STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 7/31/23-8/3/23. The survey team returned to the facility on 8/7/23 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 8/7/23. The facility was found in compliance with the requirement (CFR 483.73, Emergency Preparedness. Event ID #1QI011.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 7/31/23-8/4/23. The survey team returned to the facility on 8/7/23 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 8/7/23. Therefore, the exit date was 8/7/23. The following intakes were investigated NC00205000; NC00204584; NC00204587; NC00204578; NC00204493; NC00204657; NC00205007; NC00203954; NC00202559; NC00202299; NC00202752;NC00203004;NC00203808;NC00203809; NC00205092; NC00205452. 11 of the 45 complaint allegations resulted in a deficiency. Intakes NC00205000, NC00204584, NC00204578, NC200204578, and NC00204587 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25 at tag F692 at a scope and severity	F 000		

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

Electronically Signed | 09/01/2023

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F 000	Continued From page 1 (J) The tags F684 and F692 constituted Substandard Quality of Care. Immediate jeopardy began on 7/5/23 and removed on 8/4/23. An extended survey was conducted.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		9/6/23

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F 565	Continued From page 2 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and review of the Resident Council Minutes, the facility failed to respond to repeat concerns related to dietary issues voiced by residents during Resident Council meetings for 3 of 4 months (April 19, 2023, June 22, 2023, July 19, 2023). Findings included: The Resident Council meeting minutes for April 2023, June 2023 and July 2023 revealed resident council members made the Activity Director aware of repeat dietary concerns and there was no evidence that follow up was provided to the resident council members. The minutes indicated Resident #25, Resident #249, Resident #87, Resident #171, and Resident #166 attended meetings routinely. A review of the grievance logs from April 2023-July 2023 revealed no group grievances were submitted by or on behalf of resident council members for these months. On 08/2/23 at 2:00 PM a Resident Council meeting was held and attended by 6 alert and oriented members of the resident council (Resident #25, Resident #249, Resident #87,	F 565	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. F565 1. The Resident Council Meeting was held on Aug 16,2023, the group grievance procedure was explained to the attending members by the Activity Director. 2. All residents have the potential of being affected by this deficient practice. 3. The Activity Director was educated regarding the Resident Council grievance procedure on Aug 10, 2023, by the Administrator. Department Managers were also educated on response time for resolution on 8/30/23 by the Administrator Consultant. This education will be added to the orientation program for new	

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F 565	Continued From page 3	F 565		

Resident #171, Resident #166). During the meeting the residents were notified that based on review of the facility grievance logs from April 2023-July 2023 there were no group grievances submitted by or on behalf of resident council. The residents in attendance reported that their dietary related issues had been voiced at each of these meetings. Residents #38, #29 and #2 stated that concerns with food, portion sizes of food, were ongoing and were not resolved as stated in the June 2023 minutes. The residents further revealed they were not aware of administrative efforts to resolve their concerns and were simply told repeatedly that "they were working on it" but they had not seen an improvement.

During an interview with the current Activities Director on 08/3/23 at 9:19 AM, she stated she began working in her current position in April 2023. She indicated she oversaw the Resident Council meetings and documented the minutes, but she was not aware that grievances/concerns from resident council needed to be documented as a grievance and for follow up to be addressed at the next meeting.

During an interview on 8/2/23 at 2:32 PM, the Dietary Manager (DM) revealed he began working at the facility in March 2023 and had received complaints of residents not receiving adequate portion sizes. He stated as a resolution to the complaints, portion sizes served were increased and quantities of food items purchased were also increased.

The Administrator was interviewed on 08/3/23 at 9:40 AM and she revealed that she had only been in this position for three weeks. She also

employees.
4. Resident Council grievances will be reviewed by the Administrator or designee, within 7 days after the resident council meeting to ensure proper resolution has been obtained.
5. Findings will be presented by the Administrator to the facility's Quality Assurance Performance Improvement committee monthly for 3 months and thereafter as requested by the committee.

DATE OF COMPLIANCE 9-6-23

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F 565	Continued From page 4 indicated resident council group grievances should be placed onto a grievance form and submitted to the administrator for follow up. She was not aware that the Activities Director had not been told that she needed to document resident council group grievances on a grievance form and submit it her so that she could ensure the grievances received the appropriate follow up. She further revealed that if she were to have received these grievances, she would have assigned them to the appropriate department head and reviewed the follow-up. The Administrator indicated that she would address this issue of the group grievance process with the resident council members during their next meeting.	F 565		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 578		9/6/23

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F 578	Continued From page 5 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to determine on admission a resident's desired advanced directives throughout the medical record for 3 of 35 residents (Resident #189, # 399, and # 8) reviewed for advanced directives. The findings included: 1.a. Resident #189 was admitted to the facility on 3/27/23. A review of Resident #189's quarterly Minimum Data Set (MDS) dated 6/29/23 revealed Resident had severe cognitive impairment. A review of Resident #189's care plan dated	F 578	F578 1. Most forms were completed for Resident #189, #399 and #8 on 8/1/23 by the Social Worker 2. An audit of MOST form books was completed on 8/29/23 by an outside consultant to ensure that all residents have completed MOST forms. Any issues were addressed during this audit on 9/1/23 by the Social Worker 3. Admission Coordinator, Social Workers and Licensed Nurses were educated on the MOST form procedures on 8/30/23 by the Administrator Consultant. This education will be added to the orientation program for new employees. 4. Weekly audits of MOST form books will	

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F 578	Continued From page 6 4/6/23 and last revised on 7/27/23 for advance directive. The goal was to honor Resident's advanced directive through the next review. The intervention was to follow the advanced directive on the MOST (Medical Orders for Scope of Treatment) form. A review of Resident #189's physician orders revealed no order for advance directives and/or code status. A review of unit 500's code status/advance directive book revealed there was not a MOST form or information for Resident #189's code status/advance directive in the book. On 8/2/23 at 9:50 am an interview was conducted with Charge Nurse #4, and she indicated advance directives were kept in a book at the Nurses station. She verified Resident #189 did not have a code status in electronic record and did not have a MOST form in the code status book at the Nurses station. b. Resident #399's most recent admission to the facility was 7/27/23. Resident #399 did not have a completed MDS. A review of Resident #399's medical record was conducted and there was not a physician order, a care plan or a MOST form addressing Resident #399's code status/advance directive. An interview was conducted on 8/2/23 at 9:40 am with Charge Nurse #5 and she verified Resident # 399 did not have a MOST form in the code status/advance directive book located at the Nurses station. She indicated if there was not a	F 578	be conducted by the Medical Records Clerk to ensure each resident residing in the facility has a MOST form. 5. Findings will be presented by the Medical Records Clerk to the facility Quality Assurance Performance Improvement committee monthly times 3 months and thereafter as requested by the committee. DATE OF COMPLIANCE 9-6-23	

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F 578	Continued From page 7	F 578		

MOST form in the book, then the resident was considered a full code. She indicated the book was the only place to find the code status.

During an interview on 8/3/23 at 2:40 pm with the Director of Nursing (DON) she indicated on admission Nursing should establish the code status/advance directives and obtain a signed MOST form from the Physician. She stated if there was not a signed MOST form, they were considered a full code. The DON indicated once the MOST form was established the MOST form would be placed in the advance directive/code status book located at each Nursing station. She indicated the MOST form was considered the order, and it should be in the care plan. She indicated an audit was completed on 7/24/23, and she was not aware the residents did not have advance directives in place. She indicated she expected the code status/advance directives to be in place for the residents.

2. Resident #8 was re-admitted to the facility on 6/13/23.

The admission Minimum Data Set dated 6/14/23 revealed Resident #8 to be cognitively intact.

Review of #8's care plan dated 7/24/23 revealed a focus for "advance directives" with one intervention that indicated staff to "follow advance directives on the MOST form". (Medical Orders for Scope of Treatment-a physician's order that outlines a plan of care respecting the patient's wishes concerning care at life's end).

Review of # 8's physician orders revealed no order for code status.

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F 578	Continued From page 8	F 578		

The facility's advanced directives notebook kept at the nurses' station was reviewed and did not contain a MOST form for Resident #8 to specify the resident's elected advanced directives.

On 8/3/23 at 4:41 PM an interview was conducted with Nurse #6. She revealed the nurses utilize a resident information notebook at the station that holds all residents MOST forms and that there are no longer physician orders on file regarding code status, so the notebook is the only way to know the residents code status. Nurse #6 reviewed the resident information notebook, and she was not able to locate a MOST form for Resident #8's code status and indicated that if there was not a MOST form on file then the nurse would not know the resident's codes status and would have to assume the resident is a full code. Nurse #6 confirmed that Resident #8 was a Hospice resident.

A review of the Hospice Progress Report dated 7/6/23 stated "patient is a DNR (do not resuscitate) and do not hospitalize".

On 8/3/23 at 4:51 PM an interview was conducted with the Director of Nursing. She revealed that nursing staff are trained to utilize the advance directive book to determine a resident's code status and that all residents should have a MOST form on file to reveal their choice in code status. The Director of Nursing was not aware that Resident #8 did not have a MOST form on file and confirmed that without this information the nurses would have to assume the resident is a full code until they could address the missing MOST form.

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F 578	Continued From page 9 An interview was conducted with the facility Administrator on 8/4/23 at 2:21 PM. She indicated there had been a change in the advanced directive process in July, they removed the orders from the file and that the MOST forms were to be the order to indicate code status. Her expectation was for nursing staff to have knowledge of their assigned residents code status via the MOST form.	F 578		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		8/7/23

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F 580	Continued From page 10 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Nurse Practitioner (NP) interviews the facility failed to immediately notify the physician of Resident #250's unwitnessed fall that occurred on 7/5/2023 at 1:00 p.m. The on-call physician was not notified of the fall until 7/5/2023 at 6:50 p.m. when it was discovered the resident had an altered mental status. The facility also failed to immediately notify the physician when the ordered intervention of STAT (immediate) laboratory work and normal saline (mixture of sodium chloride and water used to treat dehydration) were not able to be completed STAT. Additionally, the facility failed to notify the physician of Resident #250's tube feeding that was found leaking on the floor and in the bed.	F 580	F580 1. Resident #250 expired in the facility on 7-6-23. 2. Progress notes for all falls, STAT orders and changes in condition were reviewed for the past 30 days (from 7/1-8/2) was conducted on 8/2/2023 by the Director of Nursing (DON), Unit Manager and Minimum Data Set (MDS) nurse to verify the proper notification of medical provider and responsible party. 8/2/23 the Registered Dietician reviewed resident's medication administration record to ensure residents were receiving the correct amount of tube feeding. Any opportunities identified during this audit	

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F 580	Continued From page 11	F 580		

These failures resulted in a delay in the physician's initial assessment and initiation of treatment. Resident #250 was discovered unresponsive in her bed on 7/6/2023 at 9:50 p.m. and pronounced as deceased at 10:09 p.m. This occurred in 1 of 2 residents reviewed for notification of change.

Immediate Jeopardy began on 7/5/2023 when Resident #250 had an unwitnessed fall from the bed that occurred at 1:00 p.m. and Charge Nurse #1 failed to immediately notify the physician. Immediate jeopardy was removed on 8/4/2023 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (actual harm that is not immediate jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee training.

The findings included:

Resident #250 was admitted to the facility on 5/6/2020.

A review of the quarterly Minimum Data Set (MDS), dated 5/21/2023, revealed Resident #250 had severe cognitive impairment and had not had a fall since the prior assessment. The Resident had a feeding tube and received greater than 51% of meals and greater than 501 cubic centimeters (cc) of fluids by this route.

A review was conducted of an incident report for Resident #250, completed by Nurse # 6, dated 7/4/2023, and revealed the Resident had an unwitnessed fall from the bed. She was discovered on the floor by staff. She was free of

were corrected by the Nurse Managers by 8/3/2023.
3. 8/2/23 DON and Unit Managers educated Licensed Nurses regarding the requirement of notifying the medical provider following an incident, such as a fall, change in condition and when they are unable to obtain STAT labs. The Director of Nursing and Unit Managers educated the nurse aides and medication aides on when a change in condition is noted they are to notify the Charge Nurse immediately.
8/3/23 the Director of Nursing and Unit Managers educated licensed nurses when a resident is found to not receive the required amount of tube feeding the licensed nurse will inform the medical provider immediately.
8/2/2023 The Director of Nursing and Unit Managers educated the nurse aides on if a resident has fallen or if a change in condition is noted they are to notify the licensed nurse immediately. If the nurse aides assume the licensed nurse have not assessed the resident or tried to call the medical physician, they will call the Director of Nursing and/or Administrator. The nurse aides were informed where the Administrator and the Director of Nursing numbers are posted, which is behind each nurse’s station.
8/3/2023 The Regional Nurse Consultant educated the Director of Nursing and Unit Managers on informing the Registered Dietitian when a resident is noted to have not received the required amount of tube feeding.
8/2/2023 The Regional Director of Clinical

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F 580	Continued From page 12 injury. The physician was notified. An interview was conducted with Charge Nurse #1 on 8/1/2023 at 3:37 p.m. and revealed on 7/5/2023 Resident #250 had a second unwitnessed fall and was discovered lying on the floor at 1:00 p.m. She assessed the Resident and she had no injuries. She then conducted a neurological assessment, and the Resident was verbally responsive. She then assisted the Resident back to the bed. She did not notify a physician of the fall at that time, and she was unsure why because a provider was available in the facility on that Friday at 1:00 p.m. Later in the shift, a nursing assistant, name unknown, informed her that the Resident was not responding like usual. Charge Nurse #1 was not able to specify an approximate time. She went to assess the Resident and discovered she had an altered mental status. The Resident was responding to questions with a yes or no reply only and was lethargic (drowsy, sluggish, and difficult to arouse). Charge Nurse #1 notified the on-call physician of the change in mental status and the fall that occurred at 1:00 p.m. She was not able to specify an approximate time for the on-call physician notification. This was the first time a physician was notified of the fall. The On-call Physician conducted a visit via video conference at 6:50 PM and felt the Resident might be dehydrated. He ordered STAT (immediate) intravenous (IV) fluids of Normal Saline (NS) at 100 milliliters/hour (ml/hr.) for 72 hours, STAT laboratory work that included a complete blood count (CBC), complete metabolic panel (CMP), and a urinalysis (UA) with a culture and sensitivity (C&S). She then stated she had been unsuccessful at starting an IV for the Resident and called the on-call Physician back to	F 580	Services educated the Director of Nursing, Unit Managers, MDS Nurse and Administrator regarding the clinical morning meeting process. To include a review of residents with falls, stat labs, and change of condition to validate completion of documentation, notification of medical provider and responsible party by reviewing progress notes, incident reports, medical provider notes and orders. The Administrator and Director of Nursing will be responsible for ensuring that none of the above-mentioned staff will work without receiving this education after 8-2-23. This education will be added to the orientation program for new employees on 8-3-23 by the DON. 4. The Director of Nursing/Designee will audit progress notes, incident reports, medical provider notes and orders in the daily clinical meeting to ensure proper documentation and notification of medical provider and responsible party of any falls, change in condition stat labs and residents not receiving the proper amount of tube feeding daily for 30 days, then three times a week for 30 days, then weekly for 30 days. 5. The Director of Nursing will present findings to the facility's Quality Assurance Performance Improvement committee monthly for 3 months and thereafter as requested. Date of Compliance 8-7-23	

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request the fluids be delivered by hypodermoclysis (a method of administering fluids subcutaneously under the skin). The physician agreed and adjusted the administration route as requested and the dosage was changed to 60 ml/hr. She added she had been unable to start the hypodermoclysis fluids because she needed to order the supplies from the pharmacy, and they did not arrive on her shift. She revealed she had not notified the on-call physician that the supplies for the fluids were unavailable and would be delayed. She added she had thought the on-call physician would know the facility did not have the supplies. She conducted an in an out urine catheterization and did not receive enough urine to complete the urine lab orders. She added she had not notified the on-call physician that she was unable to collect the urine. She stated she reported to the following shift nurse to try to collect more urine.

