STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/18/24 through 11/22/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #G8DF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/18/24 through 11/22/24. Event ID# G8DF11. The following intakes were investigated NC00223809, NC00222744, NC00212346, NC00223363, NC00221939,NC00222081, NC00220866,NC00220260, NC00213283 and NC0000214925. Intake NC00223809 resulted in immediate jeopardy. 5 of the 32 complaint allegations resulted in a deficiency. 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 (J) The tags F684 and F692 constituted Substandard Quality of Care. Immdiate Jeopardy began on 10/31/24 and was removed on 11/21/24. An extended survey was conducted.	F 000		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		12/18/24

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

Electronically Signed | 12/20/2024

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F 580 SS=J	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, family member, Physician Assistant, and Medical Director interviews the facility failed to notify the physician of a significant change in condition when staff were unable to obtain a urine sample on 3 instances (10/31/24 at approximately 5:00 AM and 9:00 PM and 11/1/24 at approximately 5:30 AM) for a resident identified with complaints of burning urination and decreased fluid intake. Resident #294 was first identified with decreased nutritional and fluid intake on 10/29/24 requiring staff to push fluids (deliberately drink beyond what thirst dictates to avoid dehydration) through 11/1/24. On 10/30/24 the resident complained of burning urination (dysuria) and was ordered a urinalysis (used to detect abnormalities such as blood, protein, glucose, and indirect indicators of bacterial infection) and urine culture and sensitivity (used to diagnose a urinary tract infection and determine the best treatment). Resident #294 exhibited signs and symptoms of dehydration on 10/31/24 at approximately 9:00 PM and 11/1/24 at approximately 5:30 AM as evidenced by the inability to collect urine via an in and out catheter (inserting a thin, hollow tube into the bladder) when the resident had no recent	F 580	Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to altered mental status. The center recognizes that all patients have the potential to be affected from the noncompliance of notifying the physician as it relates to obtaining a urine sample for residents identified with complaints of burning urination and decreased fluid intake, including signs and symptoms of dehydration as evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief. A review of Resident #294's electronic medical record revealed an order for UA w/ reflex, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain a urine sample on 10/31/2024 at approximately 5:00 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed	

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F 580	Continued From page 3 episodes of urination. The first notification to a medical provider was made to the Physician Assistant when she arrived at the facility on 11/1/24 at approximately 10/10:30 AM. During this time, nursing staff continued to administer the resident's Lasix (diuretic) 20 milligrams once daily at 9:00 AM despite signs and symptoms of dehydration and did not contact the physician regarding the diuretic administration. On 11/1/24 Resident #294's family member requested the resident be sent to the hospital. Emergency Medical Services (EMS) were contacted at 3:42 PM and Resident #294 was transferred to the emergency room where he was identified with altered mental status, tachypnea (rapid and shallow breathing), poor perfusion (occurs when there is inadequate blood circulation to organs and tissues and can be an early sign of circulatory or heart problems and can lead to life-threatening conditions), hypothermia (a medical emergency that occurs when the body's temperature drops below 95°F), severe lactic acidosis (occurs when the body produces too much lactic acid and the liver can't metabolize it fast enough), and new vasopressor requirements (vasopressors are a medication that are used to treat people with low blood pressure) most consistent with septic shock (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) with end organ dysfunction. Resident #294 died at 8:26 PM on 11/1/24. This deficient practice occurred for 1 of 3 residents (Resident #294) reviewed for notification of significant changes. Immediate jeopardy began on 10/31/24 when staff failed to notify the physician of a significant change in condition when Resident #294	F 580	Lasix 20mg daily to be administered daily per physician's orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure a urine sample was obtained. nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to the physician. No discrepancies were noted. Twenty-three (23) residents identified as having a physician order to administer diuretics were audited by the Director of Nursing and Unit Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. No resident was identified with signs and symptoms of dehydration as evidenced by the inability to collect urine, therefore notification to the physician was not warranted. On 11/20/2024, a root cause analysis was completed by the Director of Clinical Services and the Executive Director regarding notifying the physician for Resident #294 when staff were unable to obtain a urine sample. It was determined through the root cause analysis that the facility failed to follow policy and procedures to notify the physician regarding change in condition as it relates to decreased fluid intake for Resident #294 receiving Lasix and unable to obtain a urine sample.	

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F 580	Continued From page 4 exhibited signs and symptoms of dehydration and staff were unable to obtain a urine specimen via an in and out catheter when the resident had no recent episodes of urination. Immediate jeopardy was removed on 11/21/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective. The findings included: Resident #294 was admitted to the facility on 10/7/24. His diagnoses included dementia, type 2 diabetes, adult failure to thrive, generalized muscle weakness, chronic kidney disease, and congestive heart failure. A physician order dated 10/7/24 indicated give Lasix oral tablet 20 milligram by mouth one time a day for edema (swelling from fluid retention). Lasix is a diuretic used to treat fluid retention that can result from congestive heart failure, kidney disease or other medical conditions. (Lasix increases the flow of urine and can lead to dehydration.) Resident #294's admission Minimum Data Set (MDS) assessment dated 10/12/24 coded Resident #294 as cognitively intact. He required supervision or touching assistance with toileting. He required setup or clean up assistance with eating. He was coded as frequently incontinent of bowel and bladder and was also coded as taking a diuretic. Resident #294's overall discharge goal was to return to the community. He was not	F 580	The Director of Clinical Services and Nurse Managers re-educated licensed nurses on notifying the physician for residents identified as having a change in condition via a Situation, Background, Assessment and Recommendation (SBAR) as it relates to assessing residents with signs and symptoms of dehydration on 11/20/2024. The licensed nurse is to assess the resident, including vitals, complete the SBAR and notify the attending physician when there is a change in the status or condition of the resident. The Director of Nursing and/or Unit Managers re-educated licensed nurses on recognizing signs and symptoms of dehydration to ensure prompt physician notification for change in condition on 11/20/2024. Staff (licensed nurses/Certified Nursing Assistants) who were not educated on 11/20/2024, will be educated by the Director of Nursing and/or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by the Director of Nursing and/or Unit Manager on notifying the physician for residents identified as having a change in condition via SBAR as it relates to assessing residents with signs and symptoms of dehydration. The Director of Clinical Services and/or Nurse Managers re-educated licensed nurses on notifying the physician via change in condition (SBAR) for residents with an order for UA/C&S and unable to obtain a urine sample on 11/20/2024. The licensed nurse is to assess the resident, including vitals, complete the SBAR and	

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F 580	Continued From page 5 coded for hospice care. A facility 24-hour condition report completed by Nurse #5 dated 10/29/24 indicated Resident #294 had poor oral intake on day shift. The facility's 24-hour condition report is a form that nurses document the status of all the residents during or at the end of their shift to communicate any pertinent information to the next shift and nursing management. (Breakfast and lunch meals are served during the day shift which starts at 7:00 AM and ends at 3:00 PM.) During an interview with Nurse #5 on 11/18/24 at 2:45 PM, she stated that she had cared for Resident #294 on 10/29/24 from 7:00 AM to 7:00 PM. Nurse #5 indicated that normally Resident # 294 consumed more than 25% of his tray food and drinks but on 10/29/24 he had eaten and drank less than 25% during breakfast, lunch and dinner and she documented it in the 24 hour report and informed the oncoming night shift nurse (Nurse # 4). A facility 24-hour condition report completed by Nurse #4 dated 10/30/24 indicated Resident #294 was complaining of burning with urination on night shift (10/29/24 11:00 PM to 10/30/29 7:00 AM shift). During an interview on 11/19/24 at 3:53 PM with Nurse #4, she stated that she was assigned to care for Resident #294 on 10/29/24 at 7:00 PM to 10/30/24 at 7:00 AM. Nurse #4 stated that during shift change Nurse #5 had informed her and documented in the 24-hour condition report that Resident #294 had a decreased oral intake with food and drinks. Nurse #4 verbalized that Resident #294 complained of burning with	F 580	notify the attending physician when there is a change in the status or condition of the resident. The Director of Clinical Services and/or Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed nurse on 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. Staff (licensed nurses/Certified Nursing Assistants) not educated on 11/20/2024, will be educated by the Director of Nursing and/or the Unit Manager prior to working the floor. Date of Immediate Jeopardy Removal = 11/21/2024 The Director of Clinical Services and/or Nurse Managers re-educated certified nursing assistants on identifying a change in condition to include signs and symptoms of dehydration and to immediately report any change in condition to the licensed nurse on 11/20/2024. Education includes any time an order is given but not able to be completed for any reason, the floor nurse or clinical manager will call the physician for additional instructions. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. Staff (licensed nurses/Certified Nursing Assistants) not educated on 11/20/2024, will be educated	

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F 580	Continued From page 6 urination during her shift and she left a note for the Provider in the physician book, noted it in the 24-hour condition report and informed the oncoming day shift nurse (Nurse #1). Nurse #4 stated that Resident #294 was stable and the only concern during her shift was complaints of burning with urination which she noted in the physician's book and she pushed fluids while Resident #294 was awake because she thought it was a sign of urinary tract infection. Resident #294's medication administration record indicated Lasix 20 mg was administered on 10/30/24 at 9:00 AM by Nurse #1. A Physician telephone order dated 10/30/2024 at 11:59 AM ordered by Physician Assistant (PA) #2 indicated urinalysis (UA), urine culture and sensitivity (C & S) for a diagnosis of dysuria. A facility 24-hour condition report dated 10/30/24 on day shift (7:00 AM to 3:00 PM) completed by Nurse #1 and evening shift (3:00 PM to 11:00 PM) completed by Nurse #6 indicated the need for a UA/C&S for Resident #294 in the morning (10/31/24). During an interview on 11/19/24 at 10:20 AM with Nurse #1, she indicated that she had cared for Resident #294 on 10/30/24. Nurse #1 stated that when she came to work on 10/30/24 at around 7:00 AM she was informed by the off going night shift nurse (Nurse #4) that Resident #294 had complained of pain with urination during the night shift (10/29/24 at 7:00 PM to 10/30/24 at 7:00 AM). Nurse #1 verbalized that a UA/C&S to rule out a urinary tract infection was ordered during her shift (10/30/24 7:00 AM- 7:00 PM) but she did not attempt to obtain a urine sample since it	F 580	by the Director of Nursing and/or Unit Manager prior to working the floor. The Director of Clinical Services and/or Nurse Managers will provide quality monitoring daily in clinical review (Monday-Friday) for 5 days, then 3 times per week for 3 weeks, then 2 times per week for 4 weeks and then weekly for 4 weeks to ensure any resident who has any change in condition. This will include any resident who is ordered diuretics, the facility is monitoring fluid intake and any acute change will have a SBAR completed and the physician notified. Any new order for diuretics, the order to monitor fluid intake will be initiated. Any new orders for urinalysis to ensure no dehydration is noted through review of lab results. The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and Quality monitoring audits will be updated as indicated.	

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would not have been picked up until around 6:00 AM the following morning. Nurse #1stated that Resident #294 was less talkative than usual on 10/30/24.

An interview was conducted on 11/20/24 at 1:40 PM with Nurse #6. He stated that he had filled in for four hours and cared for Resident #294 on 10/30/24 from 7:00 PM to 11:00 PM and he was aware that Resident #294 required a urine sample but he did not obtain it because it wouldn't have been picked up until the morning around 6:00 AM. He notified the third shift nurse (Nurse #2) to collect the urine specimen when she took over at 11:00 PM. Nurse #6 explained that the laboratory specimens were picked up by laboratory staff in the morning at approximately 6:00 AM.

A facility 24-hour condition report dated 10/31/24 on night shift (10/30/24 11:00 PM to 10/31/24 7:00 AM) completed by Nurse #2 and day shift (10/31/24 7:00 AM to 3:00 PM) completed by Nurse #1 indicated the need for a UA and C&S for Resident #294.

During an interview on 11/20/24 at 3:38 PM with Nurse #2, she stated that she had cared for Resident #294 on night shift (10/30/24 at 11:00 PM to 10/31/24 at 7:00 AM). Nurse #2 stated that when she took over the assignment that night, she was notified by the off going nurse (Nurse #6) that a urine sample was needed for Resident #294. She indicated that when she came on shift Resident # 294 was asleep and she did not recall waking him up to give him any fluids. Nurse #2 indicated that Resident #294 slept throughout her shift, and she attempted to obtain the urine specimen via an in and out catheter at around

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5:00 AM on 10/31/24 but was unsuccessful and she notified the oncoming day shift nurse (Nurse #1). Nurse #2 indicated Resident #294's incontinence brief was wet during the in and out catheter attempt. Nurse #2 also indicated that she was not Resident #294's regular nurse and she was not familiar with his baseline. She verified that she did not notify the physician that she was unable to obtain the ordered urine specimen.

