STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676384	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Sugar Land	1803 Wescott Avenue Sugar Land, TX 77479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, interview, and record review the facility failed to ensure personnel provided basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel for 1 to 7 residents (CR#1) reviewed for CPR. -RT A and LVN A failed to initiate life-saving measures (CPR) when CR#1 who had a full code (meaning all resuscitation procedures provided if their heart stops beating or stop breathing) immediately when she was found unresponsive and died . -The facility failed to ensure that CR #1 received Cardio-pulmonary resuscitation (CPR) in accordance with professional standards of practice. -The facility failed to immediately initiate CPR when CR#1 was found unresponsive at or about 5:25 a.m. EMS was called at 5:37 a.m. A delay of 12 minutes initiating CPR. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:42 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy. These failures placed residents at risk of experiencing worsening of condition, pain and death from possible delays in the initiation of an emergency response and improper implementation of CPR. Findings Included: Record review of facility census dated [DATE] revealed there were 24 residents. Record review of the facility's CMS form 672 revealed there were 7 residents that had a tracheostomy and ventilator out of 24 residents. (continued on next page)

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

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

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's face sheet dated [DATE] revealed she was an [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia (a condition where the body has low levels of oxygen in the blood), Type 2 Diabetes Mellitus without complications (a condition in which the body has trouble controlling blood sugar), anoxic brain damage(condition caused by a lack of oxygen which could lead to brain death), pulmonary hypertension A type of high blood pressure that affects arteries in the lungs and in the heart), dependence on ventilator, tracheostomy. CR#1 was designated as full code. Record review of CR#1's MDS dated [DATE] revealed Section B0100- Comatose (Persistent vegetative state/no discernible consciousness was documented as 1-(Yes). Section C500- BIMS summary score was left blank. GG0115- Functional Limitations was coded 2 (which meant impairment on both sides) for both upper and lower extremities which included: shoulder, elbow, wrist, hand and hip knee, ankle and foot. Section GG0120- Mobility devices were coded Z. (none of the above), which meant she did not use a cane, walker, wheelchair, limb prosthesis in the last 7 days. Section GG0130 revealed A. Eating was coded as 88 (not attempted due to medical condition or safety concern) and eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing were coded as 01 (which meant CR#1 was dependent- helper does all of the effort. Section GG0170- Mobility revealed A. Roll left and right was coded as 01- which meant CR#1 was dependent- helper does all of the effort. B. Sit to lying, C. Lying to sitting on side of the bed; D. Sit to stand; E. Chair/bed-to-chair transfer and walk 10 feet were all coded as 88, which meant not attempted due to medical or safety concern. Section H0300- Urinary Incontinence and Bowel incontinence were both coded as 3. Which meant she was always incontinent. Section O. Special treatment, Procedures, and programs performed revealed respiratory treatment (C1) oxygen therapy; (D1) Suctioning and (E1) Tracheostomy care were all coded as B. While a resident. Record review of CR#1's care plan dated [DATE] and revised/cancelled on [DATE] revealed the following care areas: CR#1 required supplemental oxygen for respiratory status hypoxemia, respiratory illness. Goal: Resident will tolerate use of oxygen and oxygen saturations will remain within normal ranges through the next review and interventions were: Monitor for complications r/t oxygen use (ears, nose, dry mucous membranes) follow up with MD and preventative measures. CR#1 had potential for impaired gas exchange, CHF, shortness of breath, tracheostomy status, vent dependent. Goal: CR#1's respiratory function will WNL as evidence by: normal rate, rhythm and depth of respirations, no dyspnea and oxygen states WNL. Interventions: Monitor for signs and symptoms of shallow rapid respirations, diminished or absent breath sounds, hypoxia, elevate head of bed. All interventions were to be done by LVN or RN and assess and report signs and symptoms of impaired respiratory functions were assigned to nursing department. CR#1 had an advanced directive evidence by: Full Code. Goals included: CR#1's wishes would be honored. Interventions: CPR will be performed as ordered, follow facility protocol for identification of code status and keep family informed of change in condition. Record review of CR#1's nursing progress notes for [DATE] revealed the following: Effective date: [DATE] at 6:48 a.m. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Note Text: Author: LVN A - Writer assessed and monitor resident q 2 hour and prn , no distress noted, writer checked on about 0500, feeding is running well, around 05:15, two assigned staff changed resident on the last round, pt was ok per staff members. Around 0530, RT went to the room and came back and called this writer to resident's room, Writer asked to call 911 because resident was in distress. EMS team called by this writer at 0537 am. Writer was able to palpate residents' pulse and CPR was started, AED was used and 911 arrived at 0540 and took over. Resident was pronounced at 06:14am. Effective Date: [DATE] at 7:30 a.m. Note Text: Author: LVN A -Writer called emergency contact FM and notified her that resident in distress, CPR was initiated, and EMS was called, and resident was pronounced death. Will notify MD. Record review of EMS incident report for CR#1 revealed they were called to the facility on [DATE] at 5:37 a. m. for CR#1 in cardiac arrest and arrived at the facility at 5:47 a.m. CR#1 was observed to be lying in a bed unresponsive and severely swollen. Patient was pulseless and apneic. Nursing staff was forcibly bagging the patient and no compressions were being performed at this time. The nurse was adamant that the patient had a pulse and that the bagging was difficult but effective. Patient pulses were checked and absent. CPR was started at this time. Manual compressions were continued throughout the CPR. Patient's trach tube was confirmed to not be in a correct position (or false pathway) and was not oxygenating the patient. Patient facial anatomy due to swelling was too distorted to control her airway by any other means. CR#1 had severe subcutaneous emphysema and skin was cold. CR#1 had swelling to the face, neck, chest and her whole arms (both left and right). Trach tube was removed and a [NAME] bag was used to locate her tracheotomy. An ET tube was placed, and CPR continued. The nurse stated that CR#1 was alert just 8 minutes before the 911 call. EPI was administered per guidelines. Patient was moved to the floor to facilitate higher quality CPR. CPR was continued per department guidelines. It was noted that CR#1 was in asystole and remained in asystole for the duration of the call. EMS called medical doctor C via phone for an order to terminate CPR efforts after 20 minutes. Medical doctor C agreed, and ultrasound was utilized to confirm no heart wall movement but due to emphysema there was no view of the heart. CPR was discontinued. The scene was turned over to local police department. An in-field pronouncement was done. CR#1 was determined expired at 6:13 a.m. Record review of handwritten statement submitted to the Administrator by LVN A on [DATE], she wrote Respiratory Therapist A called her to CR#1's room around 5:25 a.m. CR#1 was unresponsive with palpable pulse. LVN A activated 911 call at 5:37 a.m. and EMS arrived at 5:40 a.m. CR#1 was pronounced deceased at 6:14 a.m. Record review of CR#1's ADL record dated [DATE] revealed CNAs were responsible for incontinent care. The record shows that CR#1 had her brief changed: [DATE]- 00:57 (12:57am) 17:59 (5:59pm) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	23:57 (11:57pm). There was no documentation that CNAs entered CR#1's room for incontinent care since before midnight. CR#1's incident occurred on [DATE] at or about 5:25 a.m. An interview with the DON on [DATE] at 10:29 a.m., she said she had been employed at the facility since [DATE]st, 2024. She stated LVN A called her on ([DATE]) and said RT yelled for her to come to CR#1's room after finding her unresponsive. She said CR#1 was in respiratory distress when RT A discovered the circuit had become dislodged. She said CR#1 was a full code so both LVN A and RT A knew to immediate start CPR. CR#1 was on a mechanical ventilator and G-tube. She said she was admitted with chronic conditions. She said CR#1 was diabetic and had hypertension and heart condition. Investigator asked what could have caused her respiratory distress, she said she was told by LVN A that the circuit was dislodged and, on the floor, but CR#1 had co-morbidities that could have caused her distress. She said LVN A said when she was solicited to the room, the resident had agonal breathing and she was not sure why RT A was trying to get supplies to intubate the resident. She said LVN A told her she could not intubate in a SNF. When asked how the staff knew CR#1 was full code she said staff are aware of how to find whether patients are full code or DNR. She said it was in PCC under CR#1's profile and it is also on the crash cart. CR#1 was pronounced deceased at the facility by EMS. In a telephone interview on [DATE] at 12:46pm, FM #1 states she was called early in the morning around 7:15am on [DATE]. She said she was told staff discovered CR#1 was not breathing and that they could not revive her. She said the DON stated CR#1 was not breathing and went into cardiac arrest. She said she immediately called FM#2 as she was the RP. She said when she arrived EMS and the police were there. She said the facility did not call them immediately when she was in distress, and she wish they would have called her and FM#2 after calling EMS. She said CR#1 was not capable of turning her head. She was comatose. She said staff had to do everything for her. She said this was heartbreaking. In a telephone interview with FM #2 on [DATE] at 1:01p.m. she stated she had a missed call from the facility at 7:14am, due to her phone being on silent. She said FM#1 notified her on the morning of CR#1's death. She said CR#1 had only been at the facility since [DATE]. She said she came from a local L-TAC. She said she arrived at the facility by 8am and they were cleaning her and preparing her for the medical examiner she believed. She said the police had arrived. She said she was not called when CR#1 had a change in condition, she said staff said it was because when they found her, she was not breathing. She was in cardiac arrest. She asked if we could speak later, she was distraught. She said she just did not understand why they could not save her. The call ended. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 3:19 p.m. LVN A revealed she worked the 6p-6am shift and had been employed with the facility since [DATE]. She said she did rounds at or about 8pm on [DATE] and provided G-tube medications for CR#1. She said CR#1 did not have any medications after 8pm. She said at that time, CR#1's ventilator alarm was not beeping. She said she saw RT A go into CR#1's room and figured she was doing rounds. She said she went to assist another resident down the hall. Then, she heard Respiratory Therapist A (RT) yelling for her to come to CR#1's room to be a witness on [DATE] at or about 5:25am. She said RT A did not immediately disclose what she wanted her to witness. She said RT A began to gather trachea supplies but said she did not have another circuit. RT A left out of the room, and this is when she noticed the circuit on the floor near where she was standing. The circuit was not connected to the ventilator. She said RT A was attempting to re-insert CR#1's inner cannula but was unsuccessful. She said she took CR#1's pulse because she was having agonal breathing. She had a palpable pulse. But, no air was coming from the bag. She ran to get the crash cart and began giving her air. She said she used the AED. She said she called 911 from her cell phone at 5:37am and she and RT A began CPR. She said a backboard was placed behind her back as they provided CPR with CR#1 in bed. She said EMS arrived and took over CPR. CR#1 expired while they were performing CPR. She stated she was the only nurse on the shift, and there were two CNAs and RT A. She said there is usually only (1) nurse on the overnight shift. She said she was not responsible for suctioning CR#1. She said RT's have 12-hour shifts and are there around the clock. She said RT's are responsible for suctioning and all related trach care. She said she was CPR certified. She said she was not sure how long the ventilator was alarming. An interview with CNA A on [DATE] at 4:22 p.m., revealed he and can B changed CR#1's brief at approximately 5:00 a.m. Then, they changed her roommates' brief. He stated CR#1 was not gasping for air nor was her ventilator alarming. He said CR#1 eyes were opened. She was not in respiratory distress while they were in her room. He stated he heard yelling when he was going to put trash out and LVN A said they needed the crash cart. He stated he went to get the crash cart for her and when he came back EMS was already there. An interview with RT A on [DATE] at 12:59 p.m., stated she had been employed at the facility since [DATE]. She normally worked the 6p-6a shift. She said there is a RT in the facility 24-hours a day. She stated on the early morning of [DATE], She said at or about 4:37 a.m. she provided trach care and brushed CR#1's teeth and then did the same for her roommate. She said then she proceeded to provide trach care for a resident two doors down from CR#1's room. She said she thought she heard a vent alarming when she turned the suctioning machine off. She said she heard the vent alarm coming from CR#1's room. She said she did not see the nurse at the nursing station and finished the care for the resident. She said about 3 minutes she finished and went to CR#1's room which was at the time in approximately 3 minutes. Then, she entered CR#1's room at approximately 5:20 a.m. She added that before she returned to the CR#1 room for the alarming vent she saw the CNAs coming from the room after she left CR#1's room. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She said she discovered the vent circuit was on the floor but still attached. She said she noticed CR#1's trach was out, so she pushed it back in and it was still attached to the trach tie. She said she took off the vent and started bagging her to give her deeper breaths because she was having agonal breathing. She said she called in LVN A to come to witness because the resident had an extra airway on the wall. She said she tried to inflate air into her cuff and continue to bag her but it still was not inflating. She tried to inflate again but the cuff would not stay. She said she knew the cuff was blown. She said they took the one off the wall, put it in her, inflated it and begin the bag her again. Her rate was 12 she kept it there while she was bagging her the rate on the machine was 16. She said she knew CR#1 was going into cardiac arrest when she found her. She said she told LVN A to call 911 because she did not have an inner trachea tube and was told she was not allowed to intubate in a SNF. So, there was nothing she could do but put the lateral trach in her that was a size 4. She said that is what she did. She said what they were doing was not helping with the AED, so they started CPR because her pulse was low. LVN A checked pulse while she was bagging. CNA A got the crash cart while LVN A was doing chest compressions. She said the cardiac board was placed behind her back as she was still in the bed. LVN A called 911. She called from her cell phone and kept on speaker while listening to 911 operator. EMS arrived quickly. She was unsure about the time they arrived. She said they took the trach out and they intubated her. Fire department told her she could not she could not intubate at a nursing home. In an interview with the Administrator on [DATE] at 5:22 p.m., she said she had been employed at the facility almost 2 weeks. She said she called in the incident because it was an unusual death. When asked why it was considered an unusual death, she said because the circuit was found on the floor, her trach became dislodged, and [NAME] seemed to know what happened. She said she believed while the CNAs were repositioning and changing CR#1's brief her trach might have come dislodged. She said CNA B clocked out at 5:16 a.m. and CNA A was still there when the incident occurred. She said she spoke to both CNAs, and they stated the ventilator was not alarming after they changed her. She said all nurses were CPR certified. She said at the time, there was 1 nurse, two CNAs and the RT in the building. She said she would be adding another nurse to work the night shift. She said from her understanding, CR#1 was found unresponsive, and RT A took some time to try to get the trach in and they started CPR when she was unable to get the trach back inserted. EMS arrived quickly and took over CPR. She was pronounced deceased at the facility. She said the MD and family had been notified. In an interview on [DATE] at 6:06 p.m., CNA B stated she had been employed at the facility about 1 year. She stated her normal shift is 6p-6a. She said she and CNA B went into CR#1's room right at about 5:00 a.m. , her brief was changed no bed bath. Then, she was repositioned she was left on her right side. Went to her roommate and changed her brief. She said the vent alarm was not beeping. She said if it would have started alarming, they have to call the RT or the nurse on duty. Resident eyes were opened. She said the circuit was still attached. She said she did not see RT A go into the room because after they changed CR#1 and her roommate she left. She said CNA A was still there until 6am. She said CR#1's tubing was on the pillow and was not detached. She said the vent machine would alarm if the circuit was dislodged. She said CNAs are responsible for taking vitals when they first start the shift. No vitals the taken when they were in her room changing her. She said CR#1's breathing was normal nothing different. She said CR#1 could not move her head. She is stiff when they turn her everything turned with her. She said someone must lift her head if it needed to be moved. Record review of LVN A's certification card revealed she had taken CPR on ,d+[DATE] and was valid until , d+[DATE]. It was an e-card that she printed from a website. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of RT A's CPR certification card revealed it was not legible. The date and where it was taken was hazy. No other copy was available. In a subsequent interview with RT A on [DATE] at 6:35pm, she said LVN A was not conducting CPR correctly. She said she had to correct her because she had her fist bald up and her other hand on top. She should have had hand over hand, laced and heel of the hand in the center of the chest when doing compressions. She said she was concerned about LVN A and other nurses being able to conduct CPR effectively. In addition, she said there was no way she could have left the resident in the other room because she was suctioning her when she heard the alarm. She said a nurse should be available at the nursing station or the facility should have some other means for being able to call staff for help in an emergency. She said the facility staff did not use any radios nor intercom. She said tracheostomy supplies were kept in bins in the RT office. She said she did not have a circuit and that is why she went to the office. All supplies should have been kept in the residents' room. She said also staff do not respond to the vent alarms timely. She added CR#1 was getting air underneath her skin from the ventilator every time she bagged her, causing her to swell. She said CR#1 was really trying to breath on her own obviously with a size 4 trach. She said she voiced these concerns with the RT Director. Record review of cardio-pulmonary resuscitation policy dated ,d+[DATE] revealed: Personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. General Guidelines: 1. Sudden cardiac arrest is a loss of heart function due to abnormal heart rhythms (arrhythmias). Cardiac arrest occurs soon after symptoms appear. 5. Early delivery of a shock with a defibrillator plus CPR within ,d+[DATE] minutes of collapse csn further increase chances of survival. 