STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676161	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on observation, interviews and record reviews, the facility failed to immediately consult with the resident's physician and notify the resident representative when there was a significant change in the resident's condition or need to alter treatment significantly for one (Resident #1) of eight residents reviewed for notify of changes. -The facility failed to notify Resident #1's physician and responsible party when the resident showed signs of an altered mental status for at least 22 hours and was later diagnosed with severe sepsis at the local hospital. On 09/03/24, an Immediate Jeopardy was identified. The IJ template was provided to the facility on [DATE] at 5:45 PM. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. This failure could place residents at risk of not receiving immediate medical attention and required notifications being made when there is a change in their condition., which could lead to worsening of conditions and serious injury or harm. Findings included: Record review of Resident #1's face sheet, dated, 08/30/24, revealed the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included: Paraplegia (paralysis of the legs and lower body), Osteomyelitis (a bone infection that can occur when bacteria or fungi spread to the bone), and Polyneuropathy (malfunction of many peripheral nerves throughout the body). Record review of Resident #1's Admission MDS assessment, dated 07/11/24, revealed the resident had a BIMS score of 13 which suggested he was cognitively intact. Resident #1 was always incontinent of bowel and bladder. The Admission MDS assessment reflected Resident #1 was able to make himself understood. Further review reflected Resident #1 admitted with stage 4 pressure ulcers and required IV medication and isolation for infectious disease. (continued on next page)

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #1's care plan initiated on 07/12/24 reflected the resident was at risk for hospitalization r/t sepsis. Interventions included administer medications as ordered, observe for changes in level of consciousness, mental status, or orientation and report significant changes to provider as indicated . Record review of Resident #1's progress notes reflected there was not a progress note by LVN B on 08/25/24 documenting that the aides reportedly witnessed a change of condition of the resident. Record review of Resident #1's progress notes, dated 08/26/24 at 03:36 AM by RN C, reflected the following: [Resident #1] yelling and screaming, stating he is not in bed and he [sic] going to fall. I need a forklift right now. I am tired of that man being [sic] my room, he is right there behind my bed. [Resident #1] is diaphoretic (sweating heavily), noted ring [sic] tinged urine in Foley. He is afebrile (without fever) at this time 98.9, resp 18, heart rate 102, blood glucose 126mg/dl. SPO2 97% on room air. Spent at bedside to console and reorient [Resident #1]. Care and monitoring ongoing. Record review of Resident #1's progress notes, dated 08/26/24 at 05:01 AM by RN C, reflected the following: [Resident #1] cont to shout out for help. Help me get this forklift. Also rambling speech unable to make sense of. Gave sponge bath and noted noted [sic] sacral wound foul smelling, ordered and sent UA specimen to lab. Cont to console and reassure [Resident #1] Record review of Resident #1's progress notes, dated 08/26/24 at 02:18 PM by LVN R, reflected the following: [Resident #1] had a UA collected this morning, results pending, new orders for STAT CBC, BMP, awaiting collection. Record review of Resident #1's progress notes, dated 08/27/24 at 04:39 AM by RN C, reflected the following: [Resident #1] has vomited approx. 150 cc brown emesis. [Resident #1] cont to have hallucinations at night seeing a man in room that is not present. [Resident #1] is easily consoled. Care and monitoring ongoing. Record review of Resident #1's progress notes, dated 08/27/24 at 10:00 AM by RN D, reflected the following: [Resident #1] hallucinating. HR 105, BP WNL, [Resident #1] c/o of nausea and dry heaving. Wound has foul smell. STAT CBC, CMP and UA sent to NP, Received order for NS @ 75 ml/hr and IM rocephin. [Resident #1] is preparing for discharge today. Discussed worsening condition with [DON] and [social services] and [NP]. [DON] and [social services] discussed with [Resident #1] and [RP]. [RP] has requested him to be sent to [local hospital] for further evaluation. [Transport service] gave ETA 1030 Record review of Resident #1's hospital records, dated 08/27/24, reflected the following: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Chief complaint: [Resident #1] presents with AMS, hallucinations, baseline GCS (neurological scale) 15 but presenting with hallucinations over the past 48-72 hours. Being seen at [nursing facility] for wound care. . Laboratory Results: CBC with differential -WBC- 27.O6; reference range (4.00-11.00) Comprehensive Metabolic Panel -Glucose-101; reference range (70-100) -Potassium-2.7; reference range (3.5-5.0) . Final Diagnoses: severe sepsis, leukocytosis (high white blood cell count), hypokalemia (low potassium). Record review of Resident #1's orders on 08/30/24, reflected the following: -Cleanse wound with 1/4 strength Dakins (topical antiseptic). Apply skin prep to peri-wound. Windowpane around open wound with vac. Drape. Place foam in open wound and cover with vac. Drape. Cut small suction hole in drape and apple suction tubing. Attach tubing to clean canister tubing and turn machine on. Assure good suction. If unable to obtain seal, apply wet to dry dressing and change daily until vac can be reestablished. Wet to dry dressing daily and prn. Directions: one time a day every Tuesday, Thursday, and Saturday for wound care. Start Date: 07/13/24. End Date: 08/28/24 In an interview on 08/29/24 at 08:30AM, RN X, who worked at the local hospital, stated Resident #1 was admitted to the hospital on 08/27/24 for altered mental status and was diagnosed with severe sepsis likely due to a wound infection and UTI. RN X stated there were concerns that Resident #1's wounds were not being properly treated at the nursing facility and he was malnourished. RN X did not provide any further information. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an observation and interview on 08/29/24 at 08:45 AM, Resident #1 was lying in bed with a catheter and IV abx in place. Resident #1 was responsive but was unable to speak much due to physical and mental state. Resident #1 stated he felt better. He denied being neglected at the nursing facility; however, he stated there were good and bad staff there. Resident #1 stated he was provided all meals and treatments to his knowledge. Resident #1 stated he often refused the meals because he did not like the texture. Interview with Resident #1's RP, who was sitting bedside at the hospital, revealed she did not initially have concerns for abuse/neglect of Resident #1 during his stay at the nursing facility however, when she visited the resident at the nursing facility on 08/25/24 he was hallucinating and not acting like himself . RP stated Resident #1 stated he needed a forklift for work and stated there was a man standing in his room, and that is when she knew something was wrong. RP stated this was reported to staff whom she could not recall. RP stated Resident #1 was receiving wound care as ordered to her knowledge however, there had been an occasion where the wound vacuum had to be replaced due to not working properly. RP stated Resident #1 was very thin when he admitted to the nursing facility because he would be afraid to eat due to having a history of constipation, which started while at home. RP stated Resident #1 would be going back home with her once discharged from the hospital as he had been issued a notice that his insurance would no longer cover his stay at the nursing facility. In an interview on 08/29/24 at 12:57 PM, the DON stated Resident #1 admitted to the facility with infected wounds and had to