An interview was conducted on 11/20/24 at 2:12 PM with NA #2 who had cared for Resident #294 on 10/30/24 and 10/31/24 on night shift. NA #2 stated that Resident #294 took only a few sips of water during her shifts and when she changed his incontinence brief there was very little urine. NA #2 stated that Nurse #3 was aware of Resident's condition from the beginning of her shift when she had told NA #2 to offer and encourage the Resident to drink water when she went to check on him.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 10/31/24 at 9:00 AM by Nurse #1.

During an interview with Nurse #1 on 11/19/24 at 10:20 AM she stated that when she came back to work on 10/31/24 at around 7:00 AM she was informed by the off going night shift Nurse (Nurse #2) that a urine sample was still needed for Resident #294 since she had not been able to obtain the urine during the night shift. Nurse #1 stated that she did not attempt to obtain the urine sample on 10/31/24 day shift. She indicated that Resident #294 was more like he was the previous day when she had noted he was not at his baseline. He was less talkative than usual and not eating/drinking as usual and she continued to

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push fluids. Nurse #1 stated that Resident #294 normally ate and drank most of what was on his tray, and he also drank most of the water she gave him during medication administration, but on 10/31/24 he took only sips with the medication. She further stated that Resident #294 consumed 0 out of 120 milliliters of his med pass (nutritional supplementation) on 10/31/24 at approximately 9:00 AM and 5:00 PM whereas previously he consumed 100 % of the supplementation. Nurse #1 verified that she did not notify the physician of Resident #294's change of condition from baseline.

A facility 24-hour condition report completed by Nurse #3 dated 11/1/24 on night shift (10/31/24 7:00 PM to 11/1/24 7:00 AM) indicated the nurse attempted twice to collect urine unsuccessfully.

A late entry nursing progress note written by Nurse #3 dated 11/1/2024 at 6:13 AM indicated report was given to the nurse that a UA/C&S was needed. The nurse attempted to push fluids, however, resident would only take small sips. The first attempt to obtain the UA/C&S was around 9:00 PM on 10/31/24 and she was unable to collect as not enough urine came out. The writer continued to push fluids throughout the shift, again, only getting small sips. The first attempt to collect the urine was reported to the supervisor. The second attempt to obtain the UA/C&S was at 5:33 AM on 11/1/24 and was again unsuccessful. Oncoming nurse (Nurse #1) and the Unit Manager were made aware of the attempts and that the resident was still in need of a specimen or the medical doctor may need to be called to get further orders.

Nursing progress note written by Nurse #3 dated

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11/1/2024 at 6:31 AM indicated writer attempted to collect urine twice, however, was unsuccessful and Nurse #3 would report off to oncoming nurse (Nurse #1).

An interview was conducted on 11/20/24 at 1:54 PM with the Nurse #3 who was assigned to care for Resident #294 on 10/31/24 at 7:00 PM through 11/1/24 at 7:00 AM. Nurse #3 stated she had received report from the off going day shift nurse (Nurse #1) that a urine specimen was needed for Resident #294 and she attempted to obtain the specimen at around 9:00 PM on 10/31/24 and at approximately 5:30 AM on 11/1/24 via an in and out catheter both times but was unsuccessful. She stated that there was barely any urine and it was too thick to be processed. She stated that Resident #294's incontinence brief was dry during both attempts, and she was pushing fluids but Resident #294 was only taking small sips and could not get in much. Nurse #3 reported to the oncoming day shift nurse (Nurse #1) that she had been unsuccessful in obtaining the urine specimen via an in and out catheter. Nurse #3 stated that Resident #294's vital signs were completed on day shift and were stable. She stated that she could not recall if she had obtained any vital signs during her shift and if she did, she would have documented them if they were outside parameters. Nurse #3 stated that Resident #294 did not seem different than other nights she had cared for him, he was verbal and did not seem to be in any acute distress otherwise she would have informed the physician to send him out. She verified she did not notify the physician.

During an interview on 11/19/24 at 3:05 PM with Nursing Assistant (NA) #1 she stated that she

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had cared for Resident #294 on 10/30/24 through 11/1/24 during the 7:00 AM to 3:00 PM shift. NA #1 stated that during those 3 days she noticed that Resident #294 was eating and drinking less than usual, and he had become incontinent whereas previously he was using the urinal. She also stated that previously he could feed himself, but she had to feed him and offer drinks on 10/31/24 and 11/1/24 but he did not eat or drink as he usually did. NA #1 also stated that when she changed Resident #294's briefs there was minimal urine. NA #1 further stated that when she was giving Resident #294 a shower on 11/1/24 he was not as responsive as usual, he was quiet and not shouting like he would normally do during showers. She verbalized that Nurse #1 was aware of Resident #294's condition and had told NA #1 to encourage Resident #294 to drink his fluids and also to give him a shower because he kept pulling off his clothes.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 11/1/24 at 9:00 AM by Nurse #1.

A Physician order dated 11/1/24 at 10:15 AM ordered by PA #1 indicated obtain peripheral intravenous (PIV) access (small catheter inserted into a superficial vein [a vein located close to the surface of the skin]). If unable to obtain, obtain a midline (a long flexible tube that is inserted into a vein in the upper arm to deliver fluids or medication into the blood stream).

A Physician order dated 11/1/24 ordered by PA #1 indicated Sodium Chloride Intravenous Solution 0.9 %. Use 2 liters intravenously in the morning for poor oral intake for 3 Days. Administer 2 liters intravenous fluids normal saline at 100 milliliters

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per hour for 3 days. (Sodium Chloride is used to replenish lost water and salt in the body.)

During an interview with Nurse #1 on 11/19/20 at 10:20 AM, Nurse #1 stated that when she came to work on 11/1/24 at around 7:00 AM she was informed by the off going night shift nurse (Nurse #3) that a urine sample was still needed. She indicated the resident drank only sips of water during medication administration on 11/1/24. Nurse #1 revealed that she had administered Resident #294's Lasix on 10/30/24, 10/31/24 and 11/1/24 at approximately 9:00 AM despite the resident's decreased oral food and fluid intake and that she did not think to hold it or ask the provider about it. She stated Resident #294 seemed more confused than the previous 2 days, and she notified Physician Assistant (PA) #1 when she came to the facility between 10:00 AM and 11:00 AM on 11/1/24. She stated that she knew the PA would come to the facility that morning and she would let the PA know that they had not been able to obtain the urine specimen and the resident was not drinking much which was probably a sign of dehydration. PA #1 went to examine Resident #294 and ordered a midline and IV fluids. Nurse #1 stated she did not attempt to insert a peripheral line because Resident #294 was dehydrated and she could not find a visible vein. She stated that she did not notify the PA regarding the PIV because the PA had ordered a midline if a PIV was not obtained. She called the vascular team (a contracted entity that is specialized in inserting intravenous catheters) to come and insert a midline and also called Resident #294's family member to obtain consent for the midline insertion. The family member did not answer the phone, and she left a message for her. The family member arrived at the facility at

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around 3:00 PM and the Nurse informed her that the vascular team were enroute to the facility to insert the midline. The family member wanted Resident #294 to be sent to the Emergency Department (ED) due to the worsening condition and Nurse #1 stated she agreed. She informed the Unit Manager and the facility Provider and called emergency medical services (EMS) who came to transfer Resident #294 to the hospital.

A Physician Assistant (PA) progress note written by PA #1dated 11/1/24 at 11:52 AM indicated Resident #294 was seen by PA at the request of nursing for evaluation of change in condition. The resident was minimally responsive. This was a noted change from usually being agitated and interactive per nursing/therapy. The roommate reported that he had not seen Resident #294 eat over the past 3 days. Nursing attempted to obtain UA/C&S, unable to provide adequate sample even with catheter. The progress note also indicated the resident had a change in condition, altered mental status, decreased oral intake, and was clinically dehydrated. An order was provided to obtain a PIV on 11/1/24 and ordered IVF 2 liters for 3 days (11/1/24 to 11/4/24). The progress note indicated staff were unable to obtain UA/C&S given dehydration.

During an interview on 11/19/24 at 4:30 PM with Physician Assistant #1 (PA #1) she stated that she was notified by Nurse #1 when she came to the facility at around 10:30 AM on 11/1/24 that Resident #294 had a change in condition, and they had not been able to obtain a urine sample for a UA and C&S. The PA explained that when she went to assess Resident #294, he seemed dehydrated but was responsive to questions. She gave an order to insert a peripheral intravenous

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(PIV) line and if unable to obtain PIV access to obtain a midline so that they could administer IV fluids. The PA stated she normally put the two orders (PIV and midline) on the same order so that if they could not obtain a PIV they could go ahead and obtain the midline without needing a second order. The PA stated she did not know Resident #294's baseline since she was not the primary care provider for Resident #294. She also stated that she could not recall if the facility contacted her to let her know that they had not obtained an IV access. She indicated she would not have expected to be notified if they did not obtain the PIV since the order explicitly stated to obtain the midline if PIV access was unable to be obtained. PA #1 stated the timeline to contact a provider was a case-by-case basis based on Resident's status. She further stated that if the Resident was declining and they could not get an IV access then they would contact the Provider if they needed the Resident to be sent to the hospital.

An interview was conducted with the Unit Manager (UM) on 11/19/24 at 10:40 AM. The UM stated that she was notified by Nurse #1 on 11/1/24 at approximately 3:00 PM that Resident #294's family member was in the facility to see the resident and wanted him to be sent to the hospital due to altered mental status and she told Nurse #1 to go ahead and send the Resident out to the hospital per family request. The UM verbalized she was not aware if the Provider was notified about the inability to obtain the urine sample and change in condition until 11/1/24 when the Provider came to the facility between 10:00 AM and 11:00 AM.

An interview was conducted with Resident #294's

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Emergency Contact #1 (Family Member) on 11/18/24 at 3:02 PM. The family member stated that she received a voice message from Nurse #1 on 11/1/24 at approximately 1:30 PM indicating that Resident #294 was doing okay and that she wanted to give her an update. The family member decided to come to the facility to check what was going on when she tried to call back the facility and was put on hold. When she arrived at the facility around 3:00 PM she found the Resident naked and disoriented, his mouth was dry and crusty and she attempted to give him a drink and he drank it. The family member stated Nurse #1 told her she was waiting for vascular team to come and insert an intravenous line and she informed Nurse #1 that she wanted the Resident to be sent to the hospital because he was in distress and Nurse #1 called 911.

An EMS report dated 11/1/24 indicated that EMS was contacted at 3:42 PM for a non-emergent transportation due to family choice. EMS arrived at the facility at 4:02 PM and primary impression was altered mental status and secondary impression was sepsis. The chief complaint was altered mental status with onset of 10/30/24. An electrocardiogram (ECG) at 4:05 PM indicated atrial fibrillation (irregular heart rhythm characterized by rapid and irregular heartbeat). Vital signs obtained by EMS at 4:17 PM were noted as blood pressure: 103/72, pulse: 65, respirations: 8, oxygen saturation: 94 % and level of consciousness was responds to painful stimulation on the AVPU (alert, voice, pain, unresponsive scale used to measure patient's level of consciousness). EMS obtained a telephone order at 4:22 PM to administer IV fluids due to Resident #294 meeting the criteria for sepsis. IV fluids were not administered due to

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inability to establish an IV access. EMS departed facility at 4:39 PM with Resident #294 and notified the receiving hospital of sepsis indication at 5:00 PM. EMS assessment at 5:05 PM indicated Resident #294 was lethargic, non-verbal with minimal alertness, he had rapid mouth breathing, his skin was cold and dry, lung sounds were clear with increased respiratory rate and oxygen saturation readings were inconsistent due to the resident having cold hands. Resident #294 arrived at the ED at 5:41 PM.

An ED progress note dated 11/1/24 indicated that Resident #294's vital signs were noted as follows: blood pressure: 72/58, heart rate: 138, and respirations 29 at 5:45 PM and oxygen saturation: 33 %, and temperature: 93.4 degrees Fahrenheit at 6:23 pm. The progress note indicated Resident #294 presented critically ill, obtunded (reduced level of alertness and consciousness), breathing on his own with cold distal extremities with dilated pupils without response bilaterally and no response to painful stimuli. Facility stated that he had not been eating or drinking anything for 3 days, and today he was found naked by his family and encouraged the nurse to take his vital signs who then emergently called for 911. Resident #294 was found to be in metabolic acidosis (a condition in which too much acid accumulates in the body). Because of his cold extremities, they were unable to reliably obtain a pulse oximeter reading. Discussion with family revealed patient had voiced wishes to have "everything done "to sustain his life. After discussion regarding his goals of his care, family wanted the patient to continue to be full code. They understood that he was critically ill at that moment. The ED note indicated that Resident's presentation with altered mental status, tachypnea, poor perfusion,

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hypothermia, severe lactic acidosis, and new vasopressor requirements, consistent with septic shock with end organ dysfunction as cause of death. Resident #294 died at 8:26 PM on 11/1/24.

