA #2 stated she worked dayshift and was assigned Resident #1 on 12/28/2024. NA #2 stated when she rounded on Resident #1 between 7:30 am and 8:00 am, she noticed Resident #1 she had noticeable swelling of her left leg, redness near the ankle, and warmness to the touch. NA #2 stated Resident #1 had also expressed she had pain in her left leg. NA #2 stated she immediately notified Nurse #2 and stated Resident #1 was transferred to the hospital later that morning on 12/28/2024.

An interview was conducted on 1/5/2025 at 4:48 pm with NA #4. NA #4 stated she worked dayshift and assisted with caring for Resident #1 on 12/28/2024. NA #4 stated when she went in Resident #1's room at the beginning of the shift (between 7:00 am and 8:00 am) Resident #1 was complaining about her left leg being swollen. NA #4 stated Resident #1 had swelling from her left hip down to her toes. NA #4 stated there was redness towards the bottom of Resident #1's left

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lower leg, and stated Resident #1 was in a lot of pain. NA #4 stated she reported the concerns to Nurse #2.

An interview was conducted on 1/5/2025 at 12:48 pm with Nurse #2. Nurse #2 stated she worked dayshift and 12/28/2024 she was assigned Resident #1 for the first time. Nurse #2 stated she was approached by a staff member (unable to remember who) about Resident #1's left leg being swollen. Nurse #2 stated she assessed Resident #1's left leg was significantly more swollen than the right leg, had redness from the knee to the ankle, was warm to the touch, and painful (from behind the knee, the calve, and the pelvic area). Nurse #2 stated Resident #1 was experiencing pain in her left leg at that time. Nurse #2 stated Resident #1's RP called her and asked to have Resident #1 sent to the hospital for evaluation. Nurse #2 stated she tried to call the on-call provider and there was no answer, so she left a message for a return call. Nurse #2 stated she then decided to call Emergency Medical Services (EMS).

An interview was conducted on 1/6/2025 at 1:00 pm with the Director of Nursing (DON). The DON stated she was familiar with Resident #1. The DON stated she had spoken with the RP on the day Resident #1 was supposed to be discharged, 12/27/2024, about Resident #1's leg being red. The DON stated she went to Resident #1's room on 12/27/2024 and stated Resident #1 was not in any pain and stated she witnessed Resident #1 "get up and walk to the bathroom." The DON stated Resident #1 was given her scheduled acetaminophen as ordered on 12/27/2024 and stated she was unsure why Resident #1 had not received her 9:00 am dose of acetaminophen on

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12/28/2024. The DON stated if Resident #1 would have complained of pain, she would have expected the nurse to administer acetaminophen, and if the pain did not improve, she would have expected the nurse to then administer oxycodone-acetaminophen as ordered. The DON was unable to explain why Resident #1 was not given any pain medication on 12/28/2024.

An EMS report dated 12/28/2024 revealed the facility had notified dispatch at 10:18 am regarding a sick person. EMS arrived at Resident #1's room at 10:31 am. Upon arrival to the facility, staff advised EMS that Resident #1 had broken her pelvis on both sides around 11/27/2024, starting 2 weeks ago Resident #1 had noticed her left lower leg was starting to swell, and a week ago began to feel pain in the leg. EMS obtained vital signs at 10:41 am at which time Resident #1 had a blood pressure of 182/74 (normal is 120/80), a heart rate of 90 beats per minute (normal is 60 to 100 beats per minute), a respiration rate of 18 breaths per minute (normal is 12 to 20 breaths per minute), a temperature of 98.8 degrees, and a pain level of 8 out of 10 on the numerical pain scale (indicative of severe pain). While enroute to the hospital, EMS administered 4 milligrams of morphine (narcotic pain medication) for pain intravenously (through a catheter inserted in a vein).

