STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675981	A. Building B. Wing	02/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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 - Immediate jeopardy to resident health or safety 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** 19401 Based on interview and record review the facility failed to immediately consult with the physician regarding a significant change in resident's condition for 1 of 3 residents sampled for change in condition. (Reident#1) The facility failed to immediately consult the resident's physician when Resident #1 experienced a change in condition in which he began to have involuntary jerking movements. The facility failed contact Resdient #1' the physician when NP orders on 01/06/23 for a UA were not followed, and on 01/10/23 the resident was sent to the hospital septic from a UTI. An Immediate Jeopardy (IJ) situation was identified on 02/03/23 at 1:30 p.m. While the IJ was removed on 02/04/23 at 5:22 p.m., the facility remained out of compliance at a scope of isolated with actual harm, due to the facility's need to evaluate the effectiveness of the corrective systems This failure could place residents at risk for not receiving adequate care and treatment, hospitalization and possible death. Findings included: Record review of Resident #1's face sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His admitting diagnoses were depression, diabetes, obesity, anxiety, high blood pressure, and kidney disease. Resident #1 also had a diagnosis of benign prostatic hyperplasia (an age associated prostate gland enlargement tach can cause urination difficulty.) Record review of Resident #1's quarterly MDS dated [DATE] indicated he had intact cognition. The MDS indicated he was extensive assist with bed mobility, and transfer with the assistance of two people. The MDS indicated for toilet use the resident was totally dependent and required two-person physical assistance. Record review of Resident #1's care plan dated 12/28/22 indicated the resident had a problem of being incontinent of bladder. One of the interventions was monitor and document for signs and symptoms of UTI, pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in eating patterns. (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing progress note dated 1/6/23 indicated Resident #1 was alert, lying in bed with involuntary jerking movements of the BUE, unable to hold cell phone in his hand. He denied any pain or discomfort. His vital signs were within normal limits. The NP was notified an indicated a new order for a UA with culture and sensitivity if indicated. If the resident condition got worse to notify the NP. Resident #1 and his family were notified. Written by LVN A. Record review of a physician telephone order dated 01/06/23 at 7:06 p.m. indicated Resident #1 was to receive a UA with culture and sensitivity if indicated one time only until 1/8/2023. Record review of nursing progress note dated 01/10/23 at 7:05 a.m., indicated Resident #1 was lying in bed, hard to arose resident would open eyes briefly, but not answer questions that were asked, involuntary jerking movements noted to BUE. His blood pressure was 128/54, his pulse was 75, his temp was 97.3, pulse oximetry was 88 on CPAP, blood sugar was 389. He was sent to the emergency room . Written by LVN A. Record review of Resident #1's hospital physician progress notes dated 01/11/2023 indicated Resident #1 was a [AGE] year-old male who presented to the hospital on 01/10 23 with Sepsis (a life-threatening complication of an infection). He presented to the hospital with altered mental status and hypoxia (absence of enough oxygen in the tissues to sustain body functions). Resident #1's oxygen saturation in the 80s on a CPAP (Continuous Positive Airway Pressure) and revealed his creatinine was 1.5 (normal level 0.74-1.35 high level indicated kidney failure.) the potassium was 6.8. (Normal lever 3.6 to 5.2- potassium levels higher than 6.0 can be dangerous and required immediate treatment). He was encephalopathic (altered brain function) but arousable and able to maintain airway. The notes indicated the resident had acute respiratory failure with hypoxia secondary to volume overload status. Chronic kidney disease stage 3 now with worsening renal function with a plan for dialysis. Resident #1 had acute metabolic encephalopathy and sepsis with evidence of Leukocytosis (high white blood cell count), tachypnea (fast breathing) secondary to UTI. During an interview on 01/12/23 a 10:20 a.m. LVN A said she worked at the facility since 2004. She said on 01/06/23 Resident #1 had some jerking motions. She said CNA C called her to his room who said he was shaking and had a large BM. She said she assessed Resident #1 and his vital signs were normal around 3 p. m. and he appeared fine. In a later interview she said she had gone back into his room around 7:00 p.m. and he was shaking quite a bit and unable to hold his cell phone. LVN A said she called the NP and received an ordered for a UA with culture and sensitivity. She did not contact the physician. She said she did not attempt to collect the UA because she did not have time. She was off work over the weekend. She said she came back on to work on 01/09/23 and Resident #1 was fine. She did not attempt the UA on Monday, 01/09/23 because she did not have time. The LVN said on 1/9/23 Resident #1 did not eat his lunch. She said Resident #1 said it was the same thing and it was not what he wanted for lunch. On the morning of 01/10/23 she sent Resident #1 to the hospital because he was basically unresponsive and his O2 stat was low. She called the NP and family. In a later interview LVN A said the NP did not write any order for a Stat UA but all they had to do was call the lab for a weekend pickup. LVNA said she did not notify the NP the lab was not collected. During an interview on 01/12/23 at 10:55 a.m. Resident #1's family member said they received a call on 01/06/23 saying his Resident #1 had shaking movements and a UA was ordered. He said on 01/10/23 they received a call saying Resident #1 was sent to the Hospital. When they arrived at the hospital, they were told Resident #1 was septic from a UTI and need to be placed on dialysis. He said Resident #1 was in ICU, and he was still shaking. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview o 01/12/23 at 2:20 p.m. the DON said on 01/06/23 someone told her Resident #1 was having some issues. She saw LVN A coming out of his room and the nurse said Resident #1 was fine. The DON said she found out later during her investigation the LVN had contacted the NP and received an order on 01/06/23. The DON said the protocol was for the nurse to let the DON know of any changes. The DON said she had specifically asked LVN A to let her know of any changes with Resident #1, but she did not. The DON said the first time she was aware of the NP order for a UA was on 1/9/23. She said LVN A said the resident was still in need of a UA because it had not been completed. The DON said LVN A had not completed the UA and had not tried. The DON said after the VA Representative contacted the facility on 01/10/23 they began their investigation. The DON said she started in services on that day on 01/10/23 and was developing a plan of action for QA as part of their QA measures for correction. During a telephone interview on 01/12/23 at 3:50 p.m. the NP said she was not informed the Resident #1's UA was not completed. She said she should have been notified and was not. During a telephone interview on 01/24/22 at 8:09 a.m. Resident #1 said he was sick all weekend prior to going to the