A review of the On-Call Physician video visit summary, dated 7/5/2023 at 6:50 p.m., documented the resident had a fall out of the bed earlier in the day, and the staff were requesting the Resident be evaluated due to an altered mental status. The Resident presented with lethargy, increased confusion, nonverbal, and not engaging. The Resident had tenting skin (a sign of poor skin turgor that can be dehydration), was in mild distress, and had occasional moans. The assessment plan noted recent repeated falls and altered mental status (a change from a resident's base line alertness and cognition). Recommendations included to continue the facility post fall protocol, conduct a STAT CBC, CMP, UA with C&S, and NS at 100 ml/hr. x 72 hours.

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A review of the On-Call Physician summary dated 7/5/2023 at 8:35 p.m., documented Charge Nurse #1 requested to administer the IV fluids via hypodermoclysis. The order was adjusted to 60 ml/hr. NS via hypodermoclysis. Nurse reported the UA C&S and laboratory work was pending and an additional video conference was not needed.

An interview was conducted with Nurse Aide #1 (NA) on 8/1/2023 at 5:25 p.m. and she revealed she had been assigned as the care giver to Resident #250 frequently. About a month prior to July 5 7/5/2023 and July 6, 7/6/2023, she had reported to the Unit Manager (UM) the Resident's gastrostomy (G-tube) was leaking. She stated the leaking and the flap to close the tube had not closed. She was informed by the UM a piece of tape had been placed over the closure area. She stated the concerns with the leaking tube feeding continued for the month and she had tried to inform the previous administrator by going to his office and requesting to speak with him regarding Resident #250 but he "shooed" her away without listening and was ignored. She continued to provide reports regarding the leaking tube feeding to the UM. She added the Resident could move a little but did not usually fall out of the bed from movement. The two falls (7/4/23 and 7/5/23), close together, were new for the Resident.

A review of the facility progress notes for Charge Nurse #2, the 11:00 p.m. - 7:00 a.m. hall nurse for Resident #250, documented:

1) 7/6/2023 at 3:48 a.m. she attempted to collect a UA C&S from Resident #250 and a small amount returned from the in and out urine catheterization.

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2) 7/6/2023 at 4:09 a.m. Resident #250 was started on NS via hypodermoclysis running at 60 ml/hr. Attempted the UA C&S earlier with no results due to a small amount of urine. This nurse will continue to monitor.

An interview was conducted with Charge Nurse #2 on 8/3/2023 at 9:31 a.m. and she revealed the Pharmacy delivery sometimes comes as late as 2:00 a.m. She added on the night of 7/5/2023 through 7/6/2023 Resident #250 looked dehydrated during her assessment and did not respond to her name. She had not reported to the physician about the time of the pharmacy delivery because she was not aware it had not been previously reported.

A review of the electronic medical record revealed Resident #250 was discovered unresponsive in her bed on 7/6/2023 at 9:50 p.m. and pronounced as deceased at 10:09 p.m.

A review of the death certificate for Resident #250 listed the cause of death as a Cerebral Vascular Accident.

An interview was conducted with the Medical Director on 8/2/2023 at 12:25 p.m. and he revealed he was not allowed to list some conditions as the cause of death on a death certificate but if he was able, he would have listed fluid volume depletion disorder as the cause of death for Resident #250.

An interview was conducted with Nurse Practitioner (NP) #1 on 8/2/2023 at 10:17 a.m. and she revealed she had a routine visit with Resident #250 on the morning of 7/5/2023 prior to 1:00 p.m. The Resident had responded to

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questions during the visit. The NP stated this was routine visit. The On-Call physician for the medical group, had been notified on 7/5/2023 at 6:50 p.m. that the Resident had an unwitnessed fall from the bed at 1:00 p.m. When she arrived at the facility on 7/6/2023 she read the On-Call physician documentation from the 6:50 p.m. video visit and went to visit the Resident. Upon arrival in the room, the Resident had NS 60 ml/hr running via hypodermoclysis. The STAT laboratory work was not available in the electronic medical record. She called the laboratory provider and requested the results. She was informed there was pending laboratory blood work for Resident #250, but they had not been informed it was a STAT lab. The NP added she had not been notified of an error in the ordering of the STAT laboratory blood work. She revealed the failure to notify a Physician of the fall on 7/5/2023 at 1:00 p.m. and the STAT laboratory work delayed the treatment and workup. She added, if she had received the critical laboratory results, at the expected time, around noon on 7/6/2023, she would have recommended treatment at a higher level of care.

The Administrator and Corporate Consultant were notified of the immediate jeopardy on 8/2/2023 at 6:15 p.m.

The facility provided the following plan for IJ removal.

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

On 7/5/2023 resident #250 had a second unwitnessed fall from the bed at 1:00 p.m. that would have required medical attention. The

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charge nurse did not notify the medical provider regarding this fall from the bed. Approximately 6:40pm resident #250 had a change of condition. The charge nurse sent the medical director a message and called the on-call provider. The on-call provider called back and did a tele-health visit with the resident at 6:50 p.m. The nurse practitioner asked the charge nurse to perform a skin turgor on the resident and he then stated the resident seemed to be mildly dehydrated. The nurse practitioner provided stat orders on 7/5/2023 for intravenous fluids normal saline at 100 milliliters per hour and urine for culture and sensitivity. The charge nurse attempted to gain IV access and failed twice. The charge nurse called the on-call provided approximately 8:15 p.m.
The nurse practitioner gave a new order to change the IV fluids to be administered through a hypodermoclysis and change the rate to 60 milliliters per hour. Charge nurse #1 noted there were no hypodermoclysis kits in the facility. She called the pharmacy and requested the kits to be delivered on the next delivery. The kits were delivered on 7/6/2023 at 3:05 a.m. and the IV fluids were started immediately by a different charge nurse. The charge nurse obtained the urine and she stated that she was unable to obtain enough urine to for the lab to be able to run the culture and sensitivity test.

Charge nurse #1 failed to notify the physician of the second unwitnessed fall, the unavailability of the hypodermoclysis, and that she was unable to obtain enough urine for the culture and sensitivity. The charge nurse #1 also failed to notify the medical provider she failed to obtain stat labs. The nurses failed to notify the medical provider regarding the tube feeding that was found leaking

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on the floor and in the bed.

Resident #250 was discovered unresponsive on 7/6/2023 at approximately 8:45 p.m. and was pronounced deceased at 10:09 p.m.

On 8/2/2023 the Director of Nursing, unit managers, and MDS nurses reviewed current residents who have fallen during 7/1/2023 through 8/2/2023 to validate that a medical physician had been notified of the fall. Any opportunities identified during this audit will be corrected by the Nurse Managers by 8/3/2023.

On 8/2/2023 the Director of Nursing, unit managers, and MDS nurses reviewed notes during 7/1/2023 through 8/2/2023 for any change in conditions and new orders for stat labs of the current residents and validate that a medical physician was notified of the change in condition and that the stat labs were drawn. Any opportunities identified during this audit will be corrected by the Nurse Managers by 8/3/2023.

On 8/2/2023 the Registered Dietitian reviewed residents' medication administration record to ensure residents were receiving the correct amount of tube feeding. Any opportunities identified during this audit will be corrected by the Nurse Managers by 8/3/2023.

On 8/2/2023 the Director of Nursing, unit managers, and MDS nurses assessed the current residents for a change in condition. The assessment included a change in mental status, abnormal pain, a decrease in range of motion, and dehydration and will notify a medical physician immediately if a change in condition is noted.

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

On 8/2/2023 the Director of Nursing and Unit Managers educated Licensed Nurses regarding the requirement of notifying the medical provider following an incident, such as a fall, or change of condition and when they are unable to obtain a stat lab. The Director of Nursing and unit managers educated nurse aides and medication aides on when a change in condition is noted in the resident, they are to notify the Charge nurse immediately. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/3/2023 the Director of Nursing and unit managers educated licensed nurses when a resident is found to not receive the required amount of tube feeding the licensed nurses will inform medical provided immediately. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/2/2023, the Director of Nursing and unit managers educated the nurse aides on if a resident has fallen or if a change in condition is noted they are to notify the licensed nurses immediately. If the nurse aides assume the

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licensed nurses have not assessed the resident or made an attempt to call the medical physician, they will call the Director of Nursing and Administrator. The nurse aides were informed where the Administrator and the Director of Nursing numbers are posted, which is behind each nurse's station. On 8/3/2023, the Director of Nursing called the staff that were scheduled in the facility on 8/2/2023 for the hours of 7:00 a.m. until 3:00 p.m. to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. The education will include a pretest and posttest. Education will be completed by 8/3/2023.

On 8/3/2023 the Regional Nurse Consultant educated the Director of Nursing and unit managers on informing the Registered Dietitian when a resident is noted to have not received the required amount of tube feeding. Education completed on 8/3/2023.

On 8/2/2023 the Regional Director of Clinical Services educated the Director of Nursing, all unit managers, MDS nurse, and the Administrator regarding the clinical morning meeting process to include a review of residents with falls, stat labs, and change of condition, to validate completion and documentation notification of the MD and responsible party by reviewing progress notes, incident reports, medical provider notes, and orders. This education was completed on 8/2/2023.
Effective 8/3/2023 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged

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F 580	Continued From page 21 non-compliance. Date of alleged immediate jeopardy removal is 8/4/2023. On 8/7/2023 the facility's credible allegation for Immediate Jeopardy removal was validated. The validation was evidenced by record review of in-services given to staff and audits completed by staff management. Validation was also evidenced by interview of staff members from various departments. The facility's education was reviewed and included documentation of completion, per the facility's immediate jeopardy removal plan. The facility's audits were also reviewed. There was documentation that audits had been completed. Staff members from various departments were interviewed and reported that they had attended in-service training on notification of changes. The staff attendance was verified on the attendance logs. Staff members were able to report specific details of the training they had received that included notifying the medical providers following an incident, such as a fall, and if they were unable to complete a STAT order/lab. The Administrative team reported the education provided regarding notification of the medical team when a change of condition occurred. The immediate jeopardy was removed on 8/4/2023.	F 580		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that	F 637		9/6/23

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there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and medical record review, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessment within 14 days after the facility determined a significant change occurred for 1 of 1 residents (Resident #8) reviewed for Hospice.

Findings included:

Resident #8 was admitted to the facility on 12/11/15. The diagnosis included, in part, cerebrovascular disease and chronic pulmonary obstructive disease.

The significant change MDS assessment with an assessment reference date (ARD, the last day of the assessment period) of 7/24/23 was reviewed and revealed the assessment has not been completed as of 8/4/23.

Review of the Hospice admission agreement revealed Resident #8 received hospice services starting on 7/1/23.