be placed on IV abx and isolation immediately. The DON stated Resident #1 had only been admitted to the nursing facility for almost 2 months before receiving a notice of Medicare non-coverage and was due to discharge home with significant other. The DON stated Resident #1 was discharged to the local hospital on 08/27/24 instead due to AMS and smells coming from his wounds, and she did not feel it would be a safe discharge for him to go home. The DON stated it was first reported to her by RN C on 08/26/24 that Resident #1 had an AMS. The DON stated the MD was also notified by RN C and STAT orders for lab work was initiated. The DON stated Resident #1 was not ordered to be sent out to the hospital on 08/26/24. In an interview on 08/29/24 at 12:57 PM, LVN A, who was a wound care nurse, stated she worked at the nursing facility since 01/01/24. LVN A stated Resident #1 was very tiny and had 1-3 wounds in his sacrum (base of spine) area that would heal and reopen depending on how the resident was positioned. She stated Resident #1 received wound care three times weekly . LVN A stated Resident #1 had a wound vacuum to assist with healing. She stated there was one time the wound vacuum stopped working during treatment and she was able to order a new one that was delivered the same day. LVN A stated there was an order in place to do wet-to-dry care in case the wound vacuum ever stopped working, so there was never a break in care. LVN A stated Resident #1's wounds covered a large surface area and had pockets that did not allow for complete visualization. LVN A stated Resident #1 admitted with spores and bacteria that caused him to need IV abx and to be placed on isolation. LVN A denied ever smelling Resident #1's wound; however, she stated there were times when the sponge from the wound vacuum would smell. LVN A stated she went to do wound care on Resident #1 on 08/27/24 and he did not look good to her, so she went to report it to the nurse and the resident was sent out to the hospital. LVN A stated she did not get to complete wound care and only disconnected the wound vacuum for EMS to be able to transport Resident #1 to the hospital without taking the facility's equipment. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/29/24 at 02:04 PM, RN D stated she worked for 2.5 years at the facility. RN D stated she worked with Resident #1 on 08/26/24, 2pm-10pm. RN D stated the off-going nurse, RN C, reported Resident #1 was hallucinating and had a smelly wound, and the MD had already been notified and labs had been ordered. RN D stated Resident #1 did not complain about anything, slept most of her shift, and did not eat well which was not unusual. RN D stated she did not notice that Resident #1 had an AMS during that shift. RN D stated she returned to work on the morning of 08/27/24. RN D stated Resident #1's labs had come back by that time, and she reviewed them and sent them to the NP for MD. RN D stated the NP gave orders to start fluids and abx; however, just before she could get anything started, the facility made the decision to send Resident #1 out to the hospital. RN D stated when she went to check on Resident #1, he seemed off and was even yelling out for the nurse which was unusual because the resident never raised his voice. RN D stated when she helped reposition Resident #1, she could also smell his wound. In an interview on 08/29/24 at 02:25 PM, CNA E states she worked a double shift on 08/24/24 (Saturday) and worked with Resident #1. CNA E stated she assisted Resident #1 with breakfast, and he was talking to himself and stated he could see a little boy in his room that was about to fall. CNA E stated Resident #1 refused to raise his head to eat. CNA E stated by lunch time, Resident #1's hallucinations were worse, and she reported it to LVN B. CNA E stated she did not work with Resident #1 towards the end of her shift and did not know how he was for the remainder of the day or if LVN B followed up on her concerns. In an interview on 08/29/24 at 03:16 PM, LVN B stated she worked at the facility for 3 years. She stated she worked double shifts (6a-10p) on 08/24/24 and 08/25/24. LVN B stated Resident #1 was fine on 08/24/24 and she denied that CNA E or any other staff reported to her that Resident #1 was hallucinating or had a change in condition. LVN B stated she returned to the facility on [DATE] and Resident #1 was able to carry a normal conversation with her that morning and seemed fine. LVN B stated Resident #1 did not exhibit any hallucinations. LVN B stated by 7:30/8 PM she did rounds and closed Resident #1's blinds and he still seemed fine to her. LVN B stated CNA F and another aide reported to her around that time that Resident #1 had been hallucinating and seeing things. LVN B states she went back to Resident #1's room to provide care and to assess him, and Resident #1 did not say anything. LVN B denied initiating a conversation to see if the resident was hallucinating. LVN B stated she did not know how to assess for hallucinating because she could not directly ask Resident #1 if he was hallucinating. LVN B stated she did not report the aides concerns to the MD or DON and could not recall if she mentioned it to the oncoming nurse. LVN B stated any change in condition should be reported to the MD and reported at shift change. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on 08/30/24 at 09:30 AM, RN C stated she worked at the facility for almost a month. She stated she worked overnight (10p-6a) on rotating shifts. RN C stated she worked overnight with Resident #1 on 08/25/24 leading into 08/26/24. RN C stated she did not recall LVN B reporting any significant information regarding Resident #1. RN C stated Resident #1's baseline was never normal anyway due to the resident admitting to the facility with multi-resistant organisms. RN C stated Resident #1 had to be on heavy abx via IV. RN C stated Resident #1 was always sensitive about lights and noises in his room. RN C stated early morning on 08/26/24 at around 3:30 AM, there was a significant change in Resident #1's condition. RN C stated during her rounds, Resident #1 got sick to his stomach, sweaty, and was stating that there was a man in the window. RN C stated she tried to reorient Resident #1 and comforted him. RN C stated she checked Resident #1's vitals and they were normal and there was no fever, which she thought was strange with the sweating. RN C stated she notified the MD right away thinking Resident #1 might have a UTI or was growing other bacteria as he had been off IV abx for about a week. RN C stated there was also a smell on Resident #1, but she was not sure if it was coming from his wounds or the wound vacuum. RN C stated the MD ordered labs and a consult with wound nurse. In a further interview on 08/30/24 at 10:04 AM, the DON stated it was the expectation for the nurses to report any change in condition, even if it was only reported by an aide and they did not observe it themselves, at least to the oncoming nurse for continued monitoring. The DON stated the risk of not reporting changes of condition could be not providing a resident appropriate care in a timely manner. In an interview on 08/30/24 at 10:26 AM, CNA F stated she worked with Resident #1 on 08/25/24 (6a-10p). CNA F stated Resident #1's RP was visiting with him on this day. CNA F stated she assisted Resident#1 with breakfast, and he was hallucinating, and this continued throughout her shift. CNA F stated she reported it to LVN B. In an interview on 09/03/24 at 12:15 PM, the MD stated Resident #1 had recently completed a round of abx; however, it did not mean the infection was completely gone. The MD stated Resident #1 was also under the care of the infectious disease team who were monitoring his wounds and infection. The MD stated she was notified around 5:00 AM on 08/26/24 that Resident #1 was having a change of condition that included hallucinating. The MD stated she gave an order for STAT labs. The MD stated hallucinating could have been indicative of worsening of wound or an infection. The MD stated the expectation was for the nurse to