STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001614	A. BUILDING: _____ B. WING _____	C 10/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRESIDE HOUSE OF CENTRALIA	1030 MARTIN LUTHER KING BLVD CENTRALIA, IL 62801

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S 000	Initial Comments Complaint Investigation 2358381/IL165270	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) This REQUIREMENT is not met as evidenced by: There are two deficient practice statements. I. Based on interview and record review the facility failed to identify a decline in condition as an emergent situation and ensure a system was in place to obtain timely emergency transport for 3 of 6 (R1, R8, and R9) residents reviewed for hospital transfers in the sample of 9. This failure resulted in R1 not being transported to the hospital emergency room for an hour while experiencing worsening symptoms of sluggish dilated pupils, temperature of 95.7, difficulty with speech, slow response time, and facility staff were unable to obtain an oxygen saturation. R1 expired in the hospital emergency room and cause of death is documented as a massive gastrointestinal bleed. This failure has the potential to affect all 37 residents residing at the facility. II. Based on interview and record review the facility failed to protect a resident's right to be free	S9999		

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S9999	Continued From page 2 from neglect when they failed identify a change in condition as emergent and to ensure a system was in place to obtain timely emergency transport for 1 of 3 (R1) residents reviewed for neglect in the sample of 9. This failure resulted in R1 not being transported to the hospital emergency room for an hour while experiencing worsening symptoms of sluggish dilated pupils, temperature of 95.7, difficulty with speech, slow response time, and facility staff were unable to obtain an oxygen saturation. R1 expired in the hospital emergency room and cause of death is documented as a massive gastrointestinal bleed. This failure has the potential to affect all 37 residents residing at the facility. Findings Include: 1. R1's Admission Record with a print date of 10/12/23 documents R1 was admitted to the facility on 6/26/23 with diagnoses that include multiple sclerosis, malignant neoplasm of pancreas, atrial fibrillation, restless leg syndrome, neuromuscular dysfunction of bladder, major depressive disorder, cognitive communication deficit, and weakness. R1's MDS (Minimum Data Set) dated 7/3/23 documents a BIMS (Brief Interview for Mental Status) score of 15, which indicates R1 was cognitively intact. R1's Order Summary Report with active orders as of 9/30/23 documents a physician order that R1 was a full code and a physician order for Xarelto 20 milligrams (mg) one every afternoon. R1's Care Plan documents a Focus area with a	S9999		

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S9999	Continued From page 3 created date of 6/30/23 documents, "Usage of black box medications: ...Xarelto ..." The interventions documented for this Focus area include, "Monitor and assess for side effects of medications that contain black box warning PRN (as needed)." R1's Care Plan documents a Focus area with a created date of 6/27/23 of, "(R1) wishes to return home with (name of home health agencies)." The intervention documented for this Focus area is, "Evaluate and discuss with the (R1) and (V19) the prognosis for independent or assisted living. Identify, discuss and address limitations, risks, benefits, and needs for maximum independence." R1's Power of Attorney for Health Care dated 6/27/23 documents V19 (family member/spouse) was R1's agent to make decisions for her when she was not able to make them for herself. The form documents a check mark next to the following statement, "Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards." R1's Social Services Assessment and Note dated 6/27/23 documents under Social Service Note, "(R1) was admitted to (name of facility) for a short-term therapy stay following a long hospitalization. POLST (Physician Orders for Life Sustaining Treatment) FULL CODE per choice. HCPOA (Health Care Power of Attorney) husband (V19) 6/26/23 ..." R1's Progress Notes document the following: 10/03/23 2:20 PM, "resident (R1) is alert, verbal,	S9999		

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S9999	Continued From page 4 oriented x 2, sleeps well at night." 10/04/23 6:50 AM, "AM ADL's (activities of daily living) to go get chemo (chemotherapy) port placement this am. Res (R1) has been NPO (nothing by mouth). CNA (Certified Nursing Assistant) called this writer (V14) to room. (R1) having difficulty with speech et (and) slow to respond. CNAs stated at oncome of shift at 0600 (6:00 AM) was talking fine. Pupils sluggish to response, dilated. Bilat (bilateral) upper ext. (extremity) edema. Unable to get O2 sat (saturation), pale but no discoloration. Blanches pink nail beds, flaccid strength per her norm, total assist, blankets applied to increase temp (temperature) skin cool, 95.7 122/88, 84, 20 room air. Called (V24/NP-Nurse Practitioner) send to ER (emergency room) for evaluation r/t (related to) condition change. (Name of ambulance service) called at 0655 (6:55 AM) called husband and made aware of. This writer staying by room to monitor." This progress note was signed by V14 (LPN/Licensed Practical Nurse). 10/04/23 7:35 AM, "(ambulance service) here. 0745 (7:45 AM) Exit with (R1) per transfer of 4 to stretcher." 10/04/23 10:15 AM, "husband here et made aware of wife expiring. Hugged this nurse et stated thank you for taking good care of her. Belongings taken at this time. Administrators present with facilities (sic) condolences. Called (V24) et made aware of (R1) expiring per notification from husband." R1's Ambulance Patient Care Report dated 10/04/2023 documents under Response Information the Nature of Call as "Medical Emergency" and documents, "Caller	S9999		

