STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105394	A. Building B. Wing	03/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Palms	2600 Highlands Blvd N Palm Harbor, FL 34684

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46498 Based on observation, record review and interview the facility failed to provide accommodation for getting out of bed for one (Resident # 1) of nine sample residents. Findings included: On 03/09/2023 at 11:00 a.m., Resident #1 was observed lying in bed with a sheet covering him. Resident #1 call light was observed within his reach, and he appeared not in distress. Review of Resident #1 admission record showed that he was admitted to the facility on [DATE], with a diagnoses that include but not limited to Unspecified Atrial Fibrillation, Unspecified, Morbid (Severe) Obesity with Alveolar Hypoventilation, Adjustment Disorder with Anxiety and Major Depressive Disorder, Recurrent, Moderate. Review of Resident # 1 the Annual Minimum Data Set, dated dated dated [DATE], Cognitive Patterns, titled, Brief Interview for Mental Status showed a score 15 indicating cognitively intact. On 03/09/2023 at 11:00 a.m., an interview was conducted with Resident # 1. Resident #1 said his wheelchair broke down in January and he has been waiting on a replacement wheelchair for about a month. Resident #1 said he expressed his concerns to the administrator, but that she did not react until he started accusing them of neglecting him because they had not addressed his concerns. Resident # 1 said the administrator told him that the company they purchased his wheelchair from refused to return his chair because he keeps breaking the chair. Resident # 1 said the administrator told him to go online and look for a chair so they can help him, so he said that he provided the administrator with information about two companies online regarding a wheelchair. Resident #1 expressed a desire to get out of bed, go outside, and interact with other residents. Resident # 1 said that because he used to lead the resident council, he really missed interacting with other residents. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/09/2023 at 2:45 p.m. an interview was conducted with the Social Service Director, SSD. The SSD said Resident # 1 lost his wheelchair on January 31, 2022 because it was broken and the company (company name) refused to bring the wheelchair back to the facility. The SSD said they were paying $1500 a month for Resident #1 wheelchair but the chair kept having to be repaired due to the Resident #1's weight. The representative from (company name) said that the chair was not appropriate for the resident due to his weight and that the did not have another chair to accommodate Resident # 1. The SSD said the facility was able to find the resident a wheelchair in Maryland that should be coming today that would be appropriate and safe for the Resident #1. The SSD said they tried to assess Resident # 1 for a standard wheelchair, but the resident was not able to fit in the chair. The SSD said in addition to Resident # 1's weight he has also lost upper body strength, so it would have been very difficult and unsafe for him to sit up in a standard wheelchair. The SSD said he was not able to find any documentation pertaining to the assessment that was completed on Resident # 1 for a standard wheelchair, or any documentation related to any other intervention they had put in place to assist Resident # 1 to get out of bed. On 03/06/2023 at 3:00 p.m., an interview was conducted with the Nursing Home Administrator, NHA. The NHA said Resident # 1's chair was going out once a month for repairs. The NHA said that the facility had a hard time finding a chair for Resident # 1 but was able to find a bariatric chair that should be coming in today. Resident # 1's wheelchair was owned by a company called (company name), and they were responsible for repairing his wheelchair. The (company name) representative called the NHA on 02/03/2023 to tell her that they were not able to return Resident # 1 wheelchair because the wheelchair was not appropriate for him. The NHA said on 02 /14/2023 she met with Resident # 1 because he reported that he wanted to be able to get out the bed. The NHA said that she told Resident # 1 that they were working on finding him another chair, but it won't happen immediately and there may not be any wheelchair options available. The NHA said Resident #1 provided her with names of two companies he found online. The NHA said she did not have a plan in place to get Resident # 1 out of bed because she was working on trying to find him an appropriate wheelchair, but she did refer Resident # 1 to therapy. Review of facility policy Resident Rights, The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. Policy Explanation and Compliance Guidelines: planning and implementing care: Respect and dignity. c. The right to reside and receive services in the facility with reasonable accommodations of resident needs and preferences, except when to do so would endanger the health or safety of the resident needs and preferences, except when to do so would endanger the health or safety of the resident or other residents.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and policy review facility did not ensure confidentiality of medical information for one resident (#11) out of 13 residents sampled. Findings included: On 3/9/23 at 9:10 a.m. Resident #11 was observed sitting in his wheelchair in the hallway. Emergency Medical Services (EMS) and the police were also present and giving the resident attention. The Nursing Home Administrator (NHA) said the resident had become physically aggressive and the police officer was able to calm him down. She stated he was going to be taken to the hospital for evaluation and possible [NAME] Act. A review of admission records showed Resident #11 was admitted on [DATE] with diagnoses including blindness in one eye, mood disorder, generalized anxiety disorder, and major depressive disorder. A review of medical records showed a Care Plan in place for Mood Disorder and behavior problems including yelling/swearing, cursing at staff, and verbally aggressive statements. On 3/9/23 at 2:23 p.m. the NHA, Social Services Director (SSD), Director of Rehabilitation (DOR), a nurse practitioner, and a police officer were observed in the front lobby. The group were discussing Resident #11's personal health information. The discussion included the resident's first name, the resident refusing medication, his behaviors, possible [NAME] Act, and his mental health. Three facility residents as well as the receptionist were sitting within six feet of the group listening to the conversation. The topics being discussed included very personal information about Resident #11. Throughout the afternoon, Resident #11 was overheard being discussed by multiple residents in the halls. One resident was overhear say Resident #11 was [NAME] Acted. On 3/9/23 at 3:00 p.m. an interview was conducted with the DOR. He stated it is not normal to have a conversation about residents in the hallway. He said he thought it just got overwhelming with the police here and he confirmed Resident #11 was being discussed in the hallway. The DOR said he was not participating in the conversation; he was just listening to what was being said about the resident. On 3/9/23 at 3:17 p.m. an interview was conducted with the NHA. She said the police officer was not happy he was called to the facility again and pulled her, the SSD, and the Nurse Practitioner aside for a conversation. She said she had not noticed other residents sitting in the area. The NHA confirmed they were discussing Resident #11's personal medical issues and the conversation should not have occurred in the lobby. On 2/9/23 at 3:36 p.m. an interview was conducted with the SDD. He stated, you are right we shouldn't have been having the conversation in the hall. He said they should have gone to a private space because of HIPAA [Health Insurance Portability and Accountability Act.] (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled HIPAA Organizational Requirements, dated 2022, was reviewed. The policy stated the following: Policy, It is the facility's policy to comply with the organizational, policy/procedural, and documentation requirements of HIPAA. US Dept of Health and Human Services Summary of the HIPAA Privacy Rule The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public, Law 104-191, was enacted on August 21, 1996. General Principle for Uses and Disclosures, Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing. https://www.hhs.gov/sites/default/files/privacysummary.pdf

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 46234 Based on record review, interviews, hospital record review, facility documentation and policy review the facility failed to ensure one (Resident #2) of three residents reviewed for diabetic management was free from neglect regarding neglecting to provide insulin to a Resident admitted to the facility with a diagnosis of insulin dependent Type II Diabetes. Resident #2 had been using an insulin pump for just under a year and their blood glucose levels were controlled with the insulin pump. Prior to the insulin pump Resident #2 was on daily insulin injections. After admission to the facility, Resident #2 was not provided insulin and showed signs of hyperglycemia (high blood glucose levels) including lethargy, excessive thirst and coma. On [DATE] Resident #2 was found unresponsive and sent to the hospital where her blood glucose was measured to be above 500 (normal , d+[DATE]); she required hospitalization and intensive care treatment. Additionally, based on observations, interviews, and record review, the facility failed to ensure pain was managed effectively for three residents (#3, #8, and #13) out of three that were reviewed for pain. Resident #3 was admitted to the facility from the hospital on [DATE] after being diagnosed with gas gangrene and osteomyelitis of the left ankle and foot. At 6:10 p.m. on [DATE] the resident's pain medication had not been delivered to the facility. On [DATE] at 12:06 a.m. a nurse obtained access to the automated medication dispensing machine to provide Resident #3 with pain medication. Documentation showed the medication was ineffective and the resident screamed and yelled out. Over a six-day period the resident's PRN (as needed) pain medication, Hydrocodone-Acetaminophen, was documented as being ineffective four different times and nine times no pain level or re-evaluation of effectiveness was documented at all. There were no documented attempts to inform the resident's provider about the ineffective pain medication. Multiple staff members interviewed said over the six-day period Resident #3 was in the facility, they overheard her crying out due to her pain. Resident #3 took the last dose of her PRN pain medication, Hydrocodone-Acetaminophen on [DATE] at 5:46 p.m. The resident had a reported pain level of 6 out of 10 on [DATE] at 1:33 a.m. There was no documentation showing a provider or the pharmacy was called to reorder medication or access the automated medication dispensing machine for Resident #3. Interviews with staff showed the resident was in pain on the morning of [DATE] prior to going to a follow-up doctor's appointment with her Cardiologist. The resident was not given pain medication and screamed in pain on the way to the appointment. Upon arriving at the Cardiologist office, the office staff called 911 due to Resident #3 screaming in pain from the moment of her arrival. Residents #8 was showing signs of pain on interview, stated she frequently had to wait to get pain medication and said, I just want to die not in pain. Resident #13 stated she had to wait four hours for her PRN pain medication on [DATE], said it was typical to wait hours after requesting pain medication and reported staff disbelief of her reports of pain. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	These failures created a situation that resulted in serious harm to Resident #2 and #3, and the likelihood of serious harm or injury to Residents #8, and #13 and resulted in the determination of Immediate Jeopardy beginning on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to a D. Findings included: 1. A review of Resident #2's medical record showed an admitted [DATE] with diagnoses that included Type II Diabetes with hyperglycemia, Type II Diabetes with Diabetic Neuropathy and Wedge Compression fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing (primary). A review of Resident #2's physician orders related to diabetic management revealed: [DATE] Trulicity Subcutaneous Solution Pen- injector 0.75 MG[milligram]/0.5 ML[milliliter] (Dulaglutide) Inject 1.5 mg subcutaneously one time a day every Thursday for Diabetes Mellitus and remove per schedule. [DATE] Metformin HCl Oral Tablet 1000 MG give 1 tablet by mouth one time a day for Diabetes Mellitus Type II. [DATE] Steglatro 15 MG Tablet give 1 tablet by mouth one time a day for diabetes mellitus. [DATE] Farxiga Oral Tablet 10 MG (Dapagliflozin) give 1 tablet by mouth one time a day for heart failure. [DATE] Accuchecks (blood glucose checks) AC/HS (before meals and at bedtime) for Diabetes Mellitus II if below 70 or above 400 please call (Medical Director/Admitting Physician(MDir/AP) for Resident #2]). Review of the medication Trulicity on www.Trulicity.com showed, Trulicity is for adults with type 2 diabetes to improve blood sugars (glucose). Trulicity is also used in adults with type 2 diabetes to reduce the risk of a major cardiovascular events (problems having to do with heart and blood vessels) such as death, heart attack, or stroke in people who have heart disease. Trulicity is not an insulin. Trulicity acts like the natural human hormone, GLP-1, helping the body do what it's supposed to do naturally, stimulating the body's (pancreas) natural production of insulin. Consider insulin as the first injectable when: Symptoms of hyperglycemia are present and when A1C (>10%) or blood glucose levels (>=300 mg/dL) are very high. Review of the medication Steglatro on www.Steglatro.com showed, Steglatro is a prescription pill used in adults with type 2 diabetes to improve blood sugar (glucose) control along with diet and exercise. It may increase the risk of diabetic ketoacidosis in these people. STEGLATRO may cause serious side effects including Ketoacidosis (increased ketones in the blood or urine) has happened in people with type 1 or type 2 diabetes during treatment and also in people with diabetes who were sick or who had surgery during treatment with STEGLATRO. Ketoacidosis is a serious condition, which may need to be treated in a hospital and may lead to death. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medication Farxiga on www.Farxiga.com showed, Farxiga is a prescription medicine used to: -improve blood sugar control along with diet and exercise in adults with type 2 diabetes -reduce the risk of hospitalization for heart failure in adults with type 2 diabetes and known cardiovascular disease or multiple cardiovascular risk factors -reduce the risk of cardiovascular death and hospitalization for heart failure in adults with symptomatic heart failure. Review of Resident #2's record showed no physician orders for insulin. The resident's care plan did not show a focus, goal or interventions related to diabetes management. Review of Resident #2's medical record revealed a document titled, Internal Medicine Note dated [DATE]. The Internal Medicine Note showed Resident #2's medical history that included Type II diabetes mellitus treated with insulin. The list of medications on the Internal Medicine Note showed: Farxiga 10mg oral tablet Freestyle test strips Gabapentin 300 mg Humulin ,d+[DATE] Kwik Pen Macrobid 100mg Metformin 1000mg oral tablet Tramadol 50mg oral tablet Trulicity Pen 0.75mg/0.5ml Tylenol 325mg oral tablet The admission paperwork located in Resident #2's medical record showed a Medical Certification for Medicaid Long-Term Care Services for Patient Transfer Form 3008 with section L Time sensitive condition specific information: Insulin- [DATE] AM insulin signed by the DON. A review of the Medication Administration Review (MAR) showed Resident #2 never received a dose of the ordered Trulicity or Farxiga medications. Insulin was never ordered. Resident #2 received oral medications of Metformin and Steglatro as ordered. Review of the Accuchecks showed Resident #2's blood sugars for the following days: [DATE]: 6:30 AM- 263 (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11:30 AM- 200 4:30 PM- 374 9:00 PM- 220 [DATE]: 6:30 AM- 285 11:30 AM- N/A 4:30 PM- 272 9:00 PM- 341 [DATE]: 6:30 AM- 291 11:30 AM- 389 4:30 PM- 299 9:00 PM-236 [DATE]: 6:30 AM- 197 11:30 AM- 150 4:30 PM- 378 9:00 PM- 350 [DATE]: 6:30 AM- 302 11:30 AM- 398 4:30 PM- 312 9:00 PM- 356 [DATE]: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6:30 AM- 301 11:30 AM- 374 4:30 PM- 241 9:00 PM- 352 [DATE]: 6:30 AM- 289 11:30 AM- 332 4:30 PM- 319 9:00 PM- 358 [DATE]: 6:30 AM- 384 Review of Resident #2's medical record showed the following progress notes: A General Note dated [DATE] at 7:48 a.m., stated Resident found unresponsive even with sternum rub, vital signs. Doctor [Partnering doctor to the resident's MD] at bedside and gave orders to send resident to ER. Son at bedside and made aware of resident's condition. An Administration Note dated [DATE] at 8:06 a.m., showed that Resident #2 was unresponsive. A Narrative Note dated [DATE] at 8:42 a.m. showed, Resident presents with altered status and change of condition. Resident unresponsive, shallow respirations. Family at bedside. MD assessed the resident and ordered to send to the emergency room . EMS called to transfer resident to hospital. Resident received a dose of Rocephin Intramuscular [IM] Son will meet resident in hospital. (Note - Rocephine is an antibiotic.) (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:00 a.m., the Director of Nursing (DON) stated that Resident # 2 was not on insulin when she came into the facility. When asked about the Medical Certification for Medicaid Long-Term Care Services for Patient Transfer Form 3008 that showed Resident #2 received insulin on the morning of [DATE] the DON replied, Oh Yes, that was the Trulicity. When the DON was questioned about Trulicity being a GLP-1 drug and not insulin the DON replied that she would have to go review the medical record again. DON stated that she was the person who completed Resident# 2's Medical Certification for Medicaid Long-Term Care Services for Patient Transfer Form 3008 on admission and it was completed at bedside with the doctor after meeting with the family to discuss medications and the care plan. The DON stated she reviewed the medications listed on the Internal Medicine Note dated [DATE] with the doctor and family and everyone agreed on the physician orders and all orders were put in point click care (PCC, electronic medical record) during the meeting. The DON was asked if diabetic management would be a focus put on a Residents baseline and comprehensive care plan and she stated, yes. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:27 a.m, a family member of Resident #2 stated Resident #2 had been receiving three insulin shots a day then was switched to the (Brand Name 30) Insulin Pump, while at home. They said Resident #2 had a continuous glucose monitor in place. The family member said upon admission the Director of Nursing (DON) informed them insulin pumps and continuous glucose monitors were not used in the facility. The family was concerned about Resident #2's blood sugar and insulin without using the monitor and insulin pump. The family member said they had an extensive three-hour long conversation with the DON and Medical Director (MD) about their concerns and were assured Resident #2 would have her blood sugar checked three times a day and would be given insulin accordingly. The family member said the DON promised it would be handled. The family member said the DON swore and promised us and looked us in the eye and she promised this was going to be taken care of. The family member also stated the MD said, he was on top of it. The family member said they didn't know how the process worked for admission, so they brought all of Resident #2's medication, pump supplies and insulin in a bag with them to the facility. They said the DON told them they don't use any of that and they could throw it out. They said they were told the facility had their own plan. The family member said the resident's insulin pump was still attached to her for several days after admission, even though the cartridge was empty. The family member said, after a few days in the facility Resident #2 was moved to a different room; the Family Member was speaking with Resident #2's nurse and the nurse said, oh she is diabetic? The family was shocked that the nurse was surprised to learn Resident #2 was a diabetic. The Family Member said the clinical staff would always pass things off on someone else and say, they don't have it in their notes, I got called away or they were just coming on shift. The family started getting concerned because the resident was getting dopey. The family member said they mentioned it to the nurse and the nurse said Resident #2 was just grumpy that day. The family member said the resident was very thirsty all the time and it would take hours to get her water, so they went out and purchased drinks to keep in her room. They said at one point they went to visit Resident #2 and she had not eaten in two days. They notified the nurse and the nurse said, she has sepsis. The family member said when they went to visit on [DATE] the resident couldn't speak or keep her head up. They spoke to the nurse, and she said the resident had an infection, had just received antibiotics and would be doing better the next day. On [DATE] the family said the resident was still unresponsive and they spoke with the nurse again. The nurse again told them she was septic she was going to be out of it. The family said Resident #2's roommate told them the resident had been asleep the entire time they were gone. They spoke with the nurse who then had another partnering doctor from the Medical Director's practice stop by the room. The family said the doctor did not examine her; he asked about the vitals, which the nurse told him, and the doctor said she needs oxygen then left the room. The family said it took the nurse approximately 10 minutes to get oxygen on the resident. The family said they personally rubbed the resident's sternal notch, and she still wouldn't respond; they told the nurse she had to call 911. The family said they had no idea Resident #2 was not receiving insulin until they arrived at the emergency room and were told there was no record of the resident receiving insulin. The family member stated Resident #2 never woke up from the coma and she died in the Intensive Care Unit (ICU) of cardiac arrest with blood sugars of 590 and sepsis. The family member said afterwards he spoke with the NHA who said, its agency people and the Medical Director said, agency people are the cancer of this place. The family member said after Resident #2 passed away in the hospital, they came to pick up Resident #2's belongings and they spoke with the DON. They said the DON wouldn't give them a reason why Resident #2 was not given insulin. The family member said when Resident #2 was admitted to the facility she was able to talk, move around, and walk; after being in the facility she deteriorated and went into a coma. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:40 a.m. an interview was conducted with Staff C, Admissions Director (AD). She stated Resident #2 was originally going to be admitted over the weekend but since the resident had the glucose monitor and insulin pump, she spoke with the DON and they decided to defer admission until Monday when the DON and Medical Director would be there to go over medications. Staff C AD said Monday the family came in and met with the DON and Medical Director as planned. Staff C AD said when the resident came in she was able to self-propel in her wheelchair and was able to make her needs known. She said the resident was alert with some confusion but was alert enough to crack jokes. During an interview on [DATE] at 11:54 a.m., the DON said when Resident #2 came into the facility on e family member went with the resident and Medical Director to the room and another family member stayed with the DON in her office to review the resident's medical history. The DON said next the two family members, Medical Director and herself sat down and went over the resident's history and physical, medications, how medications best helped her, and what the resident needed. She said they discussed gabapentin, Tramadol, cranberry, and Colace, but she can't remember every single med [medication] we talked about. She said they also spoke about the resident's Urinary Tract Infection (UTI) fractures, and the way she took her medication. The DON said while they were meeting the Medical Director gave orders for the medications and blood glucose checks and she put the orders in the computer. She said she told the family they could not utilize the continuous glucose monitor in the resident's arm and the family would have to discontinue that because the facility did not put it in. The DON said after the resident's death, the family chose to blame her. When asked about the resident having an insulin pump, she said, not that they made me aware of and not that was accessed. She said the resident's skin was beautiful and didn't have any open areas or anything. She said the family did not make anyone aware at any time during their conversation about an insulin pump. The DON was asked again about the Medical Certification for Medicaid Long-Term care Services and Patient Transfer Form 3008 and was asked why it showed insulin was scheduled to be given. She said the form listed insulin because the family had given the resident ,d+[DATE] that morning. The DON said the family said they were not doctors and they were turning to the medical director to prescribe the medications. She said they discussed insulin, but she didn't know if the family didn't want to continue to stick her with shots. She said they wanted to make sure Metformin was doing its job. She said the order for blood glucose checks had the parameter in place to call the doctor for blood sugars less than 70 or greater than 400. She added normal blood glucose is from ,d+[DATE]; they don't like to see blood glucose over 250, but when it is this to this you follow that. The DON also added the resident was on Metformin. She said she remembered talking about Metformin and accuchecks but not specifically about insulin in the meeting with the family. She stated they wanted to see if the Metformin was working on the resident and if she needed insulin. The DON reviewed Resident #11's (another resident) blood glucose levels throughout her stay. She said when the resident's blood glucose levels become unstable, the nurse asked the nurse practitioner about adding a sliding scale (varying the dose of insulin based on blood glucose level). During an interview on [DATE] at 12:20 p.m., Staff E Nurse Practitioner (NP) who saw Resident #2 on [DATE] stated that I was not aware she was ever on insulin. If I knew that I would have put her back on insulin. The NP stated, I was never told by staff that she was insulin dependent prior to entering the facility. The NP said she noticed a change in condition in Resident #2 with more confusion on [DATE] so she immediately ordered Rocephin (an antibiotic), but the NP stated Resident #2 probably should have gone out to the hospital when the change of condition was noticed. NP stated that the professional standard of care was usually not to take Residents off of insulin once blood sugar was controlled with insulin. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 12:44 p.m., the Medical Director/Admitting Physician (MDir/AP) for Resident #2 stated that he does not usually take people off insulin once being dependent on insulin. The MDir/AP stated, I can tell you I am not against insulin pumps. The MDir/AP stated both family members were in the facility and discussed Resident #2's medications. During an additional phone interview on [DATE] at 3:00 p.m., the Medical Director/Admitting Physician (MDir/AP) reviewed Resident #2's initial note. The MDir/AP stated he had written that Duloxetine was added for depression and Gabapentin was going to be tapered off. The MDir/AP had not mentioned anything about insulin in his physician note. The MDir/AP stated he remembered speaking with Resident #2's sons and advised the Survey Team to speak with the family as he was sure they would remember better what was discussed. The MDir/AP stated that Resident #2 was not obese. The MDir/AP stated the facility did not manage insulin pumps because insulin pumps are surgically implanted under the skin and only an Endocrinologist can refill it each time. Review of the MDir/AP's initial note dated [DATE] showed This is a medically complex [AGE] year-old cachectic white female with a long-standing history of numerous comorbidities include a known history of chronic constipation, osteoporosis, with compression fractures, COPD, diabetes mellitus type 2 with neuropathy, recurrent UTIs, recurrent falls, history of small bowel obstruction, hypertension, mild dementia and osteoarthritis. She normally resides at home with her son. The initial note revealed a section case reviewed that showed, I had a lengthy discussion about the patient's care with [2 family members]. We will start duloxetine 30 milligrams (mg) daily for depression and chronic pain. Taper off Gabapentin down to 300 mg for seven days then discontinue altogether. There was no mention of insulin therapy revealed in the MD's initial note. During an interview on [DATE] at 1:30 p.m., Resident #2's primary care provider (PCP), prior to admission confirmed it was her Internal Medicine Note dated [DATE] the family brought to the facility with them upon admission. The Internal Medicine Note listed the following medication: Cranberry docusate sodium 100mg, 2 capsules twice a day, Farxiga 10 mg oral tablet, Freestyle test strips, ,Humulin ,d+[DATE] Kwik pen 70 units-30 units/ml subcutaneous suspension sliding scale, Gabapentin 300 mg oral capsules 1 time a day, Macrobid 100mg oral capsule twice a day, Metformin 1000mg oral tablet 1 time a day, Tramadol 50mg oral tablet, Trulicity Pen 0.75mg/0.5ml subcutaneous solution and Tylenol 325mg oral tablet, 650mg as needed. The PCP stated she managed the resident's medical conditions except for her diabetes; that was done by her Endocrinologist. The provider said she reviewed pharmacy records, and they indicated the resident was on a sliding scale, had an insulin pump, was on Trulicity, and Farxiga for diabetes as well. The provider added Humalog 100U was used in the insulin pump. Review of Resident #2's Insulin Delivery System, she was using prior to admission, at www.go-vgo.com revealed the user's manual for the (Brand name) series insulin pump. The manufacturer's user manual steps to applying and using the (Brand name) system included: A. (Brand name) can be worn any place where insulin can be injected or infused. Insulin is injected or infused into the subcutaneous tissue. You may apply (Brand name): - On the abdomen. The abdomen has ample flat surface area and is an accessible and comfortable location. Insulin absorption is fast, predictable, and less affected by exercise when administered through the abdomen. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Diabetic Ketoacidosis (DKA) on www.mayoclinic.org showed, Diabetic ketoacidosis is a serious complication of diabetes. The condition develops when the body can't produce enough insulin. Insulin plays a key role in helping sugar enter cells in the body. Without enough insulin, the body begins to break down fat as fuel. This causes a buildup of acids in the bloodstream called ketones. If it's left untreated, the buildup can lead to diabetic ketoacidosis. Symptoms of DKA include Being very thirsty, being weak or tired, being short of breath and being confused. Seek emergency care if your blood sugar level is higher than 300 milligrams per deciliter, or 16.7 millimoles per liter for more than one test. Remember, untreated diabetic ketoacidosis can lead to death. During an interview on [DATE] at 8:13 a.m., Resident #2's Nurse from her established endocrinology office called and stated Resident #2 was last seen on [DATE]. She said the resident had a (brand name) insulin pump with Humalog (insulin). Resident #2 was also on Trulicity once weekly, Farxiga once a day, and Metformin twice per day. She said the resident had the pump for just under one year. She said Resident #2 was previously on ,d+[DATE] (insulin) but that was stopped on ,d+[DATE]. During a phone interview on [DATE] at 8:31 a.m., Resident #2's established Endocrinologist stated Resident #2 was on the (Brand name 30) pump then in December was decreased to a (Brand name 20). Endocrinologist said Resident #2 was not on a sliding scale. Endocrinologist said when she began seeing Resident #2 on [DATE] Resident #2 was on ,d+[DATE] insulin. Endocrinology said Resident #2 did not have controlled blood glucose levels, so she was put on the (brand name) insulin pump due to her dementia and to gain better control. Endocrinologist stated on the (brand name 30) the resident was having some low blood glucose readings at night, so they decided to decrease to (Brand name 20) in [DATE]. Endocrinologist said she told the son the only time the pump should be off was when they were decreasing from 30 to 20 but other than that the pump should have remained running 24 hours. Endocrinologist stated the facility never reached out to her to discuss what Resident #2 was taking for Diabetes. People don't reach out, they should have called Endocrinologist said some Type 2 Diabetics do not require insulin, but Resident #2's blood sugar was controlled with insulin, it wouldn't have made sense to take her off insulin. Endocrinologist said she knows some facilities don't use insulin pumps, but it would have been prudent to figure out what insulin to put her on. Endocrinologist stated Resident #2 was not always compliant, but her dementia was not to the point she would refuse, even though she didn't like fingerstick. Endocrinologist stated, If you take a pump off you have to start insulin. During an interview on [DATE] at 10:25 a.m., Resident #2's family member stated the family had three bags of Resident #2's current medications, pump equipment and insulin present in the facility when Resident #2 was admitted . The family member stated that both the DON and MD would not even look into Resident #2's medication bags. The family member stated the DON and MD kept saying because the medications were from the outside, the facility couldn't use the medications so advised the family to take the medications all back home. The family member stated that all of Resident #2's current medications were in the bags brought with Resident #2 on admission. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:37 a.m., a second Family Member stated that the family were told by the facility that insulin and everything Resident #2 would need was available at the facility. The second family member stated that the facility talked about pain medications, medications for a UTI and the Medical Director (MD) and the Director of Nursing (DON), basically just put us at ease. The second family member recalled the MD and DON kept saying we have everything in house. We have the facilities, we have the doctors, we have the medical staff. The second family member stated the MD and DON wouldn't look at anything in the bag of medications because they said they couldn't use it because it was from outside. The MD and DON told the family to just take it home. The MD and DON were adamant about doing things their own way. The second family member stated the family and MD and DON talked about putting Resident #2 on insulin. The MD and DON said the facility had everything Resident #2 needed. The second family member stated the MD and DON didn't go into detail about the exact plan to provide Resident #2 insulin but stated the facility knew Resident #2 was insulin dependent. The second family member stated that insulin was Absolutely 100% the main thing. Prior to admitting Resident #2 in the facility, the family made sure the MD and DON knew Resident #2 was insulin dependent and that was the reason for the delay in admission to a Monday. The second family member stated he told the MD and DON that Resident #2 was cared for by the family at home for 5 years and made sure the MD and DON knew Resident #2 needed her insulin. The second family member stated that the facility never mentioned they would take Resident #2 off insulin and stated had the family been told they would have just taken Resident #2 back home beca [TRUNCATED]