notify her as soon as the hallucinations were observed on 08/25/24 to prevent a delay in care; however, she stated her orders would have been the same. The MD stated she would not have sent Resident #1 immediately out to the hospital before collecting labs because it may have been an issue that could have been treated at the nursing facility. The MD stated it was not uncommon for residents to hallucinate with having something like a UTI and the hospitals sometimes prefer for the nursing facilities to manage such things in-house. The MD stated the risk of not immediately reporting the change of condition could be missing an infection that was too bad for the nursing facility to manage. Review of the facility's policy titled Change of Condition and Physician/Family Notification, revised 08/11/2020, revealed in part the following: Purpose: To ensure that resident's family and/or legal representative and physician are notified of resident changes that fall under the following categories: (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-An accident resulting in injury that has the potential for needed physician intervention. -A significant change in the resident's physical, mental, or psychosocial status. -A need to significantly alter treatment. -Transfer of the resident from the facility. Procedure: When the above situations exist, the licensed nurse will contact the resident's family and their physician. . An Immediate Jeopardy (IJ) was identified on 09/03/24 at 04:45 PM. The NFA was notified of an Immediate Jeopardy (IJ) on 09/03/24 at 5:45 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal (POR) was accepted on 09/04/24 at 1:00 PM and included: [Nursing Facility] September 3, 2024 POR - Change of Condition F580 On August 25, 2024, [Resident #1] nurse was notified about a change in resident mental status. The nurse did not document her assessment or report her findings to the physician. Immediately on September 3, 2024, CCS in-serviced Administrator and DON on change of condition policy and procedure to include comprehensive assessments and notification of Physician/NP. Ln-service covered when to notify the Physician/NP for a change of condition, discussed what categories fall under change of condition, the process for notification of Physician/NP, escalation of the communication process if the Physician/NP cannot be reached, and examples of significant changes. Competency was verified via quiz. On September 3, 2024, Administrator and DON initiated in-services with the licensed nurses on change of condition policy and procedure to include comprehensive assessments and notification of Physician/NP. services covered when to notify the Physician/NP for a change of condition, discussed what categories fall under change of condition, the process for notification of Physician/NP, escalation of the communication process if the Physician/NP cannot be reached, and examples of significant changes. Competency was verified via quiz. Nursing staff will not be allowed to work until In-servicing has been completed on September 4, 2024. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On September 3, 2024, an audit was conducted by DON/Designee to identify other residents with potential change of condition. Via direct observation, staff interviews, and record review, no other residents were identified as having a change of condition. Medical Director was notified on September 3, 2024. In order to monitor current residents for potential risk, DON and CCS will monitor residents for change of condition beginning September 3, 2024, for 30 days on all residents via Triage Log. The purpose of this log is to monitor residents with acute changes in condition. DON compliance will be monitored weekly by CCS for 90 days. Thereafter, QA will monitor quarterly up to a year for compliance of change of condition, quality of care and abuse and neglect. If any issues are identified, the physician will be contacted for further medical management and family/POA of the same. The facility QA Committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. On 09/04/24 the investigator began monitoring (1:12 PM-3:30 PM) if the facility implemented their plan of removal sufficiently to remove the IJ by: Observations, interviews, and records reviews of Residents #2, #3, #4, #5, #6, #7, and #8 revealed no furthers concerns for changes in physical, mental, or psychosocial status that required the physician or family to be notified of. Observations and record reviews revealed any wounds and other care needs were being monitored and treated according to physician orders. Interview with residents and/or RPs revealed no concerns for abuse/neglect or deficit in quality of care. Record review of an in-service conducted by the CCS dated 09/03/24 with the NFA and DON. Objectives of the in-service included the Change of Condition, Comprehensive Assessments and Notifications to the physician and RP. The CCS reviewed related policies and the NFA and DON completed pre-/post-tests with a passing score. Record review of a 24-hour report audit conducted by the CCS dated 09/03/24 at 10:59 PM revealed the CCS attest that she audited the last 30 days of 24-hour reports for resident changes in condition and to ensure the Physician/NP had been notified in a timely manner. Interviews conducted with nurses and CNAs scheduled on the 6A - 2P shift [RN D, LVN J, CNA I and CNA K], on the 2P - 10P shift [LVN H, CNA G, LVN L, CNA N, LVN Q and RN C (recently transitioned from 10P - 6A shift)], and 10P - 6A shift [LVN O, LVN M and CNA P] indicated they participated in various in-service trainings. The staff stated topics of discussion included how to recognize a resident's change in condition, physician notification, documentation, and following up on lab results. Each nurse stated in their own words the procedure to notify physicians immediately about resident change in condition and lab results. Each nurse demonstrated how to perform an abdominal assessment and verbalized abnormal findings. CNAs stated in their own words' signs and symptoms of constipation, what must be reported to the charge nurse, and where to document a resident's bowel movement in the chart. Record review of in-services conducted by the DON dated 09/03/24 titled Change in Condition [with all nursing staff], POC Documentation [with CNAs], Bowel Assessment [with Nurses], Lab Services [with Nurses and Nursing Administration] and Physician Notification [with Nurses and Nursing Administration] were on-going to achieve 100% nursing dept participation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44405 Based on interview and record review, the facility failed to identify and provide needed care or services that resulted in an actual or potential decline in one or more resident's physical, mental, and psychosocial well-being for one (Resident #1) of four residents reviewed for quality of care. The facility failed to identify, monitor, assess, evaluate, and document Resident #1's changes in the bowel regimen. The facility failed to provide Resident #1 as needed (PRN) medication for constipation. The facility failed to evaluate Resident #1's bowel sounds as indicated and report significant abnormalities to the provider per the care plan intervention initiated, 07/12/2024. The facility failed to notify the provider of Resident #1's last known bowel movement on 08/08/24. The facility failed to notify the provider about Resident #1's STAT lab results received on 08/26/24 at 3:21 PM . On 08/27/24, Resident #1 was admitted to the hospital for altered mental status (AMS). Resident #1 was admitted , diagnosed , and treated for severe sepsis, chronic constipation, and fecal impaction. The facility failed to recognize Resident #1 was having a significant change of condition when he was yelling, hallucinating, and having and elevated heart rate. On 09/03/24, an Immediate Jeopardy was identified. The IJ template was provided to the facility on [DATE] at 5:45 PM. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These deficient practices placed residents at high risk of, or the likelihood of, serious injury or harm by not receiving treatment, developing complications, and the development of sepsis. Findings included: Record review of Resident #1's Admission MDS assessment dated , 07/11/24, revealed a 78-years-old male, who admitted to the facility on [DATE] with medically complex conditions including, Paraplegia (paralysis of the legs and lower body), Osteomyelitis (a bone infection that can occur when bacteria or fungi spread to the bone), and Polyneuropathy (malfunction of many peripheral nerves throughout the body). The admission MDS assessment revealed a BIMS score of 13 which suggested Resident #1 was cognitively intact. Resident #1 was always incontinent of bowel and bladder. The Admission MDS assessment reflected Resident #1 did not have constipation. Resident #1's Order Summary Report, dated 08/31/24, reflected: Order date 07/04/24: Duloxetine HCl (An antidepressant medication used to treat neuropathy [nerve pain]. Constipation is a common side effect) Oral Capsule Delayed Release Particles 60 mg. Give 1 capsule by mouth one time a day for chronic muscle or bone pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Order date 07/04/24: MiraLax (medication used to treat occasional constipation) Oral Powder 17 gm/scoop. Give 1 scoop by mouth every 24 hours as needed for laxative. Order date 07/23/24: Tramadol HCl (medication used to treat moderate to severe pain cause the digestive system to slow down its normal function that can make it hard for stool to pass, leading to constipation) Oral Tablet 50 mg. Give 1 tablet by mouth every 8 hours for pain. Review of Resident #1's comprehensive care plan initiated on 07/12/24 indicated: [Resident #1] at risk for side effects of anti-depressant medication. (Initiated 07/12/24). Interventions included monitor for side effects of anti-depressants: . constipation. (Initiated 07/12/24). The goal reflected [Resident #1] will not have any side effects of anti-depressants through the review period. (Initiated: 07/12/24; Revision: 07/24/24; Target: 10/22/24). [Resident #1] at risk related to alteration in bowel elimination constipation. (Initiated 07/12/24). Interventions included evaluate bowel sounds as indicated and report significant abnormalities to provider. (Initiated 07/12/24). The goal reflected [Resident #1] will have decreased episodes of constipation through next review period. (Initiated: 07/12/24; Revision: 07/24/24; Target: 10/22/24). [Resident #1] is on pain medication therapy Tramadol . (Initiated 07/12/24). Interventions included monitor/document/report PRN adverse reactions to analgesic therapy: altered mental status . constipation . nausea, vomiting . (Initiated 07/12/24). The goal reflected [Resident #1] will be free of any discomfort or adverse side effects from pain medication through next review period. (Initiated: 07/12/24; Revision: 07/24/24; Target: 10/22/24). Review of Resident #1's August 2024 MAR reflected Duloxetine 60 mg Delayed Release Particles capsule was administered daily as ordered on 08/01/24 - 08/27/2024. Tramadol 50 mg, 1 tablet, was administered daily, three times a day, every 8 hours as ordered on 08/01/24 - 08/27/2024 at 6:00 AM. The August 2024 MAR did not reflect MiraLax was ever administered PRN as ordered for constipation. Review of a 30-day look back at Resident #1's August 2024 ADL documentation/flow sheets for Bowel Movement reflected: On 08/05/24: 11:27 PM Incontinent, Formed/Normal, Small, Barrier cream applied. 08/06/24: 1:41 PM No Bowel Movement 8:30 PM No Bowel Movement 08/07/24: 12:41 AM Incontinent, Formed/Normal, Small, Barrier cream applied. 9:59 PM No Bowel Movement (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11:09 PM Continent, Loose/Diarrhea, Small, Barrier cream applied. 08/08/24: 1:59 PM No Bowel Movement Review of Resident #1's August 2024 progress notes did not reflect PRN medication administered for constipation and its effectiveness, interventions provided for constipation relief, or that the provider and RP were notified. Review of Resident #1's August 2024 assessments did not reflect RN C completed an abdominal assessment of the resident after he vomited brown emesis to assess for signs of constipation. Review of Resident #1's STAT lab results, dated 08/26/24, revealed in part the following: Collected date: 08/26/24 at 12:30 PM Resulted date: 08/26/24 at 03:48 PM Test results: WBC-10.6 (range reference 3.6-10.2) RBC- 3.94 (range reference 4.06-5.63) Hemoglobin- 11.7 (range reference 12.5-16.3) Hematocrit- 35.7 (range reference 36.7-47.2) . A review of Resident #1's hospital medical records dated 08/29/24 reflected [Resident #1] arrived at the ED on 08/27/24 at 11:56 AM. The reason for visit reflected Altered Mental Status (AMS) . hallucinations over the past 48-72 hours. The visit diagnoses included Severe Sepsis and Chronic constipation. The ED provider notes indicated Resident #1 appeared in acute distress, was ill-appearing, symptoms were moderately severe, and Resident #1 reported vomiting. Review of Resident #1's CT scan of Abdomen and Pelvis with Contrast final result, dated 08/27/24 at 2:24 PM, revealed an extremely large rectal stool ball with very large obstructing colonic stool burden. Findings are concerning for impaction. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/29/24 at 12:57 PM, the DON stated Resident #1 admitted to the facility with infected wounds and had to be placed on IV abx and isolation immediately. The DON stated Resident #1 had only been admitted to the nursing facility for almost 2 months before receiving a notice of Medicare non-coverage and was due to discharge home with significant other. The DON stated Resident #1 was discharged to the local hospital on 08/27/24 instead due to AMS and smells coming from his wounds, and she did not feel it would be a safe discharge for him to go home. The DON stated it was first reported to her by RN C on 08/26/24 that Resident #1 had an AMS. The DON stated the MD was also notified by RN C and STAT orders for lab work was initiated. The DON stated Resident #1 was not ordered to be sent out to the hospital on 08/26/24. During an interview on 08/29/24 at 02:25 PM, CNA E states she worked a double shift on 08/24/24 (Saturday) and worked with Resident #1. CNA E stated she assisted Resident #1 with breakfast, and he was talking to himself and stated he could see a little boy in his room that was about to fall. CNA E stated Resident #1 refused to raise his head to eat. CNA E stated by lunch time, Resident #1's hallucinations were worse, and she reported it to LVN B. CNA E stated she did not work with Resident #1 towards the end of her shift and did not know how he was for the remainder of the day or if LVN B followed up on her concerns. During an interview on 08/29/24 at 03:16 PM, LVN B stated she worked at the facility for 3 years. She stated she worked double shifts (6a-10p) on 08/24/24 and 08/25/24. LVN B stated Resident #1 was fine on 08/24/24 and she denied that CNA E or any other staff reported to her that Resident #1 was hallucinating or had a change in condition. LVN B stated she returned to the facility on [DATE] and Resident #1 was able to carry a normal conversation with her that morning and seemed fine. LVN B stated Resident #1 did not exhibit any hallucinations. LVN B stated by 7:30/8 PM she did rounds, and closed Resident #1's blinds and he still seemed fine to her. LVN B stated CNA F and another aide reported to her around that time that Resident #1 had been hallucinating and seeing things. LVN B states she went back to Resident #1's room to provide care and to assess him, and Resident #1 did not say anything. LVN B denied initiating a conversation to see if the resident was hallucinating. LVN B stated she did not know how to assess for hallucinating because she could not directly ask Resident #1 if he was hallucinating. LVN B stated she did not report the aides concerns to the MD or DON and could not recall if she mentioned it to the oncoming nurse. LVN B stated any change in condition should be reported to the MD and reported at shift change. During a further interview on 08/30/24 at 10:04 AM, the DON stated it was the expectation for the nurses to report any change in condition, even if it was only reported by an aide and they did not observe it themselves, at least to the oncoming nurse for continued monitoring. The DON stated the risk of not reporting changes of condition could be not providing a resident appropriate care in a timely manner. During an interview on 08/30/24 at 10:26 AM, CNA F stated she worked with Resident #1 on 08/25/24 (6a-10p). CNA F stated Resident #1's RP was visiting with him on this day. CNA F stated she assisted Resident#1 with breakfast, and he was hallucinating, and this continued throughout her shift. CNA F stated she reported it to LVN B. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 08/31/24 at 2:25 PM, CNA E stated that she provided direct care to Resident #1. CNA E said that she worked with Resident #1 last Saturday (08/24/24) and he was confused and talking to himself. CNA E said that Resident #1 refused breakfast because he wanted to wait for his [RP] to come feed him. CNA E said that Resident #1 took a couple bites of the food and finished his drink. CNA E said that it was her responsibility to document whenever a resident had a bowel movement. CNA E said that she could not remember if Resident #1 had a bowel movement that day or explain why it was not reflected in her documentation. During an interview on 09/02/24 at 2:32 PM, RN C indicated that she worked 08/25/24 and 08/26/24, 10P - 6A shift and was the primary nurse for Resident #1. RN C said during the 08/25/24 10P - 6A shift, Resident #1 yelled and screamed. RN C said that [Resident #1] had blood-tinged urine in his indwelling catheter, did not have a temperature, heart rate was over 100 beats per minute, but was consoled and reoriented. RN C said Resident #1 continued to shout towards the end of her shift. RN C said that she gave Resident #1 a sponge bath and thought she smelled a foul smell from the wound vac (to Resident #1 sacrum). RN C then said that she noticed a stool blob at [Resident #1] anus when she wiped, like [Resident #1] did not have a complete bowel movement and some stool was still trapped. RN C said that when she called the doctor to get an order for an UA (08/26/24 at 5:00 AM), she did not mention the incomplete bowel movement because she did not think it was an issue. RN C said that Resident #1 vomited a brown emesis (can be caused by internal bleeding in the stomach, severe constipation, or inflammation of the stomach lining) overnight on the 08/26/24, 10P - 6A shift. RN C said that she did not report Resident #1 threw up because it looked like a cupcake and she [RN R] did not believe it was a gastric bleed. RN C said that she did not know the last time Resident #1 had a bowel movement but remembered the CNA (unknown name and unable to describe) told her [RN R] that Resident #1 had a bowel movement during a shift but could not remember because the days blended. RN C said that the doctor also ordered STAT labs with the UA order. RN C said that the facility would get the STAT lab results on the same day or early the next day based on the time of day the lab was collected. RN C said that the lab results were available on 08/26/24 during the 2P - 10P shift. RN C said that the lab results could inform the doctor if the resident had an infection, diagnose diseases, or identify other issues, like a gastric bleed. RN C said she did not review the lab results or check if the doctor was notified when Resident #1 threw up brown emesis or if his confusion was related to an infection. During an interview on 09/02/24 at 2:47 PM, the ADON stated she was familiar with Resident #1. The ADON stated she was not informed of Resident #1 did not have a bowel movement or unrelieved constipation. The ADON said the CNAs should notify the charge nurse when or if a resident did not have a bowel movement during the shift. The ADON said she expected nurses to perform an abdominal assessment (listen to bowel sounds, feel the abdomen for tenderness or if firm), assess for signs of constipation, implement care plan interventions, notify clinical department heads (ADON/DON) of resident change in condition, notify the provider, and the RP. The ADON said that the risk if constipation was not treated could be hemorrhoids or a serious complication such as fecal impaction if hard stool backed up into the colon. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 09/02/24 at 3:22 PM, the DON said that she had in-serviced staff last month that anything that was different and out of the ordinary for a resident was a change in condition. The DON said that she expected nurses to monitor the resident's bowel movements for change in frequency and consistency. The DON said that the nurse should perform an initial assessment if a resident did not have a bowel movement for 2 - 3 days, decreased appetite, nausea, vomiting, and/or pain. The DON said an initial assessment for constipation would include an abdominal assessment that included visual inspection for the shape, abdominal distention, feel for firmness, localized tenderness, and listen with a stethoscope for slowed or absent bowel sounds that could suggest constipation. The DON said that the nurse should check the administration record for PRN medications/treatments, implement nurse interventions per the care plan, notify the provider with their assessment findings, the resident response to interventions, and notify the family. The DON said that Task(s) and nurse progress notes would be review every morning for documentation of bowel movements frequencies and interventions as needed. During an interview on 09/03/24 at 12:15 PM, the MD said that she gave orders to collect STAT blood labs on Monday morning (08/26/24) when she was notified that Resident #1 was hallucinating. The MD did not recall being told that Resident #1's wound had a foul smell, that he vomited, or that he was constipated related to not having or an incomplete bowel movement. The MD said that constipation could lead to several complications that included acute confusion, nausea, poor appetite, rapid heart rate, and fecal impaction. The MD said that she expected to be notified as soon as possible about any change in condition. The MD said she was not notified when the STAT lab results were received. The MD said that the NP was called first and coordinated Resident #1's care with the facility staff. Record review of the facility's Bowel (Lower Gastrointestinal [GI] Tract) Disorders - Clinical Protocol, revised September 2017, reflected assessment and recognition, cause identification, treatment, management, monitoring and follow-up of bowel dysfunction. The nurse shall assess and document/report alteration in bowel movements; quantitative and qualitative description of bowel movements; presence of fecal impaction; abdominal assessment; onset, duration, frequency, and severity of signs and symptoms. Record review of the facility's Change of Condition and Physician/Family Notification policy, reviewed 05/17/24, reflected the purpose to ensure resident's family and physician are notified of changes that fall under: - an accident resulting in injury that has the potential for needed physician interventions - a significant change (example given: Abnormal lab results) - a need to significantly alter treatment - transfer of the resident from the facility A review of the Lab and Diagnostic Test Results - Clinical Protocol reviewed December 2022, indicated: - The physician will identify and order diagnostic and lab testing; staff will process test requisition and arrange for test; the laboratory, diagnostic provider will report results to facility (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	- A nurse will review all results and report the finds to the physician/designee - A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff) - A physician will respond within an appropriate time frame, based on the request from the nursing staff and the clinical significance of the information. This response maybe by calling the facility or writing new