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S9999	Continued From page 5 (Uncooperative) No EMS (Emergency Medical Service) Vehicles (Units) Available." Under Times the report documents, "Injury: 0659 (AM) ...Recvd (received) 06:59 (AM) ...Dispatch: 07:35 (AM) ..." The Patient Care Report documents Altered Consciousness-Unresponsive as the chief complaint. Under Narrative the report documents, "Responded emergent for a direct call to (name of facility) report of a female with flaccid, decline in responsiveness, and uneven pupils. Per dispatch "nursing home refused to call 911 and wanted to wait for (name of ambulance service) ambulance knowing it (sic) we don't have any units available and will be a while." Delay to scene due to no units available. AOS (arrived on scene) to find pt (patient/R1) laying in nursing home bed. Per nursing home staff, staff noticed a change in (R1's) condition around 0600 (6:00 AM) this morning when they started their shift. Further, nurse states (R1's) temperature is 95.4 and they are attempting to warm her. (R1) is unresponsive, pale, cool, and clammy. (R1) moved to cot, secured, and loaded into ambulance. (R1) has a PICC (peripherally inserted central catheter) line to her left upper arm. (R1) placed on cardiac monitor showing sinus bradycardia, (R1) went into cardiac arrest. CPR (Cardiopulmonary Resuscitation) immediately started by (names of paramedics and emergency medical technician) contacted (name of local hospital) ED (Emergency Department) to given (sic) (R1) update upon arrival. Pads placed on (R1) showing asystole. ER (Emergency Room) staff met this unit outside and assisted in taking (R1) into emergency room ...(R1) care left with ER nursing staff ...." R1's local hospital emergency department record dated 10/04/23 documents under History, "Chief Complaint Patient (R1) presents with Cardiac	S9999		

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S9999	Continued From page 6 Arrest. Pt (R1) per EMS (emergency medical services) has been told by NH (nursing home) staff unresponsive since 0600 (6:00 AM)... they were called just pta (prior to arrival) and found (R1) unresponsive hr (heart rate) 30's in route just across street full arrest they started cpr (cardiopulmonary resuscitation) large amt (amount) of black vomit on arrival asystole on arrival accu (sic) done by us 84 on arrival, cpr continued going thru epi (epinephrine) x (times) 3, attempted intubations very large vomit in airway clogging up many yankars with blood clots difficult to get clear site, unable to pass 7 tube ? (question) mass beyond tried 6.5 still unable getting video stylet unable to see, anesthesia called but placed lma (laryngeal mask airway) and b/l (bilateral) bs (breath sounds) after still asystole and (R1) pupils fixed dilated on arrival pale waxy color entire time and US (ultrasound) cardiac no activity no pulse called tod (time of death) at 0808 (8:08 AM)." Under Physical Exam R1's hospital record documents, BP (blood pressure) 56/38, SpO2 85%...fixed and dilated pupils ...pulse with cpr then nothing ...bagging after lma b/l bs." R1's hospital record documents "Cardiac Arrest" under ED (Emergency Department) Course, Clinical Impressions. R1's Certificate of Death Worksheet documents R1 expired on 10/04/23 and Cause of Death is documented as "Massive Gastrointestinal Bleed." On 10/11/23 at 4:17 PM, V12 (CNA) stated she provided care to R1 on 10/02, 10/3, and 10/04/23. V12 stated on 10/2 and 10/3/23, R1 refused to eat and didn't want to get out of bed on those days. V12 stated R1 wasn't talking as loud, "she was kind of quiet and mumbly (sic)." V12 stated she came to work on 10/04/23 and it was reported to her by night shift, R1 had complained	S9999		

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S9999	Continued From page 7 of not feeling well through the night. V12 stated she went straight to R1's room after she got report at 6:00 AM. V12 stated she told V14 (LPN/Licensed Practical Nurse) to assess R1. V12 stated V14 first said she was going to send R1 out to the hospital for evaluation and then changed her mind and had them get R1 up to go to the appointment she had. V12 stated they got R1 up and took her to the nurse's station. V12 stated they took R1's temperature and it was around 95.0. V12 stated, V14 told them to put R1 back to bed they were calling the ambulance. V12 stated V14 told them it was going to be a little bit before the ambulance could get there because they had someone going out on a helicopter. V12 stated at that point R1 was cold and was still speaking and told them she was hurting all over. V12 stated then R1 was "kind of hollering and yelling." V12 stated, V25 (PTA/Physical Therapy Assistant) went in to check on R1 and R1 told V25 she was hurting all over. V12 stated she checked on R1 around 7:00 AM and at that time R1 was not able to verbally communicate with words. V12 stated the ambulance got to the facility around 7:30 AM. V12 stated R1 was alert but they couldn't get her to speak at that point. V12 stated the ambulance crew asked V14 as soon they got in the room why she refused to call 911. V12 said V14 told the ambulance crew as far as she knew there were no ambulances. On 10/16/23 at 11:28 AM, V25 (PTA) stated she was walking another resident down the hall when she heard R1 screaming and yelling, "help me, help me." V25 stated she finished walking the resident down the hall and went back to check on R1. V25 stated she asked R1 if she was ok and R1 didn't respond. V25 stated R1 was looking up at the ceiling so she asked R1 if she was hurting.	S9999		

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S9999	Continued From page 8 V25 stated R1 said yes and when she asked her where she was hurting R1 screamed, "everywhere." When asked if that was normal behavior for R1, V25 stated, "no." V25 stated she had never heard R1 scream out like that. V25 stated R1 was definitely not a screamer. V25 stated R1 was hollering and V25 mimicked a continuous holler. V25 stated at first there were no words and then R1 yelled the word, everywhere. V25 stated she thought this was around 6:30 AM then stated it was between 7:15 and 7:30 AM. V25 stated she reported it to the V14 (LPN). V27 stated an unknown CNA told her they had already contacted the ambulance and they were just waiting on the ambulance to get free to come get R1. On 10/11/23 at 3:27 PM, V9 (CNA) stated she provided care to R1 in the days leading up to 10/04/23 and was working when R1 was sent to the hospital. V9 stated R1 had progressively gotten worse in the three days prior to 10/04/23. V9 stated she got to work on the morning of 10/04/23 around 5:50 AM. V9 stated R1 had an appointment scheduled for that morning so she and another CNA (V12) went to R1's room around 6:10 AM. V9 stated R1 was really "out of it." V9 stated they reported it to the nurse (V14). V9 stated V14 told them to get R1 up so she could go to her appointment, so they did. V9 stated they took R1 to the nurse's station and R1 was very cold. V9 stated V14 told them to put R1 back to bed and they were sending R1 to the hospital. When asked how long it took the ambulance to arrive, V9 stated she knew it was a "whole big ordeal." V9 stated she knew they called the ambulance, and they said it was going to be awhile before they could get to the facility. V9 was not able to say when the ambulance arrived. V9 stated she remembered R1 yelling	S9999		