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and record review the facility failed to provide care and services according to accepted standards of clinical practice for four residents (#2, #3, #8, and #13) out of thirteen residents sampled. Based on record review, interviews, hospital record review, facility documentation and policy review the facility failed to ensure one (Resident #2) of three residents reviewed for diabetic management was free from neglect regarding neglecting to provide insulin to a Resident admitted to the facility with a diagnosis of insulin dependent Type II Diabetes. Additionally, based on observations, interviews, and record review, the facility failed to ensure pain was managed effectively for three residents (#3, #8, and #13) out of three that were reviewed for pain. These failures created a situation that resulted in the likelihood of serious injury or harm to Resident #2, #3, #8, and #13 and resulted in the determination of Immediate Jeopardy on [DATE]. The findings of Immediate Jeopardy were determined to be removed on [DATE] and the scope and severity was reduced to a D. Findings included: 1. A review of Resident #2's medical record showed an admitted [DATE] with diagnoses that included Type II Diabetes with hyperglycemia, Type II Diabetes with Diabetic Neuropathy and Wedge Compression fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing (primary). A review of Resident #2's physician orders related to diabetic management revealed: [DATE] Trulicity Subcutaneous Solution Pen- injector 0.75 MG[milligram]/0.5 ML[milliliter] (Dulaglutide) Inject 1.5 mg subcutaneously one time a day every Thursday for Diabetes Mellitus and remove per schedule. [DATE] Metformin HCl Oral Tablet 1000 MG give 1 tablet by mouth one time a day for Diabetes Mellitus Type II. [DATE] Steglatro 15 MG Tablet give 1 tablet by mouth one time a day for diabetes mellitus. [DATE] Farxiga Oral Tablet 10 MG (Dapagliflozin) give 1 tablet by mouth one time a day for heart failure. [DATE] Accuchecks (blood glucose checks) AC/HS (before meals and at bedtime) for Diabetes Mellitus II if below 70 or above 400 please call [MDir/AP - (Medical Director/Admitting Physician for Resident #2]). (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medication Trulicity on www.Trulicity.com showed, Trulicity is for adults with type 2 diabetes to improve blood sugars (glucose). Trulicity is also used in adults with type 2 diabetes to reduce the risk of a major cardiovascular events (problems having to do with heart and blood vessels) such as death, heart attack, or stroke in people who have heart disease. Trulicity is not an insulin. Trulicity acts like the natural human hormone, GLP-1, helping the body do what it's supposed to do naturally, stimulating the body's (pancreas) natural production of insulin. Consider insulin as the first injectable when: Symptoms of hyperglycemia are present and when A1C (>10%) or blood glucose levels (>=300 mg/dL) are very high. Review of the medication Steglatro on www.Steglatro.com showed, Steglatro is a prescription pill used in adults with type 2 diabetes to improve blood sugar (glucose) control along with diet and exercise. It may increase the risk of diabetic ketoacidosis in these people. STEGLATRO may cause serious side effects including Ketoacidosis (increased ketones in the blood or urine) has happened in people with type 1 or type 2 diabetes during treatment and also in people with diabetes who were sick or who had surgery during treatment with STEGLATRO. Ketoacidosis is a serious condition, which may need to be treated in a hospital and may lead to death. Review of the medication Farxiga on www.Farxiga.com showed, Farxiga is a prescription medicine used to: -improve blood sugar control along with diet and exercise in adults with type 2 diabetes -reduce the risk of hospitalization for heart failure in adults with type 2 diabetes and known cardiovascular disease or multiple cardiovascular risk factors -reduce the risk of cardiovascular death and hospitalization for heart failure in adults with symptomatic heart failure. Review of Resident #2's record showed no physician orders for insulin. The resident's care plan did not show a focus, goal or interventions related to diabetes management. Review of Resident #2's medical record revealed a document titled, Internal Medicine Note dated [DATE]. The Internal Medicine Note showed Resident #2's medical history that included Type II diabetes mellitus treated with insulin. The list of medications on the Internal Medicine Note showed: Farxiga 10mg oral tablet Freestyle test strips Gabapentin 300 mg Humulin ,d+[DATE] Kwik Pen Macrobid 100mg Metformin 1000mg oral tablet Tramadol 50mg oral tablet (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Trulicity Pen 0.75mg/0.5ml Tylenol 325mg oral tablet The admission paperwork located in Resident #2's medical record showed a Medical Certification for Medicaid Long-Term Care Services for Patient Transfer Form 3008 with section L Time sensitive condition specific information: Insulin- [DATE] AM insulin signed by the DON. A review of the Medication Administration Review (MAR) showed Resident #2 never received a dose of the ordered Trulicity or Farxiga medications. Insulin was never ordered. Resident #2 received oral medications of Metformin and Steglatro as ordered. Review of the Accuchecks showed Resident #2's blood sugars for the following days: [DATE]: 6:30 AM- 263 11:30 AM- 200 4:30 PM- 374 9:00 PM- 220 [DATE]: 6:30 AM- 285 11:30 AM- N/A 4:30 PM- 272 9:00 PM- 341 [DATE]: 6:30 AM- 291 11:30 AM- 389 4:30 PM- 299 9:00 PM-236 [DATE]: 6:30 AM- 197 11:30 AM- 150 (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4:30 PM- 378 9:00 PM- 350 [DATE]: 6:30 AM- 302 11:30 AM- 398 4:30 PM- 312 9:00 PM- 356 [DATE]: 6:30 AM- 301 11:30 AM- 374 4:30 PM- 241 9:00 PM- 352 [DATE]: 6:30 AM- 289 11:30 AM- 332 4:30 PM- 319 9:00 PM- 358 [DATE]: 6:30 AM- 384 Review of Resident #2's medical record showed the following progress notes: A General Note dated [DATE] at 7:48 a.m., stated Resident found unresponsive even with sternum rub, vital signs. Doctor [Partnering doctor to the resident's MD] at bedside and gave orders to send resident to ER. Son at bedside and made aware of resident's condition. An Administration Note dated [DATE] at 8:06 a.m., showed that Resident #2 was unresponsive. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Narrative Note dated [DATE] at 8:42 a.m. showed, Resident presents with altered status and change of condition. Resident unresponsive, shallow respirations. Family at bedside. MD assessed the resident and ordered to send to the emergency room . EMS called to transfer resident to hospital. Resident received a dose of Rocephin Intramuscular [IM] Son will meet resident in hospital. (Note - Rocephin an antibiotic.) During an interview on [DATE] at 10:00 a.m., the Director of Nursing (DON) stated that Resident # 2 was not on insulin when she came into the facility. When asked about the Medical Certification for Medicaid Long-Term Care Services for Patient Transfer Form 3008 that showed Resident #2 received insulin on the morning of [DATE] the DON replied, Oh Yes, that was the Trulicity. When the DON was questioned about Trulicity being a GLP-1 drug and not insulin the DON replied that she would have to go review the medical record again. DON stated that she was the person who completed Resident# 2's Medical Certification for Medicaid Long-Term Care Services for Patient Transfer Form 3008 on admission and it was completed at bedside with the doctor after meeting with the family to discuss medications and the care plan. The DON stated she reviewed the medications listed on the Internal Medicine Note dated [DATE] with the doctor and family and everyone agreed on the physician orders and all orders were put in point click care (PCC, electronic medical record) during the meeting. The DON was asked if diabetic management would be a focus put on a Residents baseline and comprehensive care plan and she stated, yes. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:27 a.m, a family member of Resident #2 stated Resident #2 had been receiving three insulin shots a day then was switched to the (Brand Name 30) Insulin Pump, while at home. They said Resident #2 had a continuous glucose monitor in place. The family member said upon admission the Director of Nursing (DON) informed them insulin pumps and continuous glucose monitors were not used in the facility. The family was concerned about Resident #2's blood sugar and insulin without using the monitor and insulin pump. The family member said they had an extensive three-hour long conversation with the DON and Medical Director (MD) about their concerns and were assured Resident #2 would have her blood sugar checked three times a day and would be given insulin accordingly. The family member said the DON promised it would be handled. The family member said the DON swore and promised us and looked us in the eye and she promised this was going to be taken care of. The family member stated the MD said, he was on top of it. The family member said they didn't know how the process worked for admission, so they brought all of Resident #2's medication, pump supplies and insulin in a bag with them to the facility. They said the DON told them they don't use any of that and they could throw it out. They said they were told the facility had their own plan. The family member said the resident's insulin pump was still attached to her for several days after admission, even though the cartridge was empty. The family member said, after a few days in the facility Resident #2 was moved to a different room; the Family Member was speaking with Resident #2's nurse and the nurse said, oh she is diabetic? The family was shocked that the nurse was surprised to learn Resident #2 was a diabetic. The Family Member said the clinical staff would always pass things off on someone else and say, they don't have it in their notes, I got called away or they were just coming on shift. The family started getting concerned because the resident was getting dopey. The family member said they mentioned it to the nurse and the nurse said Resident #2 was just grumpy that day. The family member said the resident was very thirsty all the time and it would take hours to get her water, so they went out and purchased drinks to keep in her room. They said at one point they went to visit Resident #2 and she had not eaten in two days. They notified the nurse and the nurse said, she has sepsis. The family member said when they went to visit on [DATE] the resident couldn't speak or keep her head up. They spoke to the nurse, and she said the resident had an infection, had just received antibiotics and would be doing better the next day. On [DATE] the family said the resident was still unresponsive and they spoke with the nurse again. The nurse again told them she was septic she was going to be out of it. The family said Resident #2's roommate told them the resident had been asleep the entire time they were gone. They spoke with the nurse who then had another partnering doctor from the Medical Director's practice stop by the room. The family said the doctor did not examine her; he asked about the vitals, which the nurse told him, and the doctor said she needs oxygen then left the room. The family said it took the nurse approximately 10 minutes to get oxygen on the resident. The family said they personally rubbed the resident's sternal notch, and she still wouldn't respond; they told the nurse she had to call 911. The family said they had no idea Resident #2 was not receiving insulin until they arrived at the emergency room and were told there was no record of the resident receiving insulin. The family member stated Resident #2 never woke up from the coma and she died in the Intensive Care Unit (ICU) of cardiac arrest with blood sugars of 590 and sepsis. The family member said afterwards he spoke with the NHA who said, its agency people and the Medical Director said, agency people are the cancer of this place. The family member said after Resident #2 passed away in the hospital, they came to pick up Resident #2's belongings and they spoke with the DON. They said the DON wouldn't give them a reason why Resident #2 was not given insulin. The family member said when Resident #2 was admitted to the facility she was able to talk, move around, and walk; after being in the facility she deteriorated and went into a coma. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 11:40 a.m. an interview was conducted with Staff C, Admissions Director (AD). She stated Resident #2 was originally going to be admitted over the weekend but since the resident had the glucose monitor and insulin pump, she spoke with the DON and they decided to defer admission until Monday when the DON and Medical Director would be there to go over medications. Staff C AD said Monday the family came in and met with the DON and Medical Director as planned. Staff C AD said when the resident came in she was able to self-propel in her wheelchair and was able to make her needs known. She said the resident was alert with some confusion but was alert enough to crack jokes. During an interview on [DATE] at 11:54 a.m., the DON said when Resident #2 came into the facility on e family member went with the resident and Medical Director to the room and another family member stayed with the DON in her office to review the resident's medical history. The DON said next the two family members, Medical Director and herself sat down and went over the resident's history and physical, medications, how medications best helped her, and what the resident needed. She said they discussed gabapentin, Tramadol, cranberry, and Colace, but she can't remember every single med [medication] we talked about. She said they spoke about the resident's Urinary Tract Infection (UTI) fractures, and the way she took her medication. The DON said while they were meeting the Medical Director gave orders for the medications and blood glucose checks and she put the orders in the computer. She said she told the family they could not utilize the continuous glucose monitor in the resident's arm and the family would have to discontinue that because the facility did not put it in. The DON said after the resident's death, the family chose to blame her. When asked about the resident having an insulin pump, she said, not that they made me aware of and not that was accessed. She said the resident's skin was beautiful and didn't have any open areas or anything. She said the family did not make anyone aware at any time during their conversation about an insulin pump. The DON was asked again about the Medical Certification for Medicaid Long-Term care Services and Patient Transfer Form 3008 and was asked why it showed insulin was scheduled to be given. She said the form listed insulin because the family had given the resident ,d+[DATE] that morning. The DON said the family said they were not doctors and they were turning to the medical director to prescribe the medications. She said they discussed insulin, but she didn't know if the family didn't want to continue to stick her with shots. She said they wanted to make sure Metformin was doing its job. She said the order for blood glucose checks had the parameter in place to call the doctor for blood sugars less than 70 or greater than 400. She added normal blood glucose is from ,d+[DATE]; they don't like to see blood glucose over 250, but when it is this to this you follow that. The DON aadded the resident was on Metformin. She said she remembered talking about Metformin and accuchecks but not specifically about insulin in the meeting with the family. She stated they wanted to see if the Metformin was working on the resident and if she needed insulin. The DON reviewed Resident #11's (another resident) blood glucose levels throughout her stay. She said when the resident's blood glucose levels become unstable, the nurse asked the nurse practitioner about adding a sliding scale (varying the dose of insulin based on blood glucose level). During an interview on [DATE] at 12:20 p.m., Staff E Nurse Practitioner (NP) who saw Resident #2 on [DATE] stated that I was not aware she was ever on insulin. If I knew that I would have put her back on insulin. The NP stated, I was never told by staff that she was insulin dependent prior to entering the facility. The NP said she noticed a change in condition in Resident #2 with more confusion on [DATE] so she immediately ordered Rocephin (an antibiotic), but the NP stated Resident #2 probably should have gone out to the hospital when the change of condition was noticed. NP stated that the professional standard of care was usually not to take Residents off of insulin once blood sugar was controlled with insulin. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 12:44 p.m., the Medical Director/Admitting Physician (MDir/AP) for Resident #2 stated that he does not usually take people off insulin once being dependent on insulin. The MDir/AP stated, I can tell you I am not against insulin pumps. The MDir/AP stated both family members were in the facility and discussed Resident #2's medications. During an additional phone interview on [DATE] at 3:00 p.m., the Medical Director/Admitting Physician (MDir/AP) reviewed Resident #2's initial note. The MDir/AP stated he had written that Duloxetine was added for depression and Gabapentin was going to be tapered off. The MDir/AP had not mentioned anything about insulin in his physician note. The MDir/AP stated that Resident #2 was not obese. The MD stated the facility did not manage insulin pumps because insulin pumps are surgically implanted under the skin and only an Endocrinologist can refill it each time. Review of the MDir/AP's initial note dated [DATE] showed This is a medically complex [AGE] year-old cachectic white female with a long-standing history of numerous comorbidities include a known history of chronic constipation, osteoporosis, with compression fractures, COPD, diabetes mellitus type 2 with neuropathy, recurrent UTIs, recurrent falls, history of small bowel obstruction, hypertension, mild dementia and osteoarthritis. She normally resides at home with her son. The initial note revealed a section case reviewed that showed, I had a lengthy discussion about the patient's care with [2 family members]. We will start duloxetine 30 milligrams (mg) daily for depression and chronic pain. Taper off Gabapentin down to 300 mg for seven days then discontinue altogether. There was no mention of insulin therapy revealed in the MD's initial note. During an interview on [DATE] at 1:30 p.m., Resident #2's primary care provider (PCP), prior to admission confirmed it was her Internal Medicine Note dated [DATE] the family brought to the facility with them upon admission. The Internal Medicine Note listed the following medication: Cranberry docusate sodium 100mg, 2 capsules twice a day, Farxiga 10 mg oral tablet, Freestyle test strips, ,Humulin ,d+[DATE] Kwik pen 70 units-30 units/ml subcutaneous suspension sliding scale, Gabapentin 300 mg oral capsules 1 time a day, Macrobid 100mg oral capsule twice a day, Metformin 1000mg oral tablet 1 time a day, Tramadol 50mg oral tablet, Trulicity Pen 0.75mg/0.5ml subcutaneous solution and Tylenol 325mg oral tablet, 650mg as needed. The PCP stated she managed the resident's medical conditions except for her diabetes; that was done by her Endocrinologist. The provider said she reviewed pharmacy records, and they indicated the resident was on a sliding scale, had an insulin pump, was on Trulicity, and Farxiga for diabetes as well. The provider added Humalog 100U was used in the insulin pump. During an interview on [DATE] at 4:20 p.m., Staff A Certified Nursing Assistant (CNA) stated that she remembered she gave Resident #2 a shower and Resident #2 did have an insulin pump access in her belly at shower time. Staff A CNA stated she noticed Resident #2 was declining and had a change of condition and was getting weaker on [DATE]. Further review of Resident #2's medical record revealed a Narrative Note dated [DATE], This nurse reports to Staff E NP that resident fasting blood sugars have been in 300 range consistently, Staff E NP gave new order to increase Trulicity. This nurse questioned Staff E NP about possibly putting resident on fast acting insulin. Staff E NP declines and stated Trulicity should cover resident. Narrative note was signed by Staff B Registered Nurse (RN). (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 4:35 p.m., Staff B Registered Nurse (RN) discussed the Narrative note dated [DATE]. Staff B RN stated she remembered the conversation and asked Staff E NP about putting Resident #2 on some fast-acting insulin. Staff B RN stated, I explained to the NP that I didn't know what insulin was in the pump but did inform NP Resident #2 was on insulin prior to being admitted to the facility. Staff B RN stated that she remembered the NP informed her that she was going to talk to the family about the specific insulin that was used in the pump and then Staff E NP proceeded into Resident #2's room to talk with the family about insulin. A review of the local hospital ER notes showed Resident #2 was admitted on [DATE] and The patient presents with Altered Mental Status (AMS) 2 days? Arrival by EMS from the local skilled nursing facility for evaluation of altered mental status hyperglycemia. Patient is a recent admit to the skilled nursing facility history of dementia previously living at home history of type 2 diabetes on Metformin Trulicity and Steglatro unable to obtain history from patient. Also receiving IV antibiotics for UTI. Full code per nursing home sheets reviewed by me. Additional history from son at bedside yesterday awake talking jibberish but not talking above a whisper, dec loc (decreased loss of consciousness) later that day. Son found her this morning unresponsive. Per son supposed to be on insulin 3 x a day previously on an insulin pump with continuous blood glucose monitor (CBG) but when patient moved into this facility a few days ago the pump was discontinued, and they were supposed to start her on insulin shots there is no daily insulin shots indicated on the MAR reviewed by me. The ER Rapid Triage noted patient presented with AMS/fever, from the facility, EMS stated hyperglycemia with CBG greater than 500. The ER Impression and Plan showed Resident #2 was diagnosed with Acute Diabetic Ketoacidosis (DKA) and Sepsis with a plan that Patient MUST be in a Critical Care unit or have telemetry monitoring in place and an order in place for insulin regular Additive 100 unit(s) + Sodium Chloride 0.9% intravenous solution 100 mL: UNIT/HR (hour), IV. Review of Diabetic Ketoacidosis (DKA) on www.mayoclinic.org showed, Diabetic ketoacidosis is a serious complication of diabetes. If it's left untreated, the buildup can lead to diabetic ketoacidosis. Symptoms of DKA include Being very thirsty, being weak or tired, being short of breath and being confused. Seek emergency care if your blood sugar level is higher than 300 milligrams per deciliter, or 16.7 millimoles per liter for more than one test. Remember, untreated diabetic ketoacidosis can lead to death. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on [DATE] at 8:31 a.m., Resident #2's established Endocrinologist stated Resident #2 was on the (Brand name 30) pump then in December was decreased to a (Brand name 20). Endocrinologist said Resident #2 was not on a sliding scale. Endocrinologist said when she began seeing Resident #2 on [DATE] Resident #2 was on ,d+[DATE] insulin. Endocrinology said Resident #2 did not have controlled blood glucose levels, so she was put on the (brand name) insulin pump due to her dementia and to gain better control. Endocrinologist stated on the (brand name 30) the resident was having some low blood glucose readings at night, so they decided to decrease to (Brand name 20) in [DATE]. Endocrinologist said she told the son the only time the pump should be off was when they were decreasing from 30 to 20 but other than that the pump should have remained running 24 hours. Endocrinologist stated the facility never reached out to her to discuss what Resident #2 was taking for Diabetes. People don't reach out, they should have called Endocrinologist said some Type 2 Diabetics do not require insulin, but Resident #2's blood sugar was controlled with insulin, it wouldn't have made sense to take her off insulin. Endocrinologist said she knows some facilities don't use insulin pumps, but it would have been prudent to figure out what insulin to put her on. Endocrinologist stated Resident #2 was not always compliant, but her dementia was not to the point she would refuse, even though she didn't like fingerstick. Endocrinologist stated, If you take a pump off you have to start insulin. During an interview on [DATE] at 10:25 a.m., Resident #2's family member stated the family had three bags of Resident #2's current medications, pump equipment and insulin present in the facility when Resident #2 was admitted . The family member stated that both the DON and MD would not even look into Resident #2's medication bags. The family member stated the DON and MD kept saying because the medications were from the outside, the facility couldn't use the medications so advised the family to take the medications all back home. The family member stated that all of Resident #2's current medications were in the bags brought with Resident #2 on admission. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:37 a.m., a second Family Member stated that the family were told by the facility that insulin and everything Resident #2 would need was available at the facility. The second family member stated that the facility talked about pain medications, medications for a UTI and the Medical Director (MD) and the Director of Nursing (DON), basically just put us at ease. The second family member recalled the MD and DON kept saying we have everything in house. We have the facilities, we have the doctors, we have the medical staff. The second family member stated the MD and DON wouldn't look at anything in the bag of medications because they said they couldn't use it because it was from outside. The MD and DON told the family to just take it home. The MD and DON were adamant about doing things their own way. The second family member stated the family and MD and DON talked about putting Resident #2 on insulin. The MD and DON said the facility had everything Resident #2 needed. The second family member stated the MD and DON didn't go into detail about the exact plan to provide Resident #2 insulin but stated the facility knew Resident #2 was insulin dependent. The second family member stated that insulin was Absolutely 100% the main thing. Prior to admitting Resident #2 in the facility, the family made sure the MD and DON knew Resident #2 was insulin dependent and that was the reason for the delay in admission to a Monday. The second family member stated he told the MD and DON that Resident #2 was cared for by the family at home for 5 years and made sure the MD and DON knew Resident #2 needed her insulin. The second family member stated that the facility never mentioned they would take Resident #2 off insulin and stated had the family been told they would have just taken Resident #2 back home because she needed her insulin. The second family member stated that the MD and DON never looked at the (current) medications the family brought into the facility with Resident #2 at admission. The second family member stated that he would come in daily and noticed Resident #2's face was a little drawn and she looked dehydrated. The staff told him their ice/water machine was down so he brought water for Resident #2 to drink and asked staff to please give her the water when she wanted it. The second family member stated that over the next two days, the facility never gave her the water and Resident #2's water cup was always empty. The second family member stated that Resident #2 was excessively thirsty and when he would ask the staff for water, they would reply we just gave her water. The second family member stated he would tell staff Resident #2's cup was empty and if she drank it all then she needed more. The second family member stated that he told staff that Resident #2 was extremely thirsty. The second family member stated that Resident #2 was in a little bit of a fog and would forget to eat. The second family member informed the staff that Resident #2 needed help eating but no one ever helped her. Resident #2 didn't eat while in the facility the family helped her eat when visiting. The second family member stated that on Valentines Day Resident #2 was laughing and then the next morning on [DATE], she was covered in feces and sat in feces for hours. A family member came in the morning of [DATE] around 8:00AM and Resident #2 was covered in feces then when I came in at 2:00 pm she still had feces under her nails and on some items on her tray. The next morning when the family came into the facility to visit Resident #2 and she was unresponsive. The staff said Resident #2 was nonresponsive because she had an infection and was fine. The family called 911 to send Resident #2 to the hospital. During an interview on [DATE] at 2:07 p.m. Staff G Certified Nursing Assistant (CNA) stated that Resident #2 was not responsive when passing breakfast trays, the morning of [DATE]. Staff G CNA stated that Resident #2 did not seem to be ok and reported it to the nurse. Staff G CNA stated that he remembered Resident #2 did not move and did not respond to good morning. Staff G CNA stated most of the time information such as a Resident is a diabetic is passed down verbally by the nurse to the CNA. During an interview on [DATE] at 2:17 p.m., Staff H Certified Nursing Assistant (CNA) stated he did assist Resident #2 outside for smoke breaks. Staff H CNA stated that Resident #2 was able to talk, was alert and oriented and family would come smoke with her. (continued on next page)

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F 0658 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview on [DATE] at 9:26 a.m., The Medical Director/Admitting Physician for Resident #2 (MDir/AP) stated, typically I set the highest parameter at 400. The MDir/AP stated that at the point a Residents blood sugar is above 400 a nurse is expected to contact me. The MDir/AP stated that a typical parameter is set for all diabetics and blood sugars. The MDir/AP stated that he was aware Resident #2 had an insulin pump however she was not alert enough to care for her pump such as refilling and monitoring it with dementia. The MDir/AP stated that he remembered there was a discrepancy between the ,d+[DATE] insulin and the insulin pump and that Resident #2 could not manage her own insulin pump. The MDir/AP stated that with no insulin dosage amount to refer to, it was best to just monitor Resident #2's blood sugars. The MDir/AP stated if Resident #2's blood sugar had gotten high, he would have known he needed to start her on some kind of long-acting insulin. The MDir/AP stated that Resident #2's blood sugar never went above 400 while in the facility so no one was required to contact him about high blood sugars. The MDir/AP stated that this facility does not allow the use of insulin pumps. During an interview on [DATE] at 9:48 a.m., Staff I Licensed Practical Nurse (LPN) stated that parameters depend on MD orders. The MD will say to follow facility protocol or give a direct order. Staff I LPN stated that generally any blood sugar under 70 or over 400 the nurse would notify the doctor. Staff I LPN stated that she would consider anything out of the Residents normal blood sugar range to be abnormal or high. Staff I LPN stated that if a Resident consistently showed high blood glucose levels in the 200 to 300 range and that was abnormal for the Resident then she would notify MD. Staff I LPN stated that blood sugar monitoring was very individualized. Staff I LPN stated she would look for signs and symptoms to accompany high blood glucose levels which may include excessive thirst, excessive hunger, altered mental status (AMS). Staff I LPN stated a nurse should notify the MD when blood sugar or

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41015 Based on record review, interview and policy review the facility failed to document catheter care for three of three Residents reviewed for catheter care. Resident identifiers: # 2, #7 and #8. Findings included: A review of Resident #2's medical record showed an admitted [DATE] with an admitting diagnosis of wedge compression fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing and retention of urine, unspecified. A physician order dated 02/06/23 stated, Indwelling Urinary (Foley) Catheter Care: cleanse with soap and water every shift. A second physician order dated 02/07/23 with end date 02/14/23 stated, Cefdinir Oral Capsule 300 MG Give one capsule by mouth every 12 hours for UTI (Urinary Tract Infection) 7 days. A third physician order dated 02/15/23 stated, Ceftriaxone Sodium Injection Solution Reconstituted 1 GM Inject 1 gram intramuscularly one time only for AMS (altered mental status) until 02/15/23. The treatment administration record (TAR) for February 2023 showed Indwelling Urinary Catheter Care: cleanse with soap and water every shift. The TAR showed Resident #2's catheter missed the following treatments: 02/09/23- morning shift no treatment 02/10/23 - morning shift no treatment 02/13/23- night shift no treatment 02/16/23- morning shift no treatment The sample was expanded with a review of Resident #7's and Resident #8's medical records related to catheter care. A review of Resident #7's medical record showed an admitted [DATE] with an admitting diagnosis of Type II Diabetes Mellitus with hyperglycemia, infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter, and personal history of urinary tract infections. A physician order dated 02/15/23 stated, Indwelling Urinary (Foley) Catheter Care: cleanse with soap and water every shift. The kardex stated, Provide indwelling catheter care every shift and as needed. The treatment administration record (TAR) for February 2023 showed Indwelling Urinary (Foley) Catheter Care: cleanse with soap and water every shift. The TAR showed Resident #7's catheter missed the following treatments: 02/24/23 morning shift no treatment 02/28/23 morning, evening and night shift no treatment 02/27/23 morning and evening shift no treatment (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #8's medical record showed a re-admitted [DATE] with an admitting diagnosis of other specified sepsis, Urinary Tract Infection, site not specified and personal history of urinary tract infections. A physician order dated 10/29/2022 stated, Catheter Care with soap and water every shift. A second physician order dated 03/06/23 stated, Bactrim Oral Tablet 400-80 MG (Sulfmethoxade Trimethroprim) Give 1 tablet by mouth two times a day for UTI for 7 days. The treatment administration record (TAR) for February 2023 showed Catheter Care with soap and water every shift. The TAR showed Resident #8's catheter missed the following treatments: 02/01/23 morning and evening shift no treatment 02/09/23 morning shift no treatment 02/10/23 morning shift no treatment 02/13/23- night shift no treatment 02/15/23- evening and night shift no treatment 02/24/23- morning shift no treatment 02/26/23- morning, evening and night shift no treatment 02/27/23- morning shift no treatment During an interview on 03/09/23 at 4:18 PM, Staff A Certified Nursing Assistant (CNA) stated that catheter care for some residents will come up on the kardex. Staff A CNA proceeded to say once the catheter care is completed it is charted in the resident's medical chart when it is done. During an interview on 03/09/23 at 4:22 p.m., Staff B Registered Nurse (RN) stated that a CNAs will do catheter care such as cleaning with soap and water but when it comes up in the TAR and since she has to sign off on the TAR she will help provide peri care. During an interview on 03/10/23 at 6:18 PM, Director of Nursing (DON) stated that according the Treatment Administration Record (TAR) there are missing catheter treatments for all three residents. DON confirmed the TARs were incomplete with missing treatments and the physician order was not followed as it related to catheter care. A facility's policy review titled Catheter Care with no date stated, Catheter care will be performed every shift and as needed by nursing staff.

