STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676113	A. Building B. Wing	10/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	2003 W Hutchins Place San Antonio, TX 78224

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on interview and record review, the facility failed to immediately consult a resident's physician when there was a significant change in a resident's physical, mental, or psychosocial status for 1 of 9 residents (Resident #1) reviewed for notification of changes in that: The facility failed to consult NP A of Resident #1's change in condition of persistent vomiting requiring an increase in the nausea medication. This deficient practice could place residents at risk of not having their provider consulted of changes, resulting in a delay in medical intervention. The findings were: Record review of Resident #1's face sheet, dated 10/1/2021, revealed Resident #1 was initially admitted to facility on 4/5/2019 with diagnoses of hypo-osmolality (condition where levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low levels of sodium in the blood), essential (primary) hypertension (high blood pressure), Type 2 Diabetes Mellitus, muscle wasting and atrophy, not elsewhere classified, multiple sites, and muscle weakness (generalized.) Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 8, signifying moderate cognitive impairment. Record review of Resident #1's Order Summary Report from 6/1/2021 - 10/3/2021, printed 10/4/2021, revealed Resident #1 had an order for Ondansetron HCl (a medication to prevent nausea and vomiting) Tablet 4 MG Give 1 tablet by mouth every 4 hours as needed for Nausea/vomiting, which was ordered on 8/12/2021. Record review of Resident #1's MAR and TAR for August 2021, printed 10/1/2021, revealed Resident #1 had not received a dose of ondansetron PRN during the entire month of August 2021. Record review of Resident #1's MAR and TAR for September 2021, printed 10/1/2021, revealed Resident #1 received two doses of ondansetron on 9/3/2021, and two more doses of ondansetron on 9/5/2021. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Nursing Progress Note, written by LVN I on 9/5/2021 at 6:28 p.m., revealed during a visitation with the family, Resident #1 threw up moderate amt [amount] of brown emesis. [emesis is the action or process of vomiting]. Record review of Nursing Progress Note, written by RN E on 9/6/2021 at 5:45 a.m., revealed Resident #1 had an episode of emesis. [emesis is the action or process of vomiting]. Record review of Nursing Progress Note, written by LVN C on 9/6/2021 at 9:09 a.m., revealed Resident #1 had pain which was rated as a zero on the pain scale, which indicated no pain. On 9/6/2021, LVN C completed a change in condition at 10:04 a.m., which further revealed Resident #1 had abdominal pain. Record review of Daily Skilled Note, written by LVN C on 9/6/2021 at 6:44 p.m., revealed the following documentation: emesis x2. [emesis is the action or process of vomiting]. Record review of Nursing Progress Note, written by RN E on 9/8/2021 at 2:53 a.m., revealed upon arrival to the unit resident c/o [complained of] nausea and light vomiting. I gave [Resident #1] an Ondansetron tab at 11pm a few minutes after resident had an episode of emesis measuring 200 mls [milliliters] in color yellow. During an interview on 10/4/2021 at 8:56 a.m., Administrator M stated he briefly remembered something GI-related that was discussed in a past clinical meeting on 9/6/2021. Administrator M could not recall specific details discussed. During an interview on 10/4/2021 at 1:04 p.m., LVN I confirmed Resident #1 vomited on 9/6/2021 while Resident #1 was in a family visitation. LVN I stated nausea or vomiting was not normal for Resident #1, but felt it was one-time thing because the day before, 9/4/2021, Resident #1 left the facility for a family outing and ate a lot of food. LVN I explained Resident #1 did not have a fever at the time and did not complain of any pain. LVN I stated if Resident #1 had vomited more than 3 times she would have become suspicious of an issue. During an interview on 10/4/2021 at 1:28 p.m., NP A stated she was not notified of Resident #1's and vomiting or increased ondansetron administration. NP A stated she would have preferred to be notified if a resident was receiving ondansetron more consistently than usual. During an interview on 10/4/2021 at 4:55 p.m., DON L stated the facility provided in-services on assessing gastrointestinal issues and notifying providers of any change of conditions. DON L explained the nurses should assess the abdomen for distension, ask the resident about bowel movements, and ask the resident about stomach issues. DON L stated the facility had daily meetings, including a clinical meeting in the morning which involved the direct-care staff. DON L stated issues regarding a new onset of vomiting and new utilization of PRN ondansetron would be discussed in the clinical meeting. DON L recalled Resident #1 was discussed in the facility's clinical meeting on 9/6/2021 but was unaware of any other medical issues with Resident #1 after 9/6/2021. DON L was also unaware Resident #1 received ondansetron on 9/3/2021 . During an interview on 10/5/2021 at 5:45 p.m., Administrator M revealed his expectation is to report to the collaborating physician, all abnormal lab or x-ray, results immediately. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Change of Condition Reporting, not dated, revealed the following verbiage: Policy: it is the policy of this facility that all changes in resident condition will be accessed and communicated to the physician. Purpose: to clearly define guidelines for timely notification of a change in resident condition. Procedures: Life Threatening Change .2. Licensed nurse will inform the primary physician (alternate physician or Medical Director) of resident status as soon as possible before, during or after change of condition Acute Medical Change: 1. Any sudden or serious change in a resident's condition manifested by a marked change in physical or mental behavior will be communicated to the physician with a request for physician visit promptly and/or acute care evaluation. The licensed nurse in change will notify the physician. Routine Medical Change 1. All symptoms of unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life-threatening. 2. If unable to contact attending physician or alternate timely, notify Medical Director for response and follow-up to change in resident status .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for 1 of 13 residents (Resident #1) reviewed for quality of care in that: RN E and LVN C failed to notify Resident #1's provider, NP A, of Resident #1's abnormal radiology results after resident had experienced nausea and vomiting and been administered anti-nausea medication for 3 days. As a result, Resident #1 was eventually transported to an acute care hospital and expired. This failure resulted in the identification of an Immediate Jeopardy (IJ) on [DATE]. While the immediacy was removed on [DATE], the facility remained out of compliance at a potential for more than minimal harm with a scope of isolated due to the facility's need to monitor the implementation and effectiveness of its POR (plan of removal). This failure could affect all residents and place them at risk of not receiving the necessary care and a decline in health and/or death. The findings were: Record review of Resident #1's face sheet, dated [DATE], revealed Resident #1 was initially admitted to facility on [DATE] with diagnoses of hypo-osmolality (condition where levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low levels of sodium in the blood), essential (primary) hypertension (high blood pressure), Type 2 Diabetes Mellitus, muscle wasting and atrophy, not elsewhere classified, multiple sites, and muscle weakness (generalized.) Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 8, signifying moderate cognitive impairment. Record review of Resident #1's Order Summary Report from [DATE] - [DATE], printed [DATE], revealed Resident #1 had an order for Ondansetron HCl (which was ordered on [DATE]. Record review of Resident #1's MAR and TAR for [DATE], printed [DATE], revealed Resident #1 had not received a dose of ondansetron PRN during the entire month of [DATE]. Record review of Resident #1's MAR and TAR for [DATE], printed [DATE], revealed Resident #1 received two doses of ondansetron on [DATE], administered by RN E at 5:59 a.m. and by GVN X at 4:38 p.m. and two more doses of ondansetron on [DATE], administered by LVN I at 6:32 p.m. and by RN E at 10:46 p.m. The record review did not reveal that the physician or NP was notified. Record review of Nursing Progress Note, written by LVN I on [DATE] at 6:28 p.m., revealed during a visitation with the family, Resident #1 threw up moderate amt [amount] of brown emesis. The record did not reveal that the physician or NP was notified. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Nursing Progress Note, written by RN E on [DATE] at 5:45 a.m., revealed Resident #1 had an episode of emesis. [emesis is the action or process of vomiting]. Record review of Daily Skilled Note, written by LVN C on [DATE] at 6:44 p.m., revealed the following documentation emesis x2. Record review of Nursing Progress Note, written by RN E on [DATE] at 2:53 a.m., revealed upon arrival to the unit resident c/o [complained of] nausea and light vomiting. I gave [Resident #1] an Ondansetron tab at 11pm a few minutes after resident had an episode of emesis measuring 200 mls [milliliters] in color yellow. Record review of Resident #1's KUB results, dated [DATE], revealed the following impression, mild small bowel ileus, which indicated a temporary arrest in intestinal movement. Record review of Resident #1's Order Recap report for the order dates [DATE]-[DATE], printed on [DATE] revealed the KUB was ordered on [DATE] by NP A for pain of the abdomen and emesis. [emesis is the action or process of vomiting]. Record review of facility's in-service training report, dated [DATE], revealed education was done on notifying providers of critical labs and x-rays. Further record review of this in-service training revealed only 12 nurses attended this training. Record review of Resident #1's Emergency Department Document, dated [DATE] and written by Hospital Physician B, revealed Resident #1 was admitted to a local acute care hospital on [DATE]. Further record review of Resident #1's hospital paperwork revealed Resident #1's abdomen was severely distended. [very serious swelling in the belly/stomach area]. Record review of Resident #1's CT Angiogram [a type of medical imaging testing that may or may not use a special contrast dye]), with and without contrast [a substance injected or taken orally to help improve CT studies] of the abdomen and pelvis, dated [DATE], revealed the following: findings highly suspicious for bowel ischemia [lack of blood supply] and developing bowel breakdown, without [NAME] perforation. Specifically, the proximal [upper-left quadrant of the small bowel] and mid [midsection] small bowel, stomach, and distal esophagus [a muscular tube that carries food and liquids from the mouth to the stomach, the distal portion of the esophagus is closest to the stomach] are involved. Record review of Resident #1's Emergency Department Document Addendum, dated [DATE] and written at 10:39 p.m. by Hospital Physician B, revealed Resident #1 became unresponsive while in the Emergency Department and CPR was started. Hospital Physician B wrote the following, the etiology [cause] this code was due to ischemic [lack of blood supply] bowel causing perforation. [.] It became clear after copious [plentiful amount] blood noted in the oropharynx [the back of the mouth] and on suction, that the patient's radiology of cardiac arrest was not reversible. Time of death called at 22:07 [10:07 p.m.]. Record review of facility's staff roster, printed [DATE], revealed the facility has 39 nurses employed. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 3:26 p.m., NP A confirmed she saw Resident #1 on [DATE]. NP A confirmed Resident #1's nausea was reported, by the nursing staff, as resolved during her visit [DATE] visit with Resident #1. NP A stated upon assessment she found Resident #1's abdomen to be rock hard. NP A stated she was not notified of Resident #1's abnormal KUB results from [DATE]. NP A stated she ordered a STAT KUB and an enema at first, but then changed her mind and ordered for Resident #1 to be sent to the hospital instead. During an interview on [DATE] at 4:01 p.m., Resident #1's family member stated she was on the phone with Resident #1 on [DATE] and Resident #1 stated, I'm in so much pain, and was screaming for help. Family member stated she saw Resident #1 on [DATE]. Family member described Resident #1's stomach as being very tight, [swollen] and Resident #1 was sweating. Family member stated she had brought Resident #1 food to eat and Resident #1 did not want the food. Family member discussed her concerns with LVN C and LVN C revealed to the family member that she had administered ondansetron to Resident #1 earlier and she would attempt to give Resident #1 a laxative. During an interview on [DATE] at 6:48 p.m., LVN C stated she never reviewed the results of Resident #1's abnormal KUB, dated [DATE], because RN E told her the KUB results were fine. LVN C stated, I never seen the results. LVN C explained when a nurse receives any results, regardless if the results are normal or abnormal, the nurse would inform the provider. LVN C confirmed the results and notification to the provider would require documentation in the medical record, which was not completed. During an interview on [DATE] at 7:10 a.m., LVN C confirmed she should have reviewed Resident #1's abnormal KUB results herself. LVN C stated she also gave a copy of Resident #1's abnormal KUB, dated [DATE], results to ADON I. LVN C confirmed nausea or emesis was not normal for Resident #1 but did not believe it was an issue because no one said anything. I never saw her throw up. I didn't even know if the nurses documented that she had thrown up. During an interview with a representative from X-Ray Company Y on [DATE] at 8:08 a.m., (the facility's X-ray vendor), representative confirmed the X-ray results for Resident #1 was faxed on [DATE] at 2:00 p.m. to 3 different facility fax numbers. During an interview on [DATE] at 8:56 a.m., Administrator M stated he briefly remembered something GI-related that was discussed in a past clinical meeting on [DATE]. Administrator M could not recall specific details discussed. Administrator M could not recall any specific details regarding Resident #1's discharge on [DATE]. Administrator M could not recall hearing of any concerns from providers. Administrator M confirmed that when there is a change in condition, the nursing staff should contact the provider for orders, then the provider will make a decision whether the condition can be managed in the facility or needs hospitalization . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 9:36 a.m., ADON J stated abnormal lab results should be reported to the resident's primary care provider. ADON J confirmed the facility has a clinical meeting every morning where clinical issues (including new orders or results) are discussed. ADON J elaborated, we educated staff to not go by ear and report everything and document everything. If a doctor is not answering your text you need to call them. ADON J stated the facility educated their nursing staff on promptly notifying the provider of abnormal labs. ADON J confirmed Resident #1 had no history of chronic nausea or emesis. ADON J recalled Resident #1's change of condition on [DATE] and elaborated on [DATE] Resident #1 was fine, but on [DATE] Resident #1 vomited. ADON J stated NP A visited Resident #1 on [DATE], reviewed Resident #1's radiology results, gave orders and left the building. ADON J elaborated NP A later called back a couple hours later and gave orders to send Resident #1 out to an acute care hospital. ADON J stated an educational in-service about notifying providers of abnormal lab results was done on [DATE], not on [DATE] as dated on the facility's educational in-service document. ADON J stated the date on the educational in-service was wrong. ADON J could not recall why the educational in-service was started, just that it was about Resident #1's radiology results. During an interview on [DATE] at 10:36 a.m., CNA K stated she cared for Resident #1 on [DATE]. CNA K recalled Resident #1 was complaining of a lot of stomach pain. CNA K stated she observed Resident #1 vomit once during her shift. CNA K stated she reported the issue to LVN O. During an interview on [DATE] at 11:32 a.m., RN E stated Resident #1 had episodes of nausea and vomiting the last few days before discharge. RN E recalled Resident #1's KUB ordered on [DATE] showed a small obstruction in the colon. RN E stated because the obstruction was small and Resident #1 was going to the restroom, she did not report it to the provider. RN E elaborated, I did not consider it urgent because [Resident #1] was having [bowel movements.] RN E confirmed she gave Resident #1 Zofran, then Resident #1 vomited, and Resident #1 reported feeling better. RN