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S9999	Continued From page 9 and just trying to talk while V9 was trying to get other residents up. V9 stated she kept going in R1's room to check on her. V9 stated R1 was trying to talk but couldn't get her words out, but she was yelling and mumbling. V9 stated R1 worsened because she was able to say her name when she first saw her around 6:10 AM. When asked if a nurse was with R1 during this time frame, V9 stated, not the whole time but she was in the room multiple times. On 10/12/23 at 9:38 AM, V14 (LPN) stated she provided care to R1 on 10/04/23. V14 stated she started her shift at 6:00 AM and went to R1's room around 6:05 AM. V14 stated right after that V9 and V12 (CNA's) reported to her R1 was acting different. V14 stated she assessed R1 including checking her vital signs and R1's blood pressure was 122/88. V14 stated R1 was sluggish to respond but was vocal at that time. V14 stated R1's temperature was 95.7 Fahrenheit and hypothermic measures were implemented such as extra blankets. V14 stated R1 was full of fluid but blanched pink when she blanched her. V14 stated she called the ambulance service direct around 6:15 AM and told them R1 was sluggish to respond and slurring her words, a change from 10 minutes prior. V14 stated the ambulance service told her they would send someone out. V14 stated she then went to R1's room and stayed with her. V14 then stated she passed medications to other residents on the same hallway. When asked if that meant she wasn't with R1 the whole time, V14 stated, "No, not the whole time." V14 stated R1 looked as though she was resting. When asked when the ambulance service arrived, V14 stated, V20 (RN/Registered Nurse) "hollered" down and told her there were two helicopters and all the ambulance crews were tied up, so that delayed	S9999		

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S9999	Continued From page 10	S9999		

them from arriving at the facility. V14 stated she would guess they arrived at the facility around 7:15 or 7:20 AM. V14 stated she didn't call 911. V14 stated she didn't realize she had an emergent situation. V14 stated R1 had a condition change and she wanted her out of the facility as fast as she could go but didn't think she was going to pass away. V14 stated the normal procedure for sending a resident to the hospital is to call the ambulance service direct. V14 stated she thought calling them would be her fastest response.

On 10/11/23 at 4:31 PM, V13 (EMT/Emergency Medical Technician, Basic) stated she transported R1 from the facility to the local hospital on 10/04/23. V13 stated it was unusual because R1's call came while she was on another call. V13 stated she was on the helipad and the patient she was working with had a "soft" blood pressure so the helicopter couldn't leave. V13 stated when that happens the ground crew can't leave the helipad. V13 stated she got the call around 6:39 AM from the night shift dispatcher (V27) that there was a resident (R1) at the facility with uneven pupils, flaccid, unresponsive, and sitting at the nurse's station. V13 stated she responded to dispatch to call the facility and tell them to call another service because with those symptoms they needed immediate transport, and the other crew was in another city on a different transport. V13 stated she returned to the helipad, and she got another call from dispatch at around 7:00 AM. V13 stated dispatch told her the resident (R1) was still waiting for transport. V13 stated she explained to dispatch R1 couldn't wait. V13 stated they finished at the helipad around 7:35 AM and when they called in that the call, they were on was complete, they were told the resident (R1) was still waiting for transport at the

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S9999	Continued From page 11 facility. V13 stated they went in route to the facility and arrived within less than two minutes. V13 stated the nurse (V14) told them R1 was in bed, and they were trying to warm her since her temperature was 95.4. V13 stated they asked her why she didn't call 911 and V14 told them she was busy on the hall. V13 stated when they got to R1's room she was in bed laying under a blanket. V13 stated R1 was diaphoretic, cold to touch gray/blue around her lips and outside her mouth, both pupils were dilated, and the left pupil measured a 6 while the right pupil was an 8. V13 stated facility staff helped transfer R1 to the cot and they started oxygen immediately. V13 couldn't remember if oxygen had been applied by the facility staff prior to their arrival. V13 stated once in the ambulance her partner attempted to start an IV (intravenous access) and they were unable to get a blood pressure. V13 stated then R1 "went loose" and lost her pulse. V13 stated they started CPR and R1 was spewing coffee ground emesis with compressions. V13 stated they were in route to the hospital which is less than two minutes away and they turned her care over to the ER staff when they arrived. On 10/13/23 at 4:04 PM, V27 (Dispatcher, Ambulance Service) stated she works at the ambulance service as a dispatcher on the 11 PM to 7 AM shift. V27 stated she received a call from the facility around 6:39 AM on 10/04/23 and the nurse (V14) gave her the information on R1. V27 stated she told V14 there was no crew available because they had a crew going to a regional hospital and one on the helipad. V27 stated V14 said she guessed she would wait for them. V27 stated she called the crew to get an established time frame and they said it would be 30-40 minutes. V27 stated she called the facility back around 7:00 AM to make them aware of the time	S9999		

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	IL6001614	A. BUILDING: _____ B. WING _____	C 10/23/2023