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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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46234 Based on observations, interviews, and record review, the facility failed to ensure pain was managed effectively for three residents (#3, #8, and #13) out of three that were reviewed for pain. Resident #3 was admitted to the facility from the hospital on 2/2/23 after being diagnosed with gas gangrene and osteomyelitis of the left ankle and foot. At 6:10 p.m. on 2/2/23 the resident's pain medication had not been delivered to the facility. On 2/3/23 at 12:06 a.m. a nurse obtained access to the automated medication dispensing machine to provide Resident #3 with pain medication. Documentation showed the medication was ineffective and the resident screamed and yelled out. Over a six-day period the resident's PRN (as needed) pain medication, Hydrocodone-Acetaminophen, was documented as being ineffective four different times and nine times no pain level or re-evaluation of effectiveness was documented. There were no documented attempts to inform the resident's provider about the ineffective pain medication. Multiple staff members interviewed said over the six-day period Resident #3 was in the facility, they overheard her crying out due to her pain. Resident #3 took the last dose of her PRN pain medication, Hydrocodone-Acetaminophen on 2/8/23 at 5:46 p.m. The resident had a reported pain level of 6 out of 10 on 2/9/23 at 1:33 a.m. There was no documentation showing a provider or the pharmacy was called to reorder medication or access the automated medication dispensing machine for Resident #3. Interviews with staff showed the resident was in pain on the morning of 2/9/23 prior to going to a follow-up doctor's appointment with her Cardiologist. The resident was not given pain medication and screamed in pain on the way to the appointment. Upon arriving at the Cardiologist office, the office staff called 911 due to Resident #3 screaming in pain from the moment of her arrival. Residents #8 was showing signs of pain on interview, stated she frequently had to wait to get pain medication and said, I just want to die not in pain. Resident #13 stated she had to wait four hours for her PRN pain medication on 3/10/23, said it was typical to wait hours after requesting pain medication and reported staff disbelief of her reports of pain. This failure created a situation that resulted in serious harm to Resident #3, and the likelihood of serious harm or injury to Residents #8, and #13 and resulted in the determination of Immediate Jeopardy beginning on 2/2/23. The findings of Immediate Jeopardy were determined to be removed on 3/23/23 and the scope and severity was reduced to a D. Findings included: A review of the Cardiovascular Office Visit notes for Resident #3, dated 2/10/23, showed Vitals could not be obtained due to her writhing in pain. The person that is accompanying her is stating that for the last few days she has been crying in pain and nothing has been done about this. The notes revealed the resident was being sent to the emergency department. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of records showed Resident #3 was admitted to the facility from the hospital on 2/2/23 with diagnoses including acute osteomyelitis of ankle and foot, cellulitis of left lower limb, type 2 diabetes mellitus with diabetic neuropathy, gas gangrene, pressure ulcer of left heel, stage 3, non-pressure chronic ulcer of other part of left foot with unspecified severity, cognitive communication deficit, idiopathic gout in left ankle and foot, other idiopathic peripheral autonomic neuropathy, peripheral vascular disease, pain in left foot, and acquired absence of right leg below the knee. A review of Resident #3's orders showed an order for Hydrocodone-Acetaminophen Oral tablets 5-325 mg (milligrams.) Give 1 tablet by mouth every 4 hours as needed for pain for 14 days, dated 2/2/23. No additional pain medication was ordered. Resident #3 also had an order in place for Seroquel Oral tablet 50 mg. Give 1 tablet by mouth at bedtime for anxiety and insomnia, dated 2/6/23. A review of Resident #3's care plan did not show any care plans in place related to pain. A review of Resident #3's Minimum Data Set (MDS) Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 6, showing severely impaired cognition. A review of progress notes for Resident #3 showed the following: 2/2/23 at 6:10 p.m. new admit, medication was not delivered yet. 2/3/23 at 12:06 a.m. Pharmacy gave code to pull 2 doses of Hydrocodone-Acetaminophen 5-325 mg from the automated medication dispensing machine. One administered and one put in lock box on the medication cart. The pain level charting showed the resident rated pain 10 out of 10. 2/3/23 at 1:12 a.m. Patient assignment acquired at 2300 (11:00 p.m.) Patient was loudly calling out repeatedly and escalating. Xanax and Norco (Hydrocodone-Acetaminophen) prescriptions had been faxed to the pharmacy. Nursing staff with automated medication dispensing machine access secured. The pharmacy was called for codes as patient's behavior and screaming continued to escalate, resulting in her sliding from her bed to the floor. She did not suffer any injuries. Bed was in lowest position. She was placed in a gerichair and brought out to the nurses station for close monitoring due to repeated attempts to climb out of bed. She kept calling for someone to bring her a phone, call her neighbor, call her daughter, call her son He will bring us all breakfast. Finally, after one dose of Xanax and Norco with one-on-one attention for an hour, she quieted down. 2/3/23 at 2:00 a.m. showed the patient rested quietly for about 30 minutes and then was up yelling at the top of her lungs again. A review of the Medication Administration Record (eMAR,) Medication Monitoring/Control Record, and progress notes was completed. The eMAR is where all medication given should be documented along with pain levels, and effectiveness for PRN pain medication. The Medication Monitoring/Control Record is a log kept on the medication cart and tracks the tablet counts for narcotics/controlled medications. The eMAR and Medication Monitoring/Control log combined showed Hydrocodone-Acetaminophen 5-325 mg was given as follows: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/3/23 12:06 a.m. A pain scale of 10. Re-evaluation of pain: ineffective 4:57 a.m. A pain scale of 10. Re-evaluation of pain: ineffective 8:15 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 1:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 5:20 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. A progress note on 2/3/23 at 5:58 a.m. Did not appear to provide any relief-patient continued yelling out repeatedly. There was no documentation to show a provider was notified of the ineffective pain medication for Resident #3 on 2/3/23. 2/4/23 2:51 a.m. A pain scale of 7. Re-evaluation of pian: effective. 8:00 a.m. A pain scale of 10. Re-evaluation of pain: effective 12:00 p.m. A pain scale of 10. Re-evaluation of pain: effective 4:00 p.m. A pain scale of 10. Re-evaluation of pain: effective 8:00 p.m. A pain scale of 10. Re-evaluation of pain: effective A progress note on 2/4/23 at 4:17 a.m. Resident complained of pain and discomfort all night. Resident very restless and getting little to no sleep due to pain and anxiousness asking for her children all night. 2/5/23 12:27 a.m. A pain scale of 7. Re-evaluation of pain: effective 4:30 a.m. A pain scale of 7. Re-evaluation of pain: effective 8:30 a.m. A pain scale of 10. Re-evaluation of pain: effective 2:20 p.m. A pain scale of 10. Re-evaluation of pain: effective 11:08 p.m. A pain scale of 10. Re-evaluation of pain: ineffective A progress note on 2/5/23 at 23:08. Screaming could be heard down the hall at the nurses station. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/6/23 3:11 a.m. A pain scale of 10. Re-evaluation of pain: effective 9:33 p.m. A pain scale of 6. Re-evaluation of pain: effective A progress note on 2/6/23 at 12:03 a.m. showed the follow-up pain scale was 10 out of 10. PRN medication was ineffective. Unable to determine whether her screaming is pain or behavior-Xanax and Norco did nothing to quiet her yelling. A progress note on 2/6/23 at 12:32 a.m. showed Patient was yelling at the start of my shift-could be heard down the hall-gave scheduled Xanax and PRN Norco to no avail. -+Keeping entire hall away [sic]-removed from room-taken to tv room so as not to disturb the other residents trying to sleep. There was no documentation to show a provider was notified of the ineffective pain medication or continued yelling of Resident #3 on 2/6/23. 2/7/23 3:31 a.m. A pain scale of 10. Re-evaluation of pain: effective 9:00 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 2:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 7:51 p.m. A pain scale of 5. Re-evaluation of pain: effective A progress note on 2/7/23 at 3:31 a.m. showed Resident #3 was yelling out ow. ow! 2/8/23 3:08 a.m. A pain scale of 5. Re-evaluation of pain: ineffective 8:07 a.m. A pain scale of 8. Re-evaluation of pain: effective 2:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 5:46 p.m. A pain scale of 10. Re-evaluation of pain: effective A progress note on 2/8/23 at 3:08 a.m. at showed the resident was moaning in pain. There was no documentation to show a provider was notified of the ineffective pain medication on 2/8/23 at 3:08 a.m. 2/9/23 1:33 a.m. A pain scale of 6. Re-evaluation of pain: effective (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6:00 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 10:00 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 2:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 5:40 p.m. A pain scale of 6. Re-evaluation of pain: effective The Medication Monitoring/Control Record showed the dose given on 2/9/23 at 5:40 p.m. left 0 remaining doses available to Resident #3. A review of Resident #3's Weights and Vitals Summary showed a pain scale of 6 was entered by Staff N, RN on 2/10/23 at 2:36 a.m. There was no documentation that a provider or the pharmacy were called due to the resident being out of pain medication and continuing to be in pain. A review of the Medical Director's notes, dated 2/6/23, showed the reason for appointment was admission/history and physical for Resident #3. It said on exam, the patient's foot is gangrenous and in definite need of amputation. Nursing was instructed to get resident back to podiatry this week, if unable, may need to be readmitted to the hospital. Pain was not mentioned in the provider's note. A provider note from a facility doctor that partners with the Medical Director, dated 2/9/23 said the reason for the appointment was acute care visit and risk of hospitalization due to complications of cardiovascular disease, diabetes, and risk of falls with injury. It said the resident was in bed, nonverbal but moans often, I am told it stops a little bit after her pain medication is administered which was just given prior to my visit today. Ineffective pain medication was not mentioned in the provider's note. A review of a Pain Evaluation, dated 2/9/23, showed a pain assessment interview could be conducted due to the resident being able to communicate appropriately. The resident was unable to answer questions regarding pain presence, frequency, effect on function, or intensity. It noted there were non-verbal sounds (e. g., crying, whining, gasping, moaning, or groaning) present. The evaluation noted the resident complained or showed evidence of pain daily. The evaluation was completed and signed by Staff B, RN. An interview was conducted on 3/9/23 at 4:18 p.m. with Staff A, Certified Nursing Assistant (CNA). Staff A said she took Resident #3 to her doctor's appointment on 2/10/23 with Staff D, Director of Transportation. Staff A said the resident was crying out and screaming in pain. She said the doctor's office called 911. An interview was conducted on 3/9/23 at 2:40 p.m. with Staff D, Director of Transportation. Staff D confirmed she drove Resident #3 and Staff A, CNA to a doctor's appointment on 2/10/23. She said they left the building around 12:45-1:00 p.m. Staff D said the resident was upset because her foot was hurting her. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 3/15/23 at 3:25 p.m. with the Office Manager of the Cardiovascular office Resident #3 visited on 2/10/23. The Office Manager said Resident #3 was crying out in pain from the minute she came off the elevator. She said the resident's appointment was at 3:15 p.m. and the resident and her CNA arrived around 3:35 p.m. due to going to the wrong location initially. She said the CNA that was with Resident #3 was yelling at the resident to stop screaming and shut up. The Office Manager said it was very obvious she was in pain. She said the staff at the doctor's office called 911 to have Resident #3 taken to the emergency room . The Office Manager provided statements written by the cardiovascular registered nurse (RN), cardiovascular medical assistant (MA) 1, and cardiovascular MA 2. A written statement provided by the cardiology MA 1 revealed Resident #3 could be heard crying from the waiting room. She said when she attempted to take Resident #3's vital signs, she screamed in pain. The CNA with the resident told the resident to stop crying. The cardiovascular MA 1 said she removed the pulse oximeter and blood pressure cuff and informed the aide the resident needed critical care. MA 1 said she excused herself from the triage room and went to speak with the doctor and call emergency medical services (EMS.) MA 1 said while waiting for EMS the aide could be heard multiple times telling Resident #3 to be quiet and stop yelling. A written statement provided by the cardiology RN revealed Resident #3 came into the office for a hospital follow-up and she could be heard screaming for help from the triage room. She said the resident was overheard screaming ouch my back, I have a sore on my back while being moved to the stretcher. A written statement provided by the cardiology MA 2 revealed Resident #3 and her CNA arrived late to the appointment because they went to the hospital prior to appointment and found out they were at the wrong location. MA 2 said the resident's CNA didn't seem to care much about her resident and was yelling at her to be quiet. MA 2 said for some reason the CNA wasn't aware her resident needed urgent medical attention. MA 2 said Resident #3 was in excruciating pain, yelling help me, help me, since she came to the office. A review of the (Local) Medical Transportation Run Report showed the reason for transport was acute pain. The resident's pain scale was 10 on a scale of 1-10. It said upon arrival patient was found in a wheelchair in obvious distress. Emergency Medical Services arrived for the resident on 2/10/23 at 3:20 p.m. and arrival at the hospital was shown to be at 3:37 p.m. A review of the Emergency Department records showed the reason for Resident #3's visit was complaints of pain associated with a left foot wound. It stated her pain level was 10/10 and she was anxious, crying, restless. The records show Resident #3 was given Dilaudid 1 mg (milligram) in the Emergency Department and after was noted to be resting comfortably in no acute distress. The record showed Resident #3's x-ray did not definitively show any osteomyelitis, however, did show subcutaneous gas, which consistent with patient's physical exam of crepitus along plantar surface. It revealed that was concerning for necrotizing fasciitis. The diagnosis is listed as necrotizing fasciitis left foot with a condition of guarded. Patient admitted inpatient. A review of the hospital discharge summary showed Resident #3 had a below-the-knee amputation due to sepsis in the infected leg. The resident was discharged on [DATE] to a second long term care facility. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008) from the second long-term care facility showed Resident #3 had a left below the knee amputation on 2/12/23. An observation was conducted of Resident #3 in the second long-term care facility on 3/14/23. Throughout the day the resident was resting comfortably, showing no signs of pain and no behaviors of yelling out. A follow-up interview was conducted on 3/21/23 at 12:18 p.m. with Staff A, CNA. Staff A said prior to leaving the facility for the doctor's appointment with Resident #3 on 2/10/12, the resident was in pain. Staff A said the nurse, Staff B, RN told her she was going to give the resident pain medication before they left. Staff A said she knew they had a one-hour drive to the appointment, the time there, and the one-hour drive back. Staff A said Resident #3 was screaming the whole ride. She said she didn't know why the resident was screaming because she was under the impression the nurse had given the resident her pain medication. Staff A said the resident had been crying out in pain daily since she was admitted . Staff A said the resident would be quiet and get some rest for a little bit after getting pain medication, but she would wake up and start crying out again. Staff A said she doesn't understand, because if a resident is in pain and needs medication, they should get it. She stated Resident #3 cried out in pain probably 15 hours out of every day. An interview was conducted on 3/10/23 at 6:00 p.m. with Staff O, Staffing Coordinator/Central Supply. Staff O said she was familiar with Resident #3. She said when she walked around the facility daily, Resident #3 was typically in pain and would always cry out. An interview was conducted on 3/10/12 at 6:10 p.m. with Staff P, Licensed Practical Nurse (LPN)/Unit Manager (UM). Staff P said Resident #3 was not comfortable because of the pain in her foot. She said she just wanted to lay here because of the pain. When asked about the resident not receiving pain medication prior to her appointment on 2/10/23 she said, I would have assumed the nurse would have given it to her. Staff P said they typically give pain medication before therapy and before going to appointments. She said when she gave the resident a shower, she was not in pain. Staff P said Resident #3 was in pain as soon as she got here. She said if someone talked to the resident, she would not scream but she would always say she was in pain. An interview was conducted on 3/21/23 at 1:07 p.m. with Staff Q, CNA. She stated she was familiar with Resident #3. She said the resident was always in pain and was always crying out. She said she thinks pain medications helped the resident because they would put her to sleep, but she would wake up and cry in pain again. An interview was conducted on 3/21/23 at 2:11 p.m. with Staff H, CNA. He stated he remembered Resident #3. He said she would tell him she was in pain and other times she could not talk because of her pain. An interview was conducted on 3/21/23 at 2:16 p.m. with Staff L, LPN. She said she remembers Resident #3 sitting in the dining area crying and moaning in pain. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 3/21/23 at 3:05 p.m. with the Director of Nursing (DON). The DON was observed reviewing Resident #3's medical records. The DON said she did not know the resident very well and cannot speak to her pain on a day-to-day basis. The DON stated she was looking at the resident's record to see if the screaming had to do with behaviors, psychiatric medication, or history of drug use. She said they are always looking at psych (psychiatric issues) versus pain. She said they followed up with the resident's pain and gave her pain medication. She said they had the resident followed by psychiatry (psych) as well. There was an order for psych to evaluate and follow-up as needed. She said she did not see any provider notes in the record for psychiatry. The DON confirmed there were no notes in the record where the doctor was called and notified about Resident #3's ineffective pain medication. She said she would expect the nurse to follow physician orders and if the medication is not effective, they should notify the doctor. When asked if a resident cries and reports pain should the nurse call the physician, she said, I don't know. I was not down there and cannot speak to that. The DON said if a pain medication is not effective, the nurse can try non-pharmacological approaches for pain relief. She said if the nurse did that, it would be documented in the progress notes. The DON reviewed the progress notes and confirmed nothing was documented showing other approaches to pain management were attempted. On 3/21/23 at 5:00 p.m. the DON said she was unable to find anything showing psychiatry had evaluated Resident #3 during her stay. An interview was conducted on 3/21/23 at 3:38 p.m. with Staff B, RN, who confirmed she had cared for Resident #3 a few times, including the morning she went to her follow-up Cardiology appointment. Staff B said Resident #3 would yell out a lot, even after having her pain medication. She said sometimes the medication helped with the resident's pain and sometimes it did not. She said if pain medication is ineffective, typical practice would be to call the doctor to get something different. Staff B said she never had to call the provider for Resident #3 about ineffective pain medication. She said on 2/10/23 prior to Resident #3's doctor's appointment, she doesn't remember her being in excessive pain, but she had her normal foot pain and was complaining about leg pain. She said typical practice is to try to medicate a resident prior to transporting to an appointment. She said if the resident reported a pain level of 6 out of 10, she would have given her Hydrocodone-Acetaminophen. When asked about her not giving the pain medication to Resident #3 on the morning of 2/10/23 she said she didn't remember anything specific about the morning of her appointment. An interview was conducted on 3/21/23 at 4:05 p.m. with Resident #3's provider/facility Medical Director. The doctor stated he vaguely remembers Resident #3. He recalled she had a gangrenous foot and was demented. As for behaviors, he said he believed the resident would sometimes yell out, but pain can make anyone with confusion do that. The doctor said if a resident had out of control pain, the staff would normally talk to him. He said if it was brought to his attention, there would be a progress note indicating that. He said if a pain medication was ineffective after being administered to a resident, he would expect the nurse to call him because that is the protocol. He said if he doesn't know the pain medications aren't effective, then he cannot treat them. The doctor said for a resident going out to an appointment, being jostled around he would expect the nurse to give the resident pain medication. The doctor confirmed there is an on-call provider 24 hours a day 7 days a week and staff have his direct number that he always answers. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 3/22/23 at 9:55 a.m. with Staff N, RN, who took care of Resident #3 on multiple shifts including the shift beginning 2/2/23 11:00 p.m. to 2/3/23 7:00 a.m. Staff N said she remembers Resident #3. She said the resident had a lot of pain. She said one night the resident was crying out a lot one night, so she put her in a gerichair she borrowed from another resident and moved her to the TV room. She said the resident would not settle down, even with pain medication. Staff N said, if you have a gangrenous foot you are going to be in pain. She said if the resident had a pain level of 6 she would have given her medication if it was available. She said she did not have access to the automated medication dispensing machine because she is an agency nurse, she said a staff person would have had to access it. When asked about documenting the pain scale and Hydrocodone-Acetaminophen as given then striking it out on 2/9/23 she said she could not remember why she did that or if the medication was available. An interview was conducted on 3/22/23 at 10:11 a.m. with Resident #3's family member. The family member stated Resident #3 had a lot of pain in her left foot. She said she felt like the pain medication the resident was getting never really helped. The family member said the medication knocked the resident out for a little bit and made her sleep for a sort time but didn't really do anything for the pain. She said the resident would scream out while she was visiting her, and the pain medication was not helping. The family member said she never spoke with the provider directly but did speak with two different nurses. She said she could not remember the nurses' name; one was male and one was female and they were both agency nurses. The family member said they never called the provider they would tell her, Let's just see if it works. She said the facility could never get her comfortable because of the pain and infection. The family member said when her mother got to the emergency room , they gave her something and it controlled the resident's pain without issue. She said Resident #3 was admitted to the hospital and had a left leg amputation. She said the resident is doing much better now and no longer yells out. The family member said on 2/10/23 she was in the facility with Resident #3 from 9:00 a.m. to 12:00 p.m. She said she left just prior to the resident going out to the doctor's appointment. She said the resident was yelling out in pain while she was there. She did not recall the nurse bringing Resident #3 any pain medication. An interview was conducted on 3/22/23 at 11:01 a.m. with the DON. The DON said she contacted the pharmacy and was told the only time the staff requested a code to access the automated medication dispensing machine for Resident #3 was on 2/3/23. She said they confirmed they sent 28 tablets of Hydrocodone-Acetaminophen that was received by the facility on 2/3/23. They said that was the only time Hydrocodone-Acetaminophen was sent for Resident #3. The pharmacy told the DON they did not have an order for additional doses. The DON confirmed no orders or refill requests were sent to the pharmacy. She said when a resident is down to the last few remaining tablets, the nurse should have called the doctor to get a new prescription sent to the pharmacy. She said Hydrocodone-Acetaminophen is available in the facility's Emergency Drug Kit and the nurse could have called pharmacy for a code to access it. The DON confirmed agency nurses can be put in as a one-timer user that is good for three days. Two additional residents (#8 and #13) were sampled for pain management. A review of records showed Resident #8 was admitted on [DATE] and readmitted on [DATE] with diagnoses including sepsis, urinary tract infection, surgical wound, acquired absence of other specified parts of the digestive tract and diverticulosis. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident #8's MDS (Minimum Data Set) Section C, Cognitive Patterns, showed a (Brief Interview of Mental Status) BIMS score of 15, showing she was cognitively intact. A review of orders showed the following orders related to pain: Lidoderm patch 5%. Apply topically in the morning for low back pain/shoulder pain. Remove at bedtime, rotate sites. Order date: 2/2/23. Oxycodone HCL 10mg. Give 10 mg by mouth every 4 hours as needed for severe pain. Order date: 1/24/23. Tylenol 325 mg. Give 2 by mouth every 6 hours as needed for pain. Order date: 10/29/22. A review of records showed a Care Plan in place for risk of experiencing pain associated with decreased mobility, surgical procedure and wound, morbid obesity, gastroesophageal reflux disease, diverticulosis and chronic lymphedema of bilateral lower extremities. The interventions included administer and monitor for effectiveness and for possible side effects of routine and PRN pain medication and assess/monitor for non-verbal indicators of pain (pacing, agitation, anxiety, facial grimacing, tearfulness/crying, sad/distant facial expressions, gasping/groaning, yelling out.) On 3/10/23 at 3:50 p.m. Resident #8 was observed to be lying in bed. The resident was agitated, grimacing, gagging, and having difficulty speaking. When asked if the resident is able to get pain medication when she needed it, the resident said she always has to wait. Resident #8 then stated, I just want to die not in pain. The resident was unable to continue the interview due to coughing/gagging. A staff member was called into the room to check on the resident. A review of Resident #8's Pain Evaluation, dated 2/2/23, revealed the resident has pain in the last five days that made it hard for her to sleep at night and limited her day-to-day activities. An interview was conducted on 3/10/23 at 3:55 p.m. with Resident #13, who was the roommate of Resident #8. Resident #13 said staff ignore Resident #8. She said Resident #8 has a lot of wounds and is in pain often and staff don't pay any attention to her. She said Resident #8 isn't always the nicest person and staff don't like her, but it doesn't mean she should have to be in pain. A review of records showed Resident #13 was admitted on [DATE] with diagnoses including moderate protein-calorie malnutrition, chronic gastritis, disorders involving the immune mechanism not classified elsewhere, systemic involvement of connective tissue, hypertrophic pylori stenosis, rheumatoid arthritis, epigastric pain, and pain in unspecified joint. A review of Resident #13's MDS, Section C, Cognitive Patterns, showed a BIMS score of 15, showing she was cognitively intact. A review of Resident #13's Pain Evaluation, dated 2/3/23, showed the resident frequently experienced pain or hurting over the last 5 days, making it hard to sleep at night, and limiting her day-to-day activities. A review of orders showed the following orders related to pain: (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Gabapentin 100 mg. Give 1 capsule by mouth at bedtime for neuropathy. Order date, 3/3/23. Norco (Hydrocodone-Acetaminophen) oral tablet 7.5-325 mg. Give 1 tablet by mouth every 4 hours as needed for pain. Order date, 2/8/23. MS (Morphine Sulfate) Contin Extended Release 30 mg. Give 1 tablet by mouth every 12 hours related to pain in unspecified joint. Order date, 2/6/23. A review of records showed a Care Plan in place for pain related to diagnosis of chronic gastric ulcers, delayed gastric emptying, abdominal pain. Interventions included administer and monitor for effectiveness and possible side effects from routine and PRN pain medications, monitor for change in mood or mental status, and give medications per order. An interview was conducted on 3/10/23 at 3:55 p.m. with Resident #13. The resident said on the morning of 3/10/23 she asked for a pain pill at 8:40 a.m. She said the last dose of her PRN pain medication she had was at 2:00 a.m. that morning. She said at 9:45 a.m. she still had not received her medication, so she found the nurse and asked again. The nurse told her she was on her way. Resident #13 said she got the same response from the nurse at 10:10 a.m. The resident said she went to the unit manager at 11:50 a.m. because the unit manager knows she needs her pain medication to keep it controlled or she starts having issues. The resident said the unit manager told her she would take care of it, but never came. Resident #13 said at 12:35 p.m. she asked the nurse again for her pain medication and was told other residents were in front of her and she needed to be patient, wait her turn and go back to her room. The resident said she let the nurse know her pain level was 10 out of 10 and the nurse told her if it was a 10 you wouldn't be walking. Resident #13 said she finally received her pain medication at 12:45 p.m. A review of Resident #13's eMAR showed PRN pain medication was administered on 3/10/23 at 1:46 a.m. and 4:37 p.m. A follow-up interview was conducted on 3/22/23 at 11:40 a.m. with Resident #13. She s[TRUNCATED]