6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally a licensed staff member who is certified in CPR/BLS shall initiate CPR. Preparation for cardio-pulmonary resuscitation: Obtain and maintain American Red Cross or American heart Association certification in Basic Life Support (BLS)/Cardiopulmonary (CPR) for key clinical staff members who will direct resuscitative efforts including non-licensed personnel. 3. Provide mock codes (simulations of an actual cardiac arrest) for training purposes. 4. Select and identify a CPR team for each shift in the case of an actual cardia arrest. Record review of in-services provided on [DATE]: [DATE]- Resident transfer and oral care [DATE]- Elopement [DATE]- Abuse and neglect (staff signed ,d+[DATE]-,d+[DATE]) (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]-ongoing Enhanced Barrier Precaution [DATE]-ongoing-Turning/Providing Care for vent residents (no sign in sheet was provided) An IJ was identified on [DATE] at 5:42 p.m. The IJ template was provided to the DON and later to the Administrator via email at 5:42 p.m. Record review of the facility's emergency Procedure- Cardiopulmonary Resuscitation stated in part: . personnel have completed training on the initiation of cardio-pulmonary (CPR) and basic life support (BLS), including defibrillation, for victims of sudden cardiac arrest. General Guidelines: 1. 5. Early delivery of a shock with defibrillator plus CPR within ,d+[DATE] minutes of collapse can further increase chances of survival. 6. If an individual (resident, visitor, or staff member) is found unresponsive and not breathing normally a licensed staff member who is certified in CPR/BLS shall initiate CPR Preparation for cardio-pulmonary resuscitation: 1. Obtain and maintain American Red Cross or American heart Association certification in Basic Life Support (BLS)/Cardiopulmonary (CPR) for key clinical staff members who will direct resuscitative efforts including non-licensed personnel. 3. Provide mock codes (simulations of an actual cardiac arrest) for training purposes. 4. Select and identify a CPR team for each shift in the case of an actual cardia arrest. Record review of DON job description: Summary: The primary purpose of the position is to ensure the highest quality of resident care available, support staff and establish a positive reputation in the community while delivering on the company values of wellness, compassion, customer experience. DON will plan, organize, develop, and direct the overall operation of the nursing services department. Record review of an article on Web MD website, titled What to know about agonal breathing that was medically reviewed by [NAME] MD on [DATE]. The article stated agonal breathing is when someone who is not getting enough oxygen is gasping for air. It is usually due to cardiac arrest or stroke. It is not true breathing. It is a natural reflex that happens when your brain is not getting the oxygen it needs to survive. Agonal breathing is a sign that a person is near death. People who have agonal breathing and are given cardiopulmonary resuscitation (CPR) are more likely to survive cardiac arrest than people without agonal breathing. The following Plan of Removal submitted by the facility was accepted on [DATE] at 11:57 a.m. The Immediate Jeopardy findings were identified in the following areas: F678 Cardio-Pulmonary Resuscitation: (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure that a resident received Cardio-Pulmonary Resuscitation (CPR) in accordance with professional standards of practice. The facility failed to immediately initiate CPR at or about 5:20am when CR #1 was found unresponsive. Immediate action: The facility identified residents who require Cardio-Pulmonary Resuscitation [DATE]. Facility did an audit of residents with an active Do Not Resuscitate order on [DATE]. Facility ensured a book to identify residents who are a Do Not Resuscitate was accurate and up to date [DATE]. DON/Designee will update book with new admission or change in code status as indicated. On [DATE], Administrator/DON in-serviced staff on how to locate the code status of residents in the event of an emergency code situation. Nursing Staff were trained to call CODE Blue so they can remain with the residents. The staff that stays with the residents notifies other staff members to grab the code status book and crash cart if Resident is found to not have a DNR, then CPR certified staff will initiate CPR. Staff members that have not been in-serviced will not be allowed to work their shift until they are in-serviced. On [DATE], the facility Administrator and DON began to gather the CPR certifications of staff to ensure that every shift has a CPR team per revised policy. This was completed on [DATE]. The CPR policy was evaluated by corporate chief nursing officer and amended on [DATE], to state that the CPR team will comprise of the nurse on shift and the respiratory therapist and CNAs to assist as able. Policy amendment reviewed with Ad Hoc QAPI team on [DATE]. Facilities Plan to ensure compliance quickly: Director of Nursing/Designee completed education with all nursing and respiratory staff on [DATE]. Education included RT Director started an in-service/competency with return demonstration under CPR and Trach Care and Ventilator Functionality/Process, included S/S of respiratory distress and appropriate initiation of CPR. The RT was termed on [DATE] due to attendance issues and the LVN was reeducated by the RT Director. DON/Designee will update book with new admission or change in code status as indicated. New staff will be educated in the process of identifying the code status of residents. All new staff will be trained on these policies prior to working the floor. Ad Hoc QAPI meeting held with medical director on [DATE] at 1900 (7p.m.) to review issuance of Immediate jeopardy and Policy and procedures pertaining to Cardio-Pulmonary Resuscitation. Monitoring of the plan of removal included the following: Record review of education in-service training dated [DATE] revealed the RT Director conducted in-services for and competency check, with return demonstration to cover trach care placement, and Ventilator Functionality/Processes and signs and symptoms of distress. Record review of termination notice for RT A dated [DATE] stated she was termed due to failure to report to work as scheduled without notice. Excessive absenteeism or tardiness was unacceptable. (continued on next page)

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	676384	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Sugar Land	1803 Wescott Avenue Sugar Land, TX 77479

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Ad hoc QAPI sign-in sheet for identification of fragmented system dated [DATE] revealed the facility reviewed the facility's need for training and re-education of staff to ensure they were educated on Trach care, ventilator care and CPR. IDT, DON/MDS and Administrator initiated an action plan includes the concern, corrective actions, identification of concerns, systemic changes, monitoring and Physicians. MD participated via telephone, DON, HR, MDS, Admissions Coordinator, BOM and Administrator were in attendance. Record review of in-service of re-education conducted by the RT Director was ,d+[DATE] with LVN A on [DATE] and covered CPR and signs and symptoms of respiratory distress. Record review of audit sheet of residents that were full code and list that were DNR. Record review of amended CPR policy revealed that the CPR team would consist of a nurse on shift and respiratory therapist and CNAs to assist as able. Record review of Ad Hoc QAPI sign in sheet dated [DATE] revealed: MD participated via telephone, the Administrator, HR, DON and Business Office manager attended in person. Observation on [DATE] revealed the code sheets located on the crash cart dated [DATE] near the nursing station across the hall from the RT office. All residents were listed as either being full code or DNR. Interviews ensued on [DATE]-[DATE] with staff on both shifts (6a.m.-6 p.m.) and (6p.m. to 6a.m.) for CNAs and 6 a.m.-6 p.m. for the CNAs including the DON and Administrator, LVN B, LVN C, and LVN D all on dayshift (6 a.m.-6 p.m.), Respiratory Therapist Director, Respiratory Therapist B, Housekeeping A and Housekeeping B all from the 6 a.m.-6 p.m. shift. LVN A, Respiratory Therapist C to verify in-services and to validate their understanding of the information presented. They were able identify what was neglect and example, what are some signs and symptoms of respiratory distress, the new code for emergency (CODE BLUE) used. CNAs were able to explain they were in-serviced on calling the nurse when there is an emergency and extra caution needed when re-positioning residents. LVN's were able to explain the importance of calling a code, prompt response to emergencies/vent alarms, checking the code status either in PCC or the crash cart to ensure they were able to conduct CPR. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 3:08 p.m. The facility remained out of compliance with a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation, record review and interview, the facility failed to ensure that residents who needs respiratory care is provided such care consistent with professional standards, the comprehensive care plan, the residents goals, and preferences for 1 of 5 (CR#1) residents reviewed for respiratory and tracheostomy care in that: -The facility failed to ensure that CR#1 who needed respiratory care, including tracheotomy care circuit was attached appropriately causing it to become dislodged resulting in agonal breathing, cardiac arrest, and death. -The facility failed to have emergency tracheostomy equipment at CR#1's bedside when CR#1 trach dislodged. An Immediate Jeopardy (IJ) was identified on [DATE] at 05:42pm . The IJ template was provided to the facility on [DATE] at 5:42pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained on [DATE]. This failure had the potential to place residents with tracheostomies as well as other residents requiring respiratory care at risk of not receiving the necessary care and services needed to meet their medical goals resulting in a decline in health or harm. Findings Included: Record review of facility census dated [DATE] revealed there were 24 residents. Record review of the facility's CMS form 672 revealed there were 7 residents that had a tracheostomy out of 24 residents. Record review of CR#1's face sheet dated [DATE] revealed she was an [AGE] year-old female that was admitted to the facility on [DATE] with diagnoses of chronic respiratory failure with hypoxia (a condition where the body has low levels of oxygen in the blood), Type 2 Diabetes Mellitus without complications (a condition in which the body has trouble controlling blood sugar), anoxic brain damage(condition caused by a lack of oxygen which could lead to brain death), pulmonary hypertension A type of high blood pressure that affects arteries in the lungs and in the heart), dependence on ventilator, tracheostomy. CR#1 was designated as full code. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of CR#1's MDS dated [DATE] revealed Section B0100- Comatose (Persistent vegetative state/no discernible consciousness was documented as 1-(Yes). Section C500- BIMS summary score was left blank. GG0115- Functional Limitations was coded 2 (which meant impairment on both sides) for both upper and lower extremities which included: shoulder, elbow, wrist, hand and hip knee, ankle and foot. Section GG0120- Mobility devices were coded Z. (none of the above), which meant she did not use a cane, walker, wheelchair, limb prosthesis in the last 7 days. Mobility revealed A. Roll left and right was coded as 01- which meant CR#1 was dependent- helper does all of the effort. B. Sit to lying, C. Lying to sitting on side of the bed; D. Sit to stand; E. Chair/bed-to-chair transfer and walk 10 feet were all coded as 88, which meant not attempted due to medical or safety concern. Section H0300- Urinary Incontinence and Bowel incontinence were both coded as 3. Which meant she was always incontinent. Section O. Special treatment, Procedures, and programs performed revealed respiratory treatment (C1) oxygen therapy; (D1) Suctioning and (E1) Tracheostomy care was all coded as B. While a resident. Record review of CR#1's care plan dated [DATE] and revised/cancelled on [DATE] revealed the following care areas: CR#1 required supplemental oxygen for respiratory status hypoxemia, respiratory illness. Goal: Resident will tolerate use of oxygen and oxygen saturations will remain within normal ranges through the next review. Interventions was: Monitor for complications r/t oxygen use (ears, nose, dry mucous membranes) follow up with MD and preventative measures. CR#1 had potential for impaired gas exchange, CHF, shortness of breath, tracheostomy status, vent dependent. Goal: CR#1's respiratory function will WNL as evidence by: normal rate, rhythm and depth of respirations, no dyspnea and oxygen states WNL. Interventions: Monitor for signs and symptoms of shallow rapid respirations, diminished or absent breath sounds, hypoxia, elevate head of bed. All interventions were to be done by LVN or RN and assess and report signs and symptoms of impaired respiratory functions were assigned to nursing department. Record review of CR#1's nursing progress notes for [DATE] revealed the following: Effective date: [DATE] at 6:48 a.m. Note Text: Author: LVN A - Writer assessed and monitor resident q2 hour and prn, no distress noted, writer checked on about 0500, feeding is running good, around 05:15, two assigned staff changed resident on the last round, pt was ok per staff members. Around 0530, RT went to the room and came back and called this writer to resident's room, Writer asked to call 911 because resident was in distress. EMS team called by this writer at 0537 am. Writer was able to palpate residents' pulse and CPR was started, AED was used and 911 arrived at 0540 and took over. Resident was pronounced at 06:14am. Effective Date: [DATE] at 7:30 a.m. Note Text: Author: LVN A -Writer called emergency contact FM and notified her that resident in distress, CPR was initiated, and EMS was called, and resident was pronounced death. Will notify MD. Record review of physician order summary revealed the following orders: [DATE]- Trach care as needed. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]- Tracheal suction every 4 hours and as needed. [DATE]- Change Shiley 4 inner cannula as needed. [DATE]- Enteral feedings every shift. [DATE]- Change bedside respiratory Therapy supplies; neb kit, oxygen tubing, suction set-up with tubing, canister, oral yank [NAME], oxygen concentrator air filter, in-line suction ballad, HME filters, corrugated tubing, bacterial filters. [DATE]- Trach cuff pressure checks every shift and as needed [DATE] AC 16, 350, +5, 5L every shift Record review of EMS incident report for CR#1 revealed they were called to the facility on [DATE] at 5:37 a. m. for CR#1 in cardiac arrest and arrived at the facility at 5:47 a.m CR#1 was observed to be lying in a bed unresponsive and severely swollen. Patient was pulseless and apneic. Nursing staff was forcibly bagging the patient and no compressions were being performed at this time. The nurse was adamant that the patient had a pulse and that the bagging was difficult but effective. Patient pulses were checked and absent. CPR was started at this time. Manual compressions were continued throughout the CPR. Patient's trach tube was confirmed to not be in a correct position (or false pathway) and was not oxygenating the patient. Patient facial anatomy due to swelling was too distorted to control her airway by any other means. CR#1 had severe subcutaneous emphysema and skin was cold. CR#1 had swelling to the face, neck, chest and her whole arms (both left and right). Trach tube was removed and a [NAME] bag was used to locate her tracheotomy. An ET tube was placed, and CPR continued. The nurse stated that CR#1 was alert just 8 minutes before the 911 call. EPI was administered per guidelines. Patient was moved to the floor to facilitate higher quality CPR. CPR was continued per department guidelines. It was noted that CR#1 was in asystole and remained in asystole condition (where the heart stops beating due to complete failure of the heart's electrical system) for the duration of the call. EMS called medical doctor C via phone for an order to terminate CPR efforts after 20 minutes. Medical doctor C agreed, and ultrasound was utilized to confirm no heart wall movement but due to emphysema there was no view of the heart. CPR was discontinued. The scene was turned over to local police department. An in-field pronouncement was done. CR#1 was determined expired at 6:13a.m. Record review of handwritten and signed statement submitted to the Administrator by LVN A on [DATE], she wrote Respiratory Therapist A called her to CR#1's room around 5:25am. CR#1 was unresponsive with palpable pulse. LVN A activated 911 call at 5:37am and EMS arrived at 5:40am. CR#1 was pronounced death at 6:14am. Record review of CR#1's ADL record dated [DATE] revealed CNAs were responsible for incontinent care. The record shows that CR#1 had her briefs changed: [DATE]- 00:57 (12:57am) 17:59 (5:59pm) (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	23:57 (11:57pm) There was no documentation that CNAs entered CR#1's room for incontinent care since just before midnight. CR#1's incident occurred on [DATE] at or about 5:25am. Record review of the facility's CMS form 672 revealed there were 7 residents had a tracheostomy out of 24 residents. Record review of tracheostomy competency revealed RT Director skills were checked off by RT A on [DATE]. RT Director became employed at the facility on [DATE]. Record review of RT A employment record revealed she became employed at the facility on [DATE] and all her competencies were checked by RT Director. An interview with the DON on [DATE] at 10:29am, she said she had been employed here since [DATE]st, 2024. She stated LVN A called her and said RT yelled for her to come to CR#1's room after finding her unresponsive. She said CR#1 was in respiratory distress when RT A discovered the circuit had become dislodged. CR#1 was on a mechanical ventilator and G-tube. She said CR#1 was admitted with chronic conditions. She said CR#1 was diabetic and had hypertension and heart condition. Investigator asked what could have caused her respiratory distress, she said she was told by LVN A that the circuit was dislodged and, on the floor, but CR#1 had co-morbidities that could have caused her distress. She said LVN A said when she was solicited to the room, the resident had agonal breathing and she was not sure why RT A was trying to get supplies to intubate the resident. When asked how the staff knew CR#1 was full code she said staff are aware of how to find whether patients are full code or DNR. She said it was in PCC on under CR#1's profile and it is also on the crash cart. CR#1 was pronounced deceased at the facility by EMS. Her expectation is for staff to immediately provide emergency care for all residents. She said trach care is the responsibility of the RT's. However, she expects CNAs and all other staff to let someone know if they hear the alarm sounding. In a telephone interview on [DATE] at 12:46pm, FM #1 stated she was called early in the morning around 7:15am on [DATE]. She said she was told staff discovered CR#1 was not breathing and that they could not revive her. She said the DON stated CR#1 was not breathing and went into cardiac arrest. She said she immediately called FM#2 as she was the RP. She said when she arrived EMS and the police was there. She said the facility did not call them immediately when she was in distress, and she wish they would have called her and FM#2 after calling EMS. She said CR#1 was not capable of turning her head. She was basically comatose. She said staff had to do everything for her. She said this was heartbreaking. In a telephone interview with FM #2 on [DATE] at 1:01p.m. she stated she had a missed call from the facility at 7:14am, due to her phone being on silent. She said FM#1 notified her on the morning of CR#1's death. She said CR#1 had only been at the facility since [DATE]. She said she came from a local L-TAC. She said she arrived at the facility by 8am and they were cleaning her and preparing her for the medical examiner she believed. She said the police had arrived. She said she was not called when CR#1 had a change in condition, she said staff said it was because when they found her, she was not breathing. She was in cardiac arrest. She asked if we could speak later, she was distraught. She said she just did not understand why they could not save her. The call ended. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 3:19 p.m., LVN A revealed she worked the 6p-6am shift and had been employed with the facility since [DATE]. She said she did rounds at or about 8pm on [DATE] and provided G-tube medications for CR#1. She said CR#1 did not have any medications after 8pm. She said at that time, CR#1's ventilator alarm was not beeping. She said she saw RT A go into CR#1's room and figured she was doing rounds. She said she went to assist another resident down the hall. Then, she heard Respiratory Therapist A (RT) yelling for her to come to CR#1's room to be a witness on [DATE] at or about 5:25am. She said RT A did not immediately disclose what she wanted her to witness. She said RT A began to gather trachea supplies but said she did not have another circuit. RT A left out of the room, and this is when she noticed the circuit on the floor near where she was standing. The circuit was not connected to the ventilator. She said RT A was attempting to re-insert CR#1's inner cannula but was unsuccessful. She said she took CR#1's pulse because she was having agonal breathing. She had a palpable pulse. But, no air was coming from the bag. She ran to get the crash cart and began giving her air. She said she used the AED. She said she called 911 from her cell phone at 5:37am and she and RT A began CPR. She said a backboard was placed behind her back as they provided CPR with CR#1 in bed. She said EMS arrived and took over CPR. CR#1 expired while they were performing CPR. She stated she was the only nurse on the shift, and there were two CNAs and RT A. She said there is usually only (1) nurse on the overnight shift. She said she was not responsible for suctioning CR#1. She said RT's have 12-hour shifts and are there around the clock. She said RTs are responsible for suctioning and all related trach care. She said she was CPR certified. She said she was not sure how long the ventilator was alarming. An interview with CNA A on [DATE] at 4:22 p.m. revealed he and CNA B changed CR#1's brief at approximately 5am. Then, they changed her roommates' brief. He stated CR#1 was not gasping for air nor was her ventilator alarming. He said CR#1 eyes were opened. She was not in respiratory distress while they were in her room. He stated he heard yelling when he was going to put trash out and LVN A said they needed the crash cart. He stated he went to get the crash cart for her and when he came back EMS was there. An interview with RT Director on [DATE] at 11:39 a.m., she stated she normally work 12-hour shift from 7a-7pm three times per week. She said RT A worked the overnight shift. She stated CR#1 was a vent, and trach dependent patient. She said tubing was to be changed every 7 days and prn. Vent circuit every 30 days and PRN. She stated as RT A's supervisor she did not notify her of the situation. She learned about it the next day or later that day she could not recall. RT A told her the following: RT A said she was in the room with patient two or three doors down from CR#1 when she heard the vent alarm go off. She said she went in the room and said the vent circuit was on the floor and her trach was dislodged. RT A could see the balloon. RT A said she tried to push the trach back in but patient was in respiratory distress with agonal breathing. She said she had verbally reprimanded RT A twice concerning the trach tie being too loose. She said you should only be able to stick two fingers under the tie. She said when she worked behind RT A she found loose ties. She said she told her the ties were so loose she could stick her whole hand underneath. She did not have documentation of these incidents. She stated she trained the RT's how to look for signs and symptoms of respiratory distress but had a couple of RTs she would immediate train once they came in for their shift. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with Respiratory Therapist A (RT A) on [DATE] at 12:59 p.m stated she had been employed at the facility since [DATE]. She normally worked the 6p-6a shift. She said there is a RT in the facility 24-hours a day. She stated on the early morning of [DATE], She said at or about 4:37am she provided trach care and brushed CR#1's teeth and then did the same for her roommate. She said then she proceeded to provide trach care for a resident two doors down from CR#1's room. She said she thought she heard a vent alarming when she turned the suctioning machine off. She said she heard the vent alarm coming from CR#1's room. She said she did not see the nurse at the nursing station and finished the care for the resident. She said about 3 minutes she finished and went to CR#1's room which was at the time in approximately 3 minutes. Then, she entered CR#1's room at approximately 5:20am. She added that before she returned to the CR#1 room for the alarming vent she saw the CNAs coming from the room after she left CR#1's room. She said she discovered the vent circuit was on the floor but still attached. She said she noticed CR#1's trach was out, so she pushed it back in and it was still attached to the trach tie. She said she took off the vent and started bagging her to give her deeper breaths because she was having agonal breathing. She said she called in the LVN A to come to witness because the resident had an extra airway on the wall. She said she tried to inflate air into her cuff and continue to bag her, but it still was not inflating. She tried to inflate again but the cuff would not stay. She said that is when she realized the cuff was blown. She said they took the one off the wall, put it in her, inflated it and begin to bag her again. Her rate was 12 she kept it there while she was bagging her the rate on the machine was 16. She said she knew CR#1 was going into cardiac arrest when she found her. She said she told LVN A to call 911 because she did not have an inner trachea tube and was told she was not allowed to intubate in a SNF. So, there was nothing she could do but put the lateral trach in her that was a size 4. She said so that was done. She said what she and LVN was doing was not helping with the AED, so they started CPR because her pulse was low (she thinks about 40). LVN A checked pulse while she was bagging. CNA A bought in the crash cart while LVN A was doing chest compressions. She said the cardiac board was placed behind her back as she was still in the bed. LVN called 911. She called from her cell phone and kept on speaker while listening to 911 operator. EMS arrived quickly. She said she was unsure about the time they arrived. She said they took the trach out and they intubate her. The local fire department told her she could not intubate at a nursing home. She said she had been licensed as a Registered Therapist for [AGE] years. She said she hold heartedly believe that the CNAs must have caused the circuit to dislodge because they were in the room after her. She denied that the RT Director reprimanded her for loose trach ties. She said she had not been written up or no verbal reprimand from RT Director. In an interview with the Administrator on [DATE] at 5:22 p.m., she said she had been employed at the facility almost 2 weeks. She said she called in the incident because it was an unusual death. When asked why it was considered an unusual death, she said because the circuit was found on the floor, her trach became dislodged, and no one seemed to know what happened. She said she believed while the CNAs were repositioning and changing CR#1 her trach might have been dislodged. She said CNA B clocked out at 5:16 a.m. and CNA A was still there when the incident occurred. She said she spoke to both CNAs, and they stated the ventilator was not alarming after they changed her. She said there was 1 nurse, two CNAs and the RT in the building. She said she would be adding another nurse to work the night shift. She said from her understanding, CR#1 was found unresponsive. RT A and LVN A started CPR when she was unable to get the trach back inserted. She was pronounced deceased at the facility. She said the MD and family had been notified. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] at 6:06 p.m., CNA B stated she had been employed at the facility about 1 year. She stated her normal shift is 6p-6a. She said she and CNA B went into CR#1's room right at about 5am, her brief was changed no bed bath. Then, she was repositioned she was left on her right side. Went to her roommate and changed her brief. She said the vent alarm was not beeping. She said if it would have started alarming, they must call the RT or the nurse on duty. Resident eyes were opened. She said the circuit was still attached. She said she did not see RT A go into the room because after they changed CR#1 and her roommate she left. She said CNA A was still there until 6am. She said CR#1 tubing was on the pillow and was not detached. She said the vent machine would alarm if the circuit was dislodged. She said CNAs are responsible for taking vitals when they first start the shift. No vitals the taken when they were in her room changing her. She said CR#1's breathing was normal nothing different. She said CR#1 could not move her head. She is stiff when they turn her everything turned with her. She said someone must lift her head if it needed to be moved. In a subsequent interview with on [DATE] at 6:25 p.m. RT A, she said LVN A was not conducting CPR correctly. She said she had to correct her because she had her fist bald up and her other hand on top. She should have had hand over hand, laced and heel of the hand in the center of the chest when doing compressions. She said she was concerned about her and other nurses being able to conduct CPR adequately. In addition, she said there was no way she could have left the other resident she was with when she heard the alarm. She said a nurse should be available at the nursing station or the facility should have some other means for being able to call staff for help. She said they did not use any radios nor intercom. She said tracheostomy supplies were kept in bins in the RT office. She said she did not have a circuit and that is why she went to the office. She said also staff do not respond to the vent alarms timely. She said they have alarm fatigue. She added CR#1 was getting air underneath her skin from the ventilator every time she bagged her, causing her to swell. She said CR#1 was really trying to breath on her own obviously with a size 4 trach. She said she voiced these concerns with the RT Director. She denied being reprimanded by the RT Director for having trach ties too loose. She denied having an in-service at the facility on [DATE] - [DATE]. She said training consist of signing pre-printed training forms. There was not any hands-on even when she first started working at the facility. She said in fact she trained the RT Director. Record review of payroll sheet provided on [DATE] revealed RT A worked on [DATE], [DATE], and [DATE]. Record review of tracheostomy policy dated [DATE] revealed the purpose of this procedure is to guide tracheostomy care and the cleaning of reusable trach cannulations. Procedure guidelines-Preparation and assessment: check physician orders, explain procedures to resident, wash hands, put gloves, remove oxygen mask for tracheostomy and inspect skin for signs and symptoms of infection, leakage, crepitus or dislodged, and assess resident for distress. An IJ was identified on [DATE] at 5:42 p.m. The IJ template and Plan of removal were provided to the DON and later to the Administrator via email at 5:42pm. The following Plan of Removal was submitted by the facility and was accepted on [DATE] at 11:57 a.m. and indicated the following: F695 Respiratory/Tracheostomy Care and Suctioning: (continued on next page)