orders. The NFA was notified of an Immediate Jeopardy (IJ) on 09/03/24 at 5:45 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal (POR) was accepted on 09/04/24 at 1:00 PM and included: On August 26, 2024 orders were received for STAT labs. The results were received by the facility in the early evening of August 26, 2024. The facility nurse inadvertently overlooked the lab results and did not notify the MD until August 27, 2024. Immediately on September 3, 2024, CCS inserviced DON on the prompt or timely review of laboratory results, lab policy and procedure to include the lab tracking system, lab orders, receiving lab results, and proper follow up and notifications. An inservice was initiated on the proper documentation of resident bowel function and reporting any important changes to the nurse. Competency was verified via quiz. On September 3, 2024, DON/designee initiated inservices with the licensed nurses on prompt or timely review of laboratory results, lab policy and procedure to include the lab tracking system, lab orders, receiving lab results, and proper follow up and notifications. Competency was verified via quiz. Nursing staff will not be allowed to work until inservicing has been completed on September 4, 2024. An inservice was initiated on the proper documentation of resident bowel function and reporting any important changes to the nurse. Competency was verified via quiz. Nursing staff will not be allowed to work until inservicing has been completed on September 4, 2024. On September 3, 2024, DON/designee initiated inservices with the CNAs/MA s on proper documentation of resident bowel function and reporting any important changes to the nurse. Competency was verified via quiz. Nursing staff will not be allowed to work until inservicing has been completed on September 4, 2024. On September 3, 2024, an audit of the 24-hour report and laboratory findings was conducted by DON/Designee to ensure Physician/NP has been notified timely. On September 3, 2024, an audit of BM documentation was completed by DON/designee. Medical Director was notified on September 3, 2024. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In order to monitor current residents for potential risk, DON, and CCS will monitor residents for change of condition and physician/np notification beginning September 3, 2024, for 30 days on all residents via Triage Log. The purpose of this log is to monitor residents with acute changes in condition and to ensure timely notification of Physician/NP. DON compliance will be monitored weekly by CCS for 90 days. Thereafter, QA will monitor quarterly up to a year for compliance of physician notification. The facility QA Committee will meet weekly for the next eight weeks to review compliance with the plan of action. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. On 09/04/24 the investigator began monitoring if the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of an in-service conducted by the CCS dated 09/03/24 with the NFA and DON. Objectives of the in-service included the Change of Condition, Comprehensive Assessments and Notifications to the physician and RP. The CCS reviewed related policies and the NFA and DON completed pre-/post-tests with a passing score. Record review of a 24-hour report audit conducted by the CCS dated 09/03/24 at 10:59 PM revealed the CCS attest that she audited the last 30 days of 24 hour reports for resident changes in condition and to ensure the Physician/NP had been notified in a timely manner. During an interview and record review on 07/01/24 at 2:49 PM, the DON indicated that she conducted surveillance rounds to visualize each resident's (six residents) urinary catheter site for s/s of infection and patency. The DON indicated that she performed a chart audit on each of the six residents with a urinary catheter to assure appropriate monitoring and treatment orders were in place. Record review of order summaries for the six residents revealed treatment orders were entered and TAR reflected orders were performed. Interviews conducted with nurses and CNAs scheduled on the 6A - 2P shift [RN D, LVN J, CNA I and CNA K], on the 2P - 10P shift [LVN H, CNA G, LVN L, CNA N, LVN Q and RN C (recently transitioned from 10P - 6A shift)], and 10P - 6A shift [LVN O, LVN M and CNA P] indicated they participated in various in-service trainings. The staff stated topics of discussion included how to recognize a resident's change in condition, physician notification, documentation, and following up on lab results. Each nurse stated in their own words the procedure to notify physicians immediately about resident change in condition and lab results. Each nurse demonstrated how to perform an abdominal assessment and verbalized abnormal findings. CNAs stated in their own words' signs and symptoms of constipation, what must be reported to the charge nurse, and where to document a resident's bowel movement in the chart. Record review of in-services conducted by the DON dated 09/03/24 titled Change in Condition [with all nursing staff], POC Documentation [with CNAs], Bowel Assessment [with Nurses], Lab Services [with Nurses and Nursing Administration] and Physician Notification [with Nurses and Nursing Administration] were on-going to achieve 100% nursing dept participation. On 09/03/24, an Immediate Jeopardy was identified. The IJ template was provided to the facility on [DATE] at 5:45 PM. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45054 Based on interview and record review, the facility failed to promptly notify the physician of laboratory results in accordance with facility policy and procedures for notification for one (Resident #1) of four residents reviewed for laboratory services. The facility failed to notify the provider about Resident #1's STAT lab results received on 08/26/24 at 3:21 PM. On 08/27/24, Resident #1 was admitted to the hospital for altered mental status (AMS). Resident #1 was admitted , diagnosed , and treated for severe sepsis, chronic constipation, and fecal impaction. On 09/03/24, an Immediate Jeopardy was identified. The IJ template was provided to the facility on [DATE] at 5:45 PM. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems. These deficient practices placed residents at high risk of, or the likelihood of, serious injury or harm by not receiving treatment, developing complications, and the development of sepsis. Findings included: Record review of Resident #1's Admission MDS assessment dated , 07/11/24, revealed a 78-years-old male, who admitted to the facility on [DATE] with medically complex conditions including, Paraplegia (paralysis of the legs and lower body), Osteomyelitis (a bone infection that can occur when bacteria or fungi spread to the bone), and Polyneuropathy (malfunction of many peripheral nerves throughout the body). The admission MDS assessment revealed a BIMS score of 13 which suggested Resident #1 was cognitively intact. Resident #1 was always incontinent of bowel and bladder. The Admission MDS assessment reflected Resident #1 did not have constipation. Record review of Resident #1's Order Summary Report, dated 08/31/24, reflected: Order date 07/04/24: Duloxetine HCl (An antidepressant medication used to treat neuropathy [nerve pain]. Constipation is a common side effect) Oral Capsule Delayed Release Particles 60 mg. Give 1 capsule by mouth one time a day for chronic muscle or bone pain. Order date 07/04/24: MiraLax (medication used to treat occasional constipation) Oral Powder 17 gm/scoop. Give 1 scoop by mouth every 24 hours as needed for laxative. Order date 07/23/24: Tramadol HCl (medication used to treat moderate to severe pain cause the digestive system to slow down its normal function that can make it hard for stool to pass, leading to constipation) Oral Tablet 50 mg. Give 1 tablet by mouth every 8 hours for pain. Record review of Resident #1's comprehensive care plan initiated on 07/12/24 indicated: (continued on next page)

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Green Valley Healthcare and Rehabilitation Center	6850 Rufe Snow Dr Fort Worth, TX 76148