An interview was conducted with the MDS Coordinator on 8/4/23 at 3:28 PM. She revealed

F637
1. A significant change Minimum Data Set (MDS) was completed on 8/9/2023 when facility became aware on 7/24/23 that resident #8 had choose Hospice services on 7/1/23. The modification to the MDS was completed by the MDS nurse.
2. A review of all residents that are receiving Hospice services, to ensure that a significant change MDS had been completed, was conducted by Administrator Consultant on 8/30/2023. No further issues were found.
3. Education was provided to the MDS Coordinators regarding the requirement of a significant change MDS within 14 days of the time that Hospice services is elected by the Administrator Consultant on 9/1/23. No MDS nurse is allowed to work after 9-1-23 until this education has been received. This education will be included in the new hire of MDS nurses on 9-1-23.
4. Verification of a significant change MDS will be completed by the Administrator or designee for any new resident that is receiving Hospice services weekly x 3

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F 637	Continued From page 23 that the significant change in status assessment was late because she was not aware that Resident #8 had started hospice services on 7/1/23 until 7/24/23. She further revealed that if she had been notified at the start of hospice services, she would have initiated the significant change at that time. During an interview with the Director of Nursing on 8/4/23 at 3:48PM, she acknowledged that Resident #8 started to receive hospice services on 7/1/23 and therefore the significant change assessment should have been completed within 14 days.	F 637	months. 5. Findings will be presented by the Administrator to the facility's Quality Assurance Performance Improvement committee monthly for 3 months and thereafter as requested. DATE OF COMPLIANCE 9-6-23	
F 638 SS=B	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete quarterly Minimum Data Set (MDS) assessments no later than 14 days after the Assessment Reference Date (ARD, the last day of the look-back period) for 9 of 53 residents (Residents #76, #104, #149, #165, #185, #141, #112, #171, and # 31) reviewed for resident assessments. The findings included: a. Resident #76 was admitted to the facility on 3/16/20.	F 638	F638 1. Unable to correct. Minimum Data Set (MDS) was submitted 14 days after the assessment reference date for resident #76, #104, #149 #165, #185, #141, #112, #171and #31 by the MDS Coordinator. 2. An audit was completed by MDS Coordinators for compliance with submission date on 9/1/23. All required MDSs were completed by MDS Coordinator on 9/5/23. 3. MDS coordinators were educated by the Administrator Consultant on 9/1/23 regarding compliance with guidelines for	9/6/23

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F 638	Continued From page 24 Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/23/23 and a completion date of 7/27/23. The quarterly MDS was completed 34 days after the ARD. b. Resident #104 was admitted to the facility on 8/23/21. Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/24/23 and a completion date of 7/28/23. The quarterly MDS was completed 34 days after the ARD. c. Resident #149 was admitted to the facility on 11/19/21. Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/24/23 and a completion date of 7/28/23. The quarterly MDS was completed 34 days after the ARD. d. Resident #165 was admitted to the facility on 8/9/22. Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/25/23 and a completion of 7/28/23. The quarterly MDS was completed 33 days after the ARD. e. Resident #185 was admitted to the facility on 3/21/23.	F 638	completion of MDSs within 14 days of the ARD. 4. Weekly audits for compliance with completion of MDS will be completed by Administrator for 4 weeks, then twice a month for 4 weeks, then monthly for 1 month. 5. Findings will be presented by the MDS nurse to the facility's Quality Assurance Performance Improvement committee monthly for 3 months and thereafter as requested. DATE OF COMPLIANCE 9-6-23	

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F 638	Continued From page 25	F 638		

Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/27/23 and a completion of 7/28/23. The quarterly MDS was completed 31 days after the ARD.

f. Resident #141 was admitted to the facility on 8/8/22.

Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/14/23 and a completion of 7/5/23. The quarterly MDS was completed 21 days after the ARD.

g. Resident #112 was admitted to the facility on 11/22/22.

Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/22/23 and a completion of 7/27/23. The quarterly MDS was completed 35 days after the ARD.

h. Resident #171 was admitted to the facility on 6/23/22.

Review of the resident's Minimum Data Set (MDS) assessment revealed a quarterly MDS had an Assessment Reference Date (ARD, the last day of the look-back period) of 6/23/23 and a completion of 7/27/23. The quarterly MDS was completed 34 days after the ARD.

An interview was conducted on 8/4/23 at 2:28 PM

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F 638	Continued From page 26	F 638		

with the facility's MDS Coordinator and she verified the quarterly assessment should be completed 14 days after the ARD. She indicated she was the only full time MDS Coordinator and had been assigned to other duties in the facility and that caused the assessments to be completed late. She indicated there were 2 part time MDS Coordinators that were working to get them completed.

An interview was conducted on 8/4/23 at 4:00 PM with the facility's Administrator. The Administrator indicated it was her expectation that the MDS assessments are completed timely. She indicated they were actively recruiting for another full time MDS Coordinator.

i. Resident #31 was admitted to the facility on 5/6/2020.

A review of the comprehensive MDS revealed a completion date of 1/16/2023. A review of the quarterly MDS assessment review date revealed a date of 4/18/2023. The quarterly MDS was completed and signed on 5/8/2023. This time frame was 112 days.

An interview was conducted with the MDS Coordinator on 8/3/2023 at 10:55 a.m. and she revealed she was aware some assessments had been completed late. A review of Resident #31's MDS record was conducted, and she stated it was completed and signed past the required time frame. She added, she had been pulled to cover for other departments and had not been fully staffed in the MDS department until recently.

An interview was conducted with the Administrator on 8/3/2023 at 10:03 a.m. and she

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F 638	Continued From page 27 revealed it was her expectation that MDS assessments be conducted on time.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to accurately document Preadmission Screening and Resident Review (PASARR) status and dental status on the Minimum Data Set (MDS) assessment. This occurred for 1 of 35 residents reviewed for accuracy of assessments (Resident #31). The findings included: 1.a. A level II PASARR determination notification dated 12/30/2019 was observed for Resident #31. Resident #31 was admitted to the facility on 5/6/2020 with diagnoses that included schizophrenia and a traumatic brain injury. The comprehensive MDS dated 1/16/2023 noted Resident #31 was not currently considered by the state level II PASARR process to have serious mental illness and/or intellectual disability or a related condition. An interview was conducted with MDS Consultant #1 on 8/3/2023 at 10:55 a.m. He reviewed the comprehensive MDS dated 1/16/2023 and stated the level II PASARR was coded inaccurately.	F 641	F641 1. Minimum Data Set (MDS) for Resident # 31 was modified during the survey (8/4/23) by MDS Coordinator to accurately reflect the Level 2 PASARR and the residents dental status. 2. An audit was completed by MDS Coordinators on 9/1/23 to ensure that PASARR and dental status were accurately documented. Any issues found were corrected by the MDS Coordinators by modifying the MDS by 9/5/23. 3. MDS coordinators were educated by the Administrator Consultant on 9/1/2023 regarding accuracy of the MDS. 4. The Administrator or designee will conduct weekly audits of 10% of completed MDS for compliance will be completed by then 10% twice a month, then 5% monthly. 5. Findings will be presented to the facility's Quality Assurance Performance Improvement committee by MDS Coordinator monthly for 3 months and thereafter as requested. DATE OF COMPLIANCE 9-6-23	9/6/23

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F 641	Continued From page 28 1.b. Resident #31 was admitted to the facility on 5/6/2020 with diagnoses that included schizophrenia, and a traumatic brain injury. A review of the nursing admission assessment dated 5/6/2020 documented Resident #31 had some missing teeth. A review of the Nurse Practitioner #2 progress note dated 8/13/2020 documented Resident #31 had poor dental health and was missing teeth. A review of the comprehensive MDS dated 1/16/2023 did not indicate Resident #31 had obvious or likely cavities or broken natural teeth. An observation was conducted of Resident #31 on 7/31/2023 at 9:15 a.m. Resident #31 had multiple broken teeth that were brown and black at the gum surface with visible heavy yellow coating on the unbroken teeth. An interview was conducted on 8/4/2023 at 10:21 a.m. with the MDS Coordinator at the bedside of Resident #31. She stated she observed Resident#31 had broken teeth and caries. She reviewed the comprehensive MDS and stated the assessment should have indicated his broken teeth and caries.	F 641		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		8/7/23

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F 684	Continued From page 29 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner (NP) and Medical Director interviews the facility failed to ensure a resident had on-going comprehensive assessments completed after a resident with functional quadriplegia experienced a second unwitnessed fall on 7/5/2023 at 1:00 p.m. and then later that same day had altered mental status due to suspected dehydration. A Physician video visit was conducted on 7/5/23 at 6:50 p.m. to evaluate the resident due to altered mental status. At that time the physician noted the resident had tenting skin (a sign of poor skin turgor that can be dehydration), was in mild distress, and had occasional moans. The physician ordered STAT (immediately) laboratory blood work and intravenous (IV) normal saline (mixture of sodium chloride and water used to treat dehydration). The STAT blood work was not collected until the morning of 7/6/23. The staff's failure to communicate pertinent information about the resident to each other and lack of comprehensive assessments caused a delay in medical evaluation and medical services which resulted in a serious adverse outcome. The Resident was discovered unresponsive in bed on 7/6/2023 at 9:50 p.m. and pronounced as deceased at 10:09 p.m. This occurred for 1 of 1 resident reviewed for quality of care (Resident #250). Immediate Jeopardy began on 7/5/2023 when Resident #250 had an acute change in condition and did not receive necessary care and services.	F 684	F684 1. Resident # 250 expired on 7-6-23. 2. Audit was completed by the Director of Nursing (DON), Unit Managers and Minimum Data Set (MDS) nurse on 8/2/2023 reviewing current residents from7/1-8/2 for falls, change in condition and STAT orders by reviewing the progress notes in the resident's medical record. Any concerns identified were corrected by 8-3-23 by the DON, Unit Managers or MDS Nurse. 3. 8/3/23 Regional Nurse Consultant educated Central Supply on the ordering process for clysis kits. 8/2/23 The Director of Nursing and Unit Managers educated Licensed Nurses regarding the requirements to complete fall documentation after the resident is assessed. The requirements for the documentation will be when a resident falls the licensed nurse will assess the resident immediately for pain, decrease in range of motion, and vital signs. If the resident has an unwitnessed fall the licensed nurse will assess for mental status, cognition, strength, coordination, range of motion, pain, gait and mobility and level of consciousness which will include vital signs as follows every 15 minutes for 1 hour, every 30 minutes for 1	

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Immediate Jeopardy was removed on 8/4/2023 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (actual harm that is not immediate jeopardy) to ensure the monitoring of the systems put into place and to complete facility employee training.

The findings include:

Resident #250 was admitted to the facility on 5/6/2020 with diagnoses that included functional quadriplegia, gastrostomy, and a cerebrovascular disease.

A review of the quarterly Minimum Data Set (MDS), dated 5/21/2023, revealed Resident #250 had severe cognitive impairment and had not had a fall since the prior assessment. She required extensive assistance of two staff members with bed mobility and personal hygiene and total assistance of one staff member for bathing. The Resident had a feeding tube and received greater than 51% of meals and greater than 501 cubic centimeters (cc) of fluids by this route.

A review of the Care Plan dated 5/21/2023, for Resident #250, had an identified focused area that read; The Resident had an activities of daily living self-care performance deficit related to confusion, dementia, and limited mobility. The interventions included, provide extensive assistance of staff to turn and reposition in bed, required extensive assistance with personal hygiene, and monitor/document declines in function.

An incident report dated 7/4/23 and completed by

hour, every hour for 4 hours and every 4 hours for the next 24 hours. The assessment will be documented in the resident's medical record.
8/2/23 The Director of Nursing and Unit Managers educated licensed nurses regarding change in condition. The education included charting the change in condition in the resident's medical record, calling the medical provider immediately, and implementing orders that are given stat immediately.
8/2/23 The Director of Nursing and Unit Managers educated the nurse aides on if a resident has fallen or if a change in condition is noted they are to notify the licensed nurse immediately. If the nurse aides assume the licensed nurses have not assessed the resident or made an attempt to call the medical physician, they will call the Director of Nursing and Administrator. The nurse aides ere informed where the Administrator and Director of Nursing numbers are posted, which is behind each nurse's station.
8/3/23 The Director of Nursing and Unit Managers educated the licensed nurses on if hypodermoclysis is not available in the facility they are to call the medical provider to receive new orders.
8/3/23 The Director of Nursing and Unit Managers educated the licensed nurses on what a stat lab order is given, they are to call the number to the lab company that is located at each nurse's station immediately.
8/3/23 The Director of Nursing and Unit Managers educated the licensed nurses that orders are to be carried out as the

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F 684	Continued From page 31 Charge Nurse #7, revealed the Resident #250 had an unwitnessed fall from the bed. She was discovered on the floor by staff. She was free of injury. A mental status assessment documented Resident #250 was oriented to person, place, and time. The physician was notified. The Administrator and Corporate Nurse Consultant were requested to provide any neurological exams conducted on 7/4/2023 after the fall and the fall incident report was the only documentation from Resident #250's medical record provided. An interview was conducted with the Corporate Nurse Consultant on 8/1/2023 at 11:09 a.m. and she provided a fall incident report for Resident #250 dated 7/4/2023. She confirmed this was all the documents from the medical record she had regarding the fall on 7/4/2023. An interview was conducted with Charge Nurse #7 on 8/2/2023 at 2:39 p.m. and revealed she had been assigned to Resident #250 on 7/3/2023 and 7/4/2023. When asked if she conducted assessments and provided tube feedings as ordered, she stated she documents what she had completed in the electronic medical record and tube feeding documentation would be on the Medication Administration record (MAR). An interview was conducted with Nurse Practitioner (NP) #1 on 8/2/2023 at 10:17 a.m. and she revealed she had a routine visit with Resident #250 on the morning of 7/5/2023 prior to 1:00 p.m. The Resident had responded to questions during the visit. She had not been informed on 7/4/2023 the family had concerns with leaking from the gastrostomy tube site and	F 684	medical provider orders when a resident has a change in condition. Failure to carry out the medical provider's orders may result in termination and reporting to the Board of Nursing. 4. The Director of Nursing and Administrator is responsible for ensuring that the above-mentioned staff have received the education prior working after 8-3-23. The education will be added to the orientation for new employees by the DON on 8-3-23. The Director of Nursing/Designee will audit progress notes, incident reports, medical provider notes and orders in the daily clinical meeting to ensure proper documentation and notification of medical provider and responsibility party of any falls, change in condition and stat orders daily for 30 days, then three times a week for 30 days, then weekly for 30 days. 5. The Director of Nursing will present findings to the facility's Quality Assurance Performance Improvement committee monthly for 3 months and thereafter as requested. DATE OF COMPLIANCE 8/7/23	

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had not been informed the family had concerns for dehydration.

A review of a grievance report, dated 7/6/2023, filed by the Guardian for Resident #250, revealed the family had concerns the Resident was dehydrated and her diet had been changed. It stated the family had discussed the concern with the Administrator the previous Thursday, 6/30/2023. The findings of the investigation included a note from the Administrator, that read; I spoke with the family on Tuesday, July 4, 2023, and not on Thursday. Resident showed no signs of dehydration at that time. Her skin turgor (the elasticity or firmness of skin) was good. Her mucous membranes were moist. Family were concerned regarding resident being wet and it not being urine but leakage from her tube feeding. Area being treated by the nurse. The nurse was not identified in the grievance report.
An interview was conducted with the Administrator on 8/2/2023 at 10:00 a.m. The grievance report, dated 7/6/2023 for the date of 7/4/2023, was reviewed and indicated the family had requested to meet with her. She met with the family in the Resident's room 7/4/2023. The family had expressed concerns that the Resident's tube feeding was leaking and causing dehydration. The Administrator stated assessed good skin turgor and moist mucous membranes. She did not assess the gastrostomy tube site. The Resident was wet as evidenced by dampness on her sheet. The Administrator indicated did not lift the sheet to assess if the wetness was from the tube site or urine. She requested the assigned nurse to arrange for the Resident to be provided dry sheets. She was unable to provide the name of the nurse because this was the Administrator's second day at the

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facility.