During an interview on 11/20/24 at 3:07 PM with PA #2 she stated that she was the primary care provider for Resident #2 and that she had given the telephone order on 10/30/24 for the UA/C&S due to dysuria per nursing reports. PA #2 stated that she could not recall the facility notifying her that they had not obtained the urine sample or that the Resident's condition was declining. She also stated the timeline to contact a provider was a case-by-case basis based on Resident's status.

An interview was conducted with the facility Medical Director (MD) on 11/19/24 at 4:37 PM. The MD stated he was aware of Resident #294's condition and the facility did what they were supposed to do to manage the Resident's condition. He indicated that when the Resident showed signs of a UTI, a UA was ordered and when they could not obtain a urine sample, they ordered an IV access for hydration, but the Resident was sent out before the IV access was obtained. The MD also stated that if the Resident had been sent out earlier the outcome would not have been any different. He also stated that if the UA had been obtained on 11/1/24 and was positive for a UTI they would have started the Resident on oral antibiotics and the outcome would have probably been the same. When the MD was asked if the facility staff should have notified him when they could not obtain the urine on 10/31/24 with the resident not drinking adequately as well as with continued Lasix administration, the MD stated the facility did everything right. When asked if the facility staff

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should have notified him when they didn't obtain PIV access, he stated that the vascular team had been contacted and they were on the way when the resident was sent out to the hospital.

An interview was conducted on 11/20/24 at 4:30 PM with the Director of Nursing (DON). The DON stated that if nurses were not able to obtain the urine specimen on 10/31/24 at 5:00 AM, 10/31/24 at 9:00 PM and 11/1/24 at 5:30 AM with decreased oral intake nurses should have contacted the on call provider if there was no provider in the facility. She also stated nurses should have notified the PA on 10/31/24 when they were in the building that they had not obtained the ordered urine sample and inquired about the Lasix administration due to decreased oral intake and inability to obtain the urine specimen. The DON indicated she did not expect the staff to notify the physician/PA when the PIV access was unable to be obtained as the order specifically stated that if staff were unable to obtain PIV access that they were to obtain a midline via the vascular team.

The Administrator was notified of immediate jeopardy on 11/20/24 at 6:04 PM.

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

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

Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to altered mental status. The center recognizes that all residents have the

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potential to be affected from the noncompliance of notifying the physician as it relates to obtaining a urine sample for residents identified with complaints of burning urination and decreased fluid intake, including signs and symptoms of dehydration as evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief.

A review of Resident #294's electronic medical record revealed an order for UA w/ reflex, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:00 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders.

A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure urine sample was obtained. Nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to physician. No discrepancies were noted. Twenty-three (23) residents identified as having a physician order to administer diuretics were audited by the Director of Nursing and Unit Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. No resident was identified with signs and symptoms of dehydration as evidenced by the inability to collect urine, therefore notification to the physician was not warranted.

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F 580	Continued From page 20 On 11/20/2024, a root cause analysis was completed by the Director of Clinical Services and the Executive Director regarding notifying the physician for Resident #294 when staff were unable to obtain a urine sample. It was determined through the root cause analysis that the facility failed to follow policy and procedures to notify the physician regarding change in condition as it relates to decreased fluid intake for Resident #294 receiving Lasix and unable to obtain urine sample. 2) 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 The Director of Clinical Services and Nurse Managers re-educated licensed nurses on notifying physician for residents identified as having a change in condition via Situation, Background, Assessment and Recommendation (SBAR) as it relates to assessing residents with signs and symptoms of dehydration on 11/20/2024. The licensed nurse is to assess the resident, including vitals, complete the SBAR and notify the attending physician when there is a change in the status or condition of the resident. The Director of Nursing and Unit Managers re-educated licensed nurses on recognizing signs and symptoms of dehydration to ensure prompt physician notification for change in condition on 11/20/2024. Staff (licensed nurses/ Certified Nurse Assistants) not educated on 11/20/2024, will be educated by the Director of Nursing and or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by the Director or Nursing or Unit Manager on	F 580		

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notifying physician for residents identified as having a change in condition via SBAR as it relates to assessing residents with signs and symptoms of dehydration.

The Director of Clinical Services and Nurse Managers re-educated licensed nurses on notifying physician via change in condition (SBAR) for residents with an order for UA/C&S and unable to obtain urine sample on 11/20/2024. The licensed nurse is to assess the resident, including vitals, complete the SBAR and notify the attending physician when there is a change in the status or condition of the resident.

The Director of Clinical Services and Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed nurse on 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Service and or Unit Managers. Staff (licensed nurses/ Certified Nurse Assistance) not educated on 11/20/2024, will be educated by the Director of Nursing and or Unit Manager prior to working the floor.

Date of Immediate Jeopardy Removal 11/21/2024

On 11/22/24 the facility's immediate jeopardy removal was validated by the following:
The facility provided documentation to support immediate jeopardy removal that included audits completed by the Director of Nursing/Director of Clinical Services and Unit Managers. The audits included all current residents with an order for UA/C&S from 10/20/2024 through 11/20/2024 which was revealed nine (9) residents with orders for UA/C&S and eight (8) with no further change

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F 580	Continued From page 22 in condition that required notification to physician and no discrepancies were noted. The audits also included all residents with orders for diuretics and 23 residents were identified as having a physician order to administer diuretics and to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The facility provided documentation on the education they provided to include sign-in sheets. The education information indicated that the Director of Clinical Services and Nurse Managers re-educated all licensed nurses on the following on 11/20/24: notifying physician for residents identified as having a change in condition via Situation, Background, Assessment and Recommendation (SBAR) as it relates to assessing residents with signs and symptoms of dehydration; assess the resident, including vitals, complete the SBAR and notify the attending physician when there was a change in the status or condition of the resident; and how to recognize dehydration. The Director of Clinical Services and Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and to immediately report the change in condition to the licensed nurses on 11/20/2024. Interviews confirmed that newly hired staff would be educated during orientation by the Director of Clinical Service and/or Unit Managers. Interviews with nursing staff verified the staff had been educated on all information as indicated in immediate jeopardy removal plan. The immediate jeopardy removal date of 11/21/24 was verified.	F 580		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		12/18/24

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F 641	Continued From page 23 §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 record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of hypnotics medication for 1 of 30 sampled resident reviewed (Resident # 55). Findings included: Resident #55 was admitted to the facility on 09/20/2021 with diagnoses including dementia. The annual Minimum Data Set (MDS) dated 09/01/2024 had Resident #55 coded as severely cognitively impaired, and hypnotics were taken during the look back period. The August and September 2024 Medication Administration Records (MAR) did not reveal an order for hypnotics. An interview with the Director of Nursing (DON) was conducted on 11/19/2024 at 2:49 PM. The DON stated she look at MARs as far back as April 2024 for Resident #55 and there had not been a hypnotic ordered. The DON also stated the MDS was coded incorrectly and expected the MDS nurse to code the assessment accurately. An interview with the MDS nurse was conducted on 11/19/2024 at 2:58 PM. The MDS Nurse stated she was the one who completed the MDS for Resident #55. There was a data entry error because Resident #55 was not receiving hypnotics during that time.	F 641	Resident #55's Minimum Data Set (MDS) was corrected in the area of hypnotic medications to accurately reflect the resident's status dated 09/01/2024. Resident #55 was coded as severely cognitively impaired, and hypnotics were taken during the look back period. However, Resident #55 was no longer taking hypnotic medication and the MDS has been corrected. A quality review was completed on all current resident's MDS in the area of hypnotic medications (Section N) to validate the most recent MDS assessment. They have all been validated and coded to accurately reflect the status of the residents by the MDS Coordinator on 12/18/2024. An ad hoc Quality Assurance Performance Improvement committee was held on 12/18/2024 to formulate and approve a plan of correction for the deficient practice. The Executive Director educated the MDS Coordinator to ensure accurate coding when a resident is no longer on a hypnotic medication (Section N) on 12/13/2024. The Regional MDS Coordinator reviewed education again on 12/18/2024. The Director of Clinical Services and/or	

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F 641	Continued From page 24 An interview with the Administrator was conducted on 11/22/2024 at 1:08 PM. The Administrator stated he expected the MDS assessments to be coded correctly.	F 641	Unit Managers will conduct random quality reviews of 5 resident MDS assessments in the areas of hypnotic medication (Section N) to ensure the MDS is coded accurately for 5 residents 2 times per week for 8 weeks and then weekly for 4 weeks. The Executive Director will report the results of the quality monitoring (audit) and report to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audit) will be updated as indicated.	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, family member, Physician Assistant, and Medical Director interviews, the facility staff failed to recognize the seriousness of a significant change in condition, the importance of and identify the need for urgent medical attention to address an emergent situation. On 10/29/24 a sudden decrease in food and fluid intake was observed by staff. Resident #1 reported burning with urination to the night shift nurse (10/29/24 at	F 684	Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to altered mental status. The center recognizes that all patients have the potential to be affected from the noncompliance of ensuring staff recognize significant changes in condition and providing necessary medical services for residents identified with complaints of burning	12/18/24

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F 684	Continued From page 25 11:00 PM through 10/30/24 at 7:00 AM) and an order for a urinalysis (UA) and urine culture and sensitivity (C & S) was obtained from Physician Assistant #2 on 10/30/24. No attempts were made to collect the urine specimen for the UA until 10/31/24 at around 5:00 AM and the nurse was not successful. Another nurse attempted to obtain the urine specimen the evening of 10/31/24 and the morning of 11/1/24 but was not successful. Resident #294 was administered his diuretic daily 10/29/24 through 11/1/24 despite decreased intake. The poor intake continued and by 10/31/24 Resident #294 had become incontinent of urine, there was minimal urine noted when his brief was changed, and staff had to feed him. The morning of 11/1/24 staff requested PA #1 to evaluate Resident #294 who noted the resident had a change in condition, altered mental status, decreased oral intake, and was clinically dehydrated. PA #1 ordered intravenous (IV) fluids for 3 days, but the nurse did not attempt to insert a peripheral line because Resident #294 was dehydrated, and she could not find a visible vein. The nurse contacted the vascular team to obtain IV access. On 11/1/24 Resident #294's family member arrived at the facility at approximately 3:00 PM and requested the resident be sent to the hospital and the facility requested non emergent transport. The specimen for the urinalysis had still not been collected and the IV fluids had not been initiated. EMS arrived at the facility at 4:02 PM and the primary impression was altered mental status and secondary impression was sepsis. The chief complaint was altered mental status with onset of 10/30/24. Resident #294 was transferred to the emergency department (ED) where the progress note indicated Resident #294 presented critically ill, obtunded (reduced level of alertness and	F 684	urination and decreased fluid intake, including signs and symptoms of dehydration as evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief. A review of Resident #294 electronic medical record revealed an order for UA with reflex, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:00 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect a urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physician orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure a urine sample was obtained. Nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to the physician. No discrepancies were noted. 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and/or Unit Managers to ensure no signs or symptoms of dehydration as evidenced by the inability to collect urine. The Director of Nursing and/or Unit Manager assessed current residents to include obtaining vital signs (blood pressure,	

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F 684	Continued From page 26 consciousness), breathing on his own, with cold distal extremities, with dilated pupils without response bilaterally, and no response to painful stimuli. He was identified with altered mental status, tachypnea (rapid and shallow breathing), poor perfusion (occurs when there is inadequate blood circulation to organs and tissues and can be an early sign of circulatory or heart problems and can lead to life-threatening conditions), hypothermia (a medical emergency that occurs when the body's temperature drops below 95°F), severe lactic acidosis (occurs when the body produces too much lactic acid and the liver can't metabolize it fast enough), and new vasopressor requirements (vasopressors are a medication that are used to treat people with low blood pressure) most consistent with septic shock (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) with end organ dysfunction. Resident #294 died at 8:26 PM on 11/1/24. This deficient practice occurred for 1 of 3 residents (Resident #294) reviewed for professional standards of care. Immediate jeopardy began on 10/31/24 when staff failed to recognize the seriousness of Resident #294's change in condition and obtain necessary emergent medical attention. Immediate jeopardy was removed on 11/21/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems put into place and are effective.	F 684	increased heart rate, oxygen saturation, temperature), observation of dry cracked lips, poor skin turgor and/or altered mental status and chart review to ensure there was no change in status or condition that required notifying the physician and obtaining necessary medical services to include signs and symptoms of dehydration on 11/20/2024. On 11/20/2024, a root cause analysis was completed by the Director of Clinical Services and the Executive Director regarding staff failure to recognize the seriousness of a significant change in condition and obtaining necessary medical services to address an emergent situation for Resident #294. The change in condition included complaints of burning urination, decreased fluid intake and signs or symptoms of dehydration as evidenced by the inability to collect urine via an in and out catheter. Nursing staff also continued to administer resident Lasix despite signs and symptoms of dehydration. It was determined through the root cause analysis that the facility staff failed to follow policy and procedures to recognize the seriousness of a significant change in condition and notify the physician to obtain necessary medical services to address an emergency situation. The Director of Clinical Services and/or Nurse Managers re-educated all licensed nurses on how to recognize the seriousness of a significant change in condition through assessing the resident,	