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[Resident #1] at risk for side effects of anti-depressant medication. (Initiated 07/12/24). Interventions included monitor for side effects of anti-depressants: . constipation. (Initiated 07/12/24). The goal reflected [Resident #1] will not have any side effects of anti-depressants through the review period. (Initiated: 07/12/24; Revision: 07/24/24; Target: 10/22/24). [Resident #1] at risk related to alteration in bowel elimination constipation. (Initiated 07/12/24). Interventions included evaluate bowel sounds as indicated and report significant abnormalities to provider. (Initiated 07/12/24). The goal reflected [Resident #1] will have decreased episodes of constipation through next review period. (Initiated: 07/12/24; Revision: 07/24/24; Target: 10/22/24). [Resident #1] is on pain medication therapy Tramadol . (Initiated 07/12/24). Interventions included monitor/document/report PRN adverse reactions to analgesic therapy: altered mental status . constipation . nausea, vomiting . (Initiated 07/12/24). The goal reflected [Resident #1] will be free of any discomfort or adverse side effects from pain medication through next review period. (Initiated: 07/12/24; Revision: 07/24/24; Target: 10/22/24). [Resident #1] at risk for hospitalization r/t sepsis. (Initiated 07/12/24). Interventions included administer medications as ordered, observe for changes in level of consciousness, mental status, or orientation and report significant changes to provider as indicated . Record review of Resident #1's August 2024 MAR reflected Duloxetine 60 mg Delayed Release Particles capsule was administered daily as ordered on 08/01/24 - 08/27/2024. Tramadol 50 mg, 1 tablet, was administered daily, three times a day, every 8 hours as ordered on 08/01/24 - 08/27/2024 at 6:00 AM. The August 2024 MAR did not reflect MiraLax was ever administered PRN as ordered for constipation. Record review of a 30-day look back at Resident #1's August 2024 ADL documentation/flow sheets for Bowel Movement reflected: On 08/05/24: 11:27 PM Incontinent, Formed/Normal, Small, Barrier cream applied. 08/06/24: 1:41 PM No Bowel Movement 8:30 PM No Bowel Movement 08/07/24: 12:41 AM Incontinent, Formed/Normal, Small, Barrier cream applied. 9:59 PM No Bowel Movement 11:09 PM Continent, Loose/Diarrhea, Small, Barrier cream applied. 08/08/24: (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1:59 PM No Bowel Movement Record review of Resident #1's August 2024 progress notes did not reflect PRN medication administered for constipation and its effectiveness, interventions provided for constipation relief, or that the provider and RP were notified. Record review of Resident #1's STAT lab results, dated 08/26/24, revealed in part the following: Collected date: 08/26/24 at 12:30 PM Resulted date: 08/26/24 at 03:48 PM Test results: WBC-10.6 (range reference 3.6-10.2) RBC- 3.94 (range reference 4.06-5.63) Hemoglobin- 11.7 (range reference 12.5-16.3) Hematocrit- 35.7 (range reference 36.7-47.2) . Record review of Resident #1's progress notes, dated 08/26/24 at 03:36 AM by RN C, reflected the following: [Resident #1] yelling and screaming, stating he is not in bed and he [sic] going to fall. I need a forklift right now. I am tired of that man being [sic] my room, he is right there behind my bed. [Resident #1] is diaphoretic (sweating heavily), noted ring [sic] tinged urine in Foley. He is afebrile (without fever) at this time 98.9, resp 18, heart rate 102, blood glucose 126mg/dl. SPO2 97% on room air. Spent at bedside to console and reorient [Resident #1]. Care and monitoring ongoing. Record review of Resident #1's progress notes, dated 08/26/24 at 05:01 AM by RN C, reflected the following: [Resident #1] cont to shout out for help. Help me get this forklift. Also rambling speech unable to make sense of. Gave sponge bath and noted noted [sic] sacral wound foul smelling, ordered and sent UA specimen to lab. Cont to console and reassure [Resident #1] Record review of Resident #1's progress notes, dated 08/27/24 at 10:00 AM by RN D, reflected the following: [Resident #1] hallucinating. HR 105, BP WNL, [Resident #1] c/o of nausea and dry heaving. Wound has foul smell. STAT CBC, CMP and UA sent to NP, Received order for NS @ 75 ml/hr and IM rocephin. [Resident #1] is preparing for discharge today. Discussed worsening condition with [DON] and [social services] and [NP]. [DON] and [social services] discussed with [Resident #1] and [RP]. [RP] has requested him to be sent to [local hospital] for further evaluation. [Transport service] gave ETA 1030 (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's hospital medical records dated 08/29/24 reflected [Resident #1] arrived at the ED on 08/27/24 at 11:56 AM. The reason for visit reflected Altered Mental Status (AMS) . hallucinations over the past 48-72 hours. The visit diagnoses included Severe Sepsis and Chronic constipation. The ED provider notes indicated Resident #1 appeared in acute distress, was ill-appearing, symptoms were moderately severe, and Resident #1 reported vomiting. Record review of Resident #1's CT scan of Abdomen and Pelvis with Contrast final result, dated 08/27/24 at 2:24 PM, revealed an extremely large rectal stool ball with very large obstructing colonic stool burden. Findings are concerning for impaction. In an interview on 08/29/24 at 12:57 PM, the DON stated Resident #1 admitted to the facility with infected wounds and had to be placed on IV abx and isolation immediately. The DON stated Resident #1 had only been admitted to the nursing facility for almost 2 months before receiving a notice of Medicare non-coverage and was due to discharge home with significant other. The DON stated Resident #1 was discharged to the local hospital on 08/27/24 instead due to AMS and smells coming from his wounds, and she did not feel it would be a safe discharge for him to go home. The DON stated it was first reported to her by RN C on 08/26/24 that Resident #1 had an AMS. The DON stated the MD was also notified by RN C and STAT orders for lab work was initiated. The DON stated Resident #1 was not ordered to be sent out to the hospital on 08/26/24. During an interview on 08/31/24 at 2:25 PM, CNA E stated that she provided direct care to Resident #1. CNA E said that she worked with Resident #1 last Saturday (08/24/24) and he was confused and talking to himself. CNA E said that Resident #1 refused breakfast because he wanted to wait for his [RP] to come feed him. CNA E said that Resident #1 took a couple bites of the food and finished his drink. CNA E said that it was her responsibility to document whenever a resident had a bowel movement. CNA E said that she could not remember if Resident #1 had a bowel movement that day or explain why it was not reflected in her documentation. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/02/24 at 2:32 PM, RN C indicated that she worked 08/25/24 and 08/26/24, 10P - 6A shift and was the primary nurse for Resident #1. RN C said during the 08/25/24 10P - 6A shift, Resident #1 yelled and screamed. RN C said that [Resident #1] had blood-tinged urine in his indwelling catheter, did not have a temperature, heart rate was over 100 beats per minute, but was consoled and reoriented. RN C said Resident #1 continued to shout towards the end of her shift. RN C said that she gave Resident #1 a sponge bath and thought she smelled a foul smell from the wound vac (to Resident #1 sacrum). RN C then said that she noticed a stool blob at [Resident #1] anus when she wiped, like [Resident #1] did not have a complete bowel movement and some stool was still trapped. RN C said that when she called the doctor to get an order for an UA (08/26/24 at 5:00 AM), she did not mention the incomplete bowel movement because she did not think it was an issue. RN C said that Resident #1 vomited a brown emesis (can be caused by internal bleeding in the stomach, severe constipation, or inflammation of the stomach lining) overnight on the 08/26/24, 10P - 6A shift. RN C said that she did not report Resident #1 threw up because it looked like a cupcake