hospital. He did not remember anyone trying to collect urine from him during the weekend. He said sometimes he felt better than others, but he felt sick the whole weekend. Resident #1 said he did not remember what happen on the morning of 01/10/23, he was mostly out of it. During an interview on 02/02/23 at 2:26 p.m. the MD said he was not made aware Resident #1 had a change in condition and did not receive his UA until after he went to the hospital. He said the UA was requested because when an elderly person had any change in condition it was most frequently due to a UTI. The MD said he was not aware of any issues related to Resident #1 having prostate problems, there was no indication he had a blockage. The MD said Resident #1 had a multitude of complex problems. He said the nurse could have suggested to the NP the UA be Stat. The MD said apparently, the nurse did not convey any emergency to have the UA done quickly. He said either way they wanted it done sooner rather than later. The MD said if Resident #1 had a UTI and it seemed apparent that he did. His condition would only decompensate the longer they waited to provide treatment. The MD said he had some concerns that it was not done within a day or so. The MD said that was what they expect of an order for a UA. He said usually the UA results would come back in a few hours or the next day. The MD said he and DON talked and would do better communication in the future. He said they would make sure UAs are done timely. During an interview on 02/03/23 12:10 p.m. the DON said she just did a verbal counseling with LVN A and a one on one in service with her. The DON said with this company they do not have anything written in regard to an empoyee's disciplinary actions. She said she had done some in servicing on 01/10/23 regarding labs and change in condition. However, she did not have a current system in place to train all agency staff. Record review of the facility's Change in a Resident's Condition or Status Policy revised February 2021 indicated our community promptly notified the resident, their attending physician, and the resident representative of changes in the resident's medical condition and status. The nurse would notify the residents attending physician or physician on call when there was a significant change in the resident's physical, emotional, or mental condition. If there was the need to alter the resident treatment significantly. A refusal of treatment or medications two or more consecutive times. The nurse would record in the resident's medical record information related to changes in the resident's medical or mental condition or status. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator, MDS nurse, DON, and ADON were notified on 02/03/23 at 1:30 p.m. an Immediate Jeopardy (IJ) situation was identified due to the above failures and an IJ template was provided. The facility plan of removal was accepted on 02/04/23 at 3:22 p.m. was as follows: [The facility failed to notify the Physician of failure to obtain ordered labs. The Physician was not notified that lab was not drawn, resulting in a COC that resulted in his hospitalization on [DATE]. Identify residents who could be affected All Residents have the potential to be affected. The Facility census on 1/6/23 was 43. An audit was initiated on 2/3/23 and will be completed on 2/4/23 to ensure there are no further labs that have not been drawn. DON/Designee initiated and completed a round on all current residents on 2/3/23 to determine if there are any changes in residents condition. All findings were reported to Physician and orders obtained and carried out as required. . In-Service conducted All nurses will receive education on carrying out Physicians orders, education on procedures for notifying Physicians when an order is not able to be carried out and education on Identification and reporting to Physicians any change in resident's condition using the INTERACT tools. It is not acceptable to notify NP of an acute. change of condition Nurse aides will be educated on the Stop and Watch tool to help identify early signs of condition change. Implementation Date of Changes In-servicing was initiated on 2/3/23 by the DON and will continue until it is completed by the DON/Designee on 2/4/23. Agency staff and staff on leave that work in the facility will have in-servicing completed prior to working the floor by the DON/Designee. . Involvement of Medical Director The Medical Director, [name] was notified about the immediate Jeopardy on 2/3/23. Involvement of QA (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	QAPI will review and approve Plan of Removal on 2/4/23 Who is responsible for implementation of process? Administrator and DON (Director of Nursing).] On 02/04/23 the investigator confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of the facility employee roster indicated they have 5 full time LVNs, one part time LVN and two weekend RNs and the ADON who was an LVN. They have 9 nurse's total. They had 7 CNAs. During an observation and interview on 02/04/23 at 3:39 p.m. the DON said she had a binder with a list of Agency staff, their discipline, and when they received the training. She said she would monitor what agency staff had been trained and prior to each agency staff beginning work they would receive training if they were not in the book. Observation of the book showed the training, each staff, a list of training they received. There was a list of 5 agency LVNs and two agency CNAs indicating they had been trained on labs, physician notification, identification of change in condition and physician notification. During interviews on 02/04/23 between 3:30p.m. and 5:15 p.m. three CNAs said they were educated on the Stop and Watch tool (a form used by aides to identify changes in a resident such as different symptoms, change in need for assistance, eating less, agitated, more confused or change in skin color.) to help identify early signs of condition change to the charge nurse. They said they are to fill out the form and give it to the nurse, so they have verification they told the nurse of the change in condition. They were told they could make a copy of the form and place it under department heads doors if they felt their concerns were not addressed. During interviews on 02/04/23 between 3:3 0p.m. and 5:15 p.m. were conducted with 3 facility LVNs and 1 RN and 2 agency LVNs that indicated they were knowledgeable on following physician orders, identification of resident change in condition. The nurses said they would follow guidelines for monitoring. They would monitor residents with possible UTIs for any symptoms. If a resident refused treatment, they would educate the resident on possible consequences and let the physician know of the resident status. The nurses were able to demonstrate through interviews their understanding of those policies, procedures, and in services. Record Review of a Resident record identified as needing a UA was reviewed and the facility put measures in place, such as notifying the physician, getting a timely UA. Detailed documentation of the resident condition was noted in the record to include the INTERACT assessment tool(an assessment form that is used to help nursing staff evaluate the resident for change in condition). The physician was notified of the lab results and the resident place on an antibiotic. With additional physician orders. On 02/04/23 at 5:42 p.m. the Administrator, DON, and ADON were informed the IJ was removed; however, the facility remained out of compliance at level of actual harm with a scope of isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems that were put in place.