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F 684	Continued From page 27 The findings included: Resident #294 was initially admitted to the facility on 7/2/24 with the last readmission to the facility on 10/7/24. His diagnoses included fracture of right femur (thigh bone between hip and knee), dementia, type 2 diabetes, adult failure to thrive, generalized muscle weakness, chronic kidney disease, and congestive heart failure. He was admitted to the facility for rehabilitation therapy services after hospitalization following the femur fracture. A hospital discharge summary dated 10/7/24 indicated Resident #294 was admitted to the hospital from 7/25/24 to 10/7/24 due to inability to care for himself at home after he was discharged home from SNF on 7/23/24 and readmitted to the hospital on 7/25/24. He had an unwitnessed ground-level fall early morning on 9/25/2024 at the hospital when he thought he smelled smoke in his room and got up to investigate. Plain films revealed right femoral neck fracture. Resident #294 underwent a right hip hemiarthroplasty on 9/28/2024 and was discharged to SNF on 10/7/24 with physical and occupational therapy recommendations. A physician skilled nursing facility (SNF) admission note indicated Resident #294 was seen on 10/8/24 and reason for admission was debility. The symptoms had begun 11 weeks ago and the symptoms were reported as being moderate. The note indicated that the resident had a history of type 2 diabetes, coronary artery disease and suspected major neurocognitive disorder and had presented to the hospital for failure to thrive in adult. Resident #294 was	F 684	observation, and chart review to include medications, and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics, on 11/20/2024. Staff (licenses nurses/Certified Nursing Assistants) not educated on 11/20/2024, will be educated by the Director of Nursing and/or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by the Director of Nursing and/or Unit Managers. The Director of Clinical Services and/or Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed clinical staff on 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or the Unit Managers. Date of Immediate Jeopardy Removal = 11/21/2024 The Director of Clinical Services and/or the Nurse Managers re-educated all licensed nurses on how to recognize the seriousness of a significant change in condition through assessing the resident, observation and chart review. This also includes medications and notifying the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration	

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F 684	Continued From page 28 admitted to the hospital on 6/27/24 through 7/2/24 for difficulty caring for self. He was discharged from the hospital on 7/2/24 and admitted to a skilled nursing facility and was discharged from the SNF to the community on 7/23/24 but he was unable to care for self at home and was readmitted to the hospital on 7/25/24. He was living in a trailer without access to running water or sewer and likely not consistently taking his medications. He was known to only be able to feed and dress himself but not to perform other activities of daily living (ADL) or instrumental activities of daily living (IADLs) independently, including unable to bathe himself or use toilet, often using water jugs as commodes instead. Per review of prior records, Resident had demonstrated inability to follow-up with medical providers (was lost to Cardiology follow-up for 3 years despite significant cardiac history) and was paranoid about medications, such as self-discontinuing enalapril (medication used to treat high blood pressure) because he did "not trust new pill color," demonstrating inability to make rational decisions regarding his health. The plan on the admission note indicated Resident #294 had a set of conditions, syndromes and functional impairments that would likely require frequent medication changes, other treatment changes and re-evaluations. Resident was at significant risk of worsening medical (including behavioral) status and was at significant risk for readmission to a hospital and these multiple morbidities required intensive management. Resident #294's care plan last revised on 10/8/24 had a care focus area that indicated Resident had potential for fluid deficit related to diuretic use with the goals for Resident to be free of symptoms of dehydration. Interventions included:	F 684	of diuretics on 11/20/2024. Education includes any time an order is given but not able to be completed for any reason, the floor nurse or clinical manager will call the physician for additional instructions. Staff (licensed nurses/Certified Nurse Assistants) not educated on 11/20/2024 will be educated by the Director of Nursing and/or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. The Director of Clinical Services and/or Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed clinical staff on 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. The Director of Nursing and/or Nurse Managers will provide quality monitoring daily in clinical (Monday through Friday) review for 5 days, then 3 times per week for 3 weeks, then 2 times per week for 4 weeks and then weekly for 4 weeks to ensure any resident who is ordered diuretics the facility is monitoring fluid intake, any acute change, an SBAR is completed and the physician is notified. For any new order for diuretics the order to monitor fluid intake will be initiated and new orders for urinalysis to ensure no dehydration is noted through review of lab results.	

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F 684	Continued From page 29 monitor and document intake and output as per facility policy; monitor vital signs as ordered/per protocol and record; notify physician of significant abnormalities; monitor/document/report as needed any signs/symptoms of dehydration; obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated. A physician order dated 10/7/24 indicated full code. A physician order dated 10/7/24 indicated give Lasix oral tablet 20 milligram by mouth one time a day for edema (swelling from fluid retention). Lasix is a diuretic used to treat fluid retention that can result from congestive heart failure, kidney disease or other medical conditions. Lasix increases urine output and can lead to dehydration. Resident #294's admission Minimum Data Set (MDS) assessment dated 10/12/24 coded Resident #294 as cognitively intact. He had no behaviors or rejection of care. He required supervision or touching assistance with toileting. He required setup or clean up assistance with eating. He was coded as frequently incontinent of bowel and bladder and was also coded as taking a diuretic. His weight was 137 pounds, and his height was 68 inches. Resident #294's overall discharge goal was to return to the community. He was not coded for hospice care. A 24-hour facility condition report completed by Nurse #5 dated 10/29/24 indicated Resident #294 had poor oral intake on day shift (7:00 AM to 7:00 PM). The facility's 24-hour condition report is a form that nurses document the status of all the	F 684	The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits and to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audits) will be updated as indicated.	

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residents during or at the end of their shift to communicate any pertinent information to the next shift and nursing management.

During an interview with Nurse #5 on 11/18/24 at 2:45 PM, she stated that she had cared for Resident #294 on 10/29/24 from 7:00 AM to 7:00 PM. Nurse #5 indicated that normally Resident # 294 consumed more than 25% of his tray food and drinks but on 10/29/24 he had eaten and drank less than 25% during the three meals on her shift and she documented it in the 24 hour report and informed the oncoming night shift nurse (Nurse # 4).

Vital signs documented on 10/29/24 at 1:43 PM by Nurse #5 were blood pressure (BP): 110/61, pulse:79, oxygen saturations: 96% and temperature: 98°F.

Phone interviews were attempted with Nursing Assistant (NA) #3, the NA who worked with Resident #294 during the first shift (7:00 AM to 3:00 PM) on 10/29/24, and were unsuccessful.

A 24-hour facility condition report completed by Nurse #4 dated 10/30/24 indicated Resident #294 was complaining of burning with urination on night shift (10/29/24 11:00 PM to 10/30/29 7:00 AM shift).

During an interview on 11/19/24 at 3:53 PM with Nurse #4, she stated that she was assigned to care for Resident #294 on 10/29/24 at 7:00 PM to 10/30/24 at 7:00 AM. Nurse #4 stated that during shift change Nurse #5 had informed her and documented in the 24-hour condition report that Resident #294 had a decreased oral intake with food and drinks. Nurse #4 verbalized that

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Resident #294 complained of burning with urination during her shift and she left a note for the Provider in the physician book, noted it in the 24-hour condition report and informed the oncoming day shift nurse (Nurse #1). Nurse #4 stated that Resident #294 was stable and the only concern during her shift was complaints of burning with urination which she noted in the physician's book, and she pushed fluids while Resident #294 was awake because she thought it was a sign of urinary tract infection.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 10/30/24 at 9:00 AM by Nurse #1.

A Physician telephone order dated 10/30/2024 at 11:59 AM ordered by Physician Assistant (PA) #2 indicated urinalysis (UA), urine culture and sensitivity (C & S) for a diagnosis of dysuria.

During an interview on 11/19/24 at 10:20 AM with Nurse #1, she indicated that she had cared for Resident #294 on 10/30/24. Nurse #1 stated that when she came to work on 10/30/24 at around 7:00 AM she was informed by the off going night shift nurse (Nurse #4) that Resident #294 had complained of pain with urination during the night shift (10/29/24 at 7:00 PM to 10/30/24 at 7:00 AM). Nurse #1 verbalized that a UA/CS to rule out a urinary tract infection was ordered during her shift (10/30/24 7:00 AM- 7:00 PM) but she did not attempt to obtain a urine sample since it would not have been picked up until around 6:00 AM the following morning. She stated that she was pushing fluids and Resident #294's vital signs were stable. Nurse #1 stated she did not obtain urine specimen and put in the refrigerator because it was normally collected on night shift to

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be sent out in the morning.

Vital signs documented on 10/30/24 at 3:13 PM by Nurse #1 were BP: 128/60, pulse:65, oxygen saturations: 94% and temperature: 97.5°F.

A 24-hour facility condition report dated 10/30/24 on day shift (7:00 AM to 3:00 PM) completed by Nurse #1 and evening shift (3:00 PM to 11:00 PM) completed by Nurse #6 indicated the need for a UA/CS for Resident #294 in the morning (10/31/24).

An interview was conducted on 11/20/24 at 1:40 PM with Nurse #6. He stated that he had filled in for four hours and cared for Resident #294 on 10/30/24 from 7:00 PM to 11:00 PM and he was aware that Resident #294 required a urine sample, but he did not obtain it because it wouldn't have been picked up until around 6:00 AM in the morning. He notified the third shift nurse (Nurse #2) to collect the urine specimen when she took over at 11:00 PM. Nurse #6 explained that the laboratory specimens were picked up by laboratory staff in the morning at approximately 6:00 AM. Nurse #2 stated that Resident #294 was stable and carried on conversation with him when he went to administer his 9:00 PM medications, he was in no pain and he took his medications with no concerns. Nurse #6 stated he did not collect the urine specimen and refrigerate it during his shift since a sample collected by third shift would have been fresher when it was sent out in the morning.

A 24-hour facility condition report dated 10/31/24 on night shift (10/30/24 11:00 PM to 10/31/24 7:00 AM) completed by Nurse #2 and day shift (10/31/24 7:00 AM to 3:00 PM) completed by

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Nurse #1 indicated the need for a UA and C&S for Resident #294.

During an interview on 11/20/24 at 3:38 PM with Nurse #2, she stated that she had cared for Resident #294 on the night shift (10/30/24 at 11:00 PM to 10/31/24 at 7:00 AM). Nurse #2 stated that when she took over the assignment that night, she was notified by the off going nurse (Nurse #6) that a urine sample was needed for Resident #294. She indicated that when she came on shift Resident # 294 was asleep and she did not recall waking him up to give him any fluids. Nurse #2 indicated that Resident #294 slept throughout her shift, and she attempted to obtain the urine specimen via an in and out catheter at around 5:00 AM on 10/31/24 but was unsuccessful and she notified the oncoming day shift nurse (Nurse #1). Nurse #2 indicated Resident #294's incontinence brief was wet during the in and out catheter attempt. Nurse #2 also indicated that she was not Resident #294's regular nurse and she was not familiar with his baseline. She further stated that his vital signs were obtained on day shift, but she would have obtained a set of vital signs that night if the Resident was in acute distress.

An interview was conducted on 11/20/24 at 2:12 PM with NA #2 who had cared for Resident #294 on 10/30/24 and 10/31/24 on night shift. NA #2 stated that Resident #294 took only a few sips of water during her shifts and when she changed his incontinence brief there was very little urine. NA #2 stated she worked with Nurse #3 (10/31/24 at 11:00 PM through 11/1/24 at 7:00 AM) and Nurse #3 was aware of Resident's condition from the beginning of her shift when she had told NA #2 to offer and encourage the Resident to drink water

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when she went to check on him because they needed to obtain urine. NA #2 stated she could not recall if she had reported any information about Resident #294 to Nurse #2 on 10/30/24 night shift.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 10/31/24 at 9:00 AM by Nurse #1.

During an interview on 11/19/24 at 10:20 AM with Nurse #1, she stated that when she came back to work on 10/31/24 at around 7:00 AM she was informed by the off going night shift Nurse (Nurse #2) that a urine sample was still needed for Resident #294 since she had not been able to obtain the urine during the night shift. Nurse #1 stated that she did not attempt to obtain the urine sample on 10/31/24 day shift since it would wait until the following morning at around 6:00 AM to be picked up. She indicated that Resident #294 was still not at baseline; he was less talkative than usual and not eating/drinking as usual and she continued to push fluids. Nurse #1 stated that Resident #294 normally ate and drank most of what was on his tray, and he also drank most of the water she gave him during medication administration, but on 10/31/24 he took only sips with the medication. She further stated that Resident #294 consumed 0 out of 120 milliliters of his med pass (nutritional supplementation) on 10/31/24 at approximately 9:00 AM and 5:00 PM whereas previously he consumed 100 % of the supplementation. Nurse #1 stated she recognized the resident was not at his baseline and was not eating and drinking as he usually did. The UA had been ordered the day before and Nurse #2 had not been able to obtain the specimen the previous shift. Nurse #1 stated she did not think

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of obtaining the urine during her shift to be sent to the lab and she left it for the next shift so it could be sent out the following day because it was normally collected on night shift and sent out in the morning.