A review of the nursing progress notes for 7/5/2023 written by Charge Nurse #1 included the following late entries:

- 9:04 p.m. A situation, background, assessment, recommendation (SBAR) report was completed for a fall. The report stated: At the time of the evaluation the resident's vital signs were:
Blood Pressure: 132/68 taken on 7/5/2023 at 2:40 p.m.
Pulse: 63 taken on 7/5/2023 at 2:40 p.m.
Respiratory rate: 16 taken on 7/5/2023 at 2:40 p.m.
Temperature: 97.5 taken 7/5/2023 at 2:40 p.m.
Pulse oximetry: 96% taken 7/5/2023 at 2:40 p.m.
The recommendations provided by the provider were documented to follow the facility fall protocol. The SBAR did not include vital signs for the time of the fall. A post fall blood sugar was not included.
- 9:17 p.m. An SBAR was conducted for altered mental status. The vital signs were:
Blood Pressure: 109/67 taken on 7/5/2023 at 8:11 p.m.
Pulse: 86 taken on 7/5/2023 at 8:12 p.m.
Respiratory Rate: 20 taken on 7/5/2023 at 8:12 p.m.
Temperature: 97.7 taken 7/5/2023 at 8:12 p.m.
Pulse Oximetry: 90% taken 7/5/2023 at 8:12 p.m. on room air.
Findings reported on resident for this change in condition were altered level of consciousness. The Provider recommendations included a Complete Blood Count (CBC) with no differential, Comprehensive Metabolic Panel (CMP) with glomerular filtration rate (GFR), a Urine Analysis (UA) culture and sensitivity (C&S).

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A late entry progress note written at 9:17 p.m. on 7/5/2023 by Charge Nurse #1 read: Resident rolled out of the bed onto floor, bed was in lowest position. No complaints of pain or discomfort. No injury to note. Vital signs within normal range. Resident alert and able to respond appropriately to staff. On-call made aware of incident. No new orders concerning fall to note. There were no details regarding, 1) what happened to the reported assessments, 2) the specific values for the vital signs, and 3) if the fall was witnessed or if neuro checks were initiated.

There was not a fall incident report completed on 7/5/23 by Charge Nurse #1 for Resident #250's fall. In addition, there were no documented neurological checks located in the medical record.

A late entry progress note written at 9:20 p.m. on 7/5/2023, by Charge Nurse #1 read: Resident slightly lethargic, vital signs taken, and resident denies pain. Responding appropriately to staff, telehealth contacted. Video conference call made by on call physician. Determined altered mental status with tenting of skin the Resident had some dehydration. Labs were ordered and telephone order to begin resident on Intravenous (IV) normal saline at 100ml (milliliters)/hour x 72 hours. An attempt to start the IV was unsuccessful. Contacted telehealth on call to start hypodermoclysis (a method of administering fluids or medication under the skin). On call gave a telephone order to start the Normal saline at 60 ml/hour by hypodermoclysis until an IV could be started. There were no details regarding the specific values for the vital signs or if neurological checks were initiated or continued.

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A review of the On-Call Physician video visit summary, dated 7/5/2023 at 6:50 p.m., documented the resident had a fall out of the bed earlier in the day, and the staff were requesting the Resident be evaluated due to an altered mental status. The Resident presented with lethargy, increased confusion, nonverbal, and not engaging. The Resident had tenting skin (a sign of poor skin turgor that can be dehydration), was in mild distress, and had occasional moans. The assessment plan noted recent repeated falls and altered mental status (a change from a resident's base line alertness and cognition). Recommendations included to continue the facility post fall protocol, conduct a STAT CBC, CMP, UA with C&S, and Normal Saline (NS) at 100 ml/hr. x 72 hours.

A review of the On-Call Physician summary dated 7/5/2023 at 8:35 p.m., documented Charge Nurse #1 requested to administer the IV fluids via hypodermoclysis. The order was adjusted to 60 ml/hr. NS via hypodermoclysis. The Nurse reported the UA C&S and laboratory work was pending and an additional video conference was not needed.

The Corporate Nurse Consultant and Administrator provided a copy of the SBAR notes and the telehealth visit for the date of 7/5/2023. No other neurological assessments and no fall incident report for 7/5/2023, were provided.

An interview was conducted with Charge Nurse #1 on 8/1/2023 at 3:37 p.m. and revealed on 7/5/2023 she was the assigned nurse on the 7:00 a.m. - 11:00 p.m. shift. Resident #250 had a second unwitnessed fall and was discovered lying

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flat on the floor, on the window side of the bed, at 1:00 p.m. She was unable to provide the name of the staff member that discovered the Resident on the floor. She assessed the Resident, and she had no injuries. She was unsure if the Resident had hit her head, so she completed a neurological assessment, and the Resident was verbally responsive then she and another staff member (she did not recall) assisted the Resident back to the bed. She stated she had completed the neurological assessments and documented them on a piece of paper but did not conduct them at the recommended intervals required for an unwitnessed fall, that included every 15 minutes x 4, every 30 minutes x 4, every hour x 4, then every 4 hours x 4. When asked how many assessments she had completed, she stated, a few. She added she did not document an assessment (neurological assessment or vital signs), at the time of the fall, in the electronic medical record because she accidentally shredded the paper and was unable to obtain access to the shred storage box. Charge Nurse #1 added she did not write a progress note to summarize what she had assessed and did not notify a physician of the fall at that time. She was unsure why because a provider was available in the facility on that Friday at 1:00 p.m. Later in the shift, a nursing assistant, name unknown, informed her that the Resident was not responding like usual. Charge Nurse #1 was not able to specify an approximate time. She went to assess the Resident and discovered she had an altered mental status. The Resident was responding to questions with a yes or no reply only and was lethargic (drowsy, sluggish, and difficult to arouse). Charge Nurse #1 notified the on-call physician of the change in mental status and the fall that occurred at 1:00 p.m. She was

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not able to specify an approximate time for the on-call physician notification. This was the first time a physician was notified of the fall. She stated she created an SBAR that included the information reported to the physician and included the vital signs and neurological assessment conducted. The two SBAR progress notes were created at the end of her shift.
Charge Nurse #1 explained the On-call Physician conducted a visit via video conference at 6:50 PM and felt the Resident might be dehydrated. He ordered STAT (immediate) intravenous (IV) fluids of Normal Saline (NS) at 100 milliliters/hour (ml/hr.) for 72 hours, STAT laboratory work that included a complete blood count (CBC), complete metabolic panel (CMP), and a urinalysis (UA) with a culture and sensitivity (C&S). She entered the STAT laboratory order into the computer and wrote the laboratory order on the lab book. She did not call the Laboratory provider to inform them she had STAT blood work ordered. She then stated she had been unsuccessful at starting an IV for the Resident and called the on-call Physician back to request the fluids be delivered by hypodermoclysis (a method of administering fluids subcutaneously under the skin). She added she did not request a second nurse to attempt to start the IV. The physician agreed and adjusted the administration route as requested and the dosage was changed to 60 ml/hr. She added she had been unable to start the hypodermoclysis fluids because she needed to order the supplies from the pharmacy, and they did not arrive on her shift. She revealed she had not notified the on-call physician that the supplies for the fluids were unavailable and would be delayed. Charge Nurse #1 added she had thought the on-call physician would know the facility did not have the supplies. She conducted an in and out urine

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catheterization and did not receive enough urine to complete the urine lab orders and she had not notified the on-call physician that she was unable to collect the urine. She stated she reported to the following shift, Charge nurse #2, to try to collect more urine and did not report to the nurse another attempt to start the IV was requested by the on-call physician.

An interview was conducted with Nurse Aide (NA) #1 on 8/1/2023 at 5:25 p.m. and she revealed she had been assigned as the care giver to Resident #250 frequently. She added the Resident could move a little but did not usually fall out of the bed from movement. She was assigned to Resident #250 on 7/5/2023 and 7/6/2023, day shift. She was assigned to Resident #250 on 7/5/2023, 7:00 a.m. - 11:00 p.m. On 7/6/2023 she was assigned to Resident #250 from 7:00 a.m. - 3:00 p.m. At 3:00 she was pulled to conduct showers. She was unsure what NA took over the assignment. During her shifts, she added the Resident was "squirming" around more like she was uncomfortable. She stated the Resident was not her normal self on 7/6/2023 and this was reported this to the nurse. She did was not sure of the Nurses name. About a month prior to 7/5/2023 and 7/6/2023, she had reported to the Unit Manager (UM) the Resident's gastrostomy (G-tube) was leaking. She stated the leaking and the flap (the feeding port cover) to close the tube had not closed. She was informed by the UM a piece of tape had been placed over the closure area. She stated the concerns with the leaking tube feeding continued for the month and she had tried to inform the previous Administrator by going to his office and requesting to speak with him regarding Resident #250 but he "shooed" her away without listening and was ignored. She

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continued to provide reports regarding the leaking tube feeding to the UM.

A review of the facility progress notes for Charge Nurse #2, the 11:00 p.m. - 7:00 a.m. shift hall nurse for Resident #250, documented:

1) 7/6/2023 at 3:48 a.m. she attempted to collect a UA C&S from Resident #250 and a small amount returned from the in and out urine catheterization.

2) 7/6/2023 at 4:09 a.m. Resident #250 was started on NS via hypodermoclysis running at 60 ml/hr. Attempted the UA C&S earlier with no results due to a small amount of urine. This nurse will continue to monitor.

An interview was conducted with Charge Nurse #2 on 8/3/2023 at 9:31 a.m. and she revealed she was assigned to Resident #250 on the 7/5/2023 at 11:00 p.m. - 7/6/2023 at 7:00 a.m. shift. She received a report from Charge Nurse #1 that the Resident required Hypodermoclysis at 60 ml/hour to be started when the supplies arrived from Pharmacy. She did not receive a report that the on-call Physician requested the hypodermoclysis be conducted until an IV could be obtained on the Resident. At 3:48 a.m. she received the supplies and started the ordered fluids. She attempted to collect urine and was unable. She reported the Resident appeared to be dehydrated and had labored breathing. Charge Nurse #2 did not notify the on-call physician that she was unable to collect the UA C&S or that the Resident appeared dehydrated, because she had not been told she needed to. She did not conduct scheduled neurological assessments and document them in the electronic medical record.

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A review of the 7/6/2023 NP #1 progress note documented an unwitnessed fall without injury was reported. The Resident had a new onset of tachycardia and hypotension. Fluids from hypodermoclysis was observed initiated. Orders for a CBC, CMP, UA with C&S were ordered. The laboratory results were not completed at the time of the evaluation. Vital Signs: Blood pressure 83/46, Pulse 112, temperature 97.9, oxygen saturation 95% on room air. Level of consciousness: Nonverbal, lethargic, makes eye contact when spoken to. Information regarding this encounter were shared with the Unit Manager and Director of Nursing in person.

An interview was conducted with Nurse Practitioner (NP) #1 on 8/2/2023 at 10:17 a.m. and she revealed the On-Call physician for the medical group, had been notified on 7/5/2023 at 6:50 p.m. that the Resident had an unwitnessed fall from the bed at 1:00 p.m. When she arrived at the facility on 7/6/2023 she read the On-Call physician documentation from the 6:50 p.m. video visit on 7/5/23 and went to visit the Resident. Upon arrival in the room, the Resident had NS 60 ml/hr. running via hypodermoclysis. The Resident had vital signs, taken by NP #1, that included a blood pressure of 83/46 and a pulse of 112. The low blood pressure and the tachycardia could represent dehydration or an infection, therefore she needed to evaluate the laboratory results. The STAT laboratory work was not available in the electronic medical record. She called the laboratory provider and requested the results. She was informed there was pending laboratory blood work for Resident #250, but they had not been informed it was a STAT lab. The NP added she had not been notified of an error in the ordering of the STAT laboratory blood work. She

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revealed the failure to notify a Physician of the fall on 7/5/2023 until 1:00 p.m. and the laboratory work not being drawn STAT delayed the treatment and workup. She added, if she had received the critical laboratory results, at the expected time, around noon on 7/6/2023, she would have recommended treatment at a higher level of care. She did not receive the laboratory results prior to leaving for the day.

The NP provided the following instructions and orders prior to leaving the facility on 7/6/2023:

1) Midline IV to be placed and once started, begin 0.45% normal saline at 100 ml/hr. x 2 liters.
2) Discontinue the hypodermoclysis once the Midline is obtained.
3) Obtain a chest x-ray.
4) If the chest x-ray or UA results were abnormal or if the White Blood cells were elevated, please initiate 1-gram Rocephin intramuscular every day for 7 days.
5) If the Oxygen saturation drops below 90% give supplemental oxygen via nasal cannula as needed to keep oxygen saturation above 90%.

A progress note was written by Charge Nurse #3 for the date of 7/6/2023 at 12:47 a.m. that read; Resident was alert and oriented x 1. Nurse Practitioner ordered a Midline to be placed for fluids. Laboratory blood work was ordered and blood drawn. Will continue to monitor.

A progress note was written by the Unit Manager on 7/6/2023 at 6:39 p.m. that read; This writer notified on-call Nurse Practitioner #2 about the Resident's critical lab values reported from the laboratory provider. The Blood urea nitrogen (BUN) was 157.4 (normal range 6-20 mg/dl) ,

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Sodium 156 (normal range 135 - 145 mEq/l). The X-rays were ordered per the earlier orders and an IV access provider was contacted to start the midline.

Attempts were made to interview NP #2 without success.

Review of the critical lab results revealed:
BUN at 157.4 mg/dL (normal range 6-20 mg/dL)
Na at 156 mmol/L (normal range of 136-145)
Creatinine at 6.01 mg/dL (normal range 0.5-1.2 mg/dL)
BUN/Creatinine ratio at 26.2 (range of 6-25).