An Emergency Department (ED) note dated 12/28/2024 revealed Resident #1 presented to the ED from the facility for evaluation of bilateral lower extremity swelling, which had worsened over the last 2 weeks. A bilateral venous doppler study was conducted in the ED which revealed extensive deep vein thrombi in the left and right leg. A tibia/fibula (bones in the lower leg) x-ray

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F 697	Continued From page 52 revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant.	F 697		
F 714 SS=J	Physician Delegation of Tasks to NPP CFR(s): 483.30(e)(1)(4)(f) §483.30(e) Physician delegation of tasks in SNFs. §483.30(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who- (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as defined by State law; and (iii) Is under the supervision of the physician. §483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. §483.30(f) Performance of physician tasks in NFs. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Resident,	F 714	POC for F714	1/14/25

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F 714	Continued From page 53 Resident Responsible Party (RP), Nurse Practitioner, and Medical Director interview the facility Nurse Practitioner (NP) failed to communicate and collaborate with the Medical Director after Resident #1's RP voiced concerns on 12/11/2024 that Resident #1 was not receiving an anticoagulant (blood thinning medication, used to prevent blood clots) after having a fall at home and sustaining multiple fractures of the pelvis and lumbar (lower back) spine, and was not as mobile as she had been prior to admission to the facility. The Assistant Director of Nursing (ADON) contacted the NP on 12/11/2024 at which time the NP ordered aspirin which was later discontinued due to a listed allergy due to a history of gastrointestinal bleeding. The NP instructed the ADON to consult the Medical Director for further guidance regarding anticoagulation for Resident #1 and failed to reach out to the MD herself. On 12/27/2024 Resident #1 was evaluated by the NP at which time Resident #1 had pain, increased swelling, and a positive Homan's sign (pain behind the knee when the person's toes are pointed towards their head, indicative of a deep vein thrombosis/blood clot) in her left lower extremity. Resident #1 was transferred to the hospital on 12/28/2024 where she was diagnosed with the serious adverse outcome of deep vein thrombosis to her bilateral lateral lower extremities, requiring anticoagulation, and hospitalization. The deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for change in condition. Immediate jeopardy began on 12/11/2024 when the NP failed to collaborate with the Medical Director for guidance about anticoagulation concerns raised by Resident #1's RP. Immediate jeopardy was removed on 1/8/2025 when the	F 714	Corrective action taken for residents affected by alleged deficient practice: Resident #1 was transferred to hospital on 12/28/24. Corrective action for residents identified as having the potential to be affected by the same deficient practice: On 1/7/25 the Medical Director audited residents seen within the last thirty days by the Nurse Practitioner to determine if further collaboration was required. No residents identified at risk or in need of further collaboration. Measures put in place or systemic changes made to ensure deficient practice will not recur: On 1/7/25 the Administrator met with the Medical Director (MD) and Nurse Practitioner (NP) and reviewed the expectations of the MD and NP communicating and collaborating with each other. NP should consult with MD in any circumstance regarding medical management needing a higher level of care or beyond his/her scope of practice. The agreement between the providers was reviewed, no changes were made to the provider Collaborative Agreement. The NP was educated on when she should consult with the MD based on review of scope of practice and collaborative provider agreement.	

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F 714	Continued From page 54 facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance with a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: A Collaborative Practice Agreement (Nurse Practitioner) revealed "the undersigned Nurse Practitioner ("NP") and the undersigned physician ("Physician") agree that NP shall practice in collaborative practice with Physician in accordance with terms of this Collaborative Practice Agreement (this "Agreement")." The "Physician shall be continuously available for communication, consultation, collaboration, referral, and evaluation of care provided by NP. Consultation, which may include telecommunication, with Physician shall occur, at a minimum, (i) in any circumstance where NP feels uncertain regarding management of any patient problem or concern; (ii) when medical management is beyond NP's scope of practice; and (iii) when a patient requests the involved Physician." The Collaborate Practice Agreement was signed by the NP on 11/23/2024 and the Medical Director on 11/24/2024. Resident #1 was admitted to the facility on 12/2/2024 with diagnoses which included multiple pelvic fractures, fracture of the lumbosacral spine (lower back and tailbone), and a history of a gastrointestinal bleed (bleeding in the digestive tract). Resident #1's medical record revealed Resident	F 714	On 1/7/25 the Medical Director/Senior partner of provider group educated the MD and all attending Physicians and on call that the NP should consult with MD in any circumstance regarding medical management needing a higher level of care or beyond his/her scope of practice defined by the North Carolina Medical Board and North Carolina Board of Nursing. On 1/7/25 The Medical Director informed the Administrator and DON that the MD and NP will have weekly meetings to ensure ongoing collaboration, and the MD will report any results of the meetings to Administrator and DON. The practice administrator of the provider group will ensure all new Medical Doctors, Attending Physicians and midlevel Practitioner's be educated on the expectation for collaboration with the Medical Director in any circumstance regarding medical management needing a higher level of care or beyond his/her scope of practice defined by the North Carolina Medical Board and North Carolina Board of Nursing. Indicate how facility plans to monitor its performance to make sure solutions are sustained: Beginning 1/14/25, the Medical Director is required to submit ongoing weekly reports of his weekly meetings with the Nurse Practitioner to the Administrator. The Administrator will review and audit the reports for trends or patterns. The results of the Administrator audits of the Medical	