Vital signs documented on 10/31/24 at 3:43 PM by Nurse #1 were BP: 101/66, pulse:58, oxygen saturations: 94% and temperature: 97.2°F.

A 24-hour facility condition report completed by Nurse #3 dated 11/1/24 on night shift (10/31/24 7:00 PM to 11/1/24 7:00 AM) indicated the nurse attempted twice to collect urine unsuccessfully.

A late entry nursing progress note written by Nurse #3 dated 11/1/2024 at 6:13 AM indicated report was given to the nurse that a UA/C&S was needed. The nurse attempted to push fluids, however, resident would only take small sips. The first attempt to obtain the UA/CS was around 9:00 PM on 10/31/24 and she was unable to collect as not enough urine came out. The writer continued to push fluids throughout the shift, again, only getting small sips. The first attempt to collect the urine was reported to the supervisor. The second attempt to obtain the UA/C&S was at 5:33 AM on 11/1/24 and was again unsuccessful. Oncoming nurse (Nurse #1) and the Unit Manager were made aware of the attempts and that patient is still in need of a specimen or the medical doctor may need to be called to get further orders.

Nursing progress note written by Nurse #3 dated 11/1/2024 at 6:31 AM indicated writer attempted to collect urine twice, however, was unsuccessful and Nurse #3 would report off to oncoming nurse (Nurse #1).

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An interview was conducted on 11/20/24 at 1:54 PM with the Nurse #3 who was assigned to care for Resident #294 on 10/31/24 at 7:00 PM through 11/1/24 at 7:00 AM. Nurse #3 stated she had received report from the off going day shift nurse (Nurse #1) that a urine specimen was needed for Resident #294 and she attempted to obtain the specimen at around 9:00 PM on 10/31/24 and at approximately 5:30 AM on 11/1/24 via an in and out catheter both times but was unsuccessful. She stated that there was barely any urine, and it was too thick to be processed. She stated that Resident #294's incontinence brief was dry during both attempts, and she was pushing fluids but Resident #294 was only taking small sips and could not get in much. Nurse #3 reported to the oncoming day shift nurse (Nurse #1) that she had been unsuccessful in obtaining the urine specimen via an in and out catheter. Nurse #3 stated that Resident #294's vital signs were completed on day shift on 10/31/24 and were stable. She stated that she could not recall if she had obtained any vital signs during her shift and if she did, she would have documented them if they were outside parameters. Nurse #3 stated that Resident #294 was verbal and did not seem to be in any acute distress otherwise she would have informed the physician to send him out.

During an interview on 11/19/24 at 3:05 PM with Nursing Assistant (NA) #1 she stated that she had cared for Resident #294 on 10/30/24 through 11/1/24 during the 7:00 AM to 3:00 PM shift. NA #1 stated that during those 3 days she noticed that Resident #294 was eating and drinking less than usual, and he had become incontinent whereas previously he was using the urinal. She also stated that previously he could feed himself,

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but she had to feed him and offer drinks on 10/31/24 and 11/1/24 but he did not eat or drink as he usually did. NA #1 also stated that when she changed Resident #294's briefs there was minimal urine. NA #1 further stated that when she was giving Resident #294 a shower on 11/1/24 he was not as responsive as usual, he was quiet and not shouting like he would normally do during showers. She verbalized that Nurse #1 was aware that Resident #294 was not drinking and eating as he normally did and had told NA #1 to encourage Resident #294 to drink his fluids and also to give him a shower because he kept pulling off his clothes. NA #1 indicated Resident #294 was not alert and oriented when she completed her shift, and they were getting ready to transfer the Resident to the hospital.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 11/1/24 at 9:00 AM by Nurse #1.

A Physician Assistant (PA) progress note written by PA #1dated 11/1/24 at 11:52 AM indicated Resident #294 was seen by PA at the request of nursing for evaluation of change in condition. The resident was minimally responsive. This was a noted change from usually being agitated and interactive per nursing/therapy. The roommate reported that he had not seen Resident #294 eat over the past 3 days. Nursing attempted to obtain UA/CS, unable to provide adequate sample even with catheter. The progress note also indicated the resident had a change in condition, altered mental status, decreased oral intake, and was clinically dehydrated. An order was provided to obtain a PIV on 11/1/24 and ordered IVF (intravenous fluids) 2 liters for 3 days (11/1/24 to 11/4/24). PA #1 progress note indicated she

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confirmed hold parameters for insulins with decreased oral intake, although blood sugar was in 300s (normal range between 70 and 100 milligrams per deciliter). The progress note also indicated unable to obtain UA/CS given dehydration.

During an interview on 11/19/24 at 4:30 PM with Physician Assistant #1 (PA #1) she stated that she was notified by Nurse #1 when she came to the facility at around 10:30 AM on 11/1/24 that Resident #294 had a change in condition, and they had not been able to obtain a urine sample for a UA and CS. The PA explained that when she went to assess Resident #294, he seemed dehydrated but was responsive to questions. She gave an order to insert a peripheral intravenous (PIV) line and if unable to obtain PIV access to obtain a midline so that they could administer IV fluids. The PA stated she did not know Resident #294's baseline since she was not the primary care provider for Resident #294. She also stated that she could not recall if the facility contacted her to let her know that they had not obtained an IV (intravenous) access.

A Physician order dated 11/1/24 at 10:15 AM ordered by PA #1 indicated to obtain peripheral intravenous (PIV) access (small catheter inserted into a superficial vein [a vein located close to the surface of the skin]). If unable to obtain, obtain a midline (a long flexible tube that is inserted into a vein in the upper arm to deliver fluids or medication into the blood stream).

A Physician order dated 11/1/24 ordered by PA #1 indicated Sodium Chloride Intravenous Solution 0.9 %. Use 2 liters intravenously in the morning for poor oral intake for 3 Days. Administer 2 liters

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intravenous fluids normal saline at 100 milliliters per hour for 3 days. (Sodium Chloride is used to replenish lost water and salt in the body.)

During an interview with Nurse #1 on 11/19/20 at 10:20 AM, Nurse #1 stated that when she came to work on 11/1/24 at around 7:00 AM she was informed by the off going night shift nurse (Nurse #3) that a urine sample was still needed. Nurse #1 stated she checked on Resident #1 several times that morning and she had administered his morning medications at around 9:00 AM which he took with 25% of his med pass nutritional supplementation. Nurse #1 revealed that she had administered Resident #294's Lasix on 10/30/24, 10/31/24 and 11/1/24 at approximately 9:00 AM despite the resident's decreased oral food and fluid intake and that she did not think to hold it or ask the provider about it. She stated Resident #294 seemed more confused than the previous 2 days, and she notified Physician Assistant (PA) #1 when she came to the facility between 10:00 AM and 11:00 AM on 11/1/24. PA #1 went to examine Resident #294 and ordered a midline and IV fluids. Nurse #1 stated she did not attempt to insert a peripheral line because Resident #294 was dehydrated and she could not find a visible vein. She called the vascular team (a contracted entity that is specialized in inserting intravenous catheters) between 10:00 AM and 11:00 AM to come and insert a midline and also called Resident #294's family member to obtain consent for the midline insertion. The family member did not answer the phone, and she left a message for her. The family member arrived at the facility at around 3:00 PM and the Nurse informed her that the vascular team was enroute to the facility to insert the midline. Nurse #1 indicated Resident #249 was quieter around 3:00 PM compared to

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earlier in the day. The family member wanted Resident #294 to be sent to the Emergency Department (ED) due to the worsening condition and Nurse #1 stated she agreed. She informed the Unit Manager and the facility Provider and called emergency medical services (EMS) who came to transfer Resident #294 to the hospital.

An interview was conducted with the Unit Manager (UM) on 11/19/24 at 10:40 AM. The UM stated that she was notified by Nurse #1 on 11/1/24 at approximately 3:00 PM that Resident #294's family member was in the facility to see the resident and wanted him to be sent to the hospital due to altered mental status and she told Nurse #1 to go ahead and send the Resident out to the hospital per family request. The UM verbalized she was not aware if the Provider was notified about the inability to obtain the urine sample and change in condition until 11/1/24 when the Provider came to the facility between 10:00 AM and 11:00 AM. The UM stated that Resident #294 was being provided treatment at the facility, but the family member was the one that wanted the Resident to be sent out. During the interview the UM initially told the surveyor that intravenous access had been obtained and fluids administered but when she further looked in Resident #294's medical records she stated that she thought the fluids had been administered but they were not.

An interview was conducted with Resident #294's Emergency Contact #1 (Family Member) on 11/18/24 at 3:02 PM. The family member stated that she received a voice message from Nurse #1 on 11/1/24 at approximately 1:30 PM indicating that Resident #294 was doing okay and that she wanted to give her an update. The family member

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decided to come to the facility to check what was going on when she tried to call back the facility and was put on hold. When she arrived at the facility at around 3:00 PM she found the Resident naked and disoriented, his mouth was dry and crusty, and she attempted to give him a drink and he drank it. The family member stated Nurse #1 told her she was waiting for vascular team to come and insert an intravenous line and she informed Nurse #1 that she wanted the Resident to be sent to the hospital because he was in distress and Nurse #1 called 911. The family member also stated that Nurse #1 checked the Resident's vital signs during their conversation in the room and Nurse #1 immediately administered oxygen to the Resident after she checked the oxygen saturations.
During an interview on 11/19/24 at 10:20 AM with Nurse #1 she stated that she had checked Resident #294's vital signs before he was transferred to the ED but she could not recall what they were, all she could remember was that oxygen saturation was below 90 % and she administered oxygen.

Emergency medical services (EMS) report dated 11/1/24 indicated that EMS was contacted at 3:42 PM for a non-emergent transportation due to family choice. EMS arrived at the facility at 4:02 PM and primary impression was altered mental status and secondary impression was sepsis. The chief complaint was altered mental status with onset of 10/30/24. An electrocardiogram (ECG) at 4:05 PM indicated atrial fibrillation (irregular heart rhythm characterized by rapid and irregular heartbeat). Vital signs obtained by EMS at 4:17 PM were noted as blood pressure: 103/72, pulse: 65, respirations: 8, oxygen saturation: 94 % and level of consciousness was

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responds to painful stimulation on the AVPU (alert, voice, pain, unresponsive scale used to measure patient's level of consciousness). EMS obtained a telephone order at 4:22 PM to administer IV fluids due to Resident #294 meeting the criteria for sepsis. IV fluids were not administered due to inability to establish IV access. EMS departed facility at 4:39 PM with Resident #294 and notified the receiving hospital of sepsis indication at 5:00 PM. EMS assessment at 5:05 PM indicated Resident #294 was lethargic, non-verbal with minimal alertness, he had rapid mouth breathing, his skin was cold and dry, lung sounds were clear with increased respiratory rate and oxygen saturation readings were inconsistent due to the resident having cold hands. Resident #294 arrived at the ED at 5:41 PM.

Emergency department (ED) progress note dated 11/1/24 indicated that Resident #294's vital signs were noted as follows: blood pressure: 72/58, heart rate: 138, and respirations 29 at 5:45 PM and oxygen saturation: 33 %, and temperature: 93.4 degrees Fahrenheit at 6:23 pm. The progress note indicated Resident #294 presented critically ill, obtunded (reduced level of alertness and consciousness), breathing on his own with cold distal extremities with dilated pupils without response bilaterally and no response to painful stimuli. Facility stated that he had not been eating or drinking anything for 3 days, and today he was found naked by his family and encouraged the nurse to take his vital signs who then emergently called for 911. Resident #294 was found to be in metabolic acidosis (a condition in which too much acid accumulates in the body). Because of his cold extremities, they were unable to reliably obtain a pulse oximeter reading. Discussion with

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family revealed patient had voiced wishes to have "everything done "to sustain his life. After discussion regarding his goals of his care, family wanted the patient to continue to be full code. They understood that he was critically ill at that moment. The ED note indicated that Resident's presentation with altered mental status, tachypnea (rapid and shallow breathing), poor perfusion (occurs when there is inadequate blood circulation to organs and tissues and can be an early sign of circulatory or heart problems and can lead to life-threatening conditions), hypothermia (a medical emergency that occurs when the body's temperature drops below 95°F), severe lactic acidosis (occurs when the body produces too much lactic acid and the liver can't metabolize it fast enough), and new vasopressor requirements (vasopressors are a medication that are used to treat people with low blood pressure) most consistent with septic shock (a life-threatening condition that happens when the blood pressure drops to a dangerously low level after an infection) with end organ dysfunction as cause of death. Resident #294 died at 8:26 PM on 11/1/24.