A progress note was written by Nurse #3 at 10:44 p.m. written by Charge Nurse #3, that read; Resident #250 was discovered unresponsive in her bed on 7/6/2023 at 9:50 p.m. and pronounced as deceased at 10:09 p.m.

An interview was conducted with Charge Nurse #3 on 8/3/2023 at 11:02 a.m. She revealed she had an assignment change on 7/6/2023 at 3:00 p.m. and was then assigned to Resident #250. This was the first time she was assigned to this resident. She stated she did not get all the information she was supposed to get in report. The Director of Nursing was present during the report. She thought the Resident had transitioned to Hospice services based on her report and that the Resident was experiencing an expected decline. She was not informed of the pending laboratory values and when the critical laboratory value results were received, the Unit Manager had received them and failed to inform her of the status and the family had been in to visit the Resident. She reported she was informed by a staff member and did not recall the name,

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that the Resident was unresponsive at 8:50- 9:00 p.m. (the progress note stated 9:50) and she went to the telephone to contact the physician and the Guardian. That was when she discovered the Resident was a full code and she began cardiopulmonary resuscitation (CPR). The team contacted 911 and emergency medical services (EMS) arrived around 10:00 p.m. and pronounced the Resident as deceased at 10:09 p.m. The Midline was never placed.

An interview was conducted with the Corporate Nurse Consultant on 8/2/2023 at 12:48 p.m. and she reviewed the Laboratory provider results for Resident #250, dated 7/6/2023. She stated the results should have indicated the term, "STAT" somewhere on the results. She investigated and discovered the Laboratory order should have been entered into the electronic medical record and then the Nurse was expected to call the laboratory provider to inform them the order was STAT. She was informed this step did not occur because the nurse forgot to call.

The death certificate signed by the Physician on 7/20/23 revealed the immediate cause of death were Cerebrovascular Accident (CVA), Vascular dementia, Lupus, and Dysphagia as late effect of CVA.

An interview was conducted with the Medical Director on 8/2/2023 at 12:25 p.m. and he revealed he was not allowed to list some conditions as the cause of death on a death certificate but if he was able, he would have listed fluid volume depletion disorder as the cause of death for Resident #250. He added it was his expectation that neurological assessments be conducted following an unwitnessed fall and

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documented in the electronic medical record. He stated it was his expectation that STAT laboratory work be conducted as ordered.

The Administrator and Corporate consultant were notified of the immediate jeopardy (IJ) on 8/2/2023 at 6:12 p.m.

The facility provided the following plan for IJ removal.

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

On 7/4/2023 resident #250 had an unwitnessed fall approximately 11:07 a.m. The charge nurse stated in her interview that a nurse aide informed her the resident had slid out of the bed. Upon entering the residents' room, the charge nurse noted the resident sitting on the floor with her back up against the nightstand. She asked the resident if she slid out of the bed and the resident shook her head yes. The charge nurse assessed the resident for pain, abnormal range of motion, and obtained her vitals. She stated that this was all within normal limits. The charge nurse assessed the resident for mental status, cognition, strength, coordination, range of motion, pain, gait and mobility, and level of consciousness because she was under the impression the fall was witnessed by the nurse aide. The charge nurse stated the lack of documentation was due to her becoming busy and it was a lapse in judgement. There is no supporting documentation regarding the on-going assessments being performed on the resident on 7/4/2023.

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On 7/5/2023 resident #250 had an unwitnessed fall approximately 1:00 p.m. The charge nurse stated in her interview that the maintenance assistant discovered the resident on the floor approximately 1:00 p.m. He asked the resident if she was okay, and she gave him a smile. The charge nurse was informed immediately and assessed the residents' range of motion, pain level, and vital signs. The charge nurse stated that the resident was not in pain and the range of motion and vital signs were within normal limits. During the duration of the day the charge nurse increased her rounds on the resident to ensure she did not have a change in condition. During the rounds the charge nurse stated she assessed the residents mental status, cognition, strength, coordination, range of motion, pain, gait and mobility, and level of consciousness. The mental status, cognition, strength, coordination, range of motion, pain, gait and mobility, and level of consciousness were within normal limits. The charge nurse stated the lack of documentation about the findings of her assessment were due to her throwing the sheet she had documented on in the shredder box and no one had a key to open the box. The charged nurse was asked why there was a lack of documentation in the residents' medical record from the fall and she stated that the day was extremely busy, and time got away from her.

On 7/5/2023 approximately 6:40 p.m. resident #250 was found to have a change in her mental status and the charge nurse informed the medical provider immediately. The medical provider called through tele-health and gave the charge nurse stat orders to obtain blood work, and urine for a culture and sensitivity and administer fluids via IV at 100mls per hour. The nurse attempted to start the IV twice and was unsuccessful. The

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nurse stated that she attempted to locate another nurse on a different unit and was unable to locate the nurse she was looking for. She called the on-call medical provider and received an order to run the fluids via hypodermoclysis and change the rate to 60mls per hour. The charge nurse could not locate a hypodermoclysis kit in the facility. She then called the pharmacy to send some kits on the next run. She stated she failed to call the provider back because she assumed the kits would be delivered before she left the facility. There is supporting documentation on 7/5/2023 at the following times 9:04 p.m., 9:11p.m., 9:17 p.m., and 9:50 p.m. On 7/6/2023 the kits arrived at the facility at approximately 3:00 a.m. The charge nurse that was on duty applied the cylsis kit and started the IV fluids approximately 3:20 a.m.

The charge nurse #1 entered the orders for the blood work to be drawn stat in the resident's medical record, however she failed to enter the orders into the lab computer system and failed to call the lab company for the labs to be drawn. She stated the reason is due to her forgetting that she needed to call the lab company to have the labs drawn stat. The blood work was drawn as a routine lab on 7/6/2023 due to the 11:00 p.m. to 7:00 a.m. nurse writing a requisition form at 6:00 a.m. and resulted at 5:28 p.m. per the lab results in the resident's medical record. The nurse practitioner viewed the resident medical recorded and noted the stat labs that were ordered had not resulted. She placed another order in the residents' medical record to obtain stat labs, however the NP was unaware of the labs being drawn that morning. The charge nurses and unit managers failed to call the lab company to follow-up on lab results. The NP called the lab

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company approximately 3:00 p.m. to follow up on the results and she was informed the labs were not drawn stat. She then asked the lab company to have the labs run stat. The lab work resulted at 5:28 p.m., and the critical labs were called to the facility at 6:28 p.m. to the unit manager. The unit manager attempted to reach out to the provider on-call immediately. The provider called the unit manager back approximately 9:23 p.m. with no new orders. The charge nurse stated the resident was last seen at 8:45 p.m. and the resident was resting. The resident was found to be unresponsive on 7/6/2023 approximately at 8:45 p.m. and resident was pronounced deceased at 10:09 p.m.

On 8/3/2023, the Regional Nurse Consultant spoke with the Director of Client Services for the pharmacy regarding the cylsis kits. He stated that the kits are normally not sent to the facility unless it is requested. The Director of Client Services stated that 12 clysis kits will be sent to the facility on 8/4/2023.

On 8/3/2023, the Regional Nurse Consultant educated Central Supply on the ordering process for the cylsis kits, such as filling out the ordering form and faxing the sheet to pharmacy or calling the pharmacy to request to amount that is needed, to ensure 10 kits are in the facility for licensed nurses to access in the medication rooms.

On 8/2/2023 the Director of Nursing, unit managers, and MDS nurse reviewed current residents that had fallen on 7/1/2023 through 8/2/2023 to ensure nurse assessed residents for a change in condition by reviewing the progress notes in the residents' medical record. The

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assessments included range of motion to ensure within normal limits, pain to ensure resident has no abnormal pain, mental status, cognition, strength, coordination, gait and mobility, and level of consciousness to ensure there were no changes to the residents. There were no abnormal findings.

On 8/2/2023 the Director of Nursing, unit managers, and MDS nurse reviewed current residents progress notes from the medical providers from 7/1/2023 through 8/2/2023 to ensure orders that were ordered stat were implemented immediately. There were no stat orders that were not implemented immediately.

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

On 8/2/2023 the Director of Nursing and Unit Managers educated Licensed Nurses regarding the requirements to complete fall documentation after the resident is assessed. The requirements for the documentation will be when a resident falls the licensed nurse will assess the resident immediately for pain, decrease in range of motion, and vital signs. If the resident has an unwitnessed fall the licensed nurse will assess for mental status, cognition, strength, coordination, range of motion, pain, gait and mobility, and level of consciousness which will include vital signs as follows every 15 minutes for 1 hour, every 30 minutes for 1 hour, every 1 hour for 4 hours, and every 4 hours for the next 24 hours. The assessments will be documented in the resident's medical record. On 8/3/2023 the Director of Nursing called the staff that were scheduled in

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the facility on 8/2/2023 for the hours of 7:00 a.m. until 3:00 p.m. that were not in the facility on 8/3/2023 to ensure education was received and understood over the phone. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/2/2023 the Director of Nursing and unit managers educated the licensed nurses regarding a change in condition. The education included charting the change in condition in the residents' medical record, calling the medical physician immediately, and implementing orders that are given stat immediately. On 8/3/2023, Director of Nursing called the licensed nurses that were scheduled in the facility on 8/2/2023 for the hours of 7:00 a.m. until 3:00 p.m. to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/2/2023, the Director of Nursing and unit managers educated the nurse aides on if a resident has fallen or if a change in condition is noted they are to notify the licensed nurses immediately. If the nurse aides assume the licensed nurses have not assessed the resident or made an attempt to call the medical physician, they will call the Director of Nursing and Administrator. The nurse aides were informed where the Administrator and the Director of

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Nursing numbers are posted, which is behind each nurse's station. On 8/3/2023, the Director of Nursing called the staff that were scheduled in the facility on 8/2/2023 for the hours of 7:00 a.m. until 3:00 p.m. to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/2/2023 the Director of Nursing and unit managers educated the licensed nurses on if a hypodermoclysis is not available in the facility they are to call the medical provider to receive new orders. On 8/3/2023, the Director of Nursing called the staff that were scheduled in the facility on 8/2/2023 for the hours of 7:00 a.m. until 3:00 p.m. to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/2/2023 the Director of Nursing and Unit managers educated the licensed nurses on when a stat lab order is given, they are to call the number to the lab company that is located at each nurse's station immediately. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.
On 8/3/2023 the Director of Nursing and Unit

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managers educated the licensed nurses that orders are to be carried out as the medical provider ordered when a resident has a change in condition. Failure to carry out the medical provider orders may result in termination and reporting to the board of nursing. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

Effective 8/3/2023 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 8/4/2023.

On 8/7/2023 the facility's credible allegation for Immediate Jeopardy removal was validated. The validation was evidenced by record review of in-services given to staff and audits completed by staff management. Validation was also evidenced by interview of staff members from various departments.

The facility's education was reviewed and included documentation of completion, per the facility's immediate jeopardy removal plan. The facility's audits were also reviewed. There was documentation that audits had been completed.

Staff members from various departments were interviewed and reported that they had attended in-service training on charting a change of condition in the resident's medical record, calling the medical physician immediately, and

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F 684	Continued From page 52 implementing orders that are given STAT. The staff attendance was verified on the attendance logs. Staff members were able to report specific details of the training they had received that included notifying the medical providers following an incident for a change of condition, documentation of a change of condition in the chart, and completion of all orders as ordered. The Administrative team reported the education provided regarding notification of the medical team when a change of condition occurred. The immediate jeopardy was removed on 8/4/2023.	F 684		
F 692 SS=J	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		8/7/23

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F 692	Continued From page 53 This REQUIREMENT is not met as evidenced by: Based on record review and staff, Registered Dietician (RD), Speech Therapy (SLP), Nurse Practitioner (NP) and Physician interviews, the facility failed to maintain the hydration status for 1 of 2 residents reviewed for tube feedings (Resident # 250). When it was determined the resident was dehydrated, the facility failed to administer ordered fluids immediately, and failed to complete STAT (immediate) laboratory orders to assess the resident and provide information to the physician for needed treatment. The resident had critical laboratory values of Blood Urea Nitrogen (BUN) - 157.4 milligrams per deciliter (mg/dL) (normal range 6 - 20 mg/dL) (test measures the amount of urea nitrogen found in blood), Creatinine at 6.01 mg/dL (normal range 0.5-1.2 mg/dL), and Sodium level (Na) -156 millimoles per liter (mmol/L) (normal range 135 - 145 mEq)(measures the amount of sodium in your blood) (elevated BUN, Creatinine and Sodium can be indicators of dehydration; dangerously high BUN levels indicates kidney damage that should be addressed immediately) on 7/6/23 at 5:30 pm. The resident was pronounced dead on 7/6/23 at 10:09 pm. This was for 1 of 2 residents (Resident #250) reviewed for tube feeding. Immediate Jeopardy began on 7/5/23 when Resident #250 was observed to have signs and symptoms of dehydration and the facility failed to ensure the resident received immediate interventions. Immediate Jeopardy was removed on 8/4/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm	F 692	F692 1. Resident #250 expired on 7-6-23. 2. The Registered Dietician (RD) reviewed all current residents that are receiving tube feeding to ensure adequate hydration was ordered. The Director of Nursing (DON) assessed current residents that are receiving tube feeding for signs and symptoms of dehydration. This audit was completed on 8-3-23. Any concerns identified were addressed on 8-3-23 by the DON or RD. 3. 8/2/23 The DON and Unit Managers educated licensed nurses to ensure residents are receiving the amount of tube feeding, this is also to include water flushes as ordered by the physician on Education includes when order for fluids is receiving the amount of tube feeding, this is to include water flushes as ordered by the medical provider. Education includes when orders for fluids are received to give stat this is to be done without lapse of time, without delay. 8/3/23 The Director of Nursing and Unit Managers educated current staff, to include housekeeping, dietary, maintenance, social workers and nursing, if they notice the tube feeding leakage, feeding pump alarming, or removal of tube, they are to notify the nurse immediately. 8/3/23 The Director of Nursing and Unit Manager educated licensed nurses,	