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S9999	Continued From page 12 frame. V27 stated she didn't get the name of the nurse who answered the phone, but she told them the time frame and they said they would let the nurse know. V27 stated it took the crew approximately 30 minutes after that to get to the facility. On 10/11/23 at 12:02 PM, V5 (Ambulance Dispatcher) stated he came on duty on 10/04/23 at 7:00 AM. V5 stated the original call came from the facility at 6:39 AM. V5 stated they had one ambulance crew out of town doing a run and a second crew working on the helipad with a stroke victim. V5 stated the night shift dispatcher (V27) called the facility back at 7:02 AM and told them it was still going to be thirty minutes before they could arrive to the facility to transport R1 to the local hospital. V5 stated the facility said they would wait. V5 stated the crew arrived at the facility at 7:35 AM. On 10/18/23 at 11:22 AM, when asked why the time on R1's ambulance report is documented as 6:59 AM when all the interviews say the first call came from the facility at 6:39 AM, V5 (ambulance dispatcher) stated the original call came in at 6:39 AM but they didn't create the call in the system because they didn't know if they would be taking the call. V5 stated they didn't create the call in the system until they talked to the crew and called the facility back. V5 stated he took a picture of the time the calls came in and the original call's picture shows it was 6:3*, with the last number not visible. V5 stated the time stamp on the call logs shows the ambulance service called the facility back at 7:02 AM. On 10/12/23 at 11:19 AM, V17 (LPN) stated she was working the day R1 was sent to the hospital. V17 stated they were getting ready to start	S9999		

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S9999	Continued From page 13 morning medication pass, and the CNA's brought R1 up for breakfast. V17 stated V14 (LPN) said she was going to send R1 out to the hospital. V17 stated they took R1 to her room and V17 started passing medications. V17 stated the ambulance service called back and said they were 20-30 minutes out. V17 stated she remembered calling that information down to V14. V17 stated she talked to R1 on her way out the door and told her goodbye. When asked if R1 responded to her, V17 stated she couldn't remember. On 10/12/23 at 1:37 PM, V20 (RN) stated she works night shift and on the morning of 10/04/23 she gave report to the oncoming nurse (V14) at approximately 6:00 AM. V20 stated V14 brought R1 to the nurse's desk and V14 said something was wrong with R1. V20 stated it was a change in condition from when she had seen R1 around 2:30 AM, when R1 was talking and asking to be repositioned. V20 stated V14 was having trouble getting R1's vital signs so she helped her and V14 called the ambulance. V20 stated she was working on paperwork when the ambulance called back, and she answered the phone. V20 stated they told her they were going to be about 30 minutes. V20 stated she told the other nurse (V17) and V17 told V14. V20 stated she finished her work and left, and the ambulance had not arrived at the facility when she left. When asked if it was typical for the ambulance to take an extra 30 minutes, V20 stated, "At times they do," When asked what they normally do in those situations V20 stated she would either call another ambulance service or call 911. On 10/12/23 at 2:33 PM, V23 (CNA) stated she worked the night before R1 was sent to the hospital. V23 stated R1 was talking to her when	S9999		

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S9999	Continued From page 14 she left the facility the morning of 10/04/23 at 6:00 AM. V23 stated R1 was very restless through the night shift and said she just didn't feel good and couldn't get comfortable. V23 stated R1's hands were very swollen and R1 couldn't use them. On 10/12/23 at 3:24 PM, V26 (CNA) stated she worked night shift beginning on 10/03/23 and leaving on the morning of 10/04/23. V26 stated R1 was very uncomfortable, R1's hands were swollen, and R1 seemed really nervous like she was scared or something. V26 stated R1 complained of a stomachache and so they gave her some tums and it helped. When asked how R1 was when she left the facility at 6:00 AM, V26 stated R1 had been up all night and was sleeping so she let her sleep. On 10/12/23 at 1:14 PM, V19 (family member) stated he saw R1 on 9/30/23 and 10/01/23. V19 stated R1 couldn't swallow and seemed kind of groggy. V19 stated the facility called him on 10/04/23 and told him they were transferring R1 to the hospital and then the hospital called him a lot later with an update. When asked what time the facility called him V19 stated he told V22 (family member). On 10/10/23 at 1:22 PM, V22 (family member) stated the facility called V19 on 10/04/23 at 6:30 AM and told V19, R1 was not acting right. V22 stated around 7:45 AM, R1 arrived at the hospital in cardiac arrest. On 10/11/23 at 3:01 PM, V6 (LPN) stated the typical time to transfer a resident to the hospital is thirty minutes or so if the ambulance is "backed up." V6 stated it has taken longer. V6 stated it has taken up to an hour. When asked if there	S9999		

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S9999	Continued From page 15 was another option for an ambulance service V6 stated the name of another ambulance service provider and stated but "sometimes they don't come this way." V6 then stated, "Honestly, if it came down to it, I would push them to the hospital. It is right next door." When asked who she calls when they need an ambulance V6 stated, "if they are unresponsive, I call 911." When asked if she was providing care to R1 when she was transferred to the hospital on 10/04/23, V6 stated she was not. V6 stated, "She (R1) wasn't one to give up. I was kind of shocked when I found out she had passed away." On 10/11/23 at 3:39 PM, V10 (LPN) stated she didn't provide care for R1. When asked what the process was to send a resident to the hospital V10 stated, they assess the resident, call the physician, get the orders, call the power of attorney, ambulance, and hospital. When asked how long this process takes V10 stated 15-20 minutes or less if there are two nurses working on it. V10 stated it usually takes the ambulance 5-10 minutes to arrive. On 10/12/23 at 10:07 AM, V15 (RN) stated the normal procedure for sending a resident to the hospital would be to assess the resident, call the doctor, if emergent she would get another nurse to get the paperwork started and call the ambulance. V15 stated if not emergent she would call the doctor, get the paperwork printed and get them sent out. V15 stated unless there is a delay with the ambulance it is a pretty speedy process. When asked what would cause a delay V15 stated the ambulance service sometimes says they don't have any crews available. V15 stated they have more than one ambulance service they can call if that happens. When asked if she ever called 911, V15 stated she had	S9999		

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S9999	Continued From page 16 many times. V15 stated she would call 911 if it was an emergent situation. When asked what the difference was in calling an ambulance service direct and calling 911, V15 stated she wasn't sure what it meant to them but to the facility it meant they needed someone at the facility "now." On 10/12/23 at 3:35 PM, this surveyor reviewed R1's progress notes dated 10/04/23 with V3 (Assistant Director or Nurses/ADON). At that time V3 stated she would have called the doctor to see what they wanted her to do. On 10/16/23 at 10:36 AM, V3 (ADON) stated she worked the night shift beginning on 10/03/23 and didn't come to the facility on 10/04/23 until around 9:00 AM. V3 stated she was told R1 had died at that time. V3 stated she was told they couldn't get R1's body temperature up and they called the doctor and were told to send R1 to the hospital. V3 stated they told her R1 was talking to them when she left the facility. This surveyor reviewed the symptoms documented in R1's progress notes and asked V3 if she would consider them emergent. V3 stated, "Yes, that could be signs of stroke." This surveyor reviewed with V3 the delay in an ambulance arriving to the facility and asked what her expectation would be and V3 stated she would have called all the ambulance services and if they weren't available, she would have called 911. On 10/16/23 at 10:24 AM, V2 (DON/Director of Nurses) stated it was not the facility's normal procedure to wait for an ambulance. V2 stated she would have called 911 if she had been at the facility. V2 stated it isn't uncommon for the ambulance service to say they don't have a crew available. V2 stated most people they send to the	S9999		

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S9999	Continued From page 17 hospital are not in emergent situations. When asked what the normal process is, V2 stated the facility staff should call the ambulance listed on the resident chart and then call other services if the residents preference provider is not available. When asked why they didn't just call 911, V2 stated most of the time it is non-emergent, so she thinks staff are just used to calling the ambulance service direct. V2 stated she was not aware of the delay for R1. On 10/16/23 at 11:08 AM, V1 (Administrator) stated she wasn't involved in R1's transfer to the hospital on 10/04/23. V1 stated she knew R1 was supposed to go out for a new chemotherapy line and had been without food and drink through the night for the procedure. V1 stated she knew R1 wasn't doing well and had been in a slow decline. V1 stated they wondered why the physician was putting her through the treatment when the outcome wasn't going to be good. V1 stated but she knew R1 wanted to fight. V1 stated she read the hospital medical records and that R1 had coded on her way to the hospital. V1 stated she got statements from V12 (CNA) and V25 (PTA) who was working. V1 stated V25 was walking another resident when she heard R1 holler out and said she was hurting everywhere. V1 stated this happened at 7:00 AM so she knew R1 was talking at that time. V1 stated she called the ambulance supervisor and talked with him. V1 stated she thought that ambulance service was their 911 ambulance. V1 stated the ambulance supervisor said they were the 911 ambulance service but there was also one in another nearby town. V1's investigation provided to this surveyor, included statements from V12 and V25, a copy of R1's hospital record that documented, "From NH	S9999		

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S9999	Continued From page 18 (nursing home) EMS states she was down since 6am when EMS arrived her pupils were fixed and dilated. CPR in process when EMS arrived (to hospital)." This hospital record had handwritten at the bottom, "Talked with (name of person) at (name of ambulance service) stated EMS denied statement that she was down since 06:00 (6:00 AM)- 'Last well time was 06 (6:00 AM)." V1's investigation also included a copy of R1's progress notes from 10/04/23. There was no outcome or interventions documented in investigation. On 10/19/23 at 10:19 AM, V1 (Administrator) was asked via email if she had provided this surveyor with her full investigation and if there were any interventions implemented after her investigation. V1 responded, "That was my investigation at that time." V1 stated she also called the manager at the ambulance service and discussed R1's transfer and asked him if they were other 911 ambulance services and the manager replied they were. V1 stated in the email she asked him if they were not available who should they call, and the manager named another local ambulance service, and she asked if that service was unavailable who should they call. V1 stated he said if they called 911 it would be another close town's ambulance if no one else was available. V1 stated she shared the information with the team and plans were made to review charts. V1 stated they completed that review on 10/11/23. V1 stated V2 (DON) scheduled a meeting with the nurses on 10/17/23 to explain to call 911 for emergencies and to call the resident ambulance choice for non-emergencies. On 10/18/23 at 11:49 AM, V5 (ambulance dispatcher) stated they notify the facility 100% of the time if they don't have a crew available. V5	S9999		

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S9999	Continued From page 19 stated they tell them they need to call for mutual aid. V5 stated they have two other options in the town that would be immediate responses. When asked what the difference was for someone to call 911 versus calling the ambulance direct, V5 stated if someone calls 911 that call goes to the police department dispatch and then they tone out this ambulance service. V5 stated if this ambulance service doesn't have a crew available, they tone out the next ambulance service and if they don't have a crew available, they tone out the next ambulance service. On 10/16/23 at 9:49 AM, V24 (Nurse Practitioner) stated she remembered getting the call on 10/04/23 related to R1's symptoms and she told them to send her to the emergency room for evaluation and treatment. V24 stated she got the call in the early morning but didn't have the time documented anywhere. This surveyor reviewed R1's progress notes and the staff interviews with V24 including the time frames. V24 stated she wasn't aware of the delay in treatment. V24 stated even if V14 didn't think it was emergent when the symptoms first started, she should have quickly realized it was. V24 stated based on what she read in R1's record it was a significant bleed that appeared to be spontaneous. V24 stated based on that she couldn't say the outcome for R1 would have been different if she had received timely care. V24 stated R1's symptoms were emergent, and she would have expected the facility to call 911. On 10/16/23 at 9:03 AM, V18 (Cancer Specialist) stated R1 had pancreatic cancer and her cancer treatment was palliative in nature, to help prevent pain and discomfort. V18 stated R1 was on Xarelto and that could increase her risk of bleeding. When asked if R1 had received	S9999		

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S9999	Continued From page 20 treatment quicker if the outcome could have been different V18 stated, "with a GI bleed the quicker the treatment the better." V18 stated he couldn't guarantee it would have made a difference in the outcome. V18 stated she couldn't be off the Xarelto due to her diagnosis, and he couldn't judge if quicker treatment would have altered the outcome. V18 stated R1 would have been at risk for complications but would hope that being in the facility it would lessen the risks. According to https://www.mayoclinic.org/diseases-conditions/gastrointestinal-bleeding/symptoms-causes/syc-20372729 the symptoms of GI bleeding can be easy to see, or not so obvious. The symptoms include vomiting blood, black, tarry stools, rectal bleeding, lightheadedness, difficulty breathing, fainting, chest pain, and abdominal pain. If the bleeding starts suddenly and gets worse quickly, the body could go into shock. The symptoms of shock include weakness or fatigue, dizziness or fainting, cool, clammy, pale skin, nausea or vomiting, not urinating, or urinating a little at a time, changes in mental status, such as anxiousness or agitation, unconsciousness, rapid pulse, rapid breathing, drop in blood pressure, and enlarged pupils. The prescribing information of Xarelto found on the website XARELTO (rivaroxaban) Label (fda.gov) and dated 12/2021 includes the following information. "5 WARNINGS AND PRECAUTIONS 5.1 Increased Risk of Thrombotic Events after Premature Discontinuation Premature discontinuation of any oral anticoagulant, including XARELTO, in the absence of adequate alternative anticoagulation increases the risk of thrombotic events. An increased rate of stroke was observed during the	S9999		

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S9999	Continued From page 21 transition from XARELTO to warfarin in clinical trials in atrial fibrillation patients. If XARELTO is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant [see Dosage and Administration (2.3, 2.4) and Clinical Studies (14.1)]. 5.2 Risk of Bleeding XARELTO increases the risk of bleeding and can cause serious or fatal bleeding. In deciding whether to prescribe XARELTO to patients at increased risk of bleeding, the risk of thrombotic events should be weighed against the risk of bleeding. Promptly evaluate any signs or symptoms of blood loss and consider the need for blood replacement. Discontinue XARELTO in patients with active pathological hemorrhage ... Risk of Hemorrhage in Acutely Ill Medical Patients at High Risk of Bleeding Acutely ill medical patients with the following conditions are at increased risk of bleeding with the use of XARELTO for primary VTE (venous thromboembolism) prophylaxis: history of bronchiectasis, pulmonary cavitation, or pulmonary hemorrhage, active cancer (i.e., undergoing acute, in-hospital cancer treatment), active gastroduodenal ulcer in the three months prior to treatment, history of bleeding in the three months prior to treatment, or dual antiplatelet therapy. XARELTO is not for use for primary VTE prophylaxis in these hospitalized, acutely ill medical patients at high risk of bleeding." 2.R9's Admission Record with a print date of 10/18/23 documents R9 was admitted to the facility on 7/16/22 with diagnoses that include hemiplegia, chronic obstructive pulmonary disease (COPD), diabetes, chronic kidney disease, heart failure, peripheral vascular disease, dysphagia, cognitive communication deficit, and aphasia.	S9999		

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S9999	Continued From page 22 R9's MDS dated 7/18/23 documents R9 had a severe cognitive impairment. R9's POLST form dated 6/20/22 documents a mark next to do not attempt resuscitation and a mark next to, "Selective treatment: Primary goal of treating medical conditions with selected medical measures, in addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate, may consider less invasive airway support ...Transfer to hospital, if indicates. Generally, avoid the intensive care unit." R9's Progress Notes document the following: 10/11/23 at 9:01 AM, "Resident (R9) yelling out in his bed all morning. (R9) looks like he has maybe had another stroke. His mouth is droopy, and his eyes are very wide like he is scared. Resident states something is wrong. This nurse sent a message to (V24) NP at this time. Awaiting a return fax with any new orders at this time." 10/11/23 9:20 AM, "(V24) called facility with the following order: Send to (name of local hospital) for eval. (evaluation) and tx (treatment). Residents POA (power of attorney) called." 10/11/23 9:25 AM, "Report called to (name of local hospital) ER and (name of local ambulance) at this time. 10/11/23 9:45 AM, "(name of local ambulance) here to transport resident to (name of local	S9999		

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S9999	Continued From page 23 hospital) at this time." R9's ambulance Patient Care Report dated 10/11/23 documents the following under Times; Injury: 8:00 AM, Received: 9:32 AM, At scene: 9:39 AM. Under chief complaint the report documents, weakness, and facial droop for one day. Under Narrative the report documents, "Received a private call and responded immediately to a local NSG (nursing) home for a patient (R9) that possibly has had a stroke. Upon our arrival and ALS assessment, we found a 67 y/o (year old) male lying in bed responding to his normal self. Upon further assessment, the NSG staff states that the patient was having some new facial drooping that started yesterday. The patients PCP (primary care physician) was contacted and wants the patient to be evaluated in the ER. The patient does have some right sided facial drooping; however, he normally has some drooping present .... Care giver's primary impression of the patient is Generalized Weakness. Additional impressions include Neurological Distress ..." R9's local hospital record dated 10/11/23 documents under History, "Chief Complaint: Patient (R9) presents with weakness, right sided, right side facial droop. Pt (patient/R1) h/o (history of) past stroke right arm paralysis and trouble speaking here with right sided facial droop NH (nursing home) noticed for last 24 hours. PT (R9) denies c/o (complaints of) anything only answers yes or no and only c/o pain when I touch him anywhere. No falls or other neuro changes per NH (nursing home) unable to get history from patient (R9). Outside window for TPA (Tissue Plasminogen Activator-used to treat blood clots in stroke victims)." R9's hospital History and Physical documents, " ...(R9) presented from the	S9999		

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nursing home with concern over facial droop. Discussed with ED (emergency department) physician who notes that pt (R9) is contracted from prior stroke and can only respond yes/no and does not note a new facial droop. ED provider found new pulmonary and hepatic masses on CT (computerized tomography) imaging thought to be due to cancer. (R9) is being admitted for acute hypoxic respiratory failure due to COPD exacerbation."

On 10/18/23 at 10:44 AM, V9 (CNA) stated she was working the day R9 was transferred to the hospital. V9 stated she knew R9 wasn't acting right. V9 stated, V12 (CNA) called V6 (LPN) down to assess him. V9 stated and they sent R9 out to the hospital. V9 stated this occurred around 9:00 AM. V9 stated R9's eyes were really big, and he cried out in pain anytime anyone touched him. V9 stated R9's mouth drooped.

On 10/18/23 at 10:52 AM, V12 (CNA) stated she was working the day R9 was sent to the hospital. V12 stated they were getting other residents up and R9 was yelling out for help. V12 stated R9 didn't look right, was in pain, eyes were really big, and his face was gaunt looking. V12 stated she got V6 (LPN). V12 stated V6 went and assessed R9, called the doctor and sent R9 out shortly after that. When asked what time this occurred V12 stated she went into R9's room between 6:30 AM and 7:30 AM. V12 stated she told V6 immediately. V12 stated it was later when R9 left the facility, "maybe around 9." When asked how she knew the time she first saw R9 and reported it to the nurse, V12 stated she was in R9's room when they were getting the residents up for breakfast and that is usually done by 7:30 AM.

On 10/17/23 at 12:59 PM, V6 (LPN) stated she

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S9999	Continued From page 25 was the nurse providing care to R9 on 10/11/23. V6 stated the CNAs (not named) got her and told her R9 didn't look right and was diaphoretic. V6 stated R9 can't communicate but can answer simple questions. V6 stated she asked R9 if he felt good and R9 stated no. V6 stated she called the doctor and they said to send him to the hospital. V6 stated she called the ambulance and waited for them to get there. V6 stated R9 was yelling out but that was normal behavior for R9. V6 stated she thought R9 may have been having another stroke. When asked if it was typical to send a fax to a physician in these situations V6 stated she didn't feel like it was that big of an emergency and the faxes go straight to V24's phone. V6 stated V24 (NP) called right back. This surveyor reviewed R9's progress notes that document it took 20 minutes for V24 to call the facility, and V6 stated she knew it didn't take 20 minutes for V24 to call back. V6 stated she probably just documented the progress note later. This surveyor reviewed R9's progress notes that document V6's progress note at 9:01 AM with an assessment that it looked like R9 may be having a stroke and the last note at 9:45 AM when R9 was transferred to the hospital, and asked V6 if it was typical to take 45 minutes to send someone to the hospital. V6 stated if it was emergent, they would call 911. V6 stated if she found someone unresponsive, in that situation then absolutely she would call 911. V6 stated (name of ambulance service) is the major problem with getting someone to the hospital quickly and they are our only option. V6 stated if she could, she would just pick the resident up and take them to the hospital since it is located right next door. When asked if she would consider stroke symptoms emergent, V6 stated, "Yes, but I didn't know. It looked like that (stroke), but I wasn't 100%. R9 was still responding to me."	S9999		

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S9999	Continued From page 26 3.R8's Admission Record with a print date of 10/18/23 documents R8 was admitted to the facility on 6/13/23 with diagnoses that include urinary tract infection, hypertension, muscle weakness, and cognitive communication deficit. R8's MDS dated 9/24/23 documents a BIMS score of 7, which indicates a moderate cognitive deficit. R8's POLST form dated 6/22/23 documents a mark next to Do Not Attempt Resuscitation and a mark next to Comfort Focused Treatment: Primary Goal of maximizing comfort. Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction .... Request transfer to hospital only if comfort needs cannot be met in current location. R8's Power of Attorney Healthcare form documents V28 (family member) as R8's agent to make decisions for her when R8 is not able to. This form documents under Life-Sustaining Treatments, "The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain." On 10/18/23 at 2:15 PM, this surveyor attempted an interview with R8, and she was not able to recall any events.	S9999		

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S9999	Continued From page 27 R8's progress notes document the following: 9/16/23 1:27 PM, 8:00 AM, Late Entry, "Resident (R8) sitting up in her recliner resting at this time. Nursing attempted to get resident to eat some of her breakfast, this nurse could not get resident to stay awake long enough. Resident just says she is so tired. Medications held related to resident being so groggy. (R8's) daughter is aware. (R8) in a private room with the door shut. Meals, nursing, and therapy continues to be given in residents room. Will continue to monitor." 9/16/23 1:30 PM, 12:00 PM Late Entry, "Resident in her recliner resting at this time. (R8) refused to eat her lunch also. (R8) just says she is so tired. (R8's) daughter is aware. (R8) in a private room with the door shut. Meals, nursing, and therapy continues to be given in residents room. Will continue to monitor." 9/16/23 5:00 PM, "(R8's) condition declining. (R8) has had decreased input, increased confusion, lethargic, and Covid positive. (R8's) daughter is at bedside and is really concerned about her mother's decline. MD (physician) notified. NOR (new order received) as follows; Send to (name of local hospital) for eval and tx." 9/16/23 5:05 PM, "1630 (4:30 PM) Report called to (name of ambulance service) at this time. Dispatcher said they are running short staffed. Report also called to (name of local hospital) ER at this time." 9/16/23 5:11 PM, "(name of ambulance service) here to transport (R8) to (name of local hospital) ER for eval and tx." 9/17/23 3:28 AM, "Admitted to (name of local	S9999		