An interview was conducted with the facility Medical Director (MD) on 11/19/24 at 4:37 PM. The MD stated he was aware of Resident #294's condition and the facility did what they were supposed to do to manage the Resident's condition. He indicated that when the Resident showed signs of a UTI, a UA was ordered and when they could not obtain a urine sample, they ordered an IV access for hydration, but the Resident was sent out before the IV access was obtained. The MD also stated that if the Resident had been sent out earlier that day on 11/1/24 the outcome would not have been any different. He

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also stated that if the UA had been obtained on 11/1/24 and was positive for a UTI they would have started the Resident on oral antibiotics and the outcome would have probably been the same.

An interview was conducted on 11/20/24 at 4:30 PM with the Director of Nursing (DON). The DON stated nurses should have had a discussion with the provider regarding Lasix administration if Resident #294 was not drinking adequately since the Resident had complained of burning with urination and they had not obtained the ordered urine specimen. The DON indicated once PA #1 evaluated the resident on 11/1/24 she ordered IV fluids which they were going to administer once vascular team obtained an IV access. She further stated that it was the family that wanted the Resident to be sent out and the Resident was sent out per family request.

The Administrator was notified of immediate jeopardy on 11/20/24 at 6:04 PM.

The facility provided the following credible allegation of immediate jeopardy removal:
1) Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to altered mental status. The center recognizes that all residents have the potential to be affected from the noncompliance of ensuring staff recognize significant changes in condition and providing necessary medical services for residents identified with complaints of burning urination and decreased fluid intake, including signs and symptoms of dehydration as

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evidenced by the inability to collect urine via an in and out catheter when the resident had a dry brief.
A review of Resident #294's electronic medical record revealed an order for UA w/ reflux, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 5:00 AM and 9:00 PM, 11/01/2024 at approximately 5:30 AM and was unable to collect urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders.
A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure a urine sample was obtained. Nine (9) residents with orders for UA/C&S and eight (8) with no further change in condition that required notification to physician. No discrepancies were noted. 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and Unit Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The Director of Nursing and or Unit Manager assessed current residents to include obtaining vital signs (blood pressure, increased heart rate, oxygen saturation, temperature), observation of dry cracked lips, poor skin turgor and or altered mental status and chart review to ensure there was no change in status or condition that required notifying the physician and obtaining necessary medical services to include signs and symptoms of dehydration on 11/20/2024.
On 11/20/2024, a root cause analysis was

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F 684	Continued From page 46 completed by the Director of Clinical Services and the Executive Director regarding staff failed to recognized the seriousness of a significant change in condition and obtaining necessary medical services to address an emergent situation for Resident #294. The change in condition included complaints of burning urination, decreased fluid intake and signs or symptoms of dehydration as evidenced by the inability to collect urine via an in out catheter. Nursing staff also continued to administer resident Lasix despite signs and symptoms of dehydration. It was determined through the root cause analysis that the facility staff failed to follow policy and procedures to recognize the seriousness of a significant change in condition and notify the physician to obtain necessary medical services to address an emergency situation. 2) 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 The Director of Clinical Services and Nurse Managers re-educated all licensed nurses on how to recognize the seriousness of a significant change in condition through assessing the resident, observation, and chart review to include medications, and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics, on 11/20/2024. Staff (licensed nurses/ Certified Nurse Assistants) not educated on 11/20/2024, will be educated by the Director of Nursing and or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by the Director of	F 684		

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F 684	Continued From page 47 Clinical Services and or Unit Managers. The Director of Clinical Services and Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Service and or Unit Managers. Date of Immediate Jeopardy Removal 11/21/2024. On 11/22/24 the facility's immediate jeopardy removal was validated by the following: The facility provided documentation to support immediate jeopardy removal that included audits completed by the Director of Nursing/Director of Clinical Services and Unit Managers. The audits included all current residents with an order for UA/CS from 10/20/2024 through 11/20/2024 which was revealed nine (9) residents with orders for UA/CS and eight (8) with no further change in condition that required notification to physician and no discrepancies were noted. The audits also included all residents with orders for diuretics and 23 residents were identified as having a physician order to administer diuretics and to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The audits also included assessments of all current residents to include obtaining vital signs (blood pressure, increased heart rate, oxygen saturation, temperature), observation of dry cracked lips, poor skin turgor and or altered mental status and chart review to ensure there was no change in status or condition that required notifying the physician and obtaining necessary medical services to include signs and symptoms of dehydration on 11/20/2024. The facility provided	F 684		

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F 684	Continued From page 48 documentation on the education they provided to include sign-in sheets. The education information indicated that the Director of Clinical Services and Nurse Managers re-educated all licensed nurses on how to recognize the seriousness of a significant change in condition through assessing the resident, observation, and chart review to include medications, and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics, on 11/20/2024. The Director of Clinical Services and Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and to immediately report the change in condition to the licensed nurses on 11/20/2024. Interviews confirmed that newly hired staff would be educated during orientation by the Director of Clinical Service and/or Unit Managers. Interviews with nursing staff verified the staff had been educated on all information as indicated in immediate jeopardy removal plan. The immediate jeopardy removal date of 11/21/24 was validated.	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	F 692		12/18/24

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F 692	Continued From page 49 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. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, family member, Physician Assistant (PA), and Medical Director interviews the facility failed to ensure staff recognized the seriousness of signs and symptoms of dehydration for a resident receiving a diuretic (Lasix 20 mg daily) and who had decreased fluid intake. Resident #294 was first identified with decreased nutritional and fluid intake on 10/29/24 requiring staff to push fluids (deliberately drink beyond what thirst dictates to avoid dehydration) through 11/1/24. Resident #294 exhibited signs and symptoms of dehydration on 10/31/24 at approximately 9:00 PM and 11/1/24 at approximately 5:30 AM as evidenced by the inability to collect urine via an in and out catheter (inserting a thin, hollow tube into the bladder) when the resident had no recent episodes of urination. During this time, nursing staff continued to administer the resident's Lasix (diuretic) 20 milligrams once daily at 9:00 AM despite signs and symptoms of dehydration. On 11/1/24 at 10:15 AM the PA ordered a peripheral intravenous (PIV) access (small catheter inserted into a superficial vein [a vein located close to the surface of the skin]) to provide intravenous fluids to the resident and staff did not attempt to insert the PIV due to the inability to find a visible vein	F 692	Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to altered mental status. The center recognizes that all patients have the potential to be affected from the noncompliance of ensuring staff recognize significant changes in condition including symptoms of dehydration. A review of Resident #294 electronic medical record revealed an order for UA w/ reflex, Urine Culture and Sensitivity with Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain a urine sample on 10/31/2024 at approximately 9:00 PM and 11/01/2024 at approximately 5:30 AM the resident was in a dry brief and staff were unable to collect a urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physician orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the	

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F 692	Continued From page 50 (dehydration can cause veins to be difficult to locate). That afternoon, Resident #294's family member requested the resident be sent to the hospital. Emergency Medical Services (EMS) were contacted at 3:42 PM and Resident #294 was transferred to the emergency room where he was identified with altered mental status, tachypnea (rapid and shallow breathing), poor perfusion (occurs when there is inadequate blood circulation to organs and tissues and can be an early sign of circulatory or heart problems and can lead to life-threatening conditions), hypothermia (a medical emergency that occurs when the body's temperature drops below 95°F), severe lactic acidosis (occurs when the body produces too much lactic acid and the liver can't metabolize it fast enough), and new vasopressor requirements (vasopressors are a medication that are used to treat people with low blood pressure) most consistent with septic shock (a life-threatening condition that happens when your blood pressure drops to a dangerously low level after an infection) with end organ dysfunction. Resident #294 died at 8:26 PM on 11/1/24. This deficient practice occurred for 1 of 3 residents (Resident #294) reviewed for dehydration. Immediate jeopardy began on 10/31/24 when staff failed to recognize the seriousness of signs and symptoms of dehydration for Resident #294 when staff were unable to collect urine via an in and out catheter when the resident had no recent episodes of urination and decreased fluid intake. Immediate jeopardy was removed on 11/21/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of "D" (no actual harm with potential for more than minimal harm that is immediate	F 692	Director of Clinical Services and/or the Unit Managers on 11/20/2024 to ensure a urine sample was obtained. No residents were identified as having an issue with lab collection that would indicate dehydration. 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and/or Unit Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The Director of Nursing and/or Unit Managers assessed current residents to include obtaining vital signs (blood pressure, increased heart rate, oxygen saturation and temperature), observation of dry cracked lips, poor skin turgor and/or altered mental status and chart review to ensure no other residents exhibited signs and symptoms of dehydration that was not addressed and communicated to the physician on 11/20/2024. No concerns were identified during this audit. On 11/20/2024, a root cause analysis was completed by the Director of Clinical Services and the Executive Director regarding staff failure to recognize the signs and symptoms of dehydration and then to provide necessary medical services to address an emergent situation for Resident #294. The resident had decreased fluid intake and signs or symptoms of dehydration as evidenced by the inability to collect urine via an in and out catheter. Nursing staff also continued to administer resident Lasix despite signs and symptoms of dehydration. It was determined through the root cause	

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F 692	Continued From page 51 jeopardy) to ensure education is completed and monitoring systems put into place and are effective. The findings included: Resident #294 was admitted to the facility on 10/7/24. His diagnoses included fracture of right femur (thigh bone between hip and knee), dementia, type 2 diabetes, adult failure to thrive, generalized muscle weakness, chronic kidney disease, and congestive heart failure. He was admitted to the facility for rehabilitation therapy services after hospitalization following the femur fracture. Resident #294's care plan last revised on 10/7/24 had a care focus area that indicated Resident had potential for fluid deficit related to diuretic use with the goals for Resident to be free of symptoms of dehydration. Interventions included: monitor and document intake and output as per facility policy; monitor vital signs as ordered/per protocol and record; notify physician of significant abnormalities; monitor/document/report as needed any signs/symptoms of dehydration; obtain and monitor lab/diagnostic work as ordered and report results to physician and follow up as indicated. A physician order dated 10/7/24 indicated give Lasix oral tablet 20 milligram by mouth one time a day for edema (swelling from fluid retention). Lasix is a diuretic used to treat fluid retention that can result from congestive heart failure, kidney disease or other medical conditions. (Lasix increases the flow of urine and can lead to dehydration.)	F 692	analysis that the facility staff failed to follow policy and procedures to recognize the seriousness of signs and symptoms of dehydration and notify the physician to obtain necessary medical services to address an emergency situation. The Director of Clinical Services and Nurse Managers re-educated all licensed nurses on how to recognize signs and symptoms of dehydration through assessing the resident, observation, and chart review to include medications, and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics on 11/20/2024. Staff (licensed nurses/Certified Nurse Assistants) not educated on 11/20/2024 will be educated by the Director of Nursing and/or Unit Managers prior to working the floor. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. The Director of Clinical Services and/or Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed clinical staff on 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. Date of Immediate Jeopardy Removal = 11/21/2024	

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F 692	Continued From page 52 Resident #294's admission Minimum Data Set (MDS) assessment dated 10/12/24 coded Resident #294 as cognitively intact. He was coded as frequently incontinent of bowel and bladder and was also coded as taking a diuretic. Resident #294's overall discharge goal was to return to the community. He was not coded for hospice care. A facility 24-hour condition report completed by Nurse #5 dated 10/29/24 indicated Resident #294 had poor oral intake on day shift. The facility's 24-hour condition report is a form that nurses document the status of all the residents during or at the end of their shift to communicate any pertinent information to the next shift and nursing management. During an interview with Nurse #5 on 11/18/24 at 2:45 PM, she stated that she had cared for Resident #294 on 10/29/24 from 7:00 AM to 7:00 PM. Nurse #5 indicated that normally Resident # 294 consumed more than 25% of his tray food and drinks but on 10/29/24 he had eaten and drank less than 25% during breakfast, lunch and dinner and she documented it in the 24 hour report and informed the oncoming night shift nurse (Nurse # 4). During an interview on 11/19/24 at 3:53 PM with Nurse #4, she stated that she was assigned to care for Resident #294 on 10/29/24 at 7:00 PM to 10/30/24 at 7:00 AM. Nurse #4 stated that during shift change Nurse #5 had informed her and documented in the 24-hour condition report that Resident #294 had a decreased oral intake with food and drinks. Nurse #4 stated that Resident #294 was stable and the only concern during her shift was complaints of burning with urination	F 692	The Director of Clinical Services and Nurse Managers re-educated all licensed nurses on how to recognize signs and symptoms of dehydration through assessing the resident, observation and chart review to include medications and notify the physician to obtain necessary medical services to address an emergent situation. This education includes emphasis on signs and symptoms of dehydration and continued administration of diuretics. Education conducted on 11/20/2024. Staff (licensed nurses/Certified Nursing Assistants) not educated on 11/20/2024 will be educated by the Director of Nursing and/or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. Date of Jeopardy Removal = 11/21/2024 The Director of Clinical Services and/or Nurse Managers re-educated all licensed nurses on how to recognize signs and symptoms of dehydration through assessing the resident, observation and chart review to include medications and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics. Education includes any time an order is given but not able to be completed for any reason, the floor nurse or clinical manager will call the physician for additional instructions. Newly hired staff will be educated during	