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F 692	Continued From page 54 with potential of more than harm that is not immediate jeopardy) to complete education and to immediately implement effective systems for residents with tube feedings to ensure adequate hydration. Findings included: Resident #250 was readmitted to the facility on 3/27/23 with diagnoses that included Cerebral Vascular Accident (CVA), lupus, dysphagia, and gastrostomy tube placement. Review of Medical Orders for Scope of Treatment (MOST) form with an effective date of 3/9/2021 revealed checked mark on "Attempt Resuscitation" with full scope of treatment including antibiotic use and feeding tube for long term if indicated. A lab report for CMP on 1/26/23 at 10:19 am revealed the results were BUN - 13.2 mg/dL, Na - 141 mmol/L, Creatinine - 0.57 mg/dL (check for normal function of kidney) (normal range 0.5 - 1.20 mg/dL), and BUN/Creatinine ratio - 23.2 (normal range 6 -25). Interview with RD on 8/2/23 at 8:28 am revealed Resident #250 had been receiving Gastrostomy Tube (GT) feedings since her admission to the facility in 2020. She stated that in October 2021, the resident had order for therapeutic nutrition formula 1.2 continuous tube feeding at 60ml/hr. A physician order on 3/23/23 revealed pleasure food with aspiration precautions was initiated. The pleasure food tray consisted of a pureed diet and thin liquids.	F 692	medication aides and nurse aides on the signs and symptoms of dehydration. 8/3/23 The Director of Nursing and Unit Managers educated license nurses on dehydration is a serious risk for the long-term tube-fed resident who is not allowed oral intake, has an altered mental status, is unable to communicate is elderly or fluid restricted, or has thirst impairment. The Director of Nursing and Administrator will ensure that the above-named staff will not work unless educated. Education will be added to the orientation program for new employees by the DON on 8-3-23. 4. The Director of Nursing or Designee will review and assess all tube-fed residents weekly for clinical signs of dehydration for 4 weeks, then 50% of tube-fed residents for 4 weeks, then 25% of tube-fed residents for 4 weeks. 5. The Director of Nursing will present the findings to the facility's Quality Assurance Performance Improvement committee monthly for 3 months and thereafter as requested. DATE OF COMPLIANCE 8-7-23	

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The quarterly Minimum Data Set (MDS) on 5/1/23 coded Resident #250 with severely impaired cognition. Resident #250 could communicate her needs to staff. She was coded to require extensive assistance with bed mobility, transfer, dressing, eating, toilet use, and personal hygiene. She was coded to have a feeding tube for nutrition.

A physician order for tube feeding on 5/4/23 revealed Resident #250 would receive a GT feed of therapeutic nutrition formula 1.2 Cal at 60 ml per hour continuous feeding and 125 ml of water flush every 4 hours. The order also included an instruction to allow tube feeding to be turned off for 2 hours per day to prevent the feeling of fullness for the resident.

A care plan dated 5/31/23 revealed a goal to remain free of side effects or complications related to tube feeding, to maintain adequate nutritional and hydration status, and no signs and symptoms of malnutrition or dehydration. The intervention included to monitor aspiration, shortness of breath, tube dysfunction/malfunction, abnormal lab values, and dehydration.

Interview with the RD on 8/2/23 at 9:10 am revealed the resident weighed 131 pounds (lbs.) on 6/12/23 and needed at least 1,800 ml of fluids per day to maintain her hydration.

A telephone interview with SLP on 8/2/23 at 11:41 am revealed she evaluated Resident #250 on 6/27/23 for her swallowing and meal consumption. She stated the facility wanted to advance the resident to bolus tube feeding due to clogging issues with her GT. She stated the

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resident needed one person assistance to eat. She stated during her assessment, the resident ate 100% with her help. She said the resident demonstrated good rehabilitation potential as she followed direction and was an active participant. She further stated that the resident could drink thin liquids.

A progress note written by RD on 6/28/23 revealed that Resident #250 was referred by Director of Nursing (DON) due to recently being seen by SLP with good oral intake of pureed diet with thin liquids. The height of 68 inches with Current Body Weight (CBW) of 131.30 (6/12/2023) with a normal Body Mass Index (BMI) of 20.0. Weight history of 1.00% change for 30 days and -0.45% for 90 days. There were no significant weight changes and/or trends present during her assessment. A weekly weight order was to monitor the resident. Resident #250 receives a pleasure tray of a pureed diet with thin liquids consuming about 51-100% of some meals. Resident previously reported that she normally doesn't eat anything by mouth. The resident on red tray status related to aspiration precautions. Resident #250 also receives therapeutic nutrition formula 1.2 at 60cc/hr. with 125cc H2O flushes q4hrs. Tube Feed (TF) may be turned off for 2 hours per day to prevent a feeling of fullness. The current TF regimen provides: 1320 mL, 1584 kcals (kilo calorie), 73-gram protein, and 1082 mL free water plus 750 mL from flushes equals to 1832 mL fluid total. The GT is also flushed with 30 ml of water before/after meds, before initiating feeding, or when there is an interruption of feeding to maintain tube patency. Resident tolerated the TF. RD Recommended to add "to promote oral intake," to change TF regimen to 8 oz bolus

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feedings of therapeutic nutrition formula 1.5 TID 1 hour after each meal if consumes less than 50% of corresponding meal to promote oral intake/nutrition support. Always give 8 oz bolus of therapeutic nutrition formula 1.5 every day at 9 pm for additional nutrition support.

Interview with RD on 8/2/23 at 8:29 am revealed that she visited Resident #250 twice a month since 2020 for her dietary evaluation. She stated Resident #250 was stable and had an order for pleasure trays with thin liquids. She stated that the Director of Nursing (DON) spoke to her on changing the continuous tube feeding to bolus for the resident was eating more than 75% of her food. The RD then recommended on 6/28/23 to give the resident pureed diet meal with thin liquids and changed the tube feeding to bolus of therapeutic nutrition formula 1.5 Cal 8oz 4 times a day with 30 ml of water flushes before and after the bolus. An additional instruction was that bolus will only be given if the resident ate less than 50% of her meal.

A physician order that was initiated on 6/28/23 revealed Resident #250's GT feeding was changed to a bolus of therapeutic nutrition formula 1.5 Cal 8oz 4 times a day with 30 ml of water flush before and after the bolus. An instruction to give bolus 1 hour after every meal if the resident ate less than 50%. A 30 ml of water flushes before and after medication was also included.

Interview with Medication Aide #1 (Med Aide) on 8/2/23 at 2:59 pm revealed she worked with Resident #250 for 2 to 3 weeks before she passed. She stated that the NA's would report how much the resident ate for her meals and if it

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was less than 50%, they should give the bolus feeding. She stated that the GT leaked feeding several times and she stated that NA #1 also reported the leaking to the Charge Nurse in the hall several times.

Review of the staff schedule provided by the Director of Nursing (DON) on 8/2/23 revealed that NA #1 was scheduled to work with Resident #250 on 7/1/23, 7/2/23, 7/3/23, 7/4/23, 7/5/23, and 7/6/23 in the morning and part of the evening shift.

Interview with NA #1 on 8/1/23 at 5:25 pm revealed she took care of Resident #250 most of the time when she was working on the third floor. She stated that the tube feeding was leaking and draining in the bed that started on June 16, 2023. She stated that when she checked the resident, the bed sheets would be wet with the tube feeding solution. She stated that the tube leaked due to the top of the GT not closing well and the nurses put tape around the top but would dislodge all the time. She also stated the GT would be clogged and it will keep the feeding pump beeping for hours before a nurse would come and stop the pump from beeping. She stated she told the Charge Nurse #1 of resident's poor meal intake which was less than 50% on 7/1/23, 7/2/23, 7/3/23, 7/4/23, 7/5/23, and 7/6/23. She stated she reported it to the Unit Manager and even reported it to the previous Administrator about the resident not eating and the GT was leaking.

Interview with RD on 8/2/23 at 8:29 am stated that therapeutic nutrition formula 1.5 Cal 8oz 4 times a day amounted to 724 ml of free water. She stated after looking at the electronic record

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filled by the NA's, the resident received all tube feeding boluses from June 28 - 30, 2023 and from July 1 - 6, 2023.

Review of the Medication Administration Record (MAR) and per mouth (PO) Intake form provided by the facility revealed Resident #250 was documented of receiving fluid on the following dates:
6/28/23 with 2,314 ml of fluid intake
6/29/23 with 2,264 ml of fluid intake
6/30/23 with 1.964 ml of fluid intake
7/1/23 with 1,894 ml of fluid intake
7/2/23 with 1,964 ml of fluid intake
7/3/23 with 2,014 ml of fluid intake
7/3/23 with 1,964 ml of fluid intake
7/4/23 with 1,964 ml of fluid intake
7/5/23 with 1,664 ml of fluid intake
7/6/23 with 2,384 ml of fluid intake.

Interview with NA #2 on 8/3/23 at 11:51 am revealed she had seen the tube feed leaking from the Resident #250's tube. She saw the G-tube removed from resident's stomach one time and was hanging out, and she reported it to the Charge Nurse on the hall. She did not remember what day it happened or who the charge nurse was at that time.

Interview with the Housekeeper #1 on 8/1/23 at 2:56 pm revealed she worked on the short hall on the third floor where Resident #250 resided. She stated that the tube feeding machine pump kept beeping and it could take an hour before nursing staff would come and look. Housekeeper #1 stated she reported the beeping to the Charge Nurse. She stated that the tube feeding leaked brown milky drips on the floor next to Resident #250's bed. She would mop them every day when

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she worked in the hall. She described the spill on the floor as big as a basketball ball and needed a scraper to remove the dried tube feeding on the floor. She reported the tube feeding leakage to her supervisor and the Charge Nurse on the hall.

Interview with the Unit Manager on 8/2/23 at 2:02 pm revealed a Charge Nurse on the floor once reported Resident #250's feeding tube was leaking a little and she didn't remember when and who reported to her. She stated it was never leaked or clogged when she was working as a charge nurse on the hall.

Interview with the Power of Attorney (POA) on 8/3/23 at 12:40 pm stated the family was visiting the resident twice a week. She stated the family told her they were worried about Resident #250's report from staff that Resident #250 was not eating well and her changed condition. She said the resident used to be alert and communicated her needs to family. She said the family reported the GT leaking to the Charge Nurse. She stated she didn't understand why the resident went downhill from the time they changed the tube feeding order.

Interview with the Administrator on 8/2/23 at 10:13 am revealed the grievance report for 7/6/23 was received after the death of the resident. She documented on the bottom of the form that she had assessed Resident #250 on 7/4/23. The Administrator wrote that Resident #250 showed no signs of dehydration at that time. She wrote the skin turgor was good, observed her with moist mucous membranes. She stated the family was concerned of dehydration and the GT leaking.

Record review of printed cellphone text

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messages provided by the facility on 7/5/23 at 6:40 pm revealed Charge Nurse #1 contacted the Physician via text messaging. She informed the Physician of Resident #250 was refusing meals, slightly lethargic and thought the resident may be dehydrated. The Physician answered that he was not the primary physician for Resident #250.

Record of telehealth document dated 7/5/23 at 6:50 pm provided by NP#1 revealed that Charge Nurse #1 contacted the on-call Physician via telehealth, and she wanted Resident #250 to get checked out for altered mental status with lethargy and increased confusion. Resident #250 was seen by the on-call Physician through video call with the Charge Nurse and skin tenting (test that can indicate severe dehydration) was seen by the on-call Physician. It was also noted that the resident had multiple falls including earlier that day on 7/5/23. The on-call Physician ordered STAT Complete Blood Count (CBC) no differential (the total number of white blood cells), Comprehensive Metabolic Panel (CMP), Serum Osmolality (the concentration of chemicals in your blood for fluid imbalance), Urinalysis with Culture and Sensitivity (UA C&S) (culture looks for bacteria that cause UTI's and sensitivity test can pinpoint the bacteria), and IV of Normal Saline (NS) at 100 ml/hr. for 72 hours. The telehealth video was not recorded according to the facility Administrator when asked for a copy of the encounter.

A Situation Background Assessment Recommendation (SBAR) note dated 7/5/23 at 8:17 pm completed by the Charge Nurse #1 revealed Resident #250 had altered mental status. The Nurse contacted the On-call Physician via telehealth, and she got the order for

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Intravenous (IV) fluids for Normal Saline (NS) to run for 100ml per hour (ml/hr.) for 72 hours, stat CBC, CMP, and UA C&S.

Record review of the telehealth document dated 7/5/23 at 8:35 pm provided by NP #1 revealed Charge Nurse #1 contacted the on-call Physician asking if they can do hypodermoclysis since she could not get an IV started and on-call Physician advised her to do hypodermoclysis at 60 ml/hr. and to continue all previous orders.

Interview with Charge Nurse #1 on 8/1/23 at 2:40 pm revealed she received an order from the on-call Physician after the Telehealth call 7/5/23 at 9:17 pm. She stated that Resident #250 was not as responsive as she was before the past two weeks. She stated she was on vacation a week before and came back the week of 7/5/23. She stated that the on-call Physician asked her to do skin tenting on the resident's skin and the on-call Physician determined that the resident was dehydrated and ordered the IV of NS for 100ml/hr. Charge Nurse #1 stated she was unsuccessful in her attempts to start an IV and there was no available nurse when she tried to seek help for the IV insertion. She called the on-call Physician again and asked for an order for hypodermoclysis (a method of administering fluids under the skin) instead of IV. She got the order to infuse NS 60ml per hour via hypodermoclysis until the IV could be placed. Charge Nurse #1 revealed that there was no hypodermoclysis kit available in the facility and she called the pharmacy to deliver hypodermoclysis kit in their next delivery. Charge Nurse #1 did not mention the order for urine C&S.

A telephone interview with Charge Nurse #2 on

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8/3/23 at 9:31 am revealed she started the hypodermoclysis on 7/6/23 at 3:57 am. She stated the pharmacy delivered the hypodermoclysis kit around 3 am. She stated that Resident #250 looked dehydrated with very dry lips. She also stated that Resident #250 had labored breathing. She stated that her attempt to collect the urine sample was unsuccessful with an in-and-out catheter because there was small amount urine output, and it was not enough to send to lab. She stated she didn't think of reporting anything to the Physician at that time.