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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** 19401 Based on observation, interview, and record review the facility failed to provide treatment and care in accordance with the comprehensive person-centered care plan and in accordance with professional standards of practice for 1 of 3 residents reviewed for care and services. (Resident #1) *The facility did not complete a provider ordered UA on 1/6/23 until 1/10/23. The resident was admitted to the hospital on the morning of 1/10/23 with a diagnosis of sepsis due to UTI. *The facility failed to increase monitoring and provide accurate documentation of attempted UA collection. *The facility failed to identify signs and symptoms of a UTI. *The facility failed to notify the physician timely when they did not compete the UA. An Immediate Jeopardy (IJ) situation was identified on 02/03/23 at 1:30 p.m. While the IJ was removed on 02/04/23 at 5:22 p.m., the facility remained out of compliance at actual harm with a scope identified isolated, due to the facility's need to evaluate the effectiveness of the corrective systems This failure could place residents at risk for not receiving adequate care and treatment to prevent hospitalization and possible death. Findings included: Record review of Resident #1's face sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His admitting diagnoses were depression, diabetes, obesity, anxiety, high blood pressure, and kidney disease. Resident #1 also had a diagnosis of benign prostatic hyperplasia(an age associated prostate gland enlargement tach can cause urination difficulty.) Record review of Resident #1's quarterly MDS dated [DATE] indicated he had intact cognition. The MDS indicated he was extensive assist with bed mobility, and transfer with the assistance of two people. The MDS indicated for toilet use the resident was totally dependent and required two-person physical assistance. Record review of Resident #1's care plan dated 12/28/22 indicated the resident had a problem of being incontinent of bladder. One of the interventions was monitor and document for signs and symptoms of UTI, pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in eating patterns. Record review of nursing progress note dated 1/6/23 Resident #1 was alert, lying in bed with involuntary jerking movements of the BUE, unable to hold cell phone in his hand. He denied any pain or discomfort. His vital signs were within normal limits. The NP was notified an indicated a new order for a UA with culture and sensitivity if indicated. If the resident condition got worse to notify the NP. Resident #1 and his family were notified. Written by LVN A. (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 a physician telephone order dated 01/06/23 at 7:06 p.m. indicated Resident #1 was to receive a UA with culture and sensitivity if indicated one time only until 1/8/2023. Record review of the facility 24-hour report dated 01/06/23 indicated the following: *Evening shift: Resident #1 had involuntary jerking of the bilateral upper extremities his vital signs were within normal limits; the NP was notified a new order for a UA and notify the NP if the condition worsened. *Night shift: there was no mention of the UA or the resident's involuntary movement. Record review of nursing progress note dated 01/07/23 at 12:21 p.m. indicated Resident #1 was in bed with family at bedside. His respirations were even and unlabored. He denied pain and voiced no concerns. There was no involuntary jerking noted at this time. Vital signs were within normal limits and no mental status change or behaviors noted. Signed by ADON Record review of the 24-hour report dated 01/07/23 indicated the following: *Resident #1 needed a UA, call the lab for pick up(at the top of the page). *Day shift: was blank for Resident #1. *Evening shift: continue jerking monitor for jerking bilateral upper extremities. *Night shift: no involuntary jerking this shift, would continue to monitor BUE for jerking. There was no documentaion on the 24-hr report that indicated a UA was attempted. Record review of the facilities 24- hour report dated 01/08/23 indicated the following: on the *Day shift: Resident #1 needed a UA. No involuntary jerking noted this shift. *Evening shift: UA needed, no involuntary jerking this shift. *night shift: stable. Record review of the 24-hour report dated 01/09/23 indicated the following: *Day shift: Resident #1 had no change. *Night shift: gave bath and clean clothes; he left; was to leave the facility at 4:30 a.m.; UA needed. Record review of a nursing progress note dated 01/10/23 at 6:22 a.m. indicated the UA was collected. Written by an agency LVN B. (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 nursing progress note dated 01/10/23 at 7:05 a.m., said Resident #1 was lying in bed, hard to arose resident would open eyes briefly, but not answer questions that were asked, involuntary jerking movements noted to BUE. His blood pressure was 128/54, his pulse was 75, his temp was 97.3, pulse oximetry was 88 on CPAP, blood sugar was 389. He was sent to the emergency room . Written by LVN A. Record review of nursing progress note created 1/10/23 at 8:23 a.m. titled late entry indicated on 01/9/23 at 11:39 a.m. Resident #1 was resting quietly in bed, he refused his lunch, with no involuntary movements to his BUE. His vital were within normal limits, no pain or distress noted at this time. Written by LVN A. Record review of nursing progress note created 01/10/23 at 11:24 a.m. titled late entry indicated on 1/6/23 at 9:00 p.m. Resident #1 had new order noted for collection of UA. An attempt was made was made but no results. Will continue to monitor and retry. Signed by the ADON. Record Review of nursing progress note created 01/10/23 at 3:52 p.m. titled late entry dated 1/7/23 at 12:20 p.m. indicated attempted to collect a UA from Resident #1 but was unsuccessful. The resident attempted to give a sample without being catharized at his request. Would continue to monitor. Written by ADON. Record review of nursing progress note created 01/10/23 at 3:49 p.m. titled late entry indicated on 01/08/23 at 11:42 a.m. Resident #1 was in bed with family at the bed side. He denied any problems at that time. He voiced no concerns. An attempt was made to collect the UA earlier in the shift but failed. The resident was requesting not to be catharized at this time, he said he would try to urinate on his own. Will continue to monitor. Signed by the ADON. Record review of Resident #1's hospital physician progress notes dated 01/11/2023 indicated Resident #1 was a [AGE] year-old male who presented to the hospital on 01/10 23 with Sepsis (a life-threatening complication of an infection). He presented to the hospital with altered mental status and hypoxia (absence of enough oxygen in the tissues to sustain body functions). Resident #1's oxygen saturation in the 80s on a CPAP (Continuous Positive Airway Pressure) and revealed his creatinine