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F 692	Continued From page 53 which she noted in the physician's book and she pushed fluids while Resident #294 was awake because she thought it was a sign of urinary tract infection. Nurse #4 stated that Resident #294 did not drink much fluids because it was at night and he slept most of the night. A Physician telephone order dated 10/30/2024 at 11:59 AM ordered by Physician Assistant (PA) #2 indicated urinalysis (UA), urine culture and sensitivity (C & S) for a diagnosis of dysuria. Resident #294's medication administration record indicated Lasix 20 mg was administered on 10/30/24 at 9:00 AM by Nurse #1. During an interview on 11/19/24 at 10:20 AM with Nurse #1, she indicated that she had cared for Resident #294 on 10/30/24. She stated that she was pushing fluids because Resident #294 had complained of burning with urination and that could have been a sign of a urinary tract infection. Nurse #1stated that Resident #294 was less talkative than usual on 10/30/24. During an interview on 11/20/24 at 3:38 PM with Nurse #2, she stated that she had cared for Resident #294 on night shift (10/30/24 at 11:00 PM to 10/31/24 at 7:00 AM). Nurse #2 stated that when she took over the assignment that night, she was notified by the off going nurse (Nurse #6) that a urine sample was needed for Resident #294. She indicated that when she came on shift Resident #294 was asleep and she did not recall waking him up to give him any fluids. Nurse #2 indicated that Resident #294 slept throughout her shift, and she attempted to obtain the urine specimen via an in and out catheter at around 5:00 AM on 10/31/24 but was unsuccessful and	F 692	orientation by the Director of Clinical Services and/or Unit Managers. The Director of Clinical Services and/or Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and to immediately report the change in condition to the licensed clinical staff on 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Services and/or Unit Managers. The Director of Nursing and/or Nurse Managers will provide quality monitoring daily (Monday through Friday) during clinical review for 5 days, then 3 times per week for 3 weeks, then 2 times per week for 4 weeks and then weekly for 4 weeks. This monitoring will be to ensure any resident who is ordered diuretics the facility is monitoring fluid intake, any acute change an SBAR is completed and the physician is notified and for any new order for diuretics the order to monitor fluid intake will be initiated and any new orders for urinalysis to ensure no dehydration is noted through review of lab results. The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring (audits) will be updated as indicated.	

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she notified the oncoming day shift nurse (Nurse #1). Nurse #2 indicated Resident #294's incontinence brief was wet during the in and out catheter attempt.

An interview was conducted on 11/20/24 at 2:12 PM with NA #2 who had cared for Resident #294 on 10/30/24 and 10/31/24 on night shift. NA #2 stated that Resident #294 took only a few sips of water during her shifts and when she changed his incontinence brief there was very little urine. NA #2 stated that Nurse #3 was aware of Resident's condition and had told her to offer and encourage the Resident to drink water when she went to check on him.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 10/31/24 at 9:00 AM by Nurse #1.

During an interview with Nurse #1 on 11/19/24 at 10:20 AM, she stated that when she came back to work on 10/31/24 at around 7:00 AM she was informed by the off going night shift Nurse (Nurse #2) that a urine sample was still needed for Resident #294 since she had not been able to obtain the urine during the night shift. She indicated that Resident #294 was more like he was the previous day (10/30/24) when she had noted he was not at his baseline. He was less talkative than usual and not eating/drinking as usual and she continued to push fluids and he did not drink much. Nurse #1 stated that Resident #294 normally ate and drank most of what was on his tray, and he also drank most of the water she gave him during medication administration, but on 10/31/24 he took only sips with the medication. She further stated that Resident #294 consumed 0 out of 120 milliliters of his med pass (nutritional

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supplementation) on 10/31/24 at approximately 9:00 AM and 5:00 PM whereas previously he consumed 100 % of the supplementation.

A facility 24-hour condition report completed by Nurse #3 dated 11/1/24 on night shift (10/31/24 7:00 PM to 11/1/24 7:00 AM) indicated the nurse attempted twice to collect urine unsuccessfully.

A late entry nursing progress note written by Nurse #3 dated 11/1/2024 at 6:13 AM indicated report was given to the nurse that a UA/C&S was needed. The nurse attempted to push fluids, however, resident would only take small sips. The first attempt to obtain the UA/C&S was around 9:00 PM on 10/31/24 and she was unable to collect as not enough urine came out. The writer continued to push fluids throughout the shift, again, only getting small sips. The first attempt to collect the urine was reported to the supervisor. The second attempt to obtain the UA/C&S was at 5:33 AM on 11/1/24 and was again unsuccessful. Oncoming nurse (Nurse #1) and the Unit Manager were made aware of the attempts and that the resident was still in need of a specimen or the medical doctor may need to be called to get further orders.

Nursing progress note written by Nurse #3 dated 11/1/2024 at 6:31 AM indicated writer attempted to collect urine twice, however, was unsuccessful and Nurse #3 would report off to oncoming nurse (Nurse #1).

An interview was conducted on 11/20/24 at 1:54 PM with the Nurse #3 who was assigned to care for Resident #294 on 10/31/24 at 7:00 PM through 11/1/24 at 7:00 AM. Nurse #3 stated she had received report from the off going day shift

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nurse (Nurse #1) that a urine specimen was needed for Resident #294 and she attempted to obtain the specimen at around 9:00 PM on 10/31/24 and at approximately 5:30 AM on 11/1/24 via an in and out catheter both times but was unsuccessful. She stated that there was barely any urine and it was too thick to be processed. She stated that Resident #294's incontinence brief was dry during both attempts, and she was pushing fluids but Resident #294 was only taking small sips and could not get in much. Nurse #3 reported to the oncoming day shift nurse (Nurse #1) that she had been unsuccessful in obtaining the urine specimen via an in and out catheter. Nurse #3 stated that Resident #294 was verbal and did not seem to be in any acute distress otherwise she would have informed the physician to send him out. She stated that when she did not obtain the urine specimen at 5:30 AM she notified the oncoming day shift nurse so that she could notify the PA that morning and they could probably get an order for an IV because he was not drinking much, they had not been able to obtain the urine sample and he was probably dehydrated.

During an interview on 11/19/24 at 3:05 PM with Nursing Assistant (NA) #1 she stated that she had cared for Resident #294 on 10/30/24 through 11/1/24 during the 7:00 AM to 3:00 PM shift. NA #1 stated that during those 3 days she noticed that Resident #294 was eating and drinking less than usual, and he had become incontinent whereas previously he was using the urinal. She also stated that previously he could feed himself, but she had to feed him and offer drinks on 10/31/24 and 11/1/24 but he did not eat or drink as he usually did. NA #1 also stated that when she changed Resident #294's briefs there was

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minimal urine. NA #1 further stated that when she was giving Resident #294 a shower on 11/1/24 he was not as responsive as usual, he was quiet and not shouting like he would normally do during showers. She verbalized that Nurse #1 was aware of Resident #294's condition and had told NA #1 to encourage Resident #294 to drink his fluids and also to give him a shower because he kept pulling off his clothes.

Resident #294's medication administration record indicated Lasix 20 mg was administered on 11/1/24 at 9:00 AM by Nurse #1.

A Physician order dated 11/1/24 at 10:15 AM ordered by PA #1 indicated obtain PIV access and if unable to obtain, obtain a midline (a long flexible tube that is inserted into a vein in the upper arm to deliver fluids or medication into the blood stream).

A Physician order dated 11/1/24 ordered by PA #1 indicated Sodium Chloride Intravenous Solution 0.9 %. Use 2 liters intravenously in the morning for poor oral intake for 3 Days. Administer 2 liters intravenous fluids normal saline at 100 milliliters per hour for 3 days. (Sodium Chloride is used to replenish lost water and salt in the body.)

During an interview with Nurse #1 on 11/19/24 at 10:20 AM, Nurse #1 stated that when she came to work on 11/1/24 at around 7:00 AM she was informed by the off going night shift nurse (Nurse #3) that a urine sample was still needed. She stated that she knew the PA would come to the facility that morning and she would let the PA know that they had not been able to obtain the specimen and the resident was not drinking much which was probably a sign of dehydration. She

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indicated the resident drank only sips of water during medication administration on 11/1/24. Nurse #1 revealed that she had administered Resident #294's Lasix on 10/30/24, 10/31/24 and 11/1/24 at approximately 9:00 AM despite the resident's decreased oral food and fluid intake and that she did not think to hold it or ask the provider about it. Nurse #1 stated she could not say why she had administered Lasix when they had been unable to obtain the urine specimen and the Resident was not drinking much. She stated Resident #294 seemed more confused than the previous 2 days, and she notified Physician Assistant (PA) #1 when she came to the facility between 10:00 AM and 11:00 AM on 11/1/24. PA #1 went to examine Resident #294 and ordered a midline and IV fluids. Nurse #1 stated she did not attempt to insert a peripheral line because Resident #294 was dehydrated and she could not find a visible vein. She called the vascular team (a contracted entity that is specialized in inserting intravenous catheters) to come and insert a midline and also called Resident #294's family member to obtain consent for the midline insertion. The family member did not answer the phone, and she left a message for her. The family member arrived at the facility at around 3:00 PM and the Nurse informed her that the vascular team were enroute to the facility to insert the midline. The family member wanted Resident #294 to be sent to the Emergency Department (ED) due to the worsening condition and Nurse #1 stated she agreed. She informed the Unit Manager and the facility Provider and called emergency medical services (EMS) who came to transfer Resident #294 to the hospital.

A PA progress note written by PA #1dated 11/1/24 at 11:52 AM indicated Resident #294 was seen

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by PA at the request of nursing for evaluation of change in condition. The resident was minimally responsive. This was a noted change from usually being agitated and interactive per nursing/therapy. The roommate reported that he had not seen Resident #294 eat over the past 3 days. Nursing attempted to obtain UA/C&S, unable to provide adequate sample even with catheter. The progress note also indicated the resident had a change in condition, altered mental status, decreased oral intake, and was clinically dehydrated. An order was provided to obtain a PIV on 11/1/24 and ordered IVF 2 liters for 3 days (11/1/24 to 11/4/24). The progress note also indicated staff were unable to obtain UA/C&S given dehydration.

During an interview on 11/19/24 at 4:30 PM with PA #1, she stated that she was notified by Nurse #1 when she came to the facility at around 10:30 AM on 11/1/24 that Resident #294 had a change in condition, and they had not been able to obtain a urine sample for a UA and C&S. The PA explained that when she went to assess Resident #294, he seemed dehydrated but was responsive to questions. She gave an order to insert a peripheral intravenous (PIV) line and if unable to obtain PIV access to obtain a midline so that they could administer IV fluids. The PA stated she did not know Resident #294's baseline since she was not the primary care provider for Resident #294. She also stated that she could not recall if the facility contacted her to let her know that they had not obtained an IV access.

An interview was conducted with the Unit Manager (UM) on 11/19/24 at 10:40 AM. The UM stated that she was notified by Nurse #1 on 11/1/24 at approximately 3:00 PM that Resident

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#294's family member was in the facility to see the resident and wanted him to be sent to the hospital due to altered mental status and she told Nurse #1 to go ahead and send the Resident out to the hospital per family request. The UM stated that Resident #294 was being provided treatment at the facility but the family member was the one that wanted the Resident to be sent out. During the interview, the UM initially told the surveyor that an intravenous access had been obtained and fluids administered but when she further looked in Resident #294's medical records she stated that she thought the fluids had been administered but they were not.

An interview was conducted with Resident #294's Emergency Contact #1 (Family Member) on 11/18/24 at 3:02 PM. The family member stated that she received a voice message from Nurse #1 on 11/1/24 at approximately 1:30 PM indicating that Resident #294 was doing okay and that she wanted to give her an update. The family member decided to come to the facility to check what was going on when she tried to call back the facility and was put on hold. When she arrived at the facility around 3:00 PM she found the Resident naked and disoriented, his mouth was dry and crusty and she attempted to give him a drink and he drank it. The family member stated Nurse #1 told her she was waiting for vascular team to come and insert an intravenous line and she informed Nurse #1 that she wanted the Resident to be sent to the hospital because he was in distress and Nurse #1 called 911. The family member also stated that Nurse #1 checked the Resident's vital signs during their conversation in the room and Nurse #1 immediately administered oxygen to the Resident after she checked the oxygen saturations.