Record review of the progress note written on 7/6/23 at 3:57 am revealed the hypodermoclysis was started by Charge Nurse #2. A note included that the attempt to collect urine sample was unsuccessful due to the small amount of urine. The note also read to continue to monitor the resident.

Interview with the NP #1 on 8/2/23 at 10:17 am revealed she visited Resident #250 in the morning of 7/6/23 around 10 am. She followed up on the stat laboratory results that were ordered by the on-call Physician and discovered they were not drawn or completed. No one from the facility staff could answer her about the labs. She said if they were ordered stat, they should already have the lab result. NP#1 stated she reordered the stat labs, chest x-ray, and reordered the IV. NP #1 spoke to the lab technician around 11 am -12 pm and stated the lab result should be out around 1 pm. She kept checking the electronic medical record around 1 pm and there was no lab result. NP #1 called the lab again to follow up and learned the lab requisition did not indicate stat. She stated the Lab Tech tracked the blood specimen to complete the testing. NP #1 stated

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she requested the RD to change the water flushes to 240ml of water for 24 hours for dehydration.

Record review of the progress note on 7/6/23 at 12:47 pm written by Charge Nurse #3 revealed the NP ordered Mid-line catheter (an 8-12 centimeters catheter inserted in the upper arm with the tip located just below the axilla) for IV fluids. The blood sample was drawn at noon and was sent to the lab for testing.

An encounter note dated 7/6/23 at 2:47 pm by the NP #1 revealed the resident was nonverbal and lethargic. The vital signs taken by the NP #1 revealed the Blood Pressure (BP) - 83/46-millimeter mercury (normal range above 90/60 and less than 120/80), and Heart Rate (HR) - 112 beats per minute (normal range 60 -100). The progress notes further revealed that Resident #250 became tachycardic (high HR) and hypotensive (low BP). NP #1 ordered Mid-line IV and to continue hypodermoclysis of Sodium chloride (NaCl) at 60 ml/hr. until IV was placed. Then begin 0.45% NaCl at 100 ml/hr. She added an order for stat chest x-ray and UA with C&S. NP #1 also ordered an increase in water flushes to 240 ml every four hours. NP #1 wrote that she was waiting for the stat CBC and CMP and would change fluids if needed. And then she wrote that for positive results, or elevated WBC, she will initiate treatment with 1gm Ceftriaxone (antibiotic) intramuscularly (IM) daily for 7 days. She added on her instruction that if SpO2 (oxygen saturation level) is less than 90% (normal range is 95% - 100%) to give supplemental oxygen via nasal cannula as needed to keep SpO2 less than 90%.

Interview with NP #1 on 8/2/23 at 11:51 am

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revealed she didn't know about issues of GT leaking or clogging of Resident #250's GT.

Interview with NP #1 at 8/2/23 on 10:17 am revealed the delay in drawing the labs and obtaining the results delayed the treatment and work up for the resident. NP #1 stated she would have sent the resident to a higher level of care for evaluation which would have provided the best possible outcome.

The progress notes on 7/6/23 at 6:39 pm written by the Unit Manager revealed she notified NP for Resident #250's critical laboratory results with a BUN at 157.4 mg/dL (normal range 6-20 mg/dL), and Na at 156 mmol/L (normal range of 136-145). The other laboratory high results were Creatinine at 6.01 mg/dL (normal range 0.5-1.2 mg/dL), and BUN/Creatinine ratio at 26.2 (range of 6-25). There were orders for chest x-ray and Mid-line IV access to be started. The progress note revealed the Unit Manager contacted IV access (a third-party company that inserts Mid-line catheter) to place Mid-line catheter.

Progress note written by Charge Nurse #3 on 7/6/223 at 10:44 pm revealed Resident #250 was found unresponsive at 9:50 pm. The emergency response was initiated immediately and 911 was called to help. Cardio-Pulmonary Resuscitation (CPR) was started. The NP #1 was notified about the resident's status. At 10:09 pm the Emergency Medical Services (EMS) team pronounced Resident #250 deceased and the Power of Attorney (POA) was notified.

Interview with Charge Nurse #3 on 8/3/23 at 11:02 am revealed that she was working with Resident #250 on 7/6/23 at 7:30 pm and that

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there was an order from the NP #1 for Mid-line catheter placement. She stated that the Mid-line catheter was never inserted, and she did not know who was supposed to insert the Mid-line catheter. She stated Resident #250 didn't look too good and the family members were in the room with the resident. She stated that the resident was able to shake her head to answer when the family was talking to her. She stated there was so much confusion at that time and it was her first-time taking care of the resident. She said she was not told by the Unit Manager what was happening with the resident.

Interview with the Physician on 8/2/23 at 12:25 pm revealed that the cause of death on the death certificate he signed for Resident #250 was chosen based on the most recent diagnoses. He stated that the state won't allow him to write fall or dehydration. He added he would have chosen Fluid Depletion Disorder based on the electronic medical record information that included critical lab values.

The death certificate signed by the Physician on 7/20/23 revealed the immediate cause of death were Cerebrovascular Accident (CVA), Vascular dementia, Lupus, and Dysphagia as late effect of CVA.

The Administrator and the Regional Nurse Consultant were notified of the immediate jeopardy on 8/2/23 at 6:12 pm.

The Administrator provided and implemented the following credible allegation of compliance on 8/4/23.

Identify those recipients who have suffered, or

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are likely to suffer, a serious adverse outcome as a result of the noncompliance.
On 6/28/2023 resident #250 had an order to receive bolus tube feeding of 8 ounces of Osmolite 1.5 for nutrition support one time a day. She also had an order to receive 8 ounces of Osmolite 1.5 for nutrition support after corresponding meal if consumed <50% three times a day. The order includes flushing with 30 cc of water before and after bolus. The resident received the new orders due to her ability to eat a puree diet and drink thin liquids per the speech therapist. The resident received a new order on 7/6/2023 to receive 240ml of water flushes every 4 hours. In interviewing the staff that worked on the unit resident resided on the residents feeding from the tube were found to be leaking on the floor from the tube hanging on the pole or leaking in the bed due to the tube becoming disconnected from the peg.

On 7/5/2023 approximately 6:40 p.m. resident #250 was found to have a change in her mental status and the charge nurse informed the medical provider immediately. On 7/5/2023 the medical provider called through tele-health at 6:50 p.m. and gave the charge nurse stat orders to obtain blood work, urine culture and sensitivity, and administer fluids via IV at 100mls per hour. The nurse attempted to start the IV twice and was unsuccessful. She called the on-call medical provider and received an order to run the fluids via hypodermoclysis and change the rate to 60mls per hour. The charge nurse could not locate a hypodermoclysis kit in the facility. She then called the pharmacy to send some kits on the next run. She stated she failed to call the provider back because she assumed the kits would be delivered before she left the facility. On

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7/6/2023 the kits arrived at the facility at approximately 3:00 a.m. The charge nurse that was on duty applied the cylsis kit and started the IV fluids approximately 3:20 a.m.

On 7/5/2023 charge nurse #1 entered the orders for the blood work to be drawn stat. The charge nurse failed to enter the orders into the lab computer system and failed to call the lab company for the labs to be drawn. She stated the reason is due to a lapse in memory to call the lab company. The charge nurse attempted to obtain urine on the resident. She stated she was unable to obtain enough for the lab company to run the lab. The blood work was drawn on 7/6/2023 at 6:00 a.m. and resulted at 5:28 p.m. The critical lab values of BUN 157.4 mg/dl and sodium level 156mEq/L were called to the unit manager at 6:28 p.m. By this evidence, the resident did not receive an adequate amount of fluid. Upon reviewing the residents' medical record there was a lack of evidence that assessments for dehydration were completed.

On 8/2/2023 Registered Dietitian reviewed and assessed current residents that are receiving tube feeding to ensure residents are receiving adequate hydration. The RD assessed the following, estimated energy needs verses what the tube feeding regimes are providing and for any complications or intolerances. The RD reviewed the residents that are receiving continuous feeding via pump to ensure the correct feeding was being administered, rate of the feeding, flushes were entered correctly on the tube feeding pump, and to verify the amount that was administered correlated to the time it was started. The RD verified the residents that are receiving their tube feeding via bolus have the

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correct tube feeding on each unit. The RD confirmed there are no further residents residing in the facility receiving food intake and supplement tube feeding. There are no residents that reside in the facility that are receiving meals and supplement tube feeding. There was no area of concern.

On 7/13/2023, the Director of Nursing was reviewing the medical recorded of resident #250. Upon reviewing the critical labs, the Director of Nursing called the medical director to receive new orders to obtain lab work on current residents that were receiving tube feeding. There were no areas of concern.

On 7/13/2023, the Director of Nursing assessed current residents on tube feeding for nutrition and hydration for signs and symptoms of dehydration due to resident #250 not assessed appropriately for dehydration. This is to ensure residents that are receiving tube feeding are being properly hydrated. There were no areas of concern.

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

On 8/2/2023, the Director of Nursing and unit managers educated license nurses to ensure residents are receiving the amount of tube feeding, this is also to include water flushes as ordered by the medical physician. Education includes when orders for fluids are received to give stat this is to be done without lapse of time, without delay. The Director of Nursing called the staff that were scheduled in the facility on 8/2/2023 for the hours of 7:00 a.m. until 3:00 p.m.

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to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.
On 8/2/2023, the Director of Nursing and unit managers educated current staff, to include housekeeping, dietary, maintenance, social workers, and nursing, if they notice the tube feeding leaking feeding pump alarming, or removal of tube, they are to notify the nurse immediately. The Director of Nursing called the following staff, housekeeping, dietary, and nursing, that were scheduled in the facility on 8/2/2023 to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/3/2023, the Director of Nursing and unit manages educated the license nurses, medication aides, and nurse aides on the signs and symptoms of dehydration, which are fatigue, dark colored urine and low urine output, dry skin, decrease in skin elasticity, and cracked lips, headaches, light-headedness and dizziness, and low blood pressure. The Director of Nursing called the license nurses, medication aides, and nurse aides that were scheduled in the facility on 8/2/2023 on all shifts throughout the day to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff,

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will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

On 8/3/2023, the Director of Nursing and unit managers educated the license nurses on dehydration is a serious risk for the long-term tube-fed resident who is not allowed oral intake, has an altered mental status, is unable to communicate, is elderly or fluid-restricted, or has thirst impairment. The Director of Nursing called the staff that were scheduled in the facility on 8/2/2023 on all shifts to ensure education was received and understood. The Director of Nursing and the Administrator will ensure no staff will work without receiving this education. Any new hires, including agency staff, will receive education prior to the start of their shift via phone or in person. Education will be completed by 8/3/2023.

Effective 8/3/2023 the Administrator will be ultimately responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 8/4/2023

On 8/7/23, the facility's credible allegation for immediate jeopardy was validated. The survey team confirmed the education and training included information on calling the Physician, NP, and On-Call NP immediately after assessing a change of mental status for any residents. Education on implementing orders that are given stat to be done immediately without lapse, to report the inability to follow a physician order (that includes not being able to get stat orders carried out) to be reported to the physician immediately. Education on assessing and documenting

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F 692	Continued From page 72 residents with change of mental status. Education on signs and symptoms of dehydration. Education of any staff who notices a gastrostomy tube leaking, feeding pump alarming or removal of tube, will notify the nurse immediately. Interview with several facility staff about getting the educations were validated. The team observed a resident on tube feeding and there were no concerns. The facility provided the logs and audits for tube feedings. The facility also implemented the monitoring process for reviewing weekly assessments for each resident with tube feedings and to assess for clinical signs of dehydration weekly. The facility's corrective action plan was validated on 8/7/23.	F 692		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically;	F 803		9/6/23

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F 803	Continued From page 73 §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interview, the facility failed to provide residents with the correct portion sizes as specified by the menus and the meal production worksheets for 1 of 1 meal observation. This practice had the potential to affect all residents with regular consistency diets. Findings included: An observation of the dietary staff plating meals from the meal steamtable in the kitchen was conducted with the Dietary Manager (DM) on 8/2/23 at 1:15 p.m. One cooked patty of hamburger steak was placed on the plates of residents receiving meals of regular texture. The hamburger steaks on the tray line were all of equal shape and size. Only one hamburger steak patty was plated for each tray observed. This surveyor requested and the DM weighed one of the cooked hamburger steak patties from the steamtable which yielded a weight of 2-ounces. The dietary department's meal production worksheet used in determining the amount of each food item to serve to each resident indicated each resident was to receive 4-ounces of cooked hamburger steak patty. Review of the manufacturer's box containing the	F 803	F803 1. The Dietary Manager added two pieces of meat to each resident□s tray on 8-2-23 to account for the correct weight of the food. 2. All residents have the potential to be affected by this deficient practice. 3. The Regional Dietary Manager and Regional Culinary Director provided education on 8-18-23 to all dietary staff on portion control. This education included the expectation that protein items will randomly be weighed on the kitchen scale after completion of the cooking process to ensure accuracy in served portions. The cooked food item portion will follow the facility menu spreadsheets. This education will be provided to all new dietary staff hired. 4. The Dietary Manager will monitor portion sizes via random weight audits of cooked proteins. This will occur 3 times a week, times 4 weeks, then twice weekly times 4 weeks and once weekly x 4 weeks. 5. The Dietary Manager will present the weight audits to the Quality Assurance Performance Improvement Committee x 3	

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F 803	Continued From page 74 frozen hamburger steak patties revealed there were 40 portions of unbreaded, raw beef steaks each weighing 4 ounces. During an interview on 8/2/23 at 2:32 p.m., the Dietary Manager (DM) revealed he began working at the facility in March 2023. The DM indicated the hamburger beef steaks ordered by dietary were to yield 4-ounces in cooked weight. He concluded the dietary department would no longer purchase this product due to its inadequate portion size when cooked.	F 803	consecutive meetings. The QAPI committee will determine the need for further monitoring after the initial correction time frame. DATE OF COMPLIANCE 9-6-23	
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on test tray observation, record reviews and interviews with residents and the Dietary Manager (DM), the facility failed to serve food that was palatable and at temperatures acceptable to 1 of 5 Halls (400 Hall). This practice had the potential to affect other residents. Findings included: Resident #26 was admitted to the facility on 05/11/09. Resident #26 resided on the 400 Hall.	F 804	F804 1. On 9-1-23, the Dietary Manager spoke with resident #26 regarding the concern of meals being cold and the taste of the food not being good. 2. All residents have the potential to be affected by this deficient practice. 3. The Regional Dietary Manager and Regional Culinary Director provided education on 8-18-23to all dietary staff on palatability, temperatures and quality of food being served. This education will be	9/6/23