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F 714	Continued From page 55 #1 had an allergy to aspirin with unknown reactions and severity. A nursing note dated 12/11/2024, authored by the Assistant Director of Nursing (ADON), revealed Resident #1's Responsible Party (RP) had requested to be placed on anticoagulant therapy and the Nurse Practitioner (NP) was notified. An order was received for Aspirin. Resident #1 had an allergy to Aspirin. The order for Aspirin was discontinued. The RP requested anticoagulation (blood thinning medication, used to prevent blood clots) due to enoxaparin (an anticoagulant injection used to prevent blood clots) being given at the hospital. Resident #1 and the RP explained that Resident #1 had a past medical history of gastrointestinal bleeding. The ADON provided education to Resident #1 and RP, that anticoagulation therapy would put Resident #1 at risk for developing a gastrointestinal bleed. An interview was conducted on 1/3/2025 at 4:00 pm with the NP. The NP stated she received notification from the ADON on 12/11/2024 that Resident #1's RP had requested Resident #1 to be placed on an anticoagulant. The NP stated she ordered aspirin to be administered daily and was later contacted by the ADON about Resident #1 having an allergy to aspirin. The NP stated she instructed the ADON to refer to the MD for further direction regarding anticoagulation. The NP stated she did not reach out or collaborate with the MD because she had instructed the ADON to do so. An NP note dated 12/18/2024 revealed Resident #1 was evaluated for a rash to bilateral lower extremities and a "dry, rough, red rash" to the left lower extremity. Resident #1 complained of mild	F 714	Director reports will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. Date of completion: 1/14/25	

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itching and was noted to have trace edema to bilateral lower extremities. The NP recommended hydrocortisone cream 1% to be applied to the left lower extremity twice daily for 5 days.

An NP note dated 12/27/2024 revealed Resident #1 was noted to have increased pain and swelling in her left lower extremity. Resident #1 was documented to have 2+ edema, increased pain, and a positive Homan's sign. The NP recommended a venous doppler study and for Resident #1 to be non-weight bearing to her left lower extremity.

A provider communication form dated 12/27/2024 revealed Resident #1 was ordered an in-house venous doppler study of the left lower extremity with a diagnosis of edema and pain as well as non-weight bearing on left lower extremity until the doppler studies were available.

Review of a nursing note dated 12/27/2024, authored by the DON, revealed Resident #1's RP was notified that a venous doppler study would not be available before Monday. The RP was "fine with that knowledge" and declined to send her to the Emergency Department (ED).

An interview was conducted on 1/6/2025 at 11:34 am via telephone with Resident #1's RP. The RP stated she had gone to speak with the Director of Nursing (DON) on 12/11/2024 regarding her concern about Resident #1 not being on an anticoagulant due to her immobility/fractures, swelling in her legs, and a family history of blood clots. The RP stated Resident #1 had received blood thinner shots at the hospital prior to admission to the facility. The RP stated Resident #1 was seen by the NP on 12/18/2024 at which

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time she had discoloration to her left leg as well as swelling and was diagnosed with a "rash." The RP stated the facility contacted her on 12/25/2024 about a planned discharge and insurance denial, at which time she expressed her concern over Resident #1's swollen left leg. The RP stated she spoke with the DON again on 12/27/2024, at which time she expressed concern about Resident #1 continuing to have swelling and pain in her left leg. The RP stated the DON had the NP evaluate Resident #1 at which time they ordered a venous doppler study. The RP stated neither the DON nor any facility staff offered to have Resident #1 sent to the hospital on 12/27/2024 for further evaluation. The RP stated she received a call on 12/28/2024 at 8:08 am (per her cell phone call log) from Resident #1 stating that her leg was hurting/more swollen and thought she needed to go to the hospital. The RP stated she called the facility at 10:08 am and insisted that the facility call EMS to have Resident #1 transferred to the hospital for further evaluation. The RP stated she received a phone call from a facility staff member at 10:21 am, at which time they reported EMS had been called. The RP stated when Resident #1 arrived at the hospital, a doppler study was performed in the ED, and Resident #1 was diagnosed with blood clots in her bilateral lower extremities and started on heparin.