E stated she gave a copy of Resident #1's KUB, dated [DATE], to LVN C. RN E elaborated she told LVN C that Resident #1 had a small bowel obstruction and Resident #1 was having bowel movements. When asked if there was anything further, she should have done, RN E stated, No, I treated the signs and symptoms and [Resident #1] was fine. During an interview on [DATE] at 1:04 p.m., LVN I confirmed Resident #1 vomited on [DATE] while Resident #1 was in a family visitation. LVN I stated nausea or vomiting was not normal for Resident #1, but felt it was a one-time thing because the day before, [DATE], Resident #1 left the facility for a family outing and ate a lot of food according to the family member. LVN I explained Resident #1 did not have a fever at the time and did not complain of any pain. LVN I stated if Resident #1 had vomited more than 3 times she would have become suspicious of an issue . During an interview on [DATE] at 1:28 p.m., NP A stated she would have preferred to be notified if a resident was receiving ondansetron more consistently than usual. NP A stated she was supposed to be notified of any abnormal results. NP A stated if she had known Resident #1's abnormal KUB results showed a small bowel ileus earlier she would have ordered for Resident #1 to be sent out immediately. NP A stated a small bowel ileus is life-threatening and elaborated, a nursing home would not have been equipped. [Resident #1] would need to be NPO, an NG tube, decompress her stomach, daily KUB. And none of that could be done in the SNF setting. During an interview on [DATE] at 2:49 p.m., NP A confirmed if she had sent Resident #1 to an acute care hospital sooner, it would have prevented any negative outcomes. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:55 p.m., DON L stated the facility provided in-services on assessing gastrointestinal issues and notifying providers of any change of conditions on [DATE]. DON L explained the nurses should assess the abdomen for distension, ask the resident about bowel movements, and ask the resident about stomach issues. DON L stated the facility had daily meetings, including a clinical meeting in the morning which involved the direct-care staff. DON L stated issues regarding a new onset of vomiting and new utilization of PRN ondansetron would be discussed in the clinical meeting. DON L recalled Resident #1 was discussed in the facility's clinical meeting on [DATE] but was unaware of any other medical issues with Resident #1 after [DATE]. DON L was also unaware Resident #1 received ondansetron on [DATE]. DON L was aware Resident #1 had an episode of emesis after a family outing on [DATE] and elaborated it wasn't an unusual amount. [Resident #1] had nausea, she threw up, but it was not like she was throwing up repeatedly. DON L did not see the vomit. DON L explained the nurse did perform a change of condition assessment on [DATE] because Resident #1 was reporting a stomachache, but at the time it was believed the issue was related to Resident #1's recent family outing. DON L recalled on [DATE] she received report NP A was upset about not being notified of a result. DON L stated she was on her way out of town when she was made aware of NP A's concerns, but she wrote up an in-service on notifying providers on that day and delegated the in-servicing to the ADONs. DON L confirmed providers should be notified if there is an abnormal result. DON L explained, what happened with [Resident #1's] KUB was there was a normal finding [at the top of the paper], but then the findings [at the bottom] says the mild ileus. So initially [the nurse] saw no evidence at the top portion, so that's what [RN E] told [LVN C]. DON L confirmed the expectation was for nurses to read the entire radiology result. When asked about the nursing staff's response to Resident #1's symptoms, DON L replied, I feel they did respond as far as treating the symptoms. They did give the PRN medication. The patient, from what I was told, has no pain or issues until the day she went out. During an interview on [DATE] at 11:50 a.m., ADON F stated during NP A's visit on [DATE], NP A had come to their office to request Resident #1's KUB results. ADON F confirmed she and LVN G provided the results to NP A. ADON F stated she, LVN G and NP A reviewed the KUB result together. ADON F stated At first, I seen the top of the x-ray results and said that looks good. [NP A] asked me to continue reading to the bottom of the paper. I verified the result, that [Resident #1] had a small bowel ileus. ADON F stated DON L was not notified of the abnormal x-ray results because DON L was not in the building. ADON F confirmed that it would have been LVN C's responsibility [current nurse on duty] to notify DON L or the ADON's F or J, but LVN C did not . ADON F stated the process for receiving and reporting abnormal results was to document the issue on the 24-hour report, notify the provider, and follow up. ADON F confirmed that a small bowel ileus was considered an urgent result. ADON F confirmed the KUB was ordered on the [DATE] and was able to recall that ADON J printed the result out and gave it to the charge nurse, LVN C, to report at the clinical meeting the next day, [DATE]. ADON J stated, My understanding the results came in - in the afternoon- no results available at shift change. ADON J confirmed LVN C had documented the results were normal, and LVN reported Resident #1 was stable. ADON F revealed was she unaware if LVN C had reviewed the results, and reiterated LVN C had the results with her at the clinical meeting on [DATE]. ADON F stated, I guess [LVN C] missed the lower part that was on the result page. ADON F confirmed that the provider was not notified same day regarding Resident #1's x-ray result, and further confirmed that she believed the bottom part of the x-ray results was missed or not read thoroughly. ADON F stated that even I did not read it (x-ray results) fully and providers should be notified immediately after results are received in hand. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility policy titled Change of Condition Reporting, not dated, revealed the following verbiage, all symptoms of unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life-threatening. Administrator M was notified of an IJ for the above failures on [DATE] at 6:03 p.m. A copy of the IJ Template was given to Administrator M and a Plan of Removal was requested. The Plan of Removal accepted on [DATE] included the following: A. Immediate Actions Taken: Education started by Clinical Resource/DON on the following topics: - Notification to Physician regarding all results for X-rays, diagnostic results, KUB, and Change of Conditions must be communicated immediately to the physician/NP and appropriate assessment of residents. In-service started [DATE] to be completed by [DATE] anyone not receiving education will not be allowed to work until in-serviced. - Licensed nurses to receive education prior to accepting shift - Audit performed on residents with orders for KUB, Chest x-ray, and diagnostics to ensure proper notification to physician of all results, audit was started [DATE] and will be completed by [DATE]. - Resident number one is no longer in the facility. B. Identification of Others Affected: - Currently there are 9 residents as of [DATE] with KUB and Chest X-ray orders who could be at risk once results are received if not communicated to MD/NP. C. Systemic Change Taken to Prevent Reoccurrence: - DON, or designee, will review all new orders and current orders for X-ray, KUB and diagnostics to identify any abnormal results and ensure they are communicated to the MD timely. Starting [DATE]. - A tracking log for KUB, Chest X-rays, and diagnostics will be initiated [DATE] and reviewed at the clinical meeting which will be held 7 days a week and will be initialed once all results are communicated to the MD/NP. - DON/Designee started in-service on [DATE] with licensed clinical staff on proper shift reporting to include review of the 24 hour report for resident change of condition, staff will also be in-serviced on what to do for a change of condition to include notification to MD/NP and RP and follow any orders received due to change of condition and notify DON of change of condition. Licensed staff will not be allowed to take a shift until they have received the in-service. Starting [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legend Oaks Healthcare and Rehabilitation Center -	2003 W Hutchins Place San Antonio, TX 78224

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- DON, or designee, will monitor education, notifications, tracking and share summary of actions taken with QAPI weekly for additional review or recommendations on timely notification of all KUB, diagnostics, X-ray and change of condition. D. Monitoring: - Daily review of orders for KUB, diagnostics, Chest X-ray and all change of conditions to ensure all results are communicated to MD/NP. Starting [DATE]. - DON/Designee will monitor notifications to physician for all Chest X-ray, KUB, diagnostic results, and change in conditions. Starting [DATE]. - Summary of IJ and corrective action to be reviewed by QAPI until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. Monthly QAPI meeting will include review of resident all results for KUB, Chest X-ray, all diagnostics and change of conditions. The surveyors' verification of the Plan of Removal from [DATE] through [DATE] was as follows: A. Immediate Actions Taken: Observation on [DATE] at 6:13 a.m. revealed, during overnight-to-day shift change, nurses were observed conducting room-to-room report. Nurses were discussing resident status, pending labs, pending medications, pending appointments, and any change of condition. During an interview on [DATE] at 3:20 p.m., Administrator M and DON L stated only 6 licensed nursing staff have not received education, all of which are PRN staff. Per DON L, they have attempted to call these 6 licensed nursing staff with no answer. Per Administrator M and DON L, these 6 remaining licensed nursing staff will not be placed on-schedule until they receive education. Per Administrator M and DON L, the Staffing Department was aware not to put the 6 remaining licensed nursing staff on-schedule until they have received the education. From [DATE] to [DATE], 26 licensed nursing staff were interviewed. Nursing staff interviews included day shift, evening shift, night shift, and weekend shift nurses. All nursing staff interviewed verbalized they received education on: - All change of condition should be documented in PCC. Provider, RP, and resident should be notified. - All lab results (abnormal and normal) will be reported to order physician upon receiving the results. If order physician is not available or unresponsive, medical director and DON will be notified immediately. Notification will be documented in a nursing progress note. - 24-hr shift report will be conducted with walking rounds. On-coming nurses verbalized they will verify lab results given by the off-going nurse. Nurses have verbalized a resident with new onset nausea would be reported to provider. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility document titled, Diagnostic Test & Lab Tracking, revealed: audit has been completed as of [DATE]. Further record review of Diagnostic Test & Lab Tracking log revealed audit reviewed labs ordered from [DATE] to [DATE]. Record review of In-Service Training Reports, dated [DATE] at 6:00 p.m., revealed education began on [DATE] and included the following: reporting change of conditions of the provider, notification to MD/NP of all KUB, X-rays, and diagnostic normal and abnormal results, and walking, room-to-room reporting at change-of-shift which will include communication of change of conditions and all diagnostic lab results. Second record review of In-Service Training Reports on [DATE] revealed 33 of 39 licensed nursing staff have been educated (85%.) B. Identification of Others Affected: Record review of all 9 residents with KUB and Chest X-ray orders revealed the following: all 9 residents' lab results were reported to ordering providers within 1 business day of lab result and physician's response was documented in a Nursing Progress Note. Each Nursing Progress Notes' date was compared with the date of creation in order to identify any possible back-dating of Nursing Progress notes. No back-dating of progress notes was identified. C. Systemic Change Taken to Prevent Reoccurrence: During an interview on [DATE] at 1:09 p.m., DON L stated timely meant immediately upon receiving the results. If the MD is unresponsive, then Medical Director and DON are to be notified. Per DON L, a process was in place for reviewing diagnostic testing and lab results 7 days a week. DON L was to be the primary reviewing of diagnostic lab results, and ADONs were to be the secondary reviewers if DON L became unavailable. Observation on [DATE] at 6:13 a.m. revealed, during overnight-to-day shift change, nurses were observed conducting room-to-room report. Nurses were discussing resident status, pending labs, pending medications, pending appointments, and any change of condition. From [DATE] to [DATE], 26 licensed nursing staff were interviewed. Nursing staff interviews included day shift, evening shift, night shift, and weekend shift nurses. All nursing staff interviewed verbalized they received education on: - All change of condition should be documented in PCC. Provider, RP, and resident should be notified. - All lab results (abnormal and normal) will be reported to order physician upon receiving the results. If order physician is not available or unresponsive, medical director and DON will be notified immediately. Notification will be documented in a nursing progress note. - 24-hr shift report will be conducted with walking rounds. On-coming nurses verbalized they will verify lab results given by the off-going nurse. Nurses have verbalized a resident with new onset nausea would be reported to provider. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of facility document titled, Diagnostic Test & Lab Tracking, revealed: audit has been completed as of [DATE]. Further record review of Diagnostic Test & Lab Tracking log revealed audit reviewed labs ordered from [DATE] to [DATE]. Record review of the facility's next QAPI agenda revealed: next QAPI meeting includes summary of IJ and corrective actions is on QAPI agenda. D. Monitoring: During an interview on [DATE] at 1:09 p.m., DON L confirmed a process was in place for reviewing diagnostic testing and lab results 7 days a week. DON L was to be the primary reviewing of diagnostic lab results, and ADONs were to be the secondary reviewers if DON L became unavailable. Record review of facility document titled, Diagnostic Test & Lab Tracking, revealed: diagnostic testing log was up to date and in place. Record review of the facility's next QAPI agenda revealed: next QAPI meeting includes summary of IJ and corrective actions is on QAPI agenda. On [DATE] at 5:37 p.m. the Administrator was notified the immediacy was lifted. The facility remained out of compliance at a potential for more than minimal harm with a scope of isolated due to the facility's need to monitor the implementation and effectiveness of its POR. Plan of Correction (POC) Verification On [DATE] licensed clinical staff was in-serviced on: Notification to physician regarding all results for X rays, diagnostic results, KUB, change of condition, proper shift reporting walking rounds, to include review of the 24 hour report for resident change of condition, assessing gastrointestinal issues and proper assessment must be communicated to the physician/NP. [DATE] - In-service sign in sheets revealed all licensed staff have signed off on all trainings listed above. Audit performed on residents with orders for KUB, chest X ray, and diagnostics to ensure proper notification to physician of all results was started [DATE] and completed on [DATE]. [DATE] - Audit logs for KUB, chest X rays, and diagnostics were examined and revealed audit was started and completed [DATE]. A tracking log for KUB, chest X rays, and diagnostics will be initiated [DATE] and reveiwed at teh clinincal meeting which will be held 7 days a week and will be initialed once all results are communicated to the MD/NP. [DATE] - Tracking log was verified and revealed start date of [DATE] ongoing to [DATE] DON/designee will review of orders for KUB, diagnostics, chest X ray and all change of conditions to ensure all resutls are communicated to MD/NP and will monitor notifications to physician for all chest X ray, KUB, diagnostic results and change of conditions. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] - Tracking log was verified and revealed review of orders was ongoing to [DATE] Summary of IJ and corrective action to be reviewed by QAPI until substantial compliance established and continue monthly for 90 days to ensure ongoing compliance. [DATE] - QAPI sign in sheet verified and content regarding IJ summary and corrective action confirmed Montly QAPI meeting will include review of resident all results for KUB, chest X ray, all diagnostics and change of conditions. [DATE] - QAPI sign in sheets revealed monthly meeting has been completed up until this date [DATE].

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on observation, interview, and record review, the facility failed to ensure 1 of 1 RNs (RN E) were able to demonstrate competency in skills and techniques for 3 of 3 resident (Resident #2, #7, and #11) observed for care and infection control, in that: RN E did not clean the glucometer after performing a blood sugar check on Resident #11 and prior to moving on to the shared room of Resident #2 and Resident #7's. This deficient practice could place residents at-risk for staff not having the appropriate skills and competencies to provide required care and services. The findings were: Record review of Resident #11's face sheet, dated 10/5/2021, revealed Resident #11 was admitted to facility on 9/30/2021 with diagnoses of acute respiratory failure with hypoxia (low oxygen level in the blood), Type 2 Diabetes Mellitus without complications, morbid (severe) obesity due to excess calories, and unspecified protein-calorie malnutrition. Record review of Resident #11's 5-Day MDS, dated [DATE], revealed Resident #11 had a BIMS score of 15, signifying little to no cognitive impairment . Record review of Resident #11's physicians orders, printed 10/6/2021, revealed Resident #11 received accuchecks to monitor her blood glucose before meals and at bedtime daily. Further review revealed Resident #11 was on a sliding scale insulin, and the dosage was based upon her accucheck results. Resident #11 was receiving routine insulin glargine twice daily to treat her diabetes. During an observation on 10/6/2021 at 8:00 a.m., RN E was observed obtaining a blood glucose check from Resident #11. RN E obtained the glucose monitor from LVN D and went into Resident #11's room. RN E placed gloves on her hands, did not provide privacy to Resident #11. RN E did not clean the bedside table. The glucose monitor was placed on the bedside table during the procedure. After completion of the procedure, RN E placed the glucose monitor into her left scrub pocket (did not clean the glucose monitor), removed her gloves, and performed hand hygiene immediately upon exiting the room. RN E removed the glucose monitor from her left scrub pocket and placed it on top of the medication cart without cleaning the monitoring device. RN E did not perform hand hygiene after touching the monitoring device. RN E then retrieved the monitoring device from the top of the medication cart and proceeded into Resident #2 and Resident #7's room without performing hand hygiene. RN E did not clean the monitoring device prior to entering or upon exiting Resident #2 and Resident 7's room. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/6/2021 at 8:41 a.m., RN E confirmed that she placed the glucose monitoring device on the bedside table of Resident #11, and she should have placed it on a clean surface or put clean paper under it. RN E further confirmed that she placed the monitoring device in her scrub pocket and removed it, did not perform hand hygiene after touching the device and placed it on the medication cart. RN E further confirmed her actions as a violation of infection control protocol. RN E further confirmed that she did not clean the machine between Residents #11, #2, and #7. RN E revealed the purpose of cleaning the machine was to prevent infections, and hand hygiene should be completed before and after wearing gloves. RN E further revealed she had not received education or training on when and how to clean the glucose monitoring device until just now from the DON. RN E stated, I guess they (staff) saw me. During an interview on 10/6/2021 at 11:20 a.m., ADON F confirmed bedside table surfaces should be cleaned before placing a glucose monitoring device on the bedside table. ADON F confirmed the glucose monitoring device should be cleaned before and after each use. ADON F was unable to recall the last time the facility did education on glucose monitoring devices and blood sugar checks. During an interview on 10/6/2021 at 2:09 p.m., DON L confirmed the glucose monitoring device should be cleaned before use, after use, and between use. DON L further confirmed she and ADON F and ADON J would assist with training staff. During an interview on 10/6/2021 at 2:57 p.m., Administrator M stated glucose monitoring devices and multi-patient use equipment should be cleaned before and after each resident. Record review of RN E's Blood Glucose Check Skills Checklist, dated 1/7/2021, revealed RN E was deemed competent in performing blood glucose checks. Further record review of this skills checklist document revealed no verbiage regarding disinfection of the glucose monitoring devices. Review of the CDC [Centers for Disease Control and Prevention] website page titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration, dated March 2, 2011, read .CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirements: Whenever possible, blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared . Record review of facility policy titled, Blood Glucose Monitoring/Machine, dated 5/2007, revealed the following verbiage: use sanitation wipes (super sani-cloth/germicidal wipes) to cleanse glucometer [glucose monitoring device] after each use. Allow to air dry on paper towel for 5 minutes.) Record review of facility policy titled, Blood Glucose Monitoring, dated 5/2007, revealed the following verbiage: disinfect area and glucometer, and disinfect glucose monitor after each use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43889 Based on observation, interview and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident, for 1 of 1 nurse medication carts (100 Hall Nurse Medication Cart) reviewed for drug administration in that: RN E passed the Nurse Medication Cart keys (including the narcotics storage bin key) to LVN D, the on-coming nurse, before performing the narcotic count. LVN D had the Nurse Medication Cart Keys for 1 hour and 27 minutes before narcotic count was performed. This deficient practice could affect all residents and place them at risk for not narcotic diversion. The findings were: During an observation on 10/6/2021 at 6:48 a.m., revealed RN E had not given report to LVN D. LVN D was currently in possession of the nurse medication cart keys for the 100 Hall nurse medication cart. LVN D was seen performing blood sugar checks on residents in 100 Hall. During an observation on 10/6/2021 at 7:36 a.m., revealed LVN D passing medications. RN E was observed sitting at the nurse's station documenting. During an observation of on 10/6/2021 at 8:13 a.m., RN E pushed the medication cart from 100 hall to the nursing station. During an observation on 10/6/2021 at 8:15 a.m., LVN D and RN E were observed conducting a narcotic medication count. LVN D and RN E both verified the medication cards with the sign out sheets in order to confirm medication, resident name, and narcotic count for each individual card. The narcotic count was completed at 8:21 a.m. and narcotic count was confirmed to be accurate. RN E signed the sheet to release responsibility of the medications to LVN D. LVN D, did not sign the narcotic sheet after finalizing the count, and placed the narcotic book in the medication drawer. LVN D then removed it shortly thereafter to sign for acceptance of the medication cart. During an interview on 10/6/2021 at 7:21 a.m., CMA U confirmed that the nurses administered all narcotics and the narcotics are kept on the nurse's medication cart. CMA U further confirmed that the narcotic count should be verified prior to handing the keys to another nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/6/2021 at 7:49 a.m. LVN D stated the purpose of the narcotic count was to make sure mediations are the exact amount, that nothing's wrong or missing. LVN D confirmed she should have received the keys after the narcotic count was completed, not before. LVN D stated the narcotic count was done before administering medications. LVN D explained I'm just working on the accuchecks [blood sugar checks.] I haven't given narcotics yet. LVN D stated I told [RN E] that we can count narcotics after I arrived on shift. [RN E] gave me the medication cart keys. I did not take a verbal report. I did walk the hall to check on the residents. I told [RN E] that we can count the narcotics when she finishes her shift. During an interview on 10/6/2021 at 8:41 a.m., RN E confirmed that shift change should take place with walking rounds for report and check on every resident. Notify the oncoming shift nurse of any follow ups or changes, after walking rounds, return to the nursing station to count narcotics. RN E further confirmed that nurses should count immediately after exchange of the report. RN E revealed the reason for counting was to ensure the narcotic count was accurate. RN E further revealed if the narcotic count was inaccurate DON L should be notified immediately. RN E further revealed the medication cart keys should not be handed off to any other nurse until the count has been verified. RN E was asked who would be responsible for the count if the medication cart keys were transferred to another nurse without counting. RN E responded that it would be on LVN D because she accepted the keys. RN E further confirmed that she was running behind on her shift and she handed off the keys to LVN D and revealed this had never happened before. RN E was asked when she last received education regarding narcotic counting. RN E stated the last time she received education on narcotic counting was during her orientation in January 2021. During an interview on 10/6/2021 at 2:09 p.m., DON L stated narcotic counts should be done after 24-hour shift reports. After the narcotic count was completed, the off-coming nurse will pass the Nurse medication cart keys to the on-coming nurse. DON L confirmed the key should not be handed over prior to the report. DON L confirmed LVN D should not have started blood sugar checks before receiving the nurse's medication cart keys. DON L confirmed that ADON F and ADON J assisted in training staff, along with herself. Record review of facility policy titled Controlled Drugs, dated 5/2007, revealed the following verbiage, upon being relieved from duty, the nurse shall transfer the key to the nurse taking her place.

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on interviews, and record reviews, the facility failed to promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders for 1 of 8 residents (Resident #1) reviewed, in that: Resident #1's abnormal x-ray result of the kidney, ureter, and bladder (KUB), was not reported promptly to the provider. This failure could affect all residents and place them at risk of not receiving the necessary care and a decline in health and/or death. The findings were: Record review of Resident #1's face sheet, dated 10/1/2021, revealed Resident #1 was initially admitted to facility on 4/5/2019 with diagnoses of hypo-osmolality (condition where levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low levels of sodium in the blood), essential (primary) hypertension (high blood pressure), Type 2 Diabetes Mellitus, muscle wasting and atrophy, not elsewhere classified, multiple sites, and muscle weakness (generalized.) Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 8, signifying moderate cognitive impairment. Record review of Resident #1's Order Summary Report from 6/1/2021 - 10/3/2021, printed 10/4/2021, revealed Resident #1 had an order for Ondansetron HCl (a medication to prevent nausea and vomiting) Tablet 4 MG Give 1 tablet by mouth every 4 hours as needed for Nausea/vomiting, which was ordered on 8/12/2021 . Record review of Resident #1's KUB (x-ray of kidneys, ureters, and bladder) dated 9/6/2021 results revealed: mild gas distended small bowel loops with come colonic air also noted. Impression: mild small bowel ileus [which indicated a temporary arrest in intestinal movement]. The KUB report was read by a physician at X-Ray Company Y. Reason: Unspecified abdominal pain. Record review of Resident #1's progress note/discharge summary dated 9/8/2021 at 1:36 p.m., NP A documented that Resident #1 had a diagnostic test performed on 9/6/2021, the KUB revealed a mild small bowel ileus, and the results were not relayed to NP A's physician group. During an interview on 10/1/2021 at 3:26 p.m., NP A stated she was not notified of Resident #1's abnormal KUB results from 9/6/21. NP A confirmed she had to ask a nurse manager, on 9/8/2021, to print the results of the KUB for her to review. NP A confirmed the facility's communication was not great. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/1/2021 at 6:48 p.m., LVN C stated she never reviewed the results of Resident #1's abnormal KUB because RN E told her the KUB results were fine. LVN C stated, I never seen the results. LVN C explained when a nurse received any results, regardless if the results are normal or abnormal, the nurse would inform the provider. During an interview on 10/1/2021 at 7:20 p.m., DON L provided x-ray results for Resident #1 dated 9/06/2021. DON L revealed there had been an issue with Resident #1 KUB results. DON L stated that NP A was mad on 9/8/2021 and had notified DON L that she did not get the KUB results for Resident #1. DON L revealed she provided an in-service to the nursing staff due to complaint voiced by NP A. During an interview with a representative from X-Ray Company Y on 10/4/2021 at 8:08 a.m., (the facility's X-ray vendor), representative confirmed the x-ray results for Resident #1 was faxed on 9/6/2021 at 2:00 p.m. to 3 different facility fax numbers. During an interview on 10/4/2021 at 8:56 a.m., Administrator M revealed that in the morning meeting, notes and issues were discussed. Administrator M further revealed that nursing would bring the concerns up to interdisciplinary team standup meeting where we discuss falls, transfers, discharges, grievances, or any department head concerns or complaints. Administrator M stated he remembered Resident #1 as being Physician T's patient, and his nurse practitioner is NP A, and confirmed that NP A never discussed anything about Resident #1 with him . During an interview on 10/4/2021 at 9:30 a.m., ADON J revealed the ADONs make sure lab/x-rays were completed, the charge nurse reports the results to the provider. ADON J confirmed that a clinical meeting was held daily, and the ADONs go through to make sure everything was completed the previous day, such as orders etc. ADON J further confirmed if she received a result, she would report it. ADON J stated if someone other than the charge nurse receives a critical result, that person must inform the charge nurses, who must follow through with notification to the provider and obtaining orders. ADON J confirmed that education was completed on 09/7/2021 regarding critical labs and x-rays need to be reported immediately to the provider. ADON J stated, we educated staff to not go by ear and report everything and document everything. If a doctor is not answering your text you need to call them. I think that the date was a mistake on the in-service. It was completed on the 9/8/2021. ADON J was asked what happened or was there an incident that required this in-service? ADON J revealed what happened was Resident #1, the date of her results was not called to the facility as critical. The x-ray company must report results to a nurse, and the results has the name of who the x-ray company spoke with. If the x-ray company has a critical result, it will read ALERT from corner to corner across the page. Critical results should be called immediately. ADON J confirmed that the KUB was faxed to the facility and not called to the facility. (continued on next page)

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	676113	A. Building B. Wing	10/06/2021

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/2021 at 11:32 a.m., RN E confirmed on the last few days prior to Resident #1's discharge (discharge date [DATE]), Resident #1 had episodes of nausea and vomiting. When asked if Resident #1 had any radiology tests ordered, RN E responded I know we ordered one. I do not know when the x-ray technician came out to obtain it. I believe it was a KUB. When RN E was asked about the result of Resident #1's x-ray she responded I think it was a small obstruction in the colon. She was having bowel movements. I work the night shift. So, if it's like a small obstruction, and she was going to the bathroom, I would normally not report it to the provider if it is not urgent. I did not consider it urgent because she was having bowel movements. When asked about the facility's protocol for notifying providers of lab results, RN E stated, Now I know we notify the doctor for everyone and notify our managers as well. RN E confirmed she did not know she had to call before. RN E further confirmed she did not feel the KUB results were critical and stated, the doctors do not like to be bothered at night. During an interview on 10/4/2021 at 4:55 p.m., DON L confirmed physicians should be notified if there is an abnormal result. DON L revealed her expectation was that the nurses read the results in full and notify the provider and place a progress note based on the lab/ x-ray result in the electronic chart. DON stated she wrote up an in-service on notifying providers on 9/8/21 and delegated the in-servicing and to the ADONs. The DON explained, what happened with [Resident #1's] KUB was there was a normal finding [at the top of the paper], but then the findings [the report] says the mild ileus. So initially [the nurse] saw no evidence at the top portion, so that's what [RN E] told [LVN C]. During an interview on 10/4/2021 at 5:45 p.m., Administrator M confirmed if there is any abnormal result the nurses should call the provider. Any abnormal result, the company will call the nurses, then call the ADON's up the chain of command to DON/Admin. Administrator M further confirmed that he briefly heard about NP A telling the ADON's of Resident #1's abnormal x-ray results. Administrator M further confirmed that the ADON's did not mention NP A's response the x-ray result. Administrator M confirmed all abnormal lab and diagnostics results should be reported immediately to the physician. During an interview on 10/5/2021 at 11:50 a.m., ADON F revealed that during NP A's visit on 9/8/2021, NP A had come to their office to request Resident #1's KUB results. ADON F confirmed she and LVN G provided the results to NP A. ADON F stated she, LVN G and NP A reviewed the KUB result together. ADON F stated At first, I seen the top of the x-ray results and said that looks good. [NP A] asked me to continue reading to the bottom of the paper. I verified the result, that [Resident #1] had a small bowel ileus. ADON F stated DON L was not notified of the abnormal x-ray results because DON L was not in the building. ADON F confirmed that it would have been LVN C's responsibility to notify DON L or the ADON's F or J, but LVN C did not. ADON F stated the process for receiving and reporting abnormal results was to document the issue on the 24-hour report, notify the provider, and follow up. ADON F confirmed that a small bowel ileus was considered an urgent result. ADON F confirmed the KUB was ordered on the 9/6/2021 and was able to recall that ADON J printed the result out and gave it to the charge nurse, LVN C, to report at the clinical meeting the next day, 9/7/2021. ADON J stated, My understanding the results came in - in the afternoon- no results available at shift change. ADON J confirmed LVN C had documented the results were normal, and LVN reported Resident #1 was stable. ADON F revealed was she unaware if LVN C had reviewed the results, and reiterated LVN C had the results with her at the clinical meeting on 9/7/2021. ADON F stated, I guess [LVN C] missed the lower part that was on the result page. ADON F confirmed that the provider was not notified same day regarding Resident #1's x-ray result, and further confirmed that she believed the bottom part of the x-ray results was missed or not read thoroughly. ADON F stated that even I did not read it (x-ray results) fully and providers should be notified immediately after results are received in hand. (continued on next page)

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility policy titled Change of Condition Reporting, not dated, revealed the following verbiage, all symptoms of unusual signs will be communicated to the physician promptly. Routine changes are a minor change in physical and mental behavior, abnormal laboratory and x-ray results that are not life-threatening.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on interviews, and record reviews, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 8 residents (Resident #1) reviewed for resident records, in that: LVN C administered medication to Resident #1 for an upset stomach on 9/7/2021 and did not input the order into the facility's EMR. This failure could place residents at risk for inaccurate and incomplete and information. Record review of Resident #1's face sheet, dated 10/1/2021, revealed Resident #1 was initially admitted to facility on 4/5/2019 with diagnoses of hypo-osmolality (condition where levels of electrolytes, proteins, and nutrients in the blood are lower than normal) and hyponatremia (low levels of sodium in the blood), essential (primary) hypertension (high blood pressure), Type 2 Diabetes Mellitus, muscle wasting and atrophy, not elsewhere classified, multiple sites, and muscle weakness (generalized.) Record review of Resident #1's Quarterly MDS, dated [DATE], revealed Resident #1 had a BIMS score of 8, signifying moderate cognitive impairment. Record review of Resident #1's order recap summary for 9/1/2021-10/31/2021, did not reveal an order for Geri-Mox for Resident #1. Record review of Resident #1's electronic medication record for September 2021, printed 10/1/2021, did not reveal an entry for Geri-Mox as having been administered for Resident #1. During an interview on 10/1/2021 at 6:48 p.m., LVN C revealed that she administered Resident #1 some medication on 9/7/2021 after the family member visited. LVN C stated, the family member had requested that I give her something for an upset stomach. During an interview on 10/4/2021 at 10:16 a.m., a policy for standing orders was requested from ADON J. During an interview on 10/4/2021 at 11:32 a.m., RN E was asked to discuss the standing order process of the facility. RN E confirmed the facility had standing orders for every doctor, which lists medications residents can be given, and for which symptom, then we can administer the medications as prescribed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/4/2021 at 2:30 p.m., LVN C confirmed she administered Geri-Mox to Resident #1 and did not input the order into Resident #1's EMR. LVN C further confirmed the process is to put an actual order in the EMR (electronic medical record) and she did not put an order in. LVN C further revealed the administration would not be in Resident #1's electronic medical record. LVN C confirmed that she should have written the order in electronic medical record/medication administration report or document the medication administration in a progress note. LVN C further confirmed that the facility has standing orders for all the doctors in the 24-hour report books, which means, you can administer certain medication without calling the providers. LVN C elaborated. There is a list of different things that we can do. It's in a physical list in a binder. If someone is feeling nauseated or constipated, you can give the medication the physician doctor wants. During an interview on 10/4/2021 at 4:55 p.m., DON L confirmed what the standing orders were for the facility and stated they're orders that the physicians put in place for the changes. There are certain things that they feel that need to be in place, such as for, so they don't have to be called. DON L further confirmed the process for standing orders were if a nurse utilizes something like Geri-Mox, it would be utilized in PCC [the facility's EMR.] It would be an order. Or at least make a progress note that it was administered. [LVN C] should have put an order in PCC, along with a progress note, so there could be a record. During an interview on 10/5/2021 at 9:05 a.m., a policy on standing orders was requested from DON L. During an interview on 10/5/2021 at 1:09 p.m., a policy on standing orders was requested again from DON L. A policy for standing orders was not provided prior to end of this investigation on 10/6/2021. Record review of the facility's standing orders included the: medication name- GERI-MOX 200-200-20 mg/5 ml; Quantity: Give 30 ml as needed every 6 hours; Physical monitors: Effectiveness 30 minutes; Substitute: yes; Monitor Note: Give for dyspepsia [difficulty digesting food] 30 ml every 6 hours up to 2 doses in 24 hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43889 Based on observation, interview, and record review, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of infections for 3 of 8 residents (Residents #11, 2 and 7) and 2 of 7 employees (RN E, CNA P, CNA V) observed for infection control, in that: 1. RN E failed to disinfect the blood glucose monitoring device before and after use, placed the monitoring device in her pocket, and placed it on top of the medication cart. RN E observed not performing proper hand hygiene. a) Hand hygiene was not performed prior to entering into Resident #11's room and the blood glucose monitor was not cleaned before and after use on Resident #11. b) Hand hygiene was not performed prior to entering into Resident #2's and Resident #7's room and the blood glucose monitor was not cleaned before and after use on Resident #2 and Resident #7. 2. CNA P failed to transport soiled linen in the hallway, without being bagged, to the soiled linen cart. 3. CNA V failed to ensure clean linen was covered when transported. These deficient practices could place residents at risk for infection due to improper care practices. The findings were: 1. Record review of Resident #11's face sheet dated 10/5/2021 revealed Resident #11 was admitted to the facility on [DATE] with diagnoses that included: Acute respiratory failure, Type II diabetes, Morbid obesity, Chronic kidney disease stage 3, Hypertension. Record review of Resident #11's 5-day MDS completed on 10/3/2021, revealed a BIMS score of 15, which indicated no cognitive impairment. Record review of Resident #11's care plan, dated 10/4/2021, revealed Resident #11 had redness to her groin, was at risk for falls, at risk of ADL self-care deficit, and that she was on antibiotics for bilateral pulmonary infiltrates [associated with pneumonia- a substance denser than air such as blood or a protein that is located in the lungs]. A care plan was not observed for Resident #2's diabetes. Record review of Resident #11's physician's orders, printed on 10/6/2021, revealed, Resident #2 was on insulin glargine twice daily for diabetes, and Humalog insulin as needed before and after meals along with monitoring the blood glucose levels. The dosage of Humalog insulin was based on a sliding scale and administered as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #2's face sheet dated 10/6/2021 revealed Resident #2 was readmitted to the facility on [DATE] with diagnoses that included: Type II diabetes, Pulmonary Embolism (blood clot in the lungs), Morbid obesity, Lupus, Bipolar disease, Schizophrenia, Chronic kidney disease stage 2, Hypertension, and recent history of Covid-19. Record review of Resident #2's quarterly MDS completed on 9/17/2021, revealed a BIMS score of 12, which indicated moderate cognitive impairment. Resident #2 was not ambulatory and required extensive assistance with ADLS of one person except for eating which indicated he required supervision and setup assistance. Record review of