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety 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** 41015 Based on record review, interviews, hospital record review, facility documentation and policy review the facility failed to ensure Residents were assessed for a change of condition. The facility failed to ensure the physician was notified and assessed for a change of condition for one (Resident #2) of three Residents reviewed for diabetic management. The facility failed to notify a physician when pain medications were ineffective for uncontrolled pain for one (Resident #3) of three Residents reviewed for pain. These failures created a situation that resulted in serious harm to Resident #2 and #3, and the likelihood of serious harm or injury to other residents resulted in the determination of Immediate Jeopardy beginning on 2/2/23. The findings of Immediate Jeopardy were determined to be removed on 3/23/23 and the scope and severity was reduced to a D. Findings included: Reference citation F600 1. A review of Resident #2's medical record showed an admitted [DATE] with diagnoses that included Type II Diabetes with hyperglycemia, Type II Diabetes with Diabetic Neuropathy and Wedge Compression fracture of second lumbar vertebra, subsequent encounter for fracture with routine healing (primary). A review of Resident #2's physician orders related to diabetic management revealed: 02/06/23 Trulicity Subcutaneous Solution Pen- injector 0.75 MG[milligram]/0.5 ML[milliliter] (Dulaglutide) Inject 1.5 mg subcutaneously one time a day every Thursday for Diabetes Mellitus and remove per schedule. 02/06/23 Metformin HCl Oral Tablet 1000 MG give 1 tablet by mouth one time a day for Diabetes Mellitus Type II. 02/06/23 Steglatro 15 MG Tablet give 1 tablet by mouth one time a day for diabetes mellitus. 02/06/23 Farxiga Oral Tablet 10 MG (Dapagliflozin) give 1 tablet by mouth one time a day for heart failure. 02/06/23 Accuchecks (blood glucose checks) AC/HS (before meals and at bedtime) for Diabetes Mellitus II if below 70 or above 400 please call [MDir/AP - (Medical Director/Admitting Physician for Resident #2]). Review of Resident #2's record showed no physician orders for insulin. The resident's care plan did not show a focus, goal or interventions related to diabetes management. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Medication Administration Review (MAR) showed Resident #2 never received a dose of the ordered Trulicity or Farxiga medications. Insulin was never ordered. Resident #2 received oral medications of Metformin and Steglatro as ordered. Review of the Accuchecks showed Resident #2's blood sugars for the following days: 02/09/23: 6:30 AM- 263 11:30 AM- 200 4:30 PM- 374 9:00 PM- 220 02/10/23: 6:30 AM- 285 11:30 AM- N/A 4:30 PM- 272 9:00 PM- 341 02/11/23: 6:30 AM- 291 11:30 AM- 389 4:30 PM- 299 9:00 PM-236 02/12/23: 6:30 AM- 197 11:30 AM- 150 4:30 PM- 378 9:00 PM- 350 02/13/23: 6:30 AM- 302 (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11:30 AM- 398 4:30 PM- 312 9:00 PM- 356 02/14/23: 6:30 AM- 301 11:30 AM- 374 4:30 PM- 241 9:00 PM- 352 02/15/23: 6:30 AM- 289 11:30 AM- 332 4:30 PM- 319 9:00 PM- 358 02/16/23: 6:30 AM- 384 Review of Residents #2's medical record showed a Skilled Nursing Note dated 02/09/23. The note showed Resident #2 was alert and oriented times three (oriented to person, place, and time). Resident #2 had a bed mobility self-performance of guided with one person assist. Resident #2's ability to transfer, walk in facility corridor, and have locomotion on unit all with a one person assist. Resident #2 was able to use toilet independently and eat with set up assistance only. The assessment was signed by Staff B RN showed, Alert and Oriented times three. No complaints of pain or discomfort. Takes meds whole without difficulty. Review of Resident #2's medical record showed a Skilled Nursing Note dated 02/12/23. The note showed Resident #2 was alert and oriented times three. Resident #2 has bed mobility self-performance of independent. Resident #2's ability to transfer was a one person assist. Resident #2's ability to walk in the facility's corridors did not occur and locomotion on the unit was total dependence. Resident #2's ability to use the toilet was one person assist, eating at independent with set up help only. The assessment showed, Resident was observed sleeping in bed with no signs of acute distress when exiting the room. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #2's medical record showed a Skilled Nursing Note dated 02/15/23. The note showed Resident #2 was oriented to person only. Resident #2 had bed mobility self-performance of extensive assistance. Resident #2's ability to transfer was total dependance and needed two-person physical assistance. Resident #2's ability to walk in the facility's corridor and locomotion on the unit did not occur. Resident #2's ability to eat changed to one-person physical assist and toileting activity did not occur. The assessment signed by Staff R Licensed Practical Nurse (LPN) and showed Resident moved to room (room #) this afternoon. Received Rocephin [an antibiotic] injection per doctors' orders related to urine cloudy pale yellow and thick. Resident's appetite is poor, has drank fluids without difficulty. Staff encouraging Resident to eat and drink. During an interview on 03/10/23 at 4:20 p.m., Staff A Certified Nursing Assistant (CNA) stated that she remembered she gave Resident #2 a shower and Resident #2 did have an insulin pump access in her belly at shower time. Staff A CNA stated that she did recall an insulin pump access in Resident #2's belly during the shower provided on 02/09/23. Staff A CNA also stated she noticed Resident #2 was declining and had a change of condition and was getting weaker on 02/09/23. Further review of Resident #2's medical record revealed a Narrative Note dated 02/15/23, This nurse reports to Staff E NP that resident fasting blood sugars have been in 300 range consistently, Staff E NP gave new order to increase Trulicity. This nurse questioned Staff E NP about possibly putting resident on fast acting insulin. Staff E NP declines and stated Trulicity should cover resident. Narrative note was signed by Staff B Registered Nurse (RN). During an interview on 03/10/23 at 4:35 p.m., Staff B Registered Nurse (RN) discussed Narrative note dated 02/15/23. Staff B RN stated she remembered the conversation and asked Staff E NP about putting Resident #2 on some fast-acting insulin. Staff B RN stated, I explained to the NP that I didn't know what insulin was in the pump but did inform Staff E NP that Resident #2 was on insulin prior to being admitted to the facility. Staff B RN stated that she also remembered Staff E NP informed her that she was going to talk to the family about the specific insulin that was used in the pump and then NP proceeded into Resident #2's room to talk with the family about insulin. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/20/23 at 10:37 a.m., a second family member stated that he would come in daily and noticed Resident #2's face was a little drawn and she looked dehydrated. The staff told him their ice/water machine was down so he brought water for Resident #2 to drink and asked staff to please give her the water when she wanted it. The second family member stated that over the next two days, the facility never gave her the water and Resident #2's water cup was always empty. The second family member stated that Resident #2 was excessively thirsty and when he would ask the staff for water, they would reply we just gave her water. The second family member stated he would tell staff Resident #2's cup was empty and if she drank it all then she needed more. The second family member stated that he told staff that Resident #2 was extremely thirsty. The second family member stated that Resident #2 was in a little bit of a fog and would forget to eat. The second family member informed the staff that Resident #2 needed help eating but no one ever helped her. Resident #2 didn't eat while in the facility the family helped her eat when visiting. The second family member stated that on Valentines Day Resident #2 was laughing and then the next morning on 02/15/23, she was covered in feces and sat in feces for hours. A family member came in the morning of 02/15/23 around 8:00AM and Resident #2 was covered in feces then when the second family member came in at 2:00pm she still had feces under her nails and on some items on her tray. The next morning on 02/16/23 when the family came into the facility to visit Resident #2 and she was unresponsive. The staff said Resident #2 was nonresponsive because she had an infection and was fine. The family called 911 to send Resident #2 to the hospital. During an interview on 03/20/23 at 2:07 p.m. Staff G Certified Nursing Assistant (CNA) stated he did remember that Resident # 2 was not responsive when passing breakfast trays, the morning of 02/16/23. Staff G CNA stated that Resident #2 did not seem to be ok and reported it to the nurse. Staff G CNA stated that he remembered Resident #2 did not move and did not respond when he said good morning. During an interview on 03/20/23 at 2:17 p.m., Staff H Certified Nursing Assistant (CNA) stated he did assist Resident #2 outside for smoke breaks. Staff H CNA stated that Resident #2 was able to talk, was alert and oriented and family would come smoke with her. During a follow up interview on 03/20/23 at 2:42 p.m., Staff B Registered Nurse (RN) stated that when Resident #2 was admitted to the facility she was confused at baseline, but she was oriented to person, place, and time. Staff B RN stated that Resident #2 was confused on basic things such as getting up by herself although she was a one person assist with her walker. Staff B RN stated that Resident #2 would try to transfer by herself, and the facility would educate her about self-transfers. Staff B RN stated that when Resident #2 showed weakness, the change of condition was reported to Staff E NP immediately. Staff B RN stated that was when Staff E NP ordered labs, UA Rocephin IM and Staff B talked to Staff E NP about Resident #2's baseline blood sugars being in the 300s which was high. Staff B RN stated she asked Staff E NP about Resident #2 getting short acting insulin and a sliding scale and the only orders were to increase Trulicity. Staff B RN stated that Staff E NP was informed Resident #2 was on insulin prior to being admitted to the facility and Staff E NP said that she would talk to the family about this. Staff B RN stated she told Staff E NP that the family told Staff B RN that Resident #2 was on the pump prior to admission. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 03/21/23 at 11:23 a.m., the Director of Nursing (DON) stated once a resident showed a change of condition, staff would be required to call a physician, get vitals, complete a Change of Condition form in the computer and notify family. The DON stated that some things that would be considered a change of condition would be a change in mental status, lethargy, abnormal behavior, and infections. The DON stated that once a change of condition is revealed the nurse should report the change of condition to the doctor immediately. During a follow-up interview on 03/21/23 at 12:00 p.m., Staff A CNA stated when assisting Resident #2 with a shower on 02/09/23 she observed Resident #2 with an insulin pump access in her lower right abdomen. Staff A CNA stated that she noticed a change of condition with Resident #2 as she was getting weaker and showing less energy. Staff A CNA stated that she reported Resident #2's change of condition immediately to Staff B RN after the shower. During a follow-up interview on 03/21/23 at 3:36 p.m., Staff B Registered Nurse (RN) stated the only changes of condition for Resident #2 that she was aware of was the day she had Staff E NP come in to assess Resident #2 and discussed with Staff E NP Resident #2's high fasting blood sugars. Staff B RN stated that was the day Rocephin was ordered on 02/15/23. Staff B RN was asked where the change of condition form was in the medical record and she said a change of condition form is usually completed but, stated if there was not one in the medical record it probably did not get done because Resident #2 was immediately taken off the unit and transferred to the other unit immediately. Staff B RN stated if the change of condition form is not in the medical record, then the Change of Condition form was not completed for 02/15/23. Staff B RN stated a change of condition form was expected to be completed but must have been missed. During an interview on 03/22/23 at 10:26 a.m., the Director of Nursing (DON) reviewed Resident #2's medical record and said there was no change of condition form in Resident #2's medical record for 02/15/23. The DON stated there was only a progress note on 02/15/23 about the change of condition and transfer to the other unit in the facility. The DON confirmed there was no change of condition form available on 02/09/23 when Staff A CNA reported to Staff B RN a change of condition observed during shower. The DON stated there was no change of condition assessment forms completed for 02/09/23 or 02/15/23 however there was a change of condition assessment form completed at Resident #2's discharge on 02/16/23. During an interview on 03/22/23 at 11:10 a.m., the DON provided a notification of change policy for review. The DON was asked about the protocol and steps for staff to follow when a change a of condition was identified. The DON stated that the facility did not have a protocol written down or in document form that discussed steps outlined for staff to follow when a change of condition was identified for a Resident. 2. A review of the Cardiovascular Office Visit notes for Resident #3, dated 2/10/23, showed Vitals could not be obtained due to her writhing in pain. The person that is accompanying her is stating that for the last few days she has been crying in pain and nothing has been done about this. The notes revealed the resident was being sent to the emergency department. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of records showed Resident #3 was admitted to the facility from the hospital on 2/2/23 with diagnoses including acute osteomyelitis of ankle and foot, cellulitis of left lower limb, type 2 diabetes mellitus with diabetic neuropathy, gas gangrene, pressure ulcer of left heel, stage 3, non-pressure chronic ulcer of other part of left foot with unspecified severity, cognitive communication deficit, idiopathic gout in left ankle and foot, other idiopathic peripheral autonomic neuropathy, peripheral vascular disease, pain in left foot, and acquired absence of right leg below the knee. A review of Resident #3's orders showed an order for Hydrocodone-Acetaminophen Oral tablets 5-325 mg (milligrams.) Give 1 tablet by mouth every 4 hours as needed for pain for 14 days, dated 2/2/23. No additional pain medication was ordered. Resident #3 also had an order in place for Seroquel Oral tablet 50 mg. Give 1 tablet by mouth at bedtime for anxiety and insomnia, dated 2/6/23. A review of Resident #3's care plan did not show any care plans in place related to pain. A review of Resident #3's Minimum Data Set (MDS) Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 6, showing severely impaired cognition. A review of progress notes for Resident #3 showed the following: 2/2/23 at 6:10 p.m. new admit, medication was not delivered yet. 2/3/23 at 12:06 a.m. Pharmacy gave code to pull 2 doses of Hydrocodone-Acetaminophen 5-325 mg from the automated medication dispensing machine. One administered and one put in lock box on the medication cart. The pain level charting showed the resident rated pain 10 out of 10. 