was 1.5 (normal level 0.74-1.35 high level indicated kidney failure.)the potassium was 6.8. (Normal lever 3.6 to 5.2- potassium levels higher than 6.0 can be dangerous and required immediate treatment). He was encephalopathic (altered brain function) but arousable and able to maintain airway. The notes indicated the resident had acute respiratory failure with hypoxia secondary to volume overload status. Chronic kidney disease stage 3 now with worsening renal function with a plan for dialysis. Resident #1 had acute metabolic encephalopathy and sepsis with evidence of Leukocytosis (high white blood cell count), tachypnea (fast breathing) secondary to UTI. Record review of the facility Provider Investigation Report dated 01/10/22 indicated the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Investigation: On 01/06/23 the administrator informed the DON Resident #1 needed to have a COVID test because he had diarrhea like symptoms. At 6:00 p.m. the DON asked [LVN A] about the resident and she said Resident #1 was fine. [LVN A] was informed to make sure to contact the DON if there was any change in Resident #1's condition. A chart review indicated [LVN A] contacted the NP on 01/06/23 at 7:00 p.m. and received a telephone order for a UA due to involuntary jerking movements. The LVN did not call the DON but waited until 01/09/23 to inform the DON of the change of condition and the new order for the UA. From1/6/23-1/8/23 the ADON checked on Resident #1 and attempted to obtain a urine sample per her report, but the resident was unable to give the sample and unwilling to have a straight catheter per her report. On 01/08/23 the DON went to the facility to provide wound care to Resident #1. He was in good spirits made no complaints and was in no distress. He asked for a sandwich after the treatment was competed. There were no jerking movements or abnormalities visible. On 01/09/23 during clinical meeting [LVN A] reported there was a UA that needed to be collected on Resident #1. LVN A told the DON she received the order on 01/06/23 but Resident #1 was acting normal today. The DON was told [LVN A] to contact the NP and tell her Resident #1 was doing okay. LVN A was told to ask the NP if Resident #1 still needed the UA or did it need to be discontinued. There was no documentation that the LVN contacted the NP as she was told to obtain the UA. On 01/10/23 at 6:22 a.m. the UA was finally collected by an agency nurse. On 01/10/23 at 7:45 a.m. Resident #1 was sent to the emergency room with altered mental status. On 01/10/23 at 2:00 PM the NP said her rationale for ordering the UA was Resident #1 had previously experienced jerking movements and the jerking movements were related a UTI. However, the UA had not been ordered as stat. The report indicated education was provided on UTI's and UA's which indicated when a nurse received the order for the UA. They must immediately contact the DON and attempt the same shift to obtain the urine sample. the nurse must not pass the order or the next shift hoping it will get done. Delaying care for possible infection can lead to complications such as sepsis. The plan of correction for the investigation was the DON would write LVN A up for failure to obtain the UA order. By her own admission she did not attempt to get the sample on 01/06/23 or 01/09/23[LVN A] failure to communicate the change of condition and new order for UA immediately to the DON also delayed patient care. In the future the nurse who received the order would be responsible for obtaining the urine sample. Nurses must no longer pass the order to the next shift. The nurses should also utilize urine dipsticks per physician standard order while waiting for UA to return for quick results and contact the physician with the results. Record review of an in service dated 01/10/23 at 4:30 p.m. indicated nurses were trained on Education on UTI's and UA's, Change in Condition and Documentation, and Labs. The in service on Labs indicated, When we obtained an order for a UA or any other type of labs. You need to notify the DON by phone right away and family members. When trying to get a UA sample and not able to obtain it. Make sure you put a progress note about how many times you tried and the reason of why you were not able to obtain the sample. (signed by 7 nurses to include LVN A.) (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 01/12/23 a 10:20 a.m. LVN A said she worked at the facility since 2004. She said on 01/06/23 Resident #1 had some jerking motions. She said CNA C called her to his room who said he was shaking and had a large BM. She said she assessed Resident #1 and his vital signs were normal around 3 p. m. and he appeared fine. She said she had gone back into his room around 7:00 p.m. and he was shaking quite a bit and unable to hold his cell phone. LVN A said she called the NP and received an ordered for a UA with culture and sensitivity. She did not attempt to collect the UA because she did not have time. She was off work over the weekend. She said she came back on to work on 01/09/23 and Resident #1 was fine. She did not attempt the UA on that 01/09/23 because she did not have time. The LVN said on 1/9/23 Resident #1 had not eaten his lunch. She said her said it was the same thing and it was not what he wanted. On the morning of 01/10/23 she sent Resident #1 to the hospital because he was basically unresponsive and his O2 stat was low. During an interview on 01/12/23 at 10:55 a.m. Resident #1's family member said they received a call on 01/06/23 saying his Resident #1 had shaking movements and a UA was ordered. He said on 01/10/23they received a call saying Resident #1 was sent to the Hospital. When they arrived at the hospital, they were told Resident #1 was septic from a UTI and need to be placed on dialysis. He said he was in ICU, and he was still shaking. During an interview on 01/12/23 at 11:30 a.m. CNA C said she went into Resident #1's room around 3 or 4 p. m. on Friday 01/06/23 to give him a bath. She said his eyes were rolled back and he was shaking. She got the assistance of CNA D to help her. Resident #1 had an extra-large BM. She told LVN A, and she came and assessed Resident #1. Resident #1 said he did not feel well. She said they finished cleaning him up and she left for the day. CNA C said she was off the weekend. During an interview on 01/12/23 at 2:00 p.m. the administrator said she had called an intake into the state agency regarding Resident #1. She said on 01/10/23 a VA Representative had informed her the facility had failed to notify the physician regarding Resident #1's change in condition. She said she felt an allegation of neglect had been made. She called it into the state and started an investigation into the incident. The Administrator said they did a review of Resident #1's record and started in servicing staff. The DON had completed in services on 01/10/23. During an interview o 01/12/23 at 2:20 p.m. the DON said on 01/06/23 someone told her Resident #1 was having some