and she [RN R] did not believe it was a gastric bleed. RN C said that she did not know the last time Resident #1 had a bowel movement but remembered the CNA (unknown name and unable to describe) told her [RN R] that Resident #1 had a bowel movement during a shift but could not remember because the days blended. RN C said that the doctor also ordered STAT labs with the UA order. RN C said that the facility would get the STAT lab results on the same day or early the next day based on the time of day the lab was collected. RN C said that the lab results were available on 08/26/24 during the 2P - 10P shift. RN C said that the lab results could inform the doctor if the resident had an infection, diagnose diseases, or identify other issues, like a gastric bleed. RN C said she did not review the lab results or check if the doctor was notified when Resident #1 threw up brown emesis or if his confusion was related to an infection. During an interview on 09/02/24 at 2:47 PM, the ADON stated she was familiar with Resident #1. The ADON stated she was not informed of Resident #1 did not have a bowel movement or unrelieved constipation. The ADON said the CNAs should notify the charge nurse when or if a resident did not have a bowel movement during the shift. The ADON said she expected nurses to perform an abdominal assessment (listen to bowel sounds, feel the abdomen for tenderness or if firm), assess for signs of constipation, implement care plan interventions, notify clinical department heads (ADON/DON) of resident change in condition, notify the provider, and the RP. The ADON said that the risk if constipation was not treated could be hemorrhoids or a serious complication such as fecal impaction if hard stool backed up into the colon. During an interview on 09/02/24 at 3:22 PM, the DON said that she had in-serviced staff last month that anything that was different and out of the ordinary for a resident was a change in condition. The DON said that she expected nurses to monitor the resident's bowel movements for change in frequency and consistency. The DON said that the nurse should perform an initial assessment if a resident did not have a bowel movement for 2 - 3 days, decreased appetite, nausea, vomiting, and/or pain. The DON said an initial assessment for constipation would include an abdominal assessment that included visual inspection for the shape, abdominal distention, feel for firmness, localized tenderness, and listen with a stethoscope for slowed or absent bowel sounds that could suggest constipation. The DON said that the nurse should check the administration record for PRN medications/treatments, implement nurse interventions per the care plan, notify the provider with their assessment findings, the resident response to interventions, and notify the family. The DON said that Task(s) and nurse progress notes would be review every morning for documentation of bowel movements frequencies and interventions as needed. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 09/03/24 at 12:15 PM, the MD said that she gave orders to collect STAT blood labs on Monday morning (08/26/24) when she was notified that Resident #1 was hallucinating. The MD did not recall being told that Resident #1's wound had a foul smell, that he vomited, or that he was constipated related to not having or an incomplete bowel movement. The MD said that constipation could lead to several complications that included acute confusion, nausea, poor appetite, rapid heart rate, and fecal impaction. The MD said that she expected to be notified as soon as possible about any change in condition. The MD said she was not notified when the STAT lab results were received. The MD said that the NP was called first and coordinated Resident #1's care with the facility staff. Record review of the facility's Bowel (Lower Gastrointestinal [GI] Tract) Disorders - Clinical Protocol, revised September 2017, reflected assessment and recognition, cause identification, treatment, management, monitoring and follow-up of bowel dysfunction. The nurse shall assess and document/report alteration in bowel movements; quantitative and qualitative description of bowel movements; presence of fecal impaction; abdominal assessment; onset, duration, frequency, and severity of signs and symptoms. Record review of the facility's Change of Condition and Physician/Family Notification policy, reviewed 05/17/24, reflected the purpose to ensure resident's family and physician are notified of changes that fall under: - an accident resulting in injury that has the potential for needed physician interventions - a significant change (example given: Abnormal lab results) - a need to significantly alter treatment - transfer of the resident from the facility A review of the Lab and Diagnostic Test Results - Clinical Protocol reviewed December 2022, indicated: - The physician will identify and order diagnostic and lab testing; staff will process test requisition and arrange for test; the laboratory, diagnostic provider will report results to facility - A nurse will review all results and report the finds to the physician/designee - A physician can be notified by phone, fax, voicemail, e-mail, mail, pager, or a telephone message to another person acting as the physician's agent (for example, office staff) - A physician will respond within an appropriate time frame, based on the request from the nursing staff and the clinical significance of the information. This response maybe by calling the facility or writing new orders. The NFA was notified of an Immediate Jeopardy (IJ) on 09/03/24 at 5:45 PM, due to the above failures and the IJ template was provided. The facility's Plan of Removal (POR) was accepted on 09/04/24 at 1:00 PM and included: (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a 24-hour report audit conducted by the CCS dated 09/03/24 at 10:59 PM revealed the CCS attest that she audited the last 30 days of 24 hour reports for resident changes in condition and to ensure the Physician/NP had been notified in a timely manner. During an interview and record review on 07/01/24 at 2:49 PM, the DON indicated that she conducted surveillance rounds to visualize each resident's (six residents) urinary catheter site for s/s of infection and patency. The DON indicated that she performed a chart audit on each of the six residents with a urinary catheter to assure appropriate monitoring and treatment orders were in place. Record review of order summaries for the six residents revealed treatment orders were entered and nTAR reflected orders were performed. Interviews conducted with nurses and CNAs scheduled on the 6A - 2P shift [RN D, LVN J, CNA I and CNA K], on the 2P - 10P shift [LVN H, CNA G, LVN L, CNA N, LVN Q and RN C (recently transitioned from 10P - 6A shift)], and 10P - 6A shift [LVN O, LVN M and CNA P] indicated they participated in various in-service trainings. The staff stated topics of discussion included how to recognize a resident's change in condition, physician notification, documentation, and following up on lab results. Each nurse stated in their own words the procedure to notify physicians immediately about resident change in condition and lab results. Each nurse demonstrated how to perform an abdominal assessment and verbalized abnormal findings. CNAs stated in their own words' signs and symptoms of constipation, what must be reported to the charge nurse, and where to document a resident's bowel movement in the chart. Record review of in-services conducted by the DON dated 09/03/24 titled Change in Condition [with all nursing staff], POC Documentation [with CNAs], Bowel Assessment [with Nurses], Lab Services [with Nurses and Nursing Administration] and Physician Notification [with Nurses and Nursing Administration] were on-going to achieve 100% nursing dept participation. On 09/03/24, an Immediate Jeopardy was identified. The IJ template was provided to the facility on [DATE] at 5:45 PM. While the IJ was removed on 09/04/24, the facility remained out of compliance at a scope of isolated and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems.