STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455881	A. Building B. Wing	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dfw Nursing & Rehab	900 W Leuda St Fort Worth, TX 76104

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview and record review the facility failed to immediately inform the physician when there was a significant change in the resident's physical and mental status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); for 1 of 6 Residents (Resident #1) whose records were reviewed for change in condition LVN B failed to contact the Attending Physician when Resident #1 had a change of condition of chest pain and low blood pressure on [DATE] and the resident expired on [DATE]. This failure resulted in the identification of an IJ (Immediate Jeopardy) on [DATE]. While the immediacy was removed on [DATE], the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope of isolated due to the facility's need to monitor the implementation and effectiveness of their corrective actions. This deficient practice could result in the residents not receiving urgent medical care and could result in death. The findings were: Record review of Resident #1's face sheet, dated [DATE], and EMR (electronic medical record) revealed, the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Angina (Chest Pain), hypotension(low blood pressure), end stage renal disease, Hemplegia and Hemparesis following Cerebral infarction. Resident was a female, age 62. The resident was her own responsible party. The resident expired at the facility on [DATE]. Record review of Resident #1's care plan, dated [DATE], revealed she was a full code. Resident #1 required assistance with Activity of daily living. Review of Resident #1's MDS assessment, dated [DATE], revealed the resident had a brief interview mental status score of 03, indicating severely impaired cognition Review of Resident #1's Medication Administration Record for [DATE] revealed the resident had an order to receive nitroglycerin for chest pain as needed . The medication was administered on [DATE] at 6:17 pm. Resident #1 had not recieived the medication prior to [DATE]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1's progress note, dated [DATE] at 3:36 pm, revealed a blood pressure of ,d+[DATE]. At 6:17 pm revealed Resident #1 was administered Nitroglycerin tablet sublingual 0.4mg. At 8:04pm revealed the blood pressure of ,d+[DATE] No notes reflected the complaint of chest pain. Review of Resident #1 physician order dated [DATE] revealed give Nitroglycerin tablet sublingual 0.4mg every five minutes as needed for Angina (Chest Pain). Review of Resident #1's progress note dated [DATE] at 8:28 am completed by LVN A Resident in bed resting this morning while making rounds with the outgoing nurse. Prior to breakfast, resident was still in bed. At 7.50am while making another round and med pass, went into the room to do her wound care, resident who is full code was found unresponsive in her bedroom. At this point CPR was initiated by this nurse while another nurse was delegated to call 911 and resuscitation measures was still in progress by this nurse and other nurses. Shortly, the paramedics and firefighters arrived and took over at the scene and continued CPR. Resident was pronounced dead at 8:22 am. Notified the physician, DON, and Administrator, Family was notified through her daughter, no further issues noted. An interview with Resident #1's family member on [DATE] on 8:07 am revealed she visited the facility on [DATE], while visiting Resident #1, the resident complained of chest pain around 6pm. She stated she pressed the call light and LVN B responded to Resident #1 that evening. She told LVN B that Resident #1 had chest pain and she wanted the resident sent to the hospital. She stated LVN B ignored her request and only provided the resident with a pill (Nitroglycerin). She stated Resident #1 passed away because of an heart attack. An interview with LVN A on [DATE] at 10:15 am (6am -2pm shift) revealed she worked on [DATE] and found Resident #1 unresponsive when attempting to do wound care. She stated the resident was unconscious, so she started CPR and called a code blue for others to respond. She stated she was not made aware Resident #1 had chest pain and a low blood pressure. An interview with LVN B on [DATE] at 1:47 pm revealed he began working at the faciltiy in 2018. He administered Nitroglycerin on [DATE] to Resident #1. He stated while working the 2:00 pm- 10:00 pm shift on [DATE], he responded to Resident #1 after a family member informed him Resident #1 had chest pain. He stated he provided the resident the medication and did not inform the physician. He did not inform the physician because there was an existing order for Nitroglycerin, so he did not. He stated the resident's chest pain was a change in condition. He assessd Resident #1 for chest pain and the effectiveness of the medication, the resident informed him the chest pain had went away. He did not follow up regarding the low blood pressure he stated. An interview with the ADM on [DATE] at 2:27 pm revealed she was not aware LVN B did not contact the physician when Resident #1 had a change in condition. The expectation for the nurses were to inform the physician when there is a change in condition. An interview with the Attending physician on [DATE] at 8:38 am revealed if Resident #1 had chest pain, it was change in condition, and he expected to have been notified. He stated he was not informed of Resident #1's chest pain and low blood pressure. He was only informed the resident expired on [DATE], by LVN B . He stated because the resident had an unusually low blood pressure, coupled with chest pain, he likely would have sent Resident #1 to the hospital for further evaluation. He stated the blood pressure of , d+[DATE] is extremely low, even though Resident #1 had a diagnosis of Hypotension. He was not made aware of the medication given for the leg pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on [DATE] at 9:45 am revealed she was not aware LVN B did not contact the attending physician when Resident #1 had a change in condition of chest pain and low blood pressure. The expectation was to notify the physician when the residents have a change in condition and follow the recommendation of the doctor. Record review of the facility's Change in a Resident's Condition or Status policy revised May, 2017 revealed Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and or status. The nurse will notify the residents Attending Physician or physician on call when there has been a: d. significant change in the resident's physical/emotional condition. A significant change is a major decline or improvement in the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. On [DATE] at 11:55 am , the Administrator was informed these failures resulted in an Immediate Jeopardy. The IJ template was provided to the Administrator. A plan of removal to remove the immediacy was requested at that time. Review of the facility's Plan of Removal, dated [DATE], reflected the following: Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date:([DATE]) The DON or designee notified Medical Director of the incident (Completed [DATE] Nursing supervisors/designees completed physical assessments on all residents to identify any changes in condition and notification was made to the physician of any noted changes. Concerns were/were not identified. The Administrator suspended the licensed nurse who was aware of significant change, but did not report it to the physician, pending investigation completed [DATE]. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: ([DATE]) The DON implemented disciplinary action with licensed nurse who was aware of significant change but did not report it to the physician (Administrator suspended Nurse immediately; additional discipline up to termination pending investigation). All licensed nurses were educated by the DON/designee on change of condition and physician notification regulations, as well as facility policy and procedure started [DATE]. Nurse aides were educated by the DON/designee on change of condition regulations to promote their situational understanding and facilitate communication with licensed nurse started [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	New hires (licensed nurses and nurse aides) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly in orientation by human resources/designee. The DON/ designee implemented a Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) with a focus on physician notification of significant changes. The PIP resulted in implementation of daily DON/designee audits of the 24-hour report (or insert name of facility specific report here) to monitor for change in resident condition. The DON/designee will also complete chart audits as follows: Three residents weekly for four weeks then. Two residents weekly for two weeks then. Two residents a month for two months. The regional/corporate/consultant nurse will visit the facility monthly to provide general oversight and monitoring of the PIP. Monitoring: Review of the In-service education started on [DATE] revealed staff were educated regarding change in condition, notification of the physician anytime the resident's physical or mental condition changed. Review of the form Change of condition dated [DATE] reflected all residents of the facility were assessed for change in condition. No residents had change of conditions that were not reported to the physician. An interview with RN C on [DATE] at 9:41 am revealed she was in-serviced on change in condition and interventions - who to notify, would include physician, DON, Adm., family. She stated notifications should be done immediately. She revealed some examples of change in condition as weakness, facial droop, chest pain, arm pain, vital signs out of normal parameters, falls with or without injury, and altered mental status. She stated any complaint of chest pain would prompt physician notification. An interview with LVN D on [DATE] at 10:04 am revealed he had been in-serviced on change in condition. LVN D was asked what change in condition meant to him. He stated anything different from resident's base line. Stated any complaints of pain in head, chest or abdomen would prompt physician notification and also to notify the family. Stated he would notify the DON and administrator after he notified the doctor. Stated if any aide report of resident seeming different would prompt further checks. Stated he used a skill form to document assessment findings. He stated he would notify the physician of any changes in conditions to the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LVN E on [DATE] at 12:40 pm revealed he had been in-serviced on change in condition. He stated a change in condition was anything out of normal for a resident. He stated it could be vital signs, a scratch, or anything. Stated he would notify physician ,family, and the DON of any change in condition. Stated all information would be documented . Stated all falls were documented. All facility staff were interviewed between [DATE] and [DATE] had all been in-serviced on Change of Condition, and reporting. Staff verbalized examples of various changes and who to notify regarding change. All nursing staff stated physician,DON,Administrator would be notified of the change and documented. An interview with LVN B on [DATE] at 10:30 am revealed he had been suspended pending the results of the investigation. He received training regarding change in condition. He stated, going forward, when a resident had a change in condition, he would promptly notify the physician. An interview with the ADM on [DATE] at 10:53 am revealed all residents had been assessed for change in condition and none was noted. All staff working at the facility had been educated regarding identifying change or condition to whom to report. All nurses are required to report change of condition to the physician and follow the instructions of the physician. An interview with the DON on [DATE] at 11:15 am revealed all staff, including nursing staff, were educated regarding change in condition and the reporting requirements. The residents were assessed and no changes were noted. The nurses were responsible for reporting changes to the physician. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 11:55 a.m. While the IJ was removed on [DATE] 11:38am, the facility remained out of compliance at a severity level of actual harm that is not an immediate threat and a scope of isolated, due to the facility's need to monitor effectiveness of their Plan of Removal.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation, interview, and record review the facility failed to, ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident's choices for one (Resident #1) of six residents reviewed for quality of care. The facility failed to provide treatment and care when Resident #1 had chest pain and an unusually low blood pressure (according to the doctor). LVN B failed to notify the doctor of the chest and low blood pressure. LVN B failed monitor and report the chest pain and low pressure. There was no evidence the nurse followed up regarding the low blood pressure. The resident expired the next day. This failure resulted in the identification of an IJ (Immediate Jeopardy) on [DATE]. While the immediacy was removed on [DATE], the facility remained out of compliance at actual harm that is not immediate jeopardy with a scope of isolated due to the facility's need to monitor the implementation and effectiveness of their corrective actions. This deficient practice could result in the residents not receiving urgent medical care and could result in death. The findings were: Record review of Resident #1's face sheet, dated [DATE], and EMR (electronic medical record) revealed, the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included: Angina (Chest Pain), hypotension(low blood pressure), end stage renal disease, Hemplegia and Hemparesis following Cerebral infarction. Resident was a female, age 62. The resident was her own responsible party. The resident expired at the facility on [DATE]. Record review of Resident #1's care plan, dated [DATE], revealed she was a full code. Resident #1 required assistance with Activity of daily living. Review of Resident #1's MDS assessment, dated [DATE], revealed the resident had a brief interview mental status score of 03, indicating severely impaired cognition Review of Resident #1's Medication Administration Record for [DATE] revealed the resident had an order to receive nitroglycerin for chest pain as needed . The medication was administered on [DATE] at 6:17 pm. Resident #1 had not recieved the medication any other time. Review of Resident #1's progress note, dated [DATE] at 3:36 pm, revealed a blood pressure of ,d+[DATE]. At 6:17 pm revealed Resident #1 was administered Nitroglycerin tablet sublingual 0.4mg. At 8:04pm revealed the blood pressure of ,d+[DATE] No notes reflected the complaint of chest pain. There was no evidence LVN A followed up regareding the low blood pressure. The notes reflect LVN A assessed the resident five minutes later, and the medication was effective. There were no addiotional notes regarding monitor the blood pressure, chest pain or leg pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #1 physician order dated [DATE] revealed give Nitroglycerin tablet sublingual 0.4mg every five minutes as needed for Angina (Chest Pain). Review of Resident #1's progress note dated [DATE] at 8:28 am completed by LVN A Resident in bed resting this morning while making rounds with the outgoing nurse. Prior to breakfast, resident was still in bed. At 7.50am while making another round and med pass, went into the room to do her wound care, resident who is full code was found unresponsive in her bedroom. At this point CPR was initiated by this nurse while another nurse was delegated to call 911 and resuscitation measures was still in progress by this nurse and other nurses. Shortly, the paramedics and firefighters arrived and took over at the scene and continued CPR. Resident was pronounced dead at 8:22 am. Notified the physician, DON, and Administrator, Family was notified through her daughter, no further issues noted. An interview with Resident #1's family member on [DATE] on 8:07 am revealed she visited the facility on [DATE], while visiting Resident #1, the resident complained of chest pain around 6pm. She stated she pressed the call light and LVN B responded to Resident #1 that evening. She told LVN B that Resident #1 had chest pain and she wanted the resident sent to the hospital. She stated LVN B ignored her request and only provided the resident with a pill (Nitroglycerin). She was informed the resident passed away because of a Heart Attack. An interview with LVN A on [DATE] at 10:15 am (6am -2pm shift) revealed she worked on [DATE] and found Resident #1 unresponsive when attempting to do wound care. She stated the resident was unconscious, so she started CPR and called a code blue for others to respond. She stated she was not made aware Resident #1 had chest pain and a low blood pressure. An interview with LVN B on [DATE] at 1:47 pm revealed he administered Nitroglycerin on [DATE] to Resident #1. He stated while working the 2:00 pm- 10:00 pm shift on [DATE], he responded to Resident #1 after a family member informed him Resident #1 had chest pain. The resident also complained of having leg pain. The resident was given pain medication for the leg pain. He stated he provided the resident the medication and did not inform the physician. He did not inform the physician because there was an existing order for Nitroglycerin, so he did not. He stated the resident's chest pain was a change in condition. The resident low blood pressure was not identified because the resident had a diagnosis of low blood pressure he stated. He did not follow up with the low pressure blood pressure for Resident #1. An interview with the ADM on [DATE] at 2:27 pm revealed she was not aware LVN B did not contact the physician when Resident #1 had a change in condition. The expectation for the nurses were to inform the physician when there is a change in condition. An interview with the Attending physician on [DATE] at 8:38 am revealed if Resident #1 had chest pain, it was change in condition, and he expected to have been notified. He stated he was not informed of Resident #1's chest pain and low blood pressure. He was only informed the resident expired on [DATE], by LVN B . He stated because the resident had an unusually low blood pressure, coupled with chest pain, he likely would have sent Resident #1 to the hospital for further evaluation. He stated the blood pressure of , d+[DATE] is extremely low, even though Resident #1 had a diagnosis of Hypotension. He was not aware the resident had also experienced leg pain, and had also recieved medication for leg pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with the DON on [DATE] at 9:45 am revealed she was not aware LVN B did not contact the attending physician when Resident #1 had a change in condition of chest pain and low blood pressure. The expectation was to notify the physician when the residents have a change in condition and follow the recommendation of the doctor. Record review of the facility's Change in a Resident's Condition or Status policy revised May, 2017 revealed Our facility shall promptly notify the resident, his or her Attending Physician, and representative of changes in the resident's medical/mental condition and or status. The nurse will notify the residents Attending Physician or physician on call when there has been a: d. significant change in the resident's physical/emotional condition. A significant change is a major decline or improvement in the resident status that will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. On [DATE] at 11:55 am , the Administrator was informed these failures resulted in an Immediate Jeopardy. The IJ template was provided to the Administrator. A plan of removal to remove the immediacy was requested at that time. Review of the facility's Plan of Removal, dated [DATE], reflected the following: Identification of Residents Affected or Likely to be Affected: The facility took the following actions to address the citation and prevent any additional residents from suffering an adverse outcome. (Completion Date:([DATE]) The DON or designee notified Medical Director of the incident (Completed [DATE] Nursing supervisors/designees completed physical assessments on all residents to identify any changes in condition and notification was made to the physician of any noted changes. Concerns were/were not identified. The Administrator suspended the licensed nurse who was aware of significant change, but did not report it to the physician, pending investigation completed [DATE]. Actions to Prevent Occurrence/Recurrence: The facility took the following actions to prevent an adverse outcome from reoccurring. (Completion Date: ([DATE]) The DON implemented disciplinary action with licensed nurse who was aware of significant change but did not report it to the physician (Administrator suspended Nurse immediately; additional discipline up to termination pending investigation). All licensed nurses were educated by the DON/designee on change of condition and physician notification regulations, as well as facility policy and procedure started [DATE]. Nurse aides were educated by the DON/designee on change of condition regulations to promote their situational understanding and facilitate communication with licensed nurse started [DATE]. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	New hires (licensed nurses and nurse aides) will be educated on change of condition and physician notification regulations, as well as facility policy and procedure, accordingly in orientation by human resources/designee. The DON/ designee implemented a Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP) with a focus on physician notification of significant changes. The PIP resulted in implementation of daily DON/designee audits of the 24-hour report (or insert name of facility specific report here) to monitor for change in resident condition. The DON/designee will also complete chart audits as follows: Three residents weekly for four weeks then. Two residents weekly for two weeks then. Two residents a month for two months. The regional/corporate/consultant nurse will visit the facility monthly to provide general oversight and monitoring of the PIP. Monitoring: Review of the In-service education started on [DATE] revealed staff were educated regarding change in condition, notification of the physician anytime the resident's physical or mental condition changed. Review of the form Change of condition dated [DATE] reflected all residents of the facility were assessed for change in condition. No residents had change of conditions that were not reported to the physician. An interview with RN C on [DATE] at 9:41 am revealed she was in-serviced on change in condition and interventions - who to notify, would include physician, DON, Adm., family. She stated notifications should be done immediately. She revealed some examples of change in condition as weakness, facial droop, chest pain, arm pain, vital signs out of normal parameters, falls with or without injury, and altered mental status. She stated any complaint of chest pain would prompt physician notification. An interview with LVN D on [DATE] at 10:04 am revealed he had been in-serviced on change in condition. LVN D was asked what change in condition meant to him. He stated anything different from resident's base line. Stated any complaints of pain in head, chest or abdomen would prompt physician notification and also to notify the family. Stated he would notify the DON and administrator after he notified the doctor. Stated if any aide report of resident seeming different would prompt further checks. Stated he used a skill form to document assessment findings. He stated he would notify the physician of any changes in conditions to the resident. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview with LVN E on [DATE] at 12:40 pm revealed he had been in-serviced on change in condition. He stated a change in condition was anything out of normal for a resident. He stated it could be vital signs, a scratch, or anything. Stated he would notify physician ,family, and the DON of any change in condition. Stated all information would be documented . Stated all falls were documented. All facility staff were interviewed between [DATE] and [DATE] had all been in-serviced on Change of Condition, and reporting. Staff verbalized examples of various changes and who to notify regarding change. All nursing staff stated physician,DON,Administrator would be notified of the change and documented. An interview with LVN B on [DATE] at 10:30 am revealed he had been suspended pending the results of the investigation. He received training regarding change in condition. He stated, going forward, when a resident had a change in condition, he would promptly notify the physician. An interview with the ADM on [DATE] at 10:53 am revealed all residents had been assessed for change in condition and none was noted. All staff working at the facility had been educated regarding identifying change or condition to whom to report. All nurses are required to report change of condition to the physician and follow the instructions of the physician. An interview with the DON on [DATE] at 11:15 am revealed all staff, including nursing staff, were educated regarding change in condition and the reporting requirements. The residents were assessed and no changes were noted. The nurses were responsible for reporting changes to the physician. An Immediate Jeopardy (IJ) situation was identified on [DATE] at 11:55 a.m. While the IJ was removed on [DATE] 11:38am, the facility remained out of compliance at a severity level of actual harm that is not an immediate threat and a scope of isolated, due to the facility's need to monitor effectiveness of their Plan of Removal.