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F 804	Continued From page 75 A review of the Quarterly Minimum Data Set (MDS) assessment dated 06/30/22 revealed Resident #26 was cognitively intact and independent with eating after assistance with meal set up. During an interview with Resident #26 on 08/01/23 at 11:15am she indicated she had concerns with her meals being cold and the taste of the food was not good. She stated she only would receive a small amount of food and it would be cold on her meal trays. Resident #26 indicated she had reported this information to the Administrator, but he never did anything about it. An interview was conducted on 08/03/23 at 1:00pm with Resident #26 during her lunch meal and she revealed she had not eaten some of her meals because they "tasted so bad." Resident #26 stated the food tasted like it was not seasoned (no salt or pepper) and it did not taste good at all. Resident #26 indicated the food was barely warm and the potatoes and rice were mushy. She stated, she just could not eat the meal and described the meal as being, "awful, cold, tasted horrible, and not fit to eat." The Resident further stated her lunch meal on 08/03/23 was just another example of the food not being "fit to eat." Her lunch meal appeared to be chopped meat (hamburger), mashed potatoes with gravy and corn. The weekly Test Meal Tray Audits conducted by the DM dated from 6/5/23-7/24/23 were reviewed. The audits were of different meal services, delivered on different floors, and were of different diets. The audits rated all the meals as "Good" in appearance, temperatures, portion control, quality, flavor, and tray accuracy.	F 804	included for all newly hired dietary staff. 4. The Dietary Manager will monitor palatability and food temperatures via test trays. This audit will be conducted 3 times a week, times 4 weeks, then twice a week times 4 weeks followed by weekly times 4 weeks. The Regional Culinary Director will monitor palatability randomly 1 time a week times 12 weeks. The Alliance Health Group Dietary Manager or designee will conduct a weekly test tray weekly times 12 weeks. 5. The Dietary Manager will present the palatability and temperature audits to the Quality Assurance Performance Improvement committee x 3 consecutive months. The QAPI committee will determine the need for further monitoring after the initial correction. DATE OF COMPLIANCE 9-6-23	

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F 804	Continued From page 76 An observation of the meal tray line service in the kitchen was conducted on 8/2/23 at 1:15 p.m. The temperatures of the food items on the steamtable were taken by the DM using a calibrated stem thermometer. The temperatures of the food items of regular consistency were greater than the acceptable 135 degrees Fahrenheit. The food items were placed on heated plates from a plate warmer. The plated meals were covered with insulated, dome shaped lids with bottoms. The covered meals were placed in a 4-sided, stainless steel delivery cart and transported via elevator to the fourth floor at 2:22 p.m. where the nursing staff immediately began serving the residents on the 400 Hall. A test meal tray of the regular textured foods was included in the meal delivery cart. On 8/2/23 at 2:32 p.m., after the residents of the 400 short hall were served, the DM and this Surveyor observed the test meal tray for palatability. The hamburger steak patty was cool to taste with a rubbery texture. The corn and rice were cold. The DM participated in the testing of the meal tray and acknowledged these findings. During an interview on 8/2/23 at 2:32 p.m., the DM revealed he began working at the facility in March 2023 and did not frequently receive complaints from residents concerning the quality of the food.	F 804		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		9/6/23

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policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct

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F 867	Continued From page 79 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview, the facility's Quality Assessment and Performance Committee (QAPI) failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint investigation survey conducted on 2/19/21, recertification/revisit and complaint survey conducted on 4/27/21 and the recertification and complaint investigation survey	F 867	F867 The facility's Quality Assurance Committee failed to maintain implemented procedures and monitor the interventions the facility put into place following the complaint investigation survey conducted on 2/19/21, recertification/revisit and complaint survey conducted on 4/27/21 and the recertification and complaint	

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F 867	Continued From page 80 conducted on 5/24/22. This was for five deficiencies in the areas of: Advanced Directives (F578), Notification of Changes (F580), Quality of Care (F684), Nutrition/Hydration Status Maintenance (692), and Menus Meet Residents Needs (F803) which were originally cited during the recertification and complaint investigation survey conducted on 5/24/22 and recited during the current recertification and complaint investigation survey conducted on 8/7/23. In addtion, Accuracy of Assessments (F641) was cited on the complaint investigation survey conducted on 2/19/21, recertification/revisit and complaint survey conducted on 4/27/21, recertification and complaint investigation survey conducted on 5/24/22 and recited during the current recertification and complaint investigation survey conducted on 8/7/23. The continued failure of the facility during four federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. Findings Included: This tag is cross referenced to: F578 - Based on record review and staff interviews the facility failed to determine on admission a resident's desired advanced directives throughout the medical record for 3 of 35 residents (Resident #189, #399, and #8) reviewed for advanced directives. During the recertification and complaint investigation survey completed on 5/24/22 the facility failed to code the minimum data set (MDS) accurately in the area of hospice for 1 of 1 resident sampled for hospice services.	F 867	investigation survey conducted on5/24/22. This was for five deficiencies in the areas of: Advanced Directives (F578), Notification of Changes (F580), Quality of Care(F684), Nutrition/Hydration Status Maintenance (692), and Menus Meet Resident's Needs (F803) which were originally cited during the recertification and complaint investigation survey conducted on 5/24/22 and recited during the current recertification and complaint investigation survey conducted on 8/7/23. In addition, Accuracy of Assessments (F641) was cited on the complaint investigation survey conducted on 2/19/21, recertification/revisit and complaint survey conducted on 4/27/21, recertification and complaint investigation survey conducted on 5/24/22 and recited during the current recertification and complaint investigation survey conducted on 8/7/23. The continued failure of the facility during four federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance and Performance Improvement Program. A plan of Correction for F578, F580, F684, F692, F803 cited during the recertification and complaint survey on 5/24/22 and F641 on recertification and complaint survey 5-24-22, recertification and complaint survey on 4/27/21 and complaint survey on 2/19/21 were submitted to CMS and accepted with follow up and return to compliance visits. Plans of correction were put into place at the time of each deficiency cited. Each plan of correction included monitoring	

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F 867	Continued From page 81 F580- Based on record review, staff, and Nurse Practitioner (NP) interviews the facility failed to immediately notify the physician of Resident #250's unwitnessed fall that occurred on 7/5/2023 at 1:00 p.m. The on-call physician was not notified of the fall until 7/5/2023 at 6:50 p.m. when it was discovered the resident had an altered mental status. The facility also failed to immediately notify the physician when the ordered intervention of STAT (immediate) laboratory work and normal saline (mixture of sodium chloride and water used to treat dehydration) were not able to be completed STAT. Additionally, the facility failed to notify the physician of Resident #250's tube feeding that was found leaking on the floor and in the bed. These failures resulted in a delay in the physician's initial assessment and initiation of treatment. Resident #250 was discovered unresponsive in her bed on 7/6/2023 at 9:50 p.m. and pronounced as deceased at 10:09 p.m. This occurred in 1 of 2 residents reviewed for notification of change. During the recertification and complaint investigation survey conducted on 5/24/22 the facility failed to: 1) immediately inform the physician when Resident #610 had an unwitnessed fall and could not get up as usual and notify the physician of x-ray results upon receipt from the radiology company. Resident #610 was diagnosed with a fractured femur and a spinal injury. 2) notify the physician, who received anticoagulant medication, fell for two of three residents reviewed for accidents. F641 - Based on observation, record review, and staff interviews the facility failed to accurately	F 867	tools, and review of monitoring tools during monthly Quality Assurance Committee meetings for a defined amount of time. Monitoring of each plan of correction was presented to the Quality Assurance Committee and no further issues were identified throughout the monitoring period and were discontinued. The Administrator initiated an in-service to all administrative staff on 8/28/23 regarding Quality Assurance Performance Improvement processes including identifying and prioritizing quality deficiencies, systemically analyzing causes of systemic quality deficiencies, developing, and implementing corrective action or performance improvement activities, and monitoring and evaluating the effectiveness of corrective action/performance improvement activities. This in-service included ensuring accuracy of audits, extending audits when appropriate, and reviewing corrective action/performance improvement activities to evaluate the effectiveness of each plan and revise as necessary. All newly hired administrative staff will receive the appropriate education during orientation. No Administrative staff will work until they have received the appropriate education. To ensure quality assurance, the Administrator will review the facility Quality Assurance Master Checklist and scheduled audits monthly to ensure that those areas noted to be deficient are systemically analyzed and corrective action implemented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 08/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW VALLEY CENTER FOR NURSING AND REHAB	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 867	Continued From page 82 document Preadmission Screening and Resident Review (PASARR) status and dental status on the Minimum Data Set (MDS) assessment. This occurred for 1 of 35 residents reviewed for accuracy of assessments (Resident #31). During the recertification and complaint investigation survey conducted on 5/24/22 the facility failed to code the minimum data set (MDS) accurately in the area of hospice for 1 of 1 resident sampled for hospice services. During the recertification/complaint and focused infection control survey conducted on 4/27/21 the facility failed to accurately code the swallowing and nutrition section (Section K) on the Minimum Data Set (MDS) assessment for 2 of 15 residents reviewed for MDS accuracy. During the complaint investigation survey conducted on 2/19/21 the facility failed to accurately code the minimum data set for impairment in range of motion and significant weight loss for 1 of 1 resident that was reviewed for range of motion and nutrition F684 - Based on record review and staff, Nurse Practitioner (NP) and Medical Director interviews the facility failed to ensure a resident had on-going comprehensive assessments completed after a resident with functional quadriplegia experienced a second unwitnessed fall on 7/5/2023 at 1:00 p.m. and then later that same day had altered mental status due to suspected dehydration. A Physician video visit was conducted on 7/5/23 at 6:50 p.m. to evaluate the resident due to altered mental status. At that time the physician noted the resident had tenting skin (a sign of poor skin turgor that can be	F 867	The Administrator will be responsible for the plan of correction. Date of Compliance: 9-6-23	

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F 867	Continued From page 83	F 867		

dehydration), was in mild distress, and had occasional moans. The physician ordered STAT (immediately) laboratory blood work and intravenous (IV) normal saline (mixture of sodium chloride and water used to treat dehydration). The STAT blood work was not collected until the morning of 7/6/23. The staff's failure to communicate pertinent information about the resident to each other and lack of comprehensive assessments caused a delay in medical evaluation and medical services which resulted in a serious adverse outcome. The Resident was discovered unresponsive in bed on 7/6/2023 at 9:50 p.m. and pronounced as deceased at 10:09 p.m. This occurred for 1 of 1 resident reviewed for quality of care (Resident #250).

During the recertification and complaint investigation survey conducted on 5/24/22 the facility failed to assess Resident #610 after he was found on the floor and was unable to get up without assistance, as he normally was able to do. Two nurse aides picked him up from the floor and put him in bed. The nurse was not informed. The next day, Resident #610 was prepared for a transfer by Social Worker Assistant #1 when Resident #610 was found in pain and had a swollen knee. An assessment was initiated, the Nurse Practitioner assessed, ordered x-rays and pain relievers. X-ray results were faxed to the facility late that night but were not seen until close to noon the following day. Resident #610 was diagnosed with a femur fracture, a spinal injury and a rectus sheath hematoma. A rectus sheath hematoma is an accumulation of blood in the sheath of the abdominus muscle. This deficient practice affected one of three residents reviewed for accidents.

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F 867	Continued From page 84	F 867		

F692- Based on record review and staff, Registered Dietician (RD), Speech Therapy (SLP), Nurse Practitioner (NP) and Physician interviews, the facility failed to maintain the hydration status for 1 of 2 residents reviewed for tube feedings (Resident # 250). When it was determined the resident was dehydrated, the facility failed to administer ordered fluids immediately, and failed to complete STAT (immediate) laboratory orders to assess the resident and provide information to the physician for needed treatment. The resident had critical laboratory values of Blood Urea Nitrogen (BUN) - 157.4 milligrams per deciliter (mg/dL) (normal range 6 - 20 mg/dL) (test measures the amount of urea nitrogen found in blood), Creatinine at 6.01 mg/dL (normal range 0.5-1.2 mg/dL), and Sodium level (Na) -156 millimoles per liter (mmol/L) (normal range 135 - 145 mEq) (measures the amount of sodium in your blood) (elevated BUN, Creatinine and Sodium can be indicators of dehydration; dangerously high BUN levels indicates kidney damage that should be addressed immediately) on 7/6/23 at 5:30 pm. The resident was pronounced dead on 7/6/23 at 10:09 pm. This was for 1 of 2 residents (Resident #250) reviewed for tube feeding.

During the recertification and complaint investigation survey conducted on 5/24/22 the facility failed to obtain weekly weights ordered by the physician for a resident with weight loss for 1 of 6 residents (Resident #23) reviewed for nutrition.

F803 - Based on observations, record reviews, and staff interview, the facility failed to provide residents with the correct portion sizes as specified by the menus and the meal production

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F 867	Continued From page 85	F 867		

worksheets for 1 of 1 meal observation. This practice had the potential to affect all residents with regular consistency diets.

During the recertification and complaint investigation survey conducted on 5/24/22 the facility failed to follow the planned menu and document an approved menu substitution made during one of one meal observation conducted. This practice affected all residents receiving a regular-textured, mechanically-altered, or pureed diet.

An interview with the Administrator on 8/4/23 at 5:22 pm revealed she was new to the facility and had only been there for 3 weeks. She stated she was not aware of any active QAPI (quality assurance and performance improvement) plans in place at the facility and that the facility had not been tracking and trending but had planned to start at the next QAPI meeting next month.