issues. She saw LVN A coming out of his room and the nurse said Resident #1 was fine. The DON said she found out later during her investigation the LVN had contacted the NP and received an order on 01/06/23. The DON said the protocol was for the nurse to let the DON know of any changes. The DON said she had specifically asked LVN A to let her know of any changes with Resident #1, but she did not. The DON said the first time she was aware of the NP order for a UA was on 1/9/23. She said LVN A said the resident was still in need of a UA because it had not been completed. The DON said LVN A had not completed the UA and had not tried. The DON said after the VA Representative contacted the facility on 01/10/23 they began their investigation. The DON said she started in services on that day and was developing a plan of action for QA as part of their QA measures for correction. (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 01/12/23 at 2:55 p.m. the ADON said she worked Saturday, 01/07 23 and Sunday, 01/08/23 as the floor nurse. The ADON said she wrote late entry progress notes on Resident #1 because she did not have enough time to write during her shift. She could not say why the notes were written two days later; on the day the resident went to the hospital. She said during the weekend Resident #1 was fine and had no issues that she noted. The ADON said on 01/07/23 she tried to get the urine sample that morning and Resident #1 was not able to produce any urine. She asked if he wanted to do the straight catheter and he said no, he wanted to try and go in his own. She said later he had family and did not want to be bothered. She said he was happy because a friend had come to visit that he had not seen in a while. The ADON said she did not know how Resident #1 ate that day, but the family brought in food. The ADON on 01/08/23 Resident #1 had no complaints or issues. The ADON said she was in serviced on labs and physician notification. During a telephone interview on 01/12/23 at 3: 30 p.m. CNA E said on 01/07/23 Resident #1 said he was not feeling his normal self. She said she knew he did not eat breakfast very well. She had to help CNA F cleanup the bed. He spilled his cereal all over the bed due to his shaking. She said as the day went on, he appeared to feel better. CNA E said she heard CNA F tell the LVN H Resident #1 was not feeling well. She he was not her resident and she only helped out when needed because he was two person. During a telephone interview on 01/12/23 at 3:35 p.m. CNA F said she recalled Resident #1 was shaking and sick all day on 01/07/23. She said he did not really eat breakfast and was shaking badly. He spilled his cereal all over the bed due to his shaking. CNA F said they had to clean up the bed. Resident #1 requested a waited spoon to eat his lunch but even with that he did not eat well. She said she had reported to the nurse LVN H he was shaking and not feeling well. LVN H said okay and acted like she already knew the resident was not feeling well. CNA F said she had changed him through the day, and he did appear to be a little better as the day progressed. His family was with him most of the day and he did okay. She said she did not work on 01/08/23. During a telephone interview on 01/12/23 at 3:40 p.m. CNA G said on the morning of 01/07/23 Resident #1 was hard to arose. She said he did not have on his CPAP so that may have been the reason. However, she said after they got him awake, he did not have any other issues that she noted. She was the medication aide and did not really provide him any care. During a telephone interview on 01/12/23 at 3:50 p.m. the NP said she was not informed the Resident #1's UA was not completed. She said she should have been notified and was not. During an interview on 01/12/23 at 4:00 p.m. CNA D said on the evening of 01/06/23 he assisted CNA C with providing care to Resident #1. He said Resident #1 was shaking and CNA C went and got the nurse. He said by the time LVN A got there Resident #1 appeared better. He said the resident did shake some during the night. Resident #1 did not know when he had urinated but knew when he was wet. CNA D said he had gone back into his room at least two times during his shift. He said Resident #1 did not complain of anything and he changed him at least once maybe twice during his shift. CNA D said Resident #1 drank a lot of water and Dr. Peppers and voided frequently. He said Resident #1 did not have another BM, but he was incontinent of urine. During an interview on 01/17/23 at 10:30 a.m. the ADON said the UA was not collected on the weekend. It was ordered on Friday and the lab does not pick up on weekends. The ADON said she had worked that weekend and had not called the doctor because Resident #1 was doing fine. (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 01/07/23 at 11:26 a.m. CNA C said she was out on Monday, 01/09/23. She had come in early on 01/10/23 to ride to another city for an appointment with Resident #1. She said on that morning he was mostly unresponsive. She helped to clean him up and they sent him to the hospital. During a telephone interview on 01/24/22 at 8:09 a.m. Resident #1 said he was sick all weekend prior to going to the hospital. He did not remember anyone trying to collect urine from him during the weekend. He said sometimes he felt better than others, but he felt sick the whole weekend. Resident #1 said he did not remember what happen on the morning of 01/10/23, he was mostly out of it. During an interview on 02/02/23 at 12:35 p.m. the DON said she was not aware Resident #1 had an order for a UA until Monday, 01/09/23. So, she was not aware of Resident #1 needed a UA. The DON said because she was unaware there was an order for the UA, she did not put any interventions in place. She was also not aware the UA was not completed for the same reason. The DON said she started to work in October 2022. She was not aware Resident #1 had issues with shaking related to a UA in the past. During interview on 02/02/23 at 12:50 p.m. the ADON said she did not get an order to monitor Resident #1 more closely. She worked as an aide one day over the weekend. She said Resident #1 would pull the light to be changed and did not appear to have a change in his urination patterns. She said the problem was by the time they got to the room he had already gone. The ADON said he was on blood pressure monitoring three times a day. They did not do anything else in regard to monitoring his behaviors. He seemed fine. She did not note any shaking and he did not complain. She said he was not a complainer. The ADON said she worked as an aide on 01/08/23, and when she went to his room, he was already wet. The ADON she tried to try and get the UA sample. She said Resident #1 refused an in and out cath. The ADON said she started working at the facility in October 2022. She was not aware Resident #1 had issues with shaking related to a UA in the past. The ADON said she was aware of the signs of a UTI in the