2/3/23 at 1:12 a.m. Patient assignment acquired at 2300 (11:00 p.m.) Patient was loudly calling out repeatedly and escalating. Xanax and Norco (Hydrocodone-Acetaminophen) prescriptions had been faxed to the pharmacy. Nursing staff with automated medication dispensing machine access secured. The pharmacy was called for codes as patient's behavior and screaming continued to escalate, resulting in her sliding from her bed to the floor. She did not suffer any injuries. Bed was in lowest position. She was placed in a gerichair and brought out to the nurses station for close monitoring due to repeated attempts to climb out of bed. She kept calling for someone to bring her a phone, call her neighbor, call her daughter, call her son He will bring us all breakfast. Finally, after one dose of Xanax and Norco with one-on-one attention for an hour, she quieted down. 2/3/23 at 2:00 a.m. showed the patient rested quietly for about 30 minutes and then was up yelling at the top of her lungs again. A review of the Medication Administration Record (eMAR,) Medication Monitoring/Control Record, and progress notes was completed. The eMAR is where all medication given should be documented along with pain levels, and effectiveness for PRN pain medication. The Medication Monitoring/Control Record is a log kept on the medication cart and tracks the tablet counts for narcotics/controlled medications. The eMAR and Medication Monitoring/Control log combined showed Hydrocodone-Acetaminophen 5-325 mg was given as follows: (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/3/23 12:06 a.m. A pain scale of 10. Re-evaluation of pain: ineffective 4:57 a.m. A pain scale of 10. Re-evaluation of pain: ineffective 8:15 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 1:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 5:20 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. A progress note on 2/3/23 at 5:58 a.m. Did not appear to provide any relief-patient continued yelling out repeatedly. There was no documentation to show a provider was notified of the ineffective pain medication for Resident #3 on 2/3/23. 2/4/23 2:51 a.m. A pain scale of 7. Re-evaluation of pian: effective. 8:00 a.m. A pain scale of 10. Re-evaluation of pain: effective 12:00 p.m. A pain scale of 10. Re-evaluation of pain: effective 4:00 p.m. A pain scale of 10. Re-evaluation of pain: effective 8:00 p.m. A pain scale of 10. Re-evaluation of pain: effective A progress note on 2/4/23 at 4:17 a.m. Resident complained of pain and discomfort all night. Resident very restless and getting little to no sleep due to pain and anxiousness asking for her children all night. 2/5/23 12:27 a.m. A pain scale of 7. Re-evaluation of pain: effective 4:30 a.m. A pain scale of 7. Re-evaluation of pain: effective 8:30 a.m. A pain scale of 10. Re-evaluation of pain: effective 2:20 p.m. A pain scale of 10. Re-evaluation of pain: effective 11:08 p.m. A pain scale of 10. Re-evaluation of pain: ineffective A progress note on 2/5/23 at 23:08. Screaming could be heard down the hall at the nurses station. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2/6/23 3:11 a.m. A pain scale of 10. Re-evaluation of pain: effective 9:33 p.m. A pain scale of 6. Re-evaluation of pain: effective A progress note on 2/6/23 at 12:03 a.m. showed the follow-up pain scale was 10 out of 10. PRN medication was ineffective. Unable to determine whether her screaming is pain or behavior-Xanax and Norco did nothing to quiet her yelling. A progress note on 2/6/23 at 12:32 a.m. showed Patient was yelling at the start of my shift-could be heard down the hall-gave scheduled Xanax and PRN Norco to no avail. -+Keeping entire hall away [sic]-removed from room-taken to tv room so as not to disturb the other residents trying to sleep. There was no documentation to show a provider was notified of the ineffective pain medication or continued yelling of Resident #3 on 2/6/23. 2/7/23 3:31 a.m. A pain scale of 10. Re-evaluation of pain: effective 9:00 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 2:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 7:51 p.m. A pain scale of 5. Re-evaluation of pain: effective A progress note on 2/7/23 at 3:31 a.m. showed Resident #3 was yelling out ow. ow! 2/8/23 3:08 a.m. A pain scale of 5. Re-evaluation of pain: ineffective 8:07 a.m. A pain scale of 8. Re-evaluation of pain: effective 2:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 5:46 p.m. A pain scale of 10. Re-evaluation of pain: effective A progress note on 2/8/23 at 3:08 a.m. at showed the resident was moaning in pain. There was no documentation to show a provider was notified of the ineffective pain medication on 2/8/23 at 3:08 a.m. 2/9/23 1:33 a.m. A pain scale of 6. Re-evaluation of pain: effective (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6:00 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 10:00 a.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 2:00 p.m. Not documented on eMAR. No documented pain scale and no documented re-evaluation. 5:40 p.m. A pain scale of 6. Re-evaluation of pain: effective The Medication Monitoring/Control Record showed the dose given on 2/9/23 at 5:40 p.m. left 0 remaining doses available to Resident #3. A review of Resident #3's Weights and Vitals Summary showed a pain scale of 6 was entered by Staff N, RN on 2/10/23 at 2:36 a.m. There was no documentation that a provider or the pharmacy were called due to the resident being out of pain medication and continuing to be in pain. A review of the Medical Director's notes, dated 2/6/23, showed the reason for appointment was admission/history and physical for Resident #3. It said on exam, the patient's foot is gangrenous and in definite need of amputation. Nursing was instructed to get resident back to podiatry this week, if unable, may need to be readmitted to the hospital. Pain was not mentioned in the provider's note. A provider note from a facility doctor that partners with the Medical Director, dated 2/9/23 said the reason for the appointment was acute care visit and risk of hospitalization due to complications of cardiovascular disease, diabetes, and risk of falls with injury. It said the resident was in bed, nonverbal but moans often, I am told it stops a little bit after her pain medication is administered which was just given prior to my visit today. Ineffective pain medication was not mentioned in the provider's note. A review of a Pain Evaluation, dated 2/9/23, showed a pain assessment interview could be conducted due to the resident being able to communicate appropriately. The resident was unable to answer questions regarding pain presence, frequency, effect on function, or intensity. It noted there were non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) present. The evaluation also noted the resident complained or showed evidence of pain daily. The evaluation was completed and signed by Staff B, RN. An interview was conducted on 3/9/23 at 4:18 p.m. with Staff A, Certified Nursing Assistant (CNA). Staff A said she took Resident #3 to her doctor's appointment on 2/10/23 with Staff D, Director of Transportation. Staff A said the resident was crying out and screaming in pain. She said the doctor's office called 911. An interview was conducted on 3/9/23 at 2:40 p.m. with Staff D, Director of Transportation. Staff D confirmed she drove Resident #3 and Staff A, CNA to a doctor's appointment on 2/10/23. She said they left the building around 12:45-1:00 p.m. Staff D said the resident was upset because her foot was hurting her. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 3/15/23 at 3:25 p.m. with the Office Manager of the Cardiovascular office Resident #3 visited on 2/10/23. The Office Manager said Resident #3 was crying out in pain from the minute she came off the elevator. She said the resident's appointment was at 3:15 p.m. and the resident and her CNA arrived around 3:35 p.m. due to going to the wrong location initially. She said the CNA that was with Resident #3 was yelling at the resident to stop screaming and shut up. The Office Manager said it was very obvious she was in pain. She said the staff at the doctor's office called 911 to have Resident #3 taken to the emergency room . The Office Manager provided statements written by the cardiovascular registered nurse (RN), cardiovascular medical assistant (MA) 1, and cardiovascular MA 2. A written statement provided by the cardiology MA 1 revealed Resident #3 could be heard crying from the waiting room. She said when she attempted to take Resident #3's vital signs, she screamed in pain. The CNA with the resident told the resident to stop crying. The cardiovascular MA 1 said she removed the pulse oximeter and blood pressure cuff and informed the aide the resident needed critical care. MA 1 said she excused herself from the triage room and went to speak with the doctor and call emergency medical services (EMS.) MA 1 said while waiting for EMS the aide could be heard multiple times telling Resident #3 to be quiet and stop yelling. A written statement provided by the cardiology RN revealed Resident #3 came into the office for a hospital follow-up and she could be heard screaming for help from the triage room. She said the resident was overheard screaming ouch my back, I have a sore on my back while being moved to the stretcher. A written statement provided by the cardiology MA 2 revealed Resident #3 and her CNA arrived late to the appointment because they went to the hospital prior to appointment and found out they were at the wrong location. MA 2 said the resident's CNA didn't seem to care much about her resident and was yelling at her to be quiet. MA 2 said for some reason the CNA wasn't aware her resident needed urgent medical attention. MA 2 said Resident #3 was in excruciating pain, yelling help me, help me, since she came to the office. A review of the (Local) Medical Transportation Run Report showed the reason for transport was acute pain. The resident's pain scale was 10 on a scale of 1-10. It said upon arrival patient was found in a wheelchair in obvious distress. Emergency Medical Services arrived for the resident on 2/10/23 at 3:20 p.m. and arrival at the hospital was shown to be at 3:37 p.m. A review of the Emergency Department records showed the reason for Resident #3's visit was complaints of pain associated with a left foot wound. It stated her pain level was 10/10 and she was anxious, crying, restless. The records show Resident #3 was given Dilaudid 1 mg in the Emergency Department and after was noted to be resting comfortably in no acute distress. The record showed Resident #3's x-ray did not definitively show any osteomyelitis, however, did show subcutaneous gas, which consistent with patient's physical exam of crepitus along plantar surface. It revealed that was concerning for necrotizing fasciitis. The diagnosis is listed as necrotizing fasciitis left foot with a condition of guarded. Patient admitted inpatient. A review of the hospital discharge summary showed Resident #3 had a below-the-knee amputation due to sepsis in the infected leg. The resident was discharged on [DATE] to a second long term care facility. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008) from the second long-term care facility showed Resident #3 had a left below the knee amputation on 2/12/23. An observation was conducted of Resident #3 in the second long-term care facility on 3/14/23. Throughout the day the resident was resting comfortably, showing no signs of pain and no behaviors of yelling out. A follow-up interview was conducted on 3/21/23 at 12:18 p.m. with Staff A, CNA. Staff A said prior to leaving the facility for the doctor's appointment with Resident #3 on 2/10/12, the resident was in pain. Staff A said the nurse, Staff B, RN told her she was going to give the resident pain medication before they left. Staff A said she knew they had a one-hour drive to the appointment, the time there, and the one-hour drive back. Staff A said Resident #3 was screaming the whole ride. She said she didn't know why the resident was screaming because she was under the impression the nurse had given the resident her pain medication. Staff A said the resident had been crying out in pain daily since she was admitted . Staff A said the resident would be quiet and get some rest for a little bit after getting pain medication, but she would wake up and start crying out again. Staff A said she doesn't understand, because if a resident is in pain and needs medication, they should get it. She stated Resident #3 cried out in pain probably 15 hours out of every day. An interview was conducted on 3/10/23 at 6:00 p.m. with Staff O, Staffing Coordinator/Central Supply. Staff O said she was familiar with Resident #3. She said when she walked around the facility daily, Resident #3 was typically in pain and would always cry out. An interview was conducted on 3/10/12 at 6:10 p.m. with Staff P, Licensed Practical Nurse (LPN)/Unit Manager (UM). Staff P said Resident #3 was not comfortable because of the pain in her foot. She said she just wanted to lay here because of the pain. When asked about the resident not receiving pain medication prior to her appointment on 2/10/23 she said, I would have assumed the nurse would have given it to her. Staff P said they typically give pain medication before therapy and before going to appointments. She said when she gave the resident a shower, she was not in pain. Staff P said Resident #3 was in pain as soon as she got here. She said if someone talked to the resident, she would not scream but she would always say she was in pain. An interview was conducted on 3/21/23 at 1:07 p.m. with Staff Q, CNA. She stated she was familiar with Resident #3. She said the resident was always in pain and was always crying out. She said she thinks pain medications helped the resident because they would put her to sleep, but she would wake up and cry in pain again. An interview was conducted on 3/21/23 at 2:11 p.m. with Staff H, CNA. He stated he remembered Resident #3. He said she would tell him she was in pain and other times she could not talk because of her pain. An interview was conducted on 3/21/23 at 2:16 p.m. with Staff L, LPN. She stated she remembers Resident #3 sitting in the dining area crying and moaning in pain. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 3/21/23 at 3:05 p.m. with the Director of Nursing (DON). The DON was observed reviewing Resident #3's medical records. The DON said she did not know the resident very well and cannot speak to her pain on a day-to-day basis. The DON stated she was looking at the resident's record to see if the screaming had to do with behaviors, psychiatric medication, or history of drug use. She said they are always looking at psych (psychiatric issues) versus pain. She said they followed up with the resident's pain and gave her pain medication. She said they had the resident followed by psychiatry (psych) as well. There was an order for psych to evaluate and follow-up as needed. She said she did not see any provider notes in the record for psychiatry. The DON confirmed there were no notes in the record where the doctor was called and notified about Resident #3's ineffective pain medication. She said she would expect the nurse to follow physician orders and if the medication is not effective, they should notify the doctor. When asked if a resident cries and reports pain should the nurse call the physician, she said, I don't know. I was not down there and cannot speak to that. The DON said if a pain medication is not effective, the nurse can try non-pharmacological approaches for pain relief. She said if the nurse did that, it would be documented in the progress notes. The DON reviewed the progress notes and confirmed nothing was documented showing other approaches to pain management were attempted. On 3/21/23 at 5:00 p.m. the DON said she was unable to find anything showing psychiatry had evaluated Resident #3 during her stay. An interview was conducted on 3/21/23 at 3:38 p.m. with Staff B, RN, who confirmed she had cared for [TRUNCATED]