Resident #2's care plan revealed Resident #2 had a focus of diabetes that included an intervention to provide medications as ordered by the physician. The care plan further revealed that Resident #2 had a self-care deficit. Record review of Resident #2's physician's orders revealed, Resident #2 was on Humalog (a fast-acting insulin) as needed before and after meals along with monitoring the blood glucose levels. The dosage of Humalog insulin was based on a sliding scale and administered as needed. Record review of Resident #7's face sheet dated 10/6/2021 revealed Resident #7 was admitted to the facility on [DATE] with diagnoses that included: Type II diabetes, Acute kidney failure, Hypertension, Covid-19, Acute respiratory failure, Hypothyroidism. Record review of Resident #7's 5-day MDS completed on 9/18/2021, revealed a BIMS score of 13, which indicated intact cognition. Resident #7's ADL's indicated that he required supervision to limited assistance of supervision to physical assistance of one person. Resident #7's ADLS include: bed mobility, transfers, dressing, toileting use, and personal hygiene were coded a number 7, which indicated the activity occurred only once or twice or the activity. Record review of Resident #7's care plan revealed Resident #7 had a focus of diabetes that included an intervention to provide medications as ordered by the physician. The care plan further revealed that Resident#4 included a focus for hypertension and a pulmonary infection. Record review of Resident #7's physician's orders revealed, Resident #7 had an order to notify the provider if the blood glucose was less than 60 milligrams per deciliter. Resident #7 was on insulin Glargine daily and on Lispro insulin daily before meals along with monitoring the blood glucose levels before meals. Resident #7 did not have parameters for administration of Lispro insulin before meals. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of on 10/6/2021 at 8:00 a.m., RN E was observed obtaining a blood glucose check from Resident #11. RN E obtained the glucose monitor from LVN D and went into Resident #11's room. RN E placed gloves on her hands, RN E, did not pull the curtain or close the door in order to provide privacy to Resident #11. RN E did not clean the bedside table. The glucose monitor was placed on the bedside table during the procedure. After completion of the procedure, RN E placed the glucose monitor into her left scrub pocket (did not clean the glucose monitor), removed her gloves, and performed hand hygiene immediately upon exiting the room. RN E removed the glucose monitor from her left scrub pocket and placed it on top of the medication cart without cleaning the monitoring device. RN E did not perform hand hygiene after touching the monitoring device. RN E then retrieved the monitoring device from the top of the medication cart and proceeded into Resident #2 and Resident #7's room without performing hand hygiene. RN E did not clean the monitoring device prior to entering or upon exiting Resident #2 and Resident #7's room. During an interview on 10/6/2021 at 8:41 a.m., RN E confirmed that she placed the glucose monitoring device on the bedside table of Resident #11, and she should have placed it on a clean surface or put clean paper under it. RN E further confirmed that she placed the monitoring device in her scrub pocket and removed it, did not perform hand hygiene after touching the device and placed it on the medication cart. RN E further confirmed her actions as a violation of infection control protocol. RN E further confirmed that she did not clean the machine between Residents #11, #2, and #7. RN E revealed the purpose of cleaning the machine was to prevent infections, and hand hygiene should be completed before and after wearing gloves. RN E further revealed she had not received education or training on when and how to clean the glucose monitoring device until just now from the DON. RN E stated, I guess they (staff) saw me. During an interview with LVN S on 10/6/2021 at 9:00 a.m., LVN S was asked to state how he would obtain blood sugar checks and clean the monitoring device. LVN S responded the monitoring device should be cleaned before and after each resident, put on gloves, prepare finger and wipe the initial drop of blood away and use the second drop for the sample. LVN S revealed he usually held the monitoring device in his gloved hands while in a resident's room. LVN S confirmed if he did lay the monitoring device down that he would lay it on the bedside table. LVN S revealed the monitoring device should never be stored in your pockets. LVN S further revealed that he was not aware of having to wait after cleaning the machine, he thought you could wipe the monitoring device and use it immediately. During an interview with RN Q on 10/6/2021 at 10:54 a.m., RN Q revealed the protocol for obtaining blood sugar check was to perform hand hygiene, gather supplies, perform hand hygiene, and put gloves on. Then perform the blood sugar, then complete remove gloves, perform hand hygiene, and wipe down the equipment. RN Q confirmed he would provide privacy. RN Q confirmed the glucometer (monitoring device) needed to be on a clean surface. RN Q further confirmed he would usually hold the glucometer. When RN Q was asked to describe what a clean surface was, RN Q stated, I would use a tray-wipe the tray down before and after each resident use. During an interview with Administrator M on 10/6/2021 at 2:57 p.m., Administrator M confirmed clean glucometers and multi patient use medical equipment should be cleaned/sanitized before and after the use of each resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities policy titled Infection Control Program revised on 05/2007, read The goals of the Infection Control Program are to: A. Decrease the risk of infection to patients and personnel. B. Monitor for occurrence of infection and implement appropriate control measures. C. Identify and correct problems relating to infection control practices . Review of the facilities policy subject titled Hand Washing revised on 05/2007, read Policy: It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, health environment for residents and staff. Purpose: Hand washing is generally considered the most important single procedure for preventing nosocomial infections 2. During an observation on 10/1/2021 at 1:27 p.m., CNA P, an agency employee, was observed coming out of unidentified resident's room, into the hallway, with gloves on, transporting soiled linen without being concealed in a plastic bag, to the soiled linen container. During an interview with CNA P on 10/01/2021 at 1:27 p.m., CNA P revealed she was an agency employee. CNA P confirmed she should have been carrying the linen away from her body and the linen should have been in a bag in the hallway. During an interview with DON L on 10/01/2021 at 7:00 p.m., DON L confirmed CNA P was an agency employee, linens should be transported in a bag, and the facility did not have training records for CNA P. DON L further confirmed there was not a policy found referring to transporting soiled linen in the hallway. During an interview with CNA R on 10/6/2021 at 7:04 a.m., CNA R stated, you do not hug it (the linen) up against your body, don't touch it, don't put it on the floor. CNA R confirmed the linen should be transported in a bag. 3. Observation on 10/6/2021 at 7:03 a.m. revealed, CNA V removed some clean linen from 100 Hall's clean linen cart and transported the clean linen uncovered while walking down 100 hall. During an interview on 10/6/2021 at 7:04 a.m., CNA V confirmed she was transporting clean linen uncovered. CNA V confirmed clean linen should be transported in a plastic bag for infection control purposes. CNA V stated she was educated recently on infection control but couldn't recall the exact date. During an interview on 10/6/2021 at 11:20 a.m., ADON F confirmed clean linen should be transported in a plastic bag once removed from the clean linen cart. During an interview on 10/6/2021 at 2:09 p.m., DON L confirmed clean linen should be transported in a plastic bag once removed from the clean linen cart. During an interview on 10/6/2021 at 2:57 p.m., Administrator M further confirmed linen cannot be touching the body, and if clean linen is touched, clean hands should be used. Administrator M revealed that 100% of the time dirty must be transported in a plastic bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facilities policy section titled Infection Control, Subject: Linen, Clean revised 05/2007, read . Note: A clean cover must completely enclose the clean linen cart before it leaves the storage area. Clean linen carts must be labeled Clean Linen. Further record review of this policy reviewed, all clean linen transport carts shall be covered.