A nursing note dated 12/28/2024 at 10:25 am, authored by Nurse #2, revealed Resident #1 requested to go to the Emergency Department (ED) for left leg pain, swelling, and tenderness. Resident #1 stated she was hurting in the calf, behind the knee, and in her pelvic area. An ultrasound doppler was ordered but the company was not available on 12/27/2024 or over the

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weekend (12/28/2024-12/29/2024). Resident #1 and the RP were concerned about the pain and swelling, which is why they requested her to be sent to the ED.

Change of condition documentation dated 12/28/2024, authored by Nurse #2, revealed Resident #1 had requested to go to the Emergency Department (ED). Resident #1's left leg was swollen (from hip to toes), painful, and tender to touch. The venous doppler study ordered 12/27/24 was unable to be performed before next week. Resident #1 was documented as having pain of a 4 on scale of 0-10 on the numerical pain scale (indicative of moderate pain) in the left knee, groin, and left lower leg. Nurse #2 attempted to notify the physician, but there was no answer, a message was left.

An interview was conducted on 1/6/2025 at 11:41 am via telephone with Resident #1. Resident #1 stated while she was at the facility she had experienced left lower leg pain and swelling. Resident #1 stated she noticed increased leg swelling and pain that began on 12/18/2024. Resident #1 stated the swelling and pain continued to get worse, and recalled her leg being so swollen on Christmas (12/25/2024) that she tried to prop her leg up and stated her leg brace was much tighter than normal. Resident #1 stated on 12/27/2024, her left leg was "really swollen." Resident #1 stated she experienced an "achy" pain and rated the pain as an 8-9 out of 10 on the numerical pain scale. Resident #1 stated the NP evaluated her on 12/27/2024 and ordered a test to be done at the facility. Resident #1 stated on 12/28/2024 she called the RP around 8:00 am and informed her that her left leg pain and swelling had gotten worse overnight and that

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	345247	A. BUILDING _____ B. WING _____	C 01/13/2025

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she thought she needed to go to the hospital. Prior to Resident #1's conversation with the RP, Resident #1 stated there were two Nurse Aides (NAs) commented on her leg and how swollen it was.

An EMS report dated 12/28/2024 revealed the facility had notified dispatch at 10:18 am regarding a sick person. EMS arrived at Resident #1's room at 10:31 am. Upon arrival to the facility, staff advised EMS that Resident #1 had broken her pelvis on both sides around 11/27/2024. Documentation revealed Resident #1 had noticed her left lower leg was starting to swell two weeks prior, and a week ago began to feel pain in the leg. Facility informed EMS the MD was aware and had ordered a doppler study which would not be available until later the following week which is why they wanted to transfer Resident #1 to the hospital. EMS obtained vital signs at 10:41 am at which time Resident #1 had a blood pressure of 182/74 (normal is 120/80), a heart rate of 90 beats per minute (normal is 60 to 100 beats per minute), a respiration rate of 18 breaths per minute (normal is 12 to 20 breaths per minute), a temperature of 98.8 degrees, and a pain level of 8 out of 10 on the numerical pain scale (indicative of severe pain). Resident #1 was transferred to the hospital at 10:45 am. EMS administered 4 milligrams (mg) of morphine for pain intravenously (through a catheter inserted in a vein).

An Emergency Department (ED) note dated 12/28/2024 revealed Resident #1 presented to the ED from the facility for evaluation of bilateral lower extremity swelling, which had worsened over the last 2 weeks. A bilateral venous doppler study was conducted in the ED which revealed

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extensive deep vein thrombi in the left and right leg. A tibia/fibula (bones in the lower leg) x-ray revealed diffuse edema. Resident #1 was admitted to the hospital and placed on a heparin infusion with plans to later transition to Eliquis, an anticoagulant. Resident #1 remained in the hospital and did not return to the facility. As of date, she was still in the hospital was unsure of her actual discharge date from the hospital to another Skilled Nursing Facility.

