STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075274	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Civita Care Center at Danbury	107 Osborne Street Danbury, CT 06810

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1), reviewed for resident rights, the facility failed to honor the resident's right for self-determination and honor the resident's right to make choices about his/her lift to interact and participate in community activities outside the facility, and failed to honor the resident's right for leave of absence (LOA) privileges upon readmission. The findings include: Resident #1 had a diagnosis of opioid dependence. The quarterly Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 indicating an intact cognition, no behaviors, and was independent with transfers and wheelchair use. The Resident Care Plan dated 2/17/26 identified Resident