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S9999	Continued From page 28 hospital) Dx (diagnosis) sepsis." R8's Ambulance Patient Care Report dated 9/16/23 documents under Times, Injury: 3:32 PM, Received 3:32 PM, At scene 5:06 PM. Under Chief Complaint the report documents, "Note: Covid +, general weakness, ALOC (altered level of consciousness)." Under Narrative the report documents, "Vehicle 46 dispatched Lights and Sirens to respond immediately to (name of facility) for a female pt (patient/R8) with covid who was weak. Arrived on scene and received report from staff stating that (R8) is just not responding as well as she normally does. (R8) is alert but states she feels a bit weak. (R8) placed on EMS stretcher via 2-man sheet lift and secured with straps x (times) 5 ...." R8's local hospital record dated 9/16/23 documents under Discharge Summary, "History of Present Illness: The patient (R8) is an 86-year-old lady, who resides at (name of facility) started having some respiratory symptoms with cough, congestion, headache, body aches, and fever. Number of residents in the facility had Covid. She was checked for Covid, which was positive. She was started on Paxlovid. Meanwhile, she started having some confusion, increased difficulty with cough, and congestion. Hence, she was sent to the emergency room. Workup in the ER revealed she had UTI (urinary tract infection). With a diagnosis of UTI, dehydration, and metabolic encephalopathy, the patient (R8) was admitted." On 10/17/23 at 11:07 AM, V28 (family member/POA) stated she came to the facility to see R8 mid-morning on 9/16/23 and R8 was very sleepy. V28 stated R8 had Covid so she was letting R8 rest. V28 stated she checked back a	S9999		

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S9999	Continued From page 29 little later and the facility told her they had held R8's medications. V28 stated she went back to the facility late afternoon and R8 didn't recognize her, R8 was very confused and disoriented. V28 stated she knew something was wrong, so she spoke to the nurse who called the doctor and they decided to send R8 to the emergency room. When asked how long it took for R8 to get transferred to the emergency room, V28 stated "It took longer than it should have. Probably greater than a two hour wait." When asked if she knew why it took so long V28 stated she guessed the ambulance they typically use said they were very busy that evening. V28 stated R8 didn't worsen during the wait and is now recovered and back at the facility. On 10/18/23 at 1:57 PM, V29 (CNA) stated she was working on the day R8 was transferred to the hospital. V29 stated R8 was almost acting manic. V29 stated R8 was confused and didn't know her name. V29 stated V28 (family member) was with R8 and asked for the doctor to be called. V29 stated the doctor was trying to order lab work but V28 stated she wanted her sent out. V29 stated so they sent R8 out to the hospital. V29 stated she didn't think it took very long for the ambulance to arrive to the facility. V29 stated, "maybe less than an hour." On 10/18/23 at 12:20 PM, V6 (LPN) stated V28 (family member) was at the facility and told the staff R8 was talking out of her mind. V6 stated R8 is confused at times. V6 stated V28 was concerned R8 had a UTI so the doctor was contacted and V6 was told to send R8 to the hospital per V28's request. V6 stated R8's symptom was confusion. This surveyor reviewed with V6 the symptoms of decreased intake, lethargy, increased confusion and Covid positive	S9999		

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S9999	Continued From page 30 result with V6 and she confirmed those were R8's symptoms. When asked how long it took for R8 to be transferred from the facility to the hospital, V6 stated she didn't remember. On 10/18/23 at 11:49 AM, V5 (ambulance dispatcher) stated the injury time is entered by the crew after they get the information from the facility and the received time is when they create the call in the system. V5 stated R8's call came in on the weekend and was created when the call came in. V5 stated the ambulance service didn't go on the calls immediately because there were no crews available. When asked if they notify the facility when there isn't a crew available, V5 stated, "Yes, 100% of the time." On 10/12/23 at 3:35 PM, V3 (ADON) stated the facility procedure if someone needs to go the hospital is to call the doctor, get an order to send them out, call the ambulance, call the emergency room with report, then call the family. When asked what they did if there was a delay with the ambulance, V3 stated she thought they had two other ambulance services they could call. V3 stated if none of them were available she would call 911, depending on how emergent the situation was. When asked what she would consider an emergent situation, V3 stated altered mental status, abnormal vital signs, signs of stroke, chest pain, and heart attack symptoms. On 10/16/23 at 10:24 AM, V2 (DON/Director of Nurses) stated it was not the facility's normal procedure to wait for an ambulance. V2 stated it isn't uncommon for the ambulance service to say they don't have a crew available. V2 stated most people they send to the hospital are not in emergent situations. When asked what the normal process is, V2 stated the facility staff	S9999		

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S9999	Continued From page 31 should call the ambulance listed on the resident chart and then call other services if the residents preference provider is not available. When asked why they didn't just call 911, V2 stated most of the time it is non-emergent, so she thinks staff are just used to calling the ambulance service direct. The facility Midnight Census provided to this surveyor on 10/11/23 documents 37 residents reside at the facility. The facility Change in a Resident's Condition or Status Policy dated February 2014 documents, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status ..." Under Policy Interpretation and Implementation, the policy documents, "1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-call Physician when there has been ...d. A significant change in the resident's physical/emotional/mental condition ...A need to transfer the resident to a hospital/treatment center ..." The facility Transfer or Discharge, Emergency policy dated December 2016 documents, "Emergency transfers or discharges may be necessary to protect the health and/or well-being of the resident(s) ....4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility shall implement the following procedures: a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; e. Notify the representative (sponsor) or other family member; f. Assist in	S9999		

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S9999	Continued From page 32 obtaining transportation; and g. Others as appropriate or necessary. "AA"	S9999		