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EMS report dated 11/1/24 indicated that EMS was contacted at 3:42 PM for a non-emergent transportation due to family choice. EMS arrived at the facility at 4:02 PM and primary impression was altered mental status and secondary impression was sepsis. The chief complaint was altered mental status with onset of 10/30/24. An electrocardiogram (ECG) at 4:05 PM indicated atrial fibrillation (irregular heart rhythm characterized by rapid and irregular heartbeat). Vital signs obtained by EMS at 4:17 PM were noted as blood pressure: 103/72, pulse: 65, respirations: 8, oxygen saturation: 94 % and level of consciousness was responds to painful stimulation on the AVPU (alert, voice, pain, unresponsive scale used to measure patient's level of consciousness). EMS obtained a telephone order at 4:22 PM to administer IV fluids due to Resident #294 meeting the criteria for sepsis. IV fluids were not administered due to inability to establish an IV access. EMS departed facility at 4:39 PM with Resident #294 and notified the receiving hospital of sepsis indication at 5:00 PM. EMS assessment at 5:05 PM indicated Resident #294 was lethargic, non-verbal with minimal alertness, he had rapid mouth breathing, his skin was cold and dry, lung sounds were clear with increased respiratory rate and oxygen saturation readings were inconsistent due to the resident having cold hands. Resident #294 arrived at the ED at 5:41 PM.

An ED progress note dated 11/1/24 indicated that Resident #294's vital signs were noted as follows: blood pressure: 72/58, heart rate: 138, and respirations 29 at 5:45 PM and oxygen saturation: 33 %, and temperature: 93.4 degrees Fahrenheit at 6:23 pm. The progress note indicated Resident

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#294 presented critically ill, obtunded (reduced level of alertness and consciousness), breathing on his own with cold distal extremities with dilated pupils without response bilaterally and no response to painful stimuli. Facility stated that he had not been eating or drinking anything for 3 days, and today he was found naked by his family and encouraged the nurse to take his vital signs who then emergently called for 911. Resident #294 was found to be in metabolic acidosis (a condition in which too much acid accumulates in the body). Because of his cold extremities, they were unable to reliably obtain a pulse oximeter reading. Discussion with family revealed patient had voiced wishes to have "everything done "to sustain his life. After discussion regarding his goals of his care, family wanted the patient to continue to be full code. They understood that he was critically ill at that moment. The ED note indicated that Resident's presentation with altered mental status, tachypnea, poor perfusion, hypothermia, severe lactic acidosis, and new vasopressor requirements, consistent with septic shock with end organ dysfunction as cause of death. Resident #294 died at 8:26 PM on 11/1/24.

An interview was conducted with the facility Medical Director (MD) on 11/19/24 at 4:37 PM. The MD stated he was aware of Resident #294's condition and the facility did what they were supposed to do to manage the Resident's condition. He indicated that when they could not obtain a urine sample, they ordered an IV access for hydration, but the Resident was sent out before the IV access was obtained. The MD also stated that if the Resident had been sent out earlier the outcome would not have been any different. When the MD was asked if the staff should have continued administering Lasix with

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decreased oral intake and inability to obtain urine with no recent episodes of urination, the MD did not elaborate and he reiterated that the facility did everything right.

An interview was conducted on 11/20/24 at 4:30 PM with the Director of Nursing (DON). The DON stated that if nurses were not able to obtain the urine specimen on 10/31/24 at 5:00 AM they should have notified the PA because PAs are normally in the building daily. She further stated that if nurses notice any signs of dehydration and the resident is not adequately drinking they should notify the on call provider if there is no provider in the building. The DON also stated that nurses should have had a discussion with the provider regarding Lasix administration if Resident #294 was not drinking adequately on 10/31/24 before administering the 9:00 AM Lasix since the Resident had complained of burning with urination and they had not obtained the ordered urine specimen.

The Administrator was notified of immediate jeopardy on 11/20/24 at 6:04 PM.

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

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

Resident #294 no longer resides in the facility. Resident was transferred to the local hospital on 11/01/2024 due to altered mental status. The center recognizes that all residents have the potential to be affected from the noncompliance of ensuring staff recognize significant changes in

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F 692	Continued From page 64 condition including signs and symptoms of dehydration. A review of Resident #294's electronic medical record revealed an order for UA w/ reflux, Urine Culture and Sensitivity with Diagnosis of Dysuria was ordered on 10/30/2024. The facility staff attempted to push fluids and obtain urine sample on 10/31/2024 at approximately 9:00 PM and 11/01/2024 at approximately 5:30 AM the resident was in a dry brief and staff was unable to collect a urine sample. A review of Resident #294 orders indicated resident was prescribed Lasix 20mg daily to be administered daily per physicians' orders. A quality review of current residents with an order for UA/C&S between 10/20/2024 through 11/20/2024 were audited by the Director of Clinical Services and Unit Managers on 11/20/2024 to ensure a urine sample was obtained. No residents were identified as having an issue with lab collection that would indicate dehydration. 23 residents were identified as having a physician order to administer diuretics and were audited by the Director of Nursing and Unit Managers to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The Director of Nursing and or Unit Manager assessed current residents to include obtaining vital signs (blood pressure, increased heart rate, oxygen saturation, temperature), observation of dry cracked lips, poor skin turgor and or altered mental status and chart review to ensure no other residents exhibited signs and symptoms of dehydration that was not addressed and communicated to the physician on 11/20/2024. No concerns were identified during this audit.	F 692		

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F 692	Continued From page 65 On 11/20/2024, a root cause analysis was completed by the Director of Clinical Services and the Executive Director regarding staff failure to recognize the signs and symptoms of dehydration and then to provide necessary medical services to address an emergent situation for Resident #294. The resident had decreased fluid intake and signs or symptoms of dehydration as evidenced by the inability to collect urine via an in out catheter. Nursing staff also continued to administer resident Lasix despite signs and symptoms of dehydration. It was determined through the root cause analysis that the facility staff failed to follow policy and procedures to recognize the seriousness of signs and symptoms of dehydration and notify the physician to obtain necessary medical services to address an emergency situation. 2) 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 The Director of Clinical Services and Nurse Managers re-educated all licensed nurses on how to recognize signs and symptoms of dehydration through assessing the resident, observation, and chart review to include medications, and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics, on 11/20/2024. Staff (licensed nurses/ Certified Nurse Assistants) not educated on 11/20/2024, will be educated by the Director of Nursing and or Unit Manager prior to working the floor. Newly hired staff will be educated during orientation by	F 692		

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F 692	Continued From page 66 the Director of Clinical Services and or Unit Managers. The Director of Clinical Services and Nurse Managers re-educated certified nursing assistants on signs and symptoms of dehydration and immediately report the change in condition to the licensed 11/20/2024. Newly hired staff will be educated during orientation by the Director of Clinical Service and or Unit Managers. Date of Immediate Jeopardy Removal 11/21/2024. On 11/22/24 the facility's immediate jeopardy removal was validated by the following: The facility provided documentation to support immediate jeopardy removal that included audits completed by the Director of Nursing/Director of Clinical Services and Unit Managers. The audits included all current residents with an order for UA/C&S from 10/20/2024 through 11/20/2024 which was revealed nine (9) residents with orders for UA/C&S with no other residents identified as having an issue with lab collection that would indicate dehydration. The audits also included all residents with orders for diuretics and 23 residents were identified as having a physician order to administer diuretics and to ensure no signs and symptoms of dehydration as evidenced by the inability to collect urine. The audits also included assessments of all current residents to include obtaining vital signs (blood pressure, increased heart rate, oxygen saturation, temperature), observation of dry cracked lips, poor skin turgor and or altered mental status and chart review to ensure no other residents exhibited signs and symptoms of dehydration that was not addressed and communicated to the	F 692		

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F 692	Continued From page 67 physician. The facility provided documentation on the education they provided to include sign-in sheets. The education information indicated that the Director of Clinical Services and Nurse Managers re-educated all licensed nurses on 11/20/24 on how to recognize signs and symptoms of dehydration through assessing the resident, observation, and chart review to include medications, and notify the physician to obtain necessary medical services to address an emergent situation with emphasis on signs and symptoms of dehydration and continued administration of diuretics. The Director of Clinical Services and Nurse Managers re-educated licensed nursing staff and nursing assistants on 11/20/24 on signs and symptoms of dehydration (decreased urination, dry mouth, cracked lips, low blood pressure, increased heart rate, sunken eyes, altered mental status, poor skin turgor). Interviews confirmed that newly hired staff would be educated during orientation by the Director of Clinical Service and/or Unit Managers. Interviews with nursing staff verified the staff had been educated on all information as indicated in immediate jeopardy removal plan. The immediate jeopardy removal date of 11/21/24 was verified.	F 692		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919		12/18/24

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F 919	Continued From page 68 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and Resident and staff interviews, the facility failed to ensure call bells were plugged into the wall panel for a dependent resident to allow them to call for assistance if needed. The deficient practice was for 1 of 30 residents reviewed for accommodation of needs (Resident #6). Findings included: Resident #6 was admitted to the facility on 05/07/2014. The quarterly Minimum Data Set (MDS) dated 08/05/2024 had Resident #6 coded as moderately cognitively impaired with clear speech, she makes herself understood and can understand others. Resident #6 was always incontinent with bowel and bladder. An observation and interview were conducted with Resident #6 on 11/18/2024 at 10:43 AM. Resident #6 was in her room, in her bed with head of bed elevated. One end of her call bell wire was placed over the top of the bed and the other end with the red button was tied around the bedrail. The call light panel was not visible from the door. Resident #6 was asked if she could use her call bell and if so to call for assistance. The Resident stated she does use her call bell and pushed the red button. The light outside of the Residents room did not light up. The panel behind the Resident's bed was checked to see if the light was on and it did not come on and the plug for the call light was not plugged in. The call bell was	F 919	The Director of Nursing made sure the call light was plugged in, in working order and in reach of Resident #6. The Director of Nursing made sure the call was in reach and not in a place where it could be pulled out of the system. The Maintenance Director and Designee audited the entire facility to ensure all residents had their call light within reach, in working order and that they were not in a place that could detach the light from the system on 12/18/2024 with no further call light system errors. Maintenance then installed missing clips to call bells to secure the call bell to prevent it from being disabled from the call bell system. Any resident can be affected by this deficient practice. An ad hoc Quality Assurance Performance Improvement committee was held on 12/18/2024 to formulate and approve a plan of correction for the deficient practice. The Director of Nursing and Executive Director completed education for the licensed clinical staff, certified nursing assistants, all departments and all contracted vendors (Therapy, Dietary, Housekeeping/Laundry) to make sure call lights are within reach, in working order and not in a place where it could be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 69 wrapped and tied around the resident's bedrail. Resident #6 stated, she used her call bell regularly. The last time she used the call bell was last evening without any issues. Nurse #7 came to Resident #6's room and found the call bell knotted up and tied to the resident's bedrail, she started to untangle the wires and then plugged the wire into the outlet. The resident was asked to push the call light, and the call light came on. An interview with Nurse #7 was conducted on 11/18/2024 at 11:11 AM. The Nurse stated all residents should have their call bells within reach and working. The Nurse also stated the last time she came in to check on the resident was an hour ago and the Nursing Assistant (NA)# 4 was giving care to Resident #6's roommate (Resident #10) and thought she would make sure the call bells were working and within reach for the residents. An interview with NA #4 was conducted on 11/18/2024 at 11:34 AM. The NA stated she usually made sure the call bells were within reach before she left the room, and she looked at the panel to make sure it was plugged in. She did not notice if the call bell was plugged in when she left the room. The NA also stated she did not know how it happened. The call bell wire could have come out when Resident #6 raised the head of her bed. An interview with the Director of Nursing (DON) was conducted 11/18/2024 at 12:32 PM. The DON stated all staff are trained to place the call bell within reach and make sure they plug into the panel prior to leaving the Residents room. She expected her staff to make sure the Residents call lights were plugged in and within the residents reach before leaving their rooms.	F 919	detached from the system for all residents before leaving the resident's room. This education also included ensuring the call bell is equipped with a clip to the bed for ease of accessibility of the resident. An ongoing audit will be conducted randomly by the Director of Nursing and/or Unit Managers for 5 residents for 3 times per week X 12 weeks to ensure call lights are within reach, in working order and not in a place where it could be detached from the system for all residents before leaving the resident's room. The Executive Director will bring to QAPI monthly for 3 months. The Director of Nursing will report all results of quality monitoring audits to the QAPI committee. Findings will be reviewed by the QAPI committee monthly and quality monitoring audits will be updated as indicated.	

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