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	676384	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Sugar Land	1803 Wescott Avenue Sugar Land, TX 77479

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to ensure that CR#1 who needed respiratory care, including tracheotomy care circuit was attached appropriately causing it to become dislodged resulting in agonal breathing, cardiac arrest and death. Immediate action: Respiratory Therapist Director completed sweep of all Ventilator/Tracheostomy residents to validate Tracheostomies were in place and attached/secured appropriately on [DATE]. No residents identified to have any respiratory distress. Administrator/designee completed a sweep of all residents requiring ventilator and tracheostomy care to validate that tracheostomy supplies were available and set up at all residents bedside on [DATE]. No issues identified. Facilities Plan to ensure compliance quickly: Respiratory Therapy Director completed education with all nursing and respiratory staff on [DATE]. Education conducted by Respiratory Therapy Director included an in-service and competency check, with return demonstration, to cover Tracheostomy Care and placement, and Ventilator Functionality/Processes, this included identifying S/S of respiratory distress and how to respond appropriately when identified. The RT involved in the incident will be termed on [DATE] due to attendance issues and the LVN was educated by the Respiratory Therapy Director. Any New or Interim staff will be educated on procedures and policies on tracheostomy care and equipment availability check off list, prior to working the floor or accepting assignment. Respiratory Therapy Director validated that a procedure is in place on [DATE], to track all tracheostomy and ventilator supplies at resident bedside. Respiratory therapist to track and sign off on the availability of these supplies at the beginning of each shift. Ad Hoc QAPI meeting held with medical director on [DATE] at 1900 (7 p.m.) to review issuance of Immediate jeopardy and Policy and procedures pertaining to Ventilator and Tracheostomy cares. Monitoring of the plan of removal included the following: Record review of education in-service training dated [DATE] revealed the RT Director conducted in-services for and competency check, with return demonstration to cover trach care placement, and Ventilator Functionality/Processes and signs and symptoms of distress with all RT's. Record review of termination notice for RT A dated [DATE] stated she was termed due to failure to report to work as scheduled without notice. Excessive absenteeism or tardiness was unacceptable. Record review of Ad hoc QAPI sign-in sheet for identification of fragmented system dated [DATE] revealed the facility reviewed the facility's need for training and re-education of staff to ensure they were educated on Trach care, ventilator care and CPR. IDT, DON/MDS and Administrator initiated an action plan includes the concern, corrective actions, identification of concerns, systemic changes, monitoring and Physicians. MD participated via telephone, DON, HR, MDS, Admissions Coordinator, BOM and Administrator were in attendance. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of in-service of re-education conducted by the RT Director was ,d+[DATE] with LVN A on [DATE] and covered signs and symptoms of respiratory distress. Record review of audit sheet revealed an audit check list of trach supplies to ensure all residents rooms were equipped with all supplies. Observation on [DATE] revealed of code sheets were located on the crash cart located near the nursing station across the hall from the RT office. All residents were listed as either being full code or DNR. Observation on [DATE] of bags hanging on the walls of residents with trachs/vents. Observation on [DATE] of clear containers in the RT office containing vent circuits, trach ties, oxygen tubing, nasal cannulas, cuffs, suction kit, suction tubing, suction machine, back board, C-collar, and gloves. gloves, Interviews ensued on [DATE]-[DATE] with staff on both shifts (6a.m.-6 p.m.) and (6p.m. to 6a.m.) for CNAs and 6 a.m.-6 p.m. for the CNAs including the DON and Administrator, LVN B, LVN D, LVN C- and LVN C agency nurse all on dayshift (6 a.m.-6 p.m.), Respiratory Therapist Director, Respiratory Therapist B, Housekeeping A and Housekeeping Ball from the 6 a.m.-6p.m. shift. LVN A, Respiratory Therapist C to verify in-services and to validate their understanding of the information presented. They were able identify what was neglect and examples, what are some signs and symptoms of respiratory distress, the new code for emergency (CODE BLUE) used. CNAs were able to tell me that they were in-services on calling the nurse when there is an emergency and re-positioning residents with airway. LVN's were able to explain the importance of calling a codes, prompt response to emergencies, and checking the code status either in PCC or the crash cart. An interview with Pulmonology physician on [DATE] at 10:45 a.m., took place after the exit of this facility and re-entry due to another complaint. While investigator was investigating allegations for Resident #8, facility pulmonary doctor revealed him to state CR#1 had a poor prognosis which he had discussed with the family prior to the incident. Investigator asked what would cause CR#1 to swell. He stated she was not getting any oxygen. He said it was his understanding that the trachea came out. He said CR#1 was vent dependent so as soon as ,d+[DATE] seconds she could have become deceased . He said trachs are very difficult to just put back in. He said most physicians have difficulties with tracheostomiesy. The skin around the area creates the problem with pushing it back in. The Administrator was informed the Immediate Jeopardy was removed on [DATE] at 3:08 p.m. The facility remained out of compliance at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25263 Based on observation interview and record reviews the facility failed to provide pharmaceutical services including procedure that assure accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident for 1 of 5 (Resident #8) residents reviewed for pharmaceutical services. -Facility failed to implement effective pharmaceutical procedures when RN A incorrectly added an order to Resident #8 to administer 12 units of Lispro insulin subcutaneously every 8 hours. Resident #8 who was not diabetic caused himcaused him to sweat and become lethargic and had to be sent to the emergency room due to hypoglycemia (low blood sugar). -The facility failed to prevent Resident #8 from receiving 48 units of insulin within 24-hours. On 8/8/2024 at 8AM (12 units of insulin) and 4PM (12 units of insulin) were administered by LVN A and on 8/9/2024 RN A administered 12 units of insulin at 8AM and 4PM totaling 24 units each day. -The facility failed to ensure there was a sliding scale order for Resident #8 and was administered 48 units of insulin within 24-hours. This failure could place residents at risk of being given inaccurate amounts of insulin or the wrong medication and placed them at risk for hypoglycemia, hospitalization s and death. An Immediate Jeopardy (IJ) was identified on 8/26/2024 at 5:32 p.m The IJ template was provided to the facility on [DATE] at 5:32pm. While the IJ was removed on 8/27/2024, the facility remained out of compliance at a scope of isolated with the severity level at a potential for more than minimal harm that is not immediate jeopardy, because all staff had not been trained on 8/26/2024. Findings Included: Record review of Resident #8's face sheet dated 8/21/2024 revealed he was an [AGE] year-old male that was admitted to the facility on [DATE] with acute and chronic respiratory failure with hypoxia (when the lungs have a difficulty exchanging oxygen and carbon dioxide with the blood), cognitive communication deficit (difficulty with communication that is caused by a cognitive impairment), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), dysphagia (difficulty swallowing) and presence of prosthetic heart valve (a one-way valve that replaces a damaged heart). Record review of Resident #8's MDS dated [DATE] revealed Section C- BIMS Summary was left blank. Section GG0103- Functional Abilities and Goals revealed eating was coded as 88 (which meant not attempted). Oral hygiene, toileting, shower, upper body dressing, lower body dressing, put on and take off footwear were all coded as 03, which meant partial/moderate assistance. Section I-Active diagnoses in last 7 days Metabolic had no X in the boxes for Diabetes Mellitus, hyponatremia, hyperkalemia, or Thyroid disorder. Section N0300- Injections had 0 for record of number of days that injections of any type were received during the last 7 days. Section N0350-Insulin the boxes had no entry which meant he was not currently taking insulin injections nor were there any orders during the last 7 days. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review revealed no other MDS was available after 6/6/2024. Record review of Resident#8's care plan initiated on 8/12/2024 revealed: It did not have a focus, goal or interventions for Diabetes Mellitus nor was Insulin address for CR#8. Record review of Resident #8's MAR provided on 8/21/2024 revealed: -Insulin Lispro Injection Solution 100 units/ML (Insulin Lispro) Inject 12 units subcutaneously every 8 hours for Diabetes and inject 0-12 under the skin before meals. Start date:8/8/2024 and discontinued on 8/10/2024. Nursing progress notes for August 2024 revealed: -8/8/2024 at 5:53 a.m. RN A documented a verbal order from MD for Resident#8 to receive 12 units of Lispro solution 100 unit/ML (Insulin Lispro) Inject 12 unit subcutaneous every 8 hours for Diabetes inject 0-12 under the skin before meal. -8/9/2024- LVN G documented that Resident#8 was sweating and lethargic. FM voiced concerns. Nurse checked BS it was 24. Administered Glucagon and continue to flush sugar water into Resident #8's g-tube. BS slowly raised to 101. FM #2 was in room. -8/10/2024- Note Text : Spoke with ER Nurse [NAME] regarding resident stated and paperwork, per ER nurse [NAME] who stated that medication list and face sheet was received from 911 crew and requesting to speak with supervisor regarding medication administration from past 2 days. Writer informed ER nurse that the phone number will be given to supervisor. Writer gave report and ER nurses' number to the supervisor. Authored by LVN B -8/10/2024- Note text: Approximately 12:30pm, spoke with NP to get order to discontinued, report also patients' change in condition from PM shift as per nurses' notes. Author e-signed by RN C. Record review of local pharmacy delivery sheet revealed RN A order for Humalog (insulin Lispro) 100 units. Further, the Humalog (insulin Lispro) was electronically signed for by RN A on 8/9/2024 at 9:17AM. Record review of Physician orders for the month of July 2024 revealed: Blood sugar check one time a day for Accucheck. Start date: 7/25/2024 and discontinued 8/5/2024. Record review of documented blood sugar checks revealed: Blood sugars documented between 7/27/2024 and 8/1/2024 revealed: 7/27- 146 7/28- 134 (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/29- 120 7/30- 138 7/31- 134 8/1 - 141 8/9 - 24 No blood sugar documentation was available between 8/2-8/8/2024. Blood sugars checked between 6/26/2024-8/9/2024 revealed no blood sugars that were under 97.0 (7/27/2024); except on 8/9/2024 when it was documented as 24.0. Record review of physician order recap report for August 2024 revealed: Fingerstick blood sugar every shift call MD if less than 60 or greater than 400 repeat BS in 15 mins until above 100 or lower than physician stated measure/result two times a day related to dysphasia, unspecified order date 8/11/2024 and start date 8/11/2024. Glucagon Hypoglycemia kit, inject 1 mg PRN for blood sugar less than 60. Ordered by NP on 8/9/2024. Insulin Lispro sliding scale if 151-200= 2 units; 201-250= 4 units; 300 or more =6 units; 301-450 call physician was ordered on 8/10/2024 and discontinued on 8/11/2024 Record review of Resident #8's hospital record dated 8/10/2024 revealed admission nurses' notes: Resident#8 was admitted to the local hospital on 8/10/2024 at 1:37 pm due to a call to local EMS that Resident#8 was unconscious then story changed to AMS. Resident arrived and admitting nurse stated she was told his BS was 24 and staff rushed in to fix. Upon reading Resident#8 information that was sent from the facility. This RN found an order for 12 units of insulin that was discontinued on 8/10/2024. Admitting nurse telephoned the facility for nurse report and medication log. She spoke with LVN B. LVN B told the hospital admitting nurse that Resident#8 had been given 12 units of insulin on 8/8 and 8/9/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/30/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on 8/22/2024 at 5:06 p.m. revealed FM said someone in his family is at the facility with Resident #8 almost 24 hours a day. He said Resident Resident#8's siblings and mother are always there. He stated on 8on 8/9/2024 he was in Resident #8's room when RN A came in and said she had to provide him with insulin. He said he questioned why Resident #8 needed insulin. RN A told him that the doctor called it in for his dysphagia. He said he moved the opening of his gown and RN A gave him a shot of insulin in his stomach about 4:00 p.m. or so. He said Resident # 8 seemed to be different after the insulin shot. He said on 8/9/2024 he thinks on or about midnight when he was supposed to get another dosage of insulin, he called LVN G because Resident #8 was sweating and lethargic. She took his blood sugar and said it was 24 so she held the insulin. He said LVN G called someone and came back and gave him something to bring his BS up. down. He said this was perhaps after midnight or early morning of 8/10/2024. He said after the nurse assured him that the blood sugar was better, he said he was not convinced because Resident #8 still was not himself. He said he was still lethargic after a few hours, so, he requested for Resident #8 to be sent to the local hospital. He said he was very concerned and spoke with the DON about his concerns. He said she was hesitant to provide him with Resident #8's medication log and even asked, why did he need it. He said he wanted to see what they had documented as the reason for the insulin. He said his family had never been told he was diabetic. He said he had dysphagia, but never heard of treating dysphagia with insulin. An interview with LVN E on 8/21/2024 at 1:03 p.m., revealed him to state he had been employed at the facility for 1 1/2 years. He stated today the DON asked him if he had provided insulin for Resident #8. He stated he did not give Resident #8 insulin. He said he saw it on the MAR but did not administer 24 units of insulin to Resident #8. He stated that he had a lot going on with different residents so he might have placed a check by the insulin but did not give it. He stated only nurses can take a verbal order over the phone and it is then entered into PCC. He stated he did not take a verbal order for insulin. He said that he had in the past taken verbal orders but not for Resident #8. He stated he questioned the insulin medication because he did not know he was diabetic or what it was being used for. He said it was several weeks ago so he thinks he brought it to the DONs attention if he was not mistaken. He said the DON called him about it on 8/11/2024 he can recall asking him to write a statement. He said he completed a statement on 8/16/2024 and told her he did not give insulin. In an interview with the DON on 8/23/2024 at 12:41 p.m. the DON said LVN E and RN A both denied they administered the medication when she spoke to them over the phone. She said she understood Resident #8 had a change in condition with shortness of breath. She said the weekend supervisor (RN C) was asked whether he had given insulin. RN C reported to her that LVN E and RN A documented that they had given him insulin but she was not sure who ordered it because the doctor said he did not order insulin and especially not 12 units. She stated the following after verifying in her computer: Lispro order entered with sliding scale on 8/11/2024. She said it would be a short acting insulin based on his blood sugar. Diagnosis: She stated he had a g-tube feedings, but no diabetes diagnosis. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When he came from the hospital on (8/7) it was in the hospital paperwork for the facility to check his blood sugars and an insulin order for sliding scale insulin. Visit from 8/7 had orders to give insulin. Weekend supervision RN C reached out the doctor over weekend and he said did not order the insulin. She said staff put orders verbal directly into PCC. She said blood sugars were to be check every shift. She said Resident #8's FM told her about the insulin, and she talked to the nurses. Found out the nurses signed that they gave but said both said they did not give it. She said the nursing staff knows that there is a code in the MAR if a medication is not given and checked off by accident. Neither used the code, nor did they solicit another nurse to verify the error. DON and Investigator walked to the nursing station where the DON stated the hospital paperwork could be found. Observation revealed on 8/23/2024 at 1:27 p.m., a clear container with papers placed both horizontally and vertically. The DON started going through this container for Resident #8's paperwork. She stacked papers on the side of the container as she viewed them. Investigator took some of the stack from inside of the container and helped review. The paperwork inside this container was for multiple residents and contained faxed orders, handwritten notes, hospital paperwork for other residents but we were unable to find hospital paperwork for Resident #8. Investigator asked the DON, if Resident #8's blood sugar had ever dropped as low as 24 in the past, is it likely someone gave him insulin despite what they are stating? She said, I guess they both did not tell me the truth. Interview with LVN G on 8/23/2024 at 4:12 p.m., stated she was an agency nurse that had only been to the facility on [DATE]. She said she worked 6a-6pm shift. She said she had not worked at the facility since 8/9/2024. She said LVN B was called into the room when FM had concerns about Resident #8 sweating, lethargic and he bottomed out. She said she spoke with the DON about it and said she was on her way to the facility. She said she gave him sugar water in his G-tube. She said LVN B showed her around and she was the only nurse as LVN B left around 11pm and she was there 6p-6a. She said she documented the incident in PCC. An interview with FM #2 on 8/26/24 at 10:23 a.m., she stated Resident #8 was sent to the ER 8/10/2024 after an overdose of insulin on 8/9/2024. She stated that LVN G seemed surprised that he was supposed to get more insulin dosage and took his blood sugar and said it was too low to give. She said FM #1 saw RN A give the insulin in fact held his gown up so she could give it to him in his stomach. She said the weekend nurse (RN C) told her when she called the hospital had ordered it. She said LVN G said he had been given 12 units of insulin according to PCC. She said LVN G and she was not going to give the 3rd based on his BS being 24. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In a telephone interview with the MD on 8/26/2024 at 11:39 a.m., he stated that nobody called him about a verbal order for insulin. He stated there is sometimes a need for insulin for example stress induced hyperglycemia, g-tube and if they have an infection,all of which could it can cause the patient's sugar to increase. Also, steroids would cause sugars to increase. He said a sliding scale order is standard for residents that are on G-tube continuously. He said he spoke with the NP. She told him she learned that Resident#8 had accidentally been given insulin and was lethargic over the weekend of 8/10/2024. He said he had been the MD at the facility a few months and was getting used to the way they do things. He had another call and said he would call back. An interview with RN A on 8/26/2024 at 2:16 p.m., revealed she had been employed at the facility since July 2024. She said she work both morning and overnight shifts it depends on the need of the facility. She said she did not administer insulin to Resident #8. When asked why it was documented as given with her initials in PCC, she said she must have checked it off by accident. She said she had a lot of residents to take care of and just do not remember giving him insulin. She said she recalled the order for 12 units in the system, but thought it was for sliding scale and his blood sugar was low, so she held it and did not give it. She stated she put in the order after reviewing hospital paperwork that had orders for sliding scale insulin. She stated that the facility staff are supposed to verify orders with physician before entry into PCC. She was asked if she spoke with the MD and received a verbal order from him, she said if she documented a verbal order from him then she either spoke to him or his NP. Investigator asked her if any other staff must verify along with nurses when the orders are verbal. She said once they received the order it is verified with the MD then it is entered into PCC, not another nurse. Record review of payroll provided on 8/21/2024 revealed RN A worked: -8/7-8/8/2024 from 6:46 PM to 10:07 AM -8/9/2024- 6:11AM- 7:23PM Record review of verbal orders policy dated February 2014 read in part 1. Verbal orders shall only be given in emergency or when the attening physician is not immediate available to sign the order. 2. Verbal orders will [NAME] be based on verbal ecxchange with the prescribing practitioner or on approved written protocols. 3. Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe orders on his or her behalf. 4. Text messaging is not an acceptable method of communicatiing. 6. Anyone writing an unauthorized verbal order will be subject to discipliary action. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the Administrator on 8/26/2024 at 4:10 p.m., revealed her to state she was made aware of the insulin situation on or about 8/10/2024 but did not know Resident #8 was not a diabetic, nor could she understand why he would have been given insulin with a Dysphagia diagnosis. She stated the nurses currently input orders directly into PCC. She stated all nurses have their own logins for PCC. She said the only people that can login remotely is the DON and the Regional Nurse. An IJ was identified on 8/26/2024 at 5:32 p.m. The IJ template and plan of removal were provided to the DON and later to the Administrator via email at 5:32pm. The following Plan of Removal submitted by the facility was accepted on 8/27/2024 at 11:32 a.m. Summary of Details which lead to outcomes On 08/26/2024 an abbreviated survey was initiated at Medical Resort Sugarland. A surveyor provided an IJ Template notification that the Survey Agency has determined that the conditions at the center constitute immediate jeopardy to resident health. The notification of the immediate jeopardy states as follows: F755 - Pharmacy Services/Procedures/Pharmacist/Records The facility failed to implement effective pharmaceutical procedures when the facility added an order to Resident #8's medical chart to administer insulin when Resident #8 is not diabetic, causing him to become lethargic and had to be sent to the emergency room for hypoglycemia. Immediate Corrective Action The Corporate Clinical Consultant provided education to the Director of Nursing on 8/26/2023 regarding monitoring new orders received. Director of Nursing/Designee/Weekend Supervisor will print the order listing reporting and check the new orders for accuracy of diagnosis and monitoring in PCC daily. This includes weekends, holidays and afterhours. Any orders entered where the communication method is telephone, or verbal will prompt the user to acknowledge the order was read back to the prescribing practitioner. Without completing this acknowledgement, the order will be saved to the Resident's chart in Pending Confirmation status. As a result, the order will not be sent to pharmacy or available for documentation in eMAR (if applicable). The order will require confirmation by a security permitted user at which time they will be required to acknowledge the order has been read back to the prescribing practitioner. Initiated in-service for all licensed nurses on Practitioner Readback for Telephone and Verbal orders on 8/27/24, ongoing. Nurses will be in-serviced prior to working their next shift. Director of Nursing assessed resident #8 to validate no s/s of hyper/hypoglycemia were noted and no adverse side effects noted related to alleged deficiency. No adverse effects were noted. Assessed on 8/26/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676384	A. Building B. Wing	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Medical Resort at Sugar Land	1803 Wescott Avenue Sugar Land, TX 77479

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Nursing completed review of medication orders to validate all insulin orders were entered correctly with proper parameters and dosing per physician orders. All orders for resident #8 had been updated to reflect appropriate parameters and orders per physician. 8/10/24; Physician was notified and reviewed orders on 8/10/24 Initiated in-service for all licensed nurses on accurate transcribing of orders on 8/26/24, ongoing. Nurses will be in-serviced prior to working their next shift, new nursing staff will be in-serviced during their orientation process. The 2 nurses who allegedly administered the insulin have been educated on ensuring parameters are monitor when administering insulin. Identification of Others The Director of Nursing/Designee completed an audit of all residents with orders for insulin, diabetic medication, and any diagnosis of diabetes on 8/26/2024 to validate that orders are in place with blood sugar monitoring in place to reflect parameters per physician. No discrepancies were identified and blood sugar monitoring in place per physician for all residents. Care plans updated as needed. Director of Nursing completed audit on 8/26/24; physician reviewed resident medications 8/26/24, no errors found. Systemic Changes Director of Nursing/Designee initiated education with all licensed nursing staff on 8/26/24 regarding accurately transcribing orders when received and put into PCC. All licensed nurses will be in service prior to their next scheduled shift. Facility used a staff roster meeting with all available staff in person and contacting each PRN and Agency staff member via phone to ensure all required staff were educated. New staff will be in-serviced during orientation period prior to working a shift. Nursing staff will not be permitted to perform direct nursing care until training has been completed. The Corporate Clinical Consultant completed education with Director of Nursing and Administrator on process of reviewing all orders daily in daily clinical meeting through running Order Listing Report in electronic health record system, reviewing all orders with team to validate orders are entered correctly, with proper parameters being monitored, including blood sugars with Insulin administration, diabetic residents monitoring and when to notify physician, initiated on 8/26/2024. Monitoring The Director of Nursing/designee will conduct monitoring of new medication orders daily in daily clinical meeting to validate appropriateness of orders, parameters in place, and directions of when to notify physician. Monitoring will occur, starting on 8/27/2024, 7 days a week for 4 weeks then Monday through Friday ongoing in daily clinical meeting. Weekend Supervisor/designee will validate appropriateness of orders, parameters in place, and directions of when to notify physician ongoing. Any trends identified will be reported to the QAPI Committee monthly and as needed until a lessor frequency until substantial compliance is achieved. Ad Hoc QAPI meeting was held on 8/26/2024 with the Medical Director, Administrator, Director of Nursing, and Nurse Management to review Immediate Jeopardy issued and plan of removal for correction going forward. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator will be responsible for the implementation of ensuring the adequate process regarding Medication Administration. The new processes/system were initiated, and all licensed nursing staff had initiated education on 8/26/2024. All licensed nurses and medication aides were in-serviced. DON/designee used a staff roster meeting with all available staff in person and contacting each PRN and Agency staff member via phone to ensure all required staff were educated, completed on 8/26/2024. Monitoring of the plan of removal included the following: In- services conducted by DON, Regional Nurse were: Accuracy in Transcribing in PCC (8 LVN's and RN's signed) Audit review form with a list of diabetics (all residents on the list were said to not have any adverse effects Monitoring of proper diagnosis Practitioner Readback for telephone or verbal orders. It will place a hold on the order until verified by DON or designee (a tool use to valid orders) Monitoring for new medication orders that had been signed off by the DON that orders were verified, Parameters in place, concerns, if concerns was the doctor notified were in columns and no concerns (9 residents were checked for new orders).Morning meeting notes dated 8/27/2024 listed 8 nursing staff. with all nurses included In-service attendance form for all nursing staff covered putting orders in PCC and when the DON, family and MD should be notified. Interviews with 4 LVN's, and 3 RN's on both morning and overnight shifts were conducted between 8/26-8/29/2024 revealed them to be able to communicate the new system of monitoring new orders, importance of re-verifying orders before placing in PCC and the new Readback feature. The Administrator was informed the Immediate Jeopardy was removed on 8/29/2024 at 1:48 p.m. The facility remained out of compliance at a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put in place.