An interview was conducted on 1/6/2025 at 5:31 pm with the Assistant Administrator. The Assistant Administrator verbalized there was an agreement between the NP and the Medical Director regarding caring for residents. The Assistant Administrator stated if the NP needed guidance she was to reach out to the Medical Director.

An interview was conducted on 1/7/2025 at 9:32 am with the Medical Director. The Medical Director stated that he collaborated with the NP by reading her notes. The Medical Director stated that he was never notified by the NP or any of the facility staff regarding Resident #1. The Medical Director stated he would have only expected the NP to reach out if there was a situation that she did not feel comfortable handling. The Medical Director stated if he had been notified about the increase in pain and swelling to Resident #1's left leg, he would have ordered a venous doppler study to be done within a day. The Medical Director stated if the venous doppler study would have been positive, indicating a blood clot, he would have started Resident #1 on an anticoagulant. The Medical Director stated if he would have been made aware the venous doppler study could not have

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been completed until the following week after it was ordered, he would have considered sending Resident #1 to the ED if she had experienced an increase in pain and swelling.

The Administrator was notified of immediate jeopardy on 1/7/2025 at 11:10 am.

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

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

The facility Nurse Practitioner (NP) failed to communicate and collaborate with the Medical Director (MD) after Resident #1's family voiced concerns regarding anticoagulation therapy. The NP ordered Aspirin and later discontinued due to a documented allergy and because of history of gastrointestinal bleeding.

The NP failed to collaborate with the MD for guidance of how to proceed. The NP did not consult with nor collaborate with the physician regarding the resident's symptoms. Resident had risk factors for Deep Vein Thrombosis (DVT), should have had coagulation therapy and sent out to the hospital for Doppler (diagnostic test to diagnose a blood clot or DVT). The NP delegated the collaboration to the Assistant Director of Nursing (ADON) instead of collaborating with the MD herself.

Resident #1 was transferred to the hospital on 12/28/24 where she was diagnosed with blood clots to her bilateral lower extremities. Resident #1 required anticoagulation and hospital

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admission.

All residents are at risk related to deficient practice

On 1/7/25 the MD audited residents seen within the last thirty days by the NP to ensure if further collaboration was required. No residents identified at risk.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be completed:

On 1/7/25 the Administrator met with the Medical Director and NP and reviewed the expectations of the MD and NP communicating and collaborating with each other. NP should consult with MD in any circumstance regarding medical management needing a higher level of care or beyond his/her scope of practice. The agreement between the providers was reviewed, no changes were made to the provider agreement. The NP was educated on when she should consult with the MD based on review of scope of practice and collaborative provider agreement.

On 1/7/25 the Medical Director/Senior partner of provider group educated the MD and all attending Physicians and on call that the NP should consult with MD in any circumstance regarding medical management needing a higher level of care or beyond his/her scope of practice defined by the North Carolina Medical Board and North Carolina Board of Nursing.

On 1/7/25 The Medical Director informed the Administrator and DON that the MD and NP will

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have weekly meetings to ensure ongoing collaboration, and the MD will report any results of the meetings to Administrator and DON.

This credible allegation of immediate jeopardy removal reviewed and approved by an AD Hoc QAPI meeting on 1/7/25.

Facility administrator notified MD of responsibility for credible allegation of immediate jeopardy removal on 01/07/25.

Alleged IJ removal date is 1/8/2025

A validation of immediate jeopardy removal was conducted on 1/13/2025. Initial audits conducted revealed the Medical Director had reviewed all resident visits for the last thirty days with no further issues present. Interviews with facility staff revealed the Nurse Practitioner was to collaborate with the Medical Director regarding any issues/concerns regarding the care of a resident. Facility nursing staff verbalized they were also to alert nursing management regarding issues/concerns so that nursing management could ensure follow-through. Interviews with the Nurse Practitioner and the Medical Director revealed they had received education regarding collaborating about resident care. The Nurse Practitioner verbalized understanding that she was supposed to reach out to the Medical Director if there was an issue in question or if something out of her scope needed to be addressed. The immediate jeopardy removal date of 1/8/2025 was validated.