elderly. During an interview on 02/02/23 at 1:30 p.m. agency LVN I said this was her third time working at the facility. When she first came she was given a brief overview of the nurses station. However she had not received any recent in service about labs or UAs. During aa interview on 02/02/23 at 1:47 p.m. LVN A said the NP did not write any order for a Stat UA but all they had to do was call the lab for a weekend pickup. LVNA said she did not notify the NP the lab was not collected. During an interview on 02/02/23 at 2:26 p.m. the MD said he was not made aware Resident #1 did not receive his UA until after he went to the hospital. He said the UA was requested because when an elderly person had any change in condition it is most frequently due to a UTI. The MD said he was not aware of any issues related to Resident #1 having prostate problems, there was no indication he had a blockage. The MD said Resident #1 had a multitude of complex problems . He said the nurse could have suggested to the NP the UA be Stat. The MD said apparently, the nurse did not convey any emergency to have the UA done quickly. He said either way they wanted it done sooner rather than later. The MD said if Resident #1 had a UTI and it seemed apparent, he did his condition would only decompensate the longer they waited to provide treatment. He said he had some concerns that it was not done within a day or so. The MD said that is what they expect of an order for a UA. He said usually a UA results will come back in a few hours or the next day. The MD said he and DON had talked and would do better communication in the future and make sure UAs are done timely. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 2/2/23 at 2:37 p.m. the lab technician at the Laboratory company the facility utilized, said the UA's do not have to be Stat on the weekend. All the facility needed to do was call and they would pick them up. Record Review of the ADON's time sheet from 01/5/23 through 1/9/23 indicated that she was not at work on 01/06/23 at 9 p.m. (ADON wrote a late entry note for that time.) During an interview on 2/2/23 at 2:50 p.m. with the HR Director and the ADON. The HR Director said the ADON clocked out on Friday, 01/06/23 at 6:28a.m. The HR Director said she did not return to work again until Saturday, 01/07/23 at 8:06 a.m. She said the ADON worked until 9:50 p.m. that day. The HR Director said on Sunday, 01/08/23 the ADON clocked in at 8:00 a.m., left for lunch from 2:30 p.m. to 3:30 p.m., clocked out at 9:06 p.m., and clocked back in at 10 23 p.m. to 11:44 p.m. The ADON said the time sheet could not be right, she worked during the time the nurses note was written. The HR Director said the pay period ended on 01/15/23 and missed punched needed to have been submitted by 01/16/23. The pay checks went out on 01/25/23 and she had no complaints about the ADON's check not being correct. The ADON continued to insist she had worked on Friday night 01/06/23. During an interview on 02/03/23 at 10:26 a.m. the ADON said she was not at the facility on Friday 01/06/23 on that night at 9:00 p.m. She said she was mistaken. The ADON said when she wrote the note, she was trying to put it in for Saturday 01/07/23. The ADON said at that time they had 3 shifts but recently switched to 12-hour shifts. She said she worked Saturday 6-2 charge nurse- from 3 to 10 as a medication aide. She said on Sunday she was CNA for first shift. The ADON said she was a CNA for first three hours on the second shift. She said she did not know why she was the only nurse that charted on Resident #1 failed attempts to get the UA. The ADON said Resident #1 did not like to be moved but he did not complain. During an interview on 2/3/23 at 11:45 a.m. LVN/treatment nurse said she was in-service on change in condition, when to call the DON and physician. She said they were to make sure to get labs timely. If unable to get a lab let the physician know and document attempts. During an interview on 02/03/23 12: 10 p.m. DON said she just did a verbal counseling with LVN A and a one on one in service with her. The DON said with this company do not have anything written. She said she had done some in servicing on 01/10/23 regarding labs and change in condition. However, she did not have a current system in place to train all agency staff. During a telephone interview on 2/3/23 at 12:22 p.m. LVN H said she remembered LVN A told her during report on 1/6/23 that Resident #1 was doing some jerking and needed a UA. She said she said not noticed any kind of jerking when she observed Resident #1. LVN H said she did not get the UA during her shift. She said when she got to Resident #1's room his brief was wet. LVN H said there was a note on the 24-hour report about getting the UA. LVN H said she could not remember if she had written a note regarding Resident #1 condition or failed attempt to obtain the UA or not. She said she really did not remember that incident well. LVN H said she received an in services regarding change in condition, and labs. LVN H said she would not have done anything any different with Resident #1. She said she let the next shift know she was unable to get the UA. This was determined to be an Immediate Jeopardy (IJ) in the area of Quality of Care on 02/03/23 at 1:30 p. m. The facility Administrator, MDS nurse, DON, and ADON were notified. The Administrator was provided with the IJ template on 02/03/23 at 1:30 p.m. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility plan of removal was accepted on 02/04/23 at 3:22 p.m. was as follows. [The facility failed to provide timely laboratory services as ordered by the Physician on 1 Resident on 1/6/23. The Physician was not notified that lab was not drawn, resulting in a COC that resulted in his hospitalization on [DATE]. Identify residents who could be affected All Residents have the potential to be affected. The Facility census on 1/6/23 was 43. An audit was initiated on 2/3/23 and will be completed on 2/4/23 to ensure there are no further labs that have not been drawn. DON/Designee initiated and completed a round on all current residents on 2/3/23 to determine if there are any changes in residents' condition. All findings were reported to Physician and orders obtained and carried out as required. In-Service conducted All nurses will receive education on Following Physicians orders, education on procedures for notifying Physicians when an order is not able to be carried out and education on Identification and reporting to Physician any change in resident's condition using the INTERACT tools. Following Physician notification and the severity of the condition nurses will follow Physicians guidance for monitoring with a minimum of daily documentation as it relates to the change of condition and vital signs. In-servicing will be completed by DON/Designee. For residents with a suspected UTI monitoring each shift will consist of urinary output, change in mentation, flank pain and odor and color. In-servicing will be completed by DON/Designee. If a resident refuses treatment or catheterization for a UA they will be educated on the risks of not following Physician orders by the charge nurse and the physician will be notified. Nurse aides will be educated on the Stop and Watch tool to help identify early signs of condition change by the DON/Designee. Implementation Date of Changes In-servicing was initiated on 2/3/23 and will be completed by 2/4/23 Agency staff and on leave or PRN nurses that work in the facility will have in-servicing completed prior to working the floor by the DON/Designee. . Involvement of Medical Director The Medical Director, [name] was notified about the immediate Jeopardy on 2/3/23. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Involvement of QA QAPI will review and approve Plan of Removal on 2/4/23 Who is responsible for implementation of process? Administrator and DON (Director of Nursing).] On 02/04/23 the investigator confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of the facility employee roster indicated they have 5 full time LVNs, one part time LVN and two weekend RNs and the ADON who is an LVN. They have 9 nurses total. They had 7 CNAs. During an observation and interview on 02/04/23 at 3: 39 p.m. DON said she had a binder with a list of Agency staff, their discipline and when they received the training. She said she would monitor what agency staff had been trained and prior to each agency staff beginning work they would receive training if they were not in the book. Observation of the book showed the training a list of staff. There was a list of 5 agency LVNs and two agency CNAs indicating they had been trained on labs, physician notification, identification of change in condition and physician notification. During interviews on 02/04/23 between 3:30p.m. and 5:15 p.m. three CNAs said they were educated on the Stop and Watch tool (a form used by aides to identify changes in a resident such as different symptoms, change in need for assistance, eating less, agitated, more confused or change in skin color.) to help identify early signs of condition change to the charge nurse. They said they are to fill out the form and give it to the nurse, so they have verification they told the nurse of the change in condition. They were told they could make a copy of the form and place it under department heads doors if they felt their concerns were not addressed. During interviews on 02/04/23 between 3:3 0p.m. and 5:15 p.m. were conducted with 3 facility LVNs and 1 RN and 2 agency LVNs that indicated they were knowledgeable on following physician orders, identification of resident change in condition. The nurses said they would follow guidelines for monitoring. They would monitor residents with possible UTIs for any symptoms. If a resident refused treatment, they would educate the resident on possible consequences and let the physician know of the resident status. The nurses were able to demonstrate through interviews their understanding of those policies, procedures, and in services. Record Review of a Resident record identified as needing a UA was reviewed and the facility put measures in place, such as notifying the physician, getting a timely UA. Detailed documentation of the resident condition was noted in the record to include the INTERACT assessment tool(an assessment form that is used to help nursing staff evaluate the resident for change in condition). The physician was notified of the lab results and the resident place on an antibiotic. With additional physician orders. On 02/04/23 at 5:42 p.m. the Administrator, DON, and ADON were informed the IJ was removed; however, the facility remained out of compliance at level of actual harm with a scope of isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems that were put in place.

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19401 Based on interview and record review the facility failed to obtain timely laboratory services to meet the needs of 1 of 2 residents reviewed for laboratory services (Resident #1.) The facility failed to obtain an UA as ordered. Resident #1 did not receive a timely UA and was hospitalized due to sepsis. An Immediate Jeopardy (IJ) situation was identified on 02/03/23 at 1:30 p.m. While the IJ was removed on 02/04/23 at 5:22 p.m., the facility remained out of compliance at actual harm with a scope identified as isolated, due to the facility's need to evaluate the effectiveness of the corrective systems This failure could place residents at risk for a delay in identifying or diagnosing medical issues, hospitalization and possible death. Findings Included. Record review of Resident #1's face sheet indicated he was a [AGE] year-old male admitted to the facility on [DATE]. His admitting diagnoses were depression diabetes, obesity, anxiety, high blood pressure, and kidney disease. Resident #1 also had a diagnosis of benign prostatic hyperplasia(an age associated prostate gland enlargement tach can cause urination difficulty.) Record review of Resident #1's quarterly MDS dated [DATE] indicated he had intact cognition. The MDS indicated he was extensive assist with bed mobility, and transfer with the assistance of two people. Record review of Resident #1's care plan Indicated the resident had a problem of being incontinent of bladder. One of the interventions was monitor and document for signs and symptoms of UTI, pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in eating patterns. Record review of nursing progress note dated 1/6/22 Resident #1 was alert, lying in bed with involuntary jerking movements of the BUE, unable to hold cell phone in his hand. He denied any pain or discomfort. His vital signs were within normal limits. The NP was notified an indicated a new order for a UA with culture and sensitivity if indicated. If the resident condition got worse to notify the NP. Resident #1 and his family were notified. Written by LVN A. Record review of a physician telephone order dated 01/06/23 at 7:06 PM indicated resident number one was to receive a UA with culture and sensitivity if indicated one time only until 1/8/2023. Record review of a nursing progress note dated 01/10/23 at 6:22 a.m. indicated the UA was collected. The note was signed by an agency LVN B. (continued on next page)

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	675981	A. Building B. Wing	02/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mineola Heights Healthcare Centre	716 Mimosa Street Mineola, TX 75773

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of nursing progress note dated 01/10/23 at 7:05 a.m. said Resident #1 was lying in bed, hard to arose resident would open eyes briefly, but not answer questions that were asked, involuntary jerking movements noted to BUE. His blood pressure was 128/54, his pulse was 75, his temp was 97.3, pulse oximetry was 88 on CPAP, blood sugar was 389. He was sent to the emergency room . Written by LVN A. Record review of resident #1 hospital physician progress notes dated 1/11/2023 indicated Resident #1 was a [AGE] year-old male who presented to the hospital on 01/10 23 with Sepsis. (a life threatening complication of an infection) He presented to the hospital with altered mental status and hypoxia. (absence of enough oxygen in the tissues to sustain body functions.) oxygen saturation in the 80s on a CPAP (Continuous Positive Airway Pressure) and revealed his creatinine was 1.5 (normal level 0.74-1.35 high level indicated kidney failure.)the potassium was 6.8. (normal lever 3.6 to 5.2- potassium levels higher than 6.0 can be dangerous and required immediate treatment) He was encephalopathic (altered brain function) but arousable and able to maintain airway. The notes indicated the resident had acute respiratory failure with hypoxia secondary to volume overload status. chronic kidney disease stage 3 now with worsening renal function with a plan for dialysis. Resident #1 had acute metabolic encephalopathy and sepsis with evidence of Leukocytosis (high white blood cell count), tachypnea (fast breathing) secondary to UTI. Record Review of a report written by the DON regarding an investigation of why Resident #1'a labs were not completed. Stated, On 01/10/23 at 6:22 a.m. the UA was finally collected by an agency nurse. On 01/10/23 at 7:45 a.m. Resident #1 was sent to the emergency room with altered mental status. On 01/10/23 at 2:00 PM the NP said her rationale for ordering the UA was Resident #1 had previously experienced jerking movements and the jerking movements were related a UTI. However, the UA had not been ordered as stat. The report indicated education was provided on UTI's and UA's which indicated when a nurse received the order for the UA. They must immediately contact the DON and attempt the same shift to obtain the urine sample. the nurse must not pass the order or the next shift hoping it will get done. Delaying care for possible infection can lead to complications such as sepsis. The plan of correction for the investigation was the DON would write the LVN A up for failure to obtain the UA order. By her own admission she did not attempt to get the sample on 01/06/23 or 01/09/23. LVN A's failure to communicate the change of condition and new order for UA immediately to the DON also delayed patient care. In the future the nurse who received the order would be responsible for obtaining the urine sample. Nurses must no longer pass the order to the next shift. The nurses should also utilize urine dipsticks per MD standard order while waiting for UA to return for quick results and contact the physician with the results. During an interview on 01/12/23 a 10:20 a.m. LVN A said she worked at the facility since 2004. She said on 01/06/23 Resident #1had some jerking motions. She said CNA C called her to his room. She said she assessed Resident #1 and his vital signs were normal. He was shaking quite a bit and unable to hold his cell phone. LVN A said she called the NP and received an ordered for a UA with culture and sensitivity. She did not attempt to collect the UA. She was off work over the weekend. She said she came back on to work on 01/09/23 and Resident #1 was fine. She did not attempt to obtain a UA on 01/09/23. On the morning of 01/10/23 she sent Resident #1 to the hospital because he was basically unresponsive and his O2 stat was low. She called the NP and family. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In-servicing was initiated on 2/3/23 and will be completed by 2/4/23. Agency staff, new nurses and nurses on leave that work in the facility will have in-servicing completed prior to working the floor. Involvement of Medical Director The Medical Director, Dr. [NAME] was notified about the immediate Jeopardy on 2/3/23. Involvement of QA QAPI will review and approve Plan of Removal on 2/4/23 Who is responsible for implementation of process? Administrator and DON (Director of Nursing).] On 02/04/23 the investigator confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Record review of the facility employee roster indicated they have 5 full time LVNs, one part time LVN and two weekend RNs and the ADON who is an LVN. They have 9 nurses total. They had 7 CNAs. During an observation and interview on 02/04/23 at 3: 39 p.m. DON said she had a binder with a list of Agency staff, their discipline and when they received the training. She said she would monitor what agency staff had been trained and prior to each agency staff beginning work they would receive training if they were not in the book. Observation of the book showed the training a list of staff. There was a list of 5 agency LVNs and two agency CNAs indicating they had been trained on labs, physician notification, identification of change in condition and physician notification. During interviews on 02/04/23 between 3:30p.m. and 5:15 p.m. three CNAs said they were educated on the Stop and Watch tool (a form used by aides to identify changes in a resident such as different symptoms, change in need for assistance, eating less, agitated, more confused or change in skin color.) to help identify early signs of condition change to the charge nurse. They said they are to fill out the form and give it to the nurse, so they have verification they told the nurse of the change in condition. They were told they could make a copy of the form and place it under department heads doors if they felt their concerns were not addressed. During interviews on 02/04/23 between 3:3 0p.m. and 5:15 p.m. were conducted with 3 facility LVNs and 1 RN and 2 agency LVNs that indicated they were knowledgeable on following physician orders, identification of resident change in condition. The nurses said they would follow guidelines for monitoring. They would monitor residents with possible UTIs for any symptoms. If a resident refused treatment, they would educate the resident on possible consequences and let the physician know of the resident status. The nurses were able to demonstrate through interviews their understanding of those policies, procedures, and in services. (continued on next page)

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F 0770 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record Review of a Resident record identified as needing a UA was reviewed and the facility put measures in place, such as notifying the physician, getting a timely UA. Detailed documentation of the resident condition was noted in the record to include the INTERACT assessment tool(an assessment form that is used to help nursing staff evaluate the resident for change in condition). The physician was notified of the lab results and the resident place on an antibiotic. With additional physician orders. During exit on 02/04/23 at 5:42 p.m. the Administrator, DON, and ADON were informed the IJ was removed; however, the facility remained out of compliance at level of actual harm with a scope of isolated due to the facility's need to complete in-service training and evaluate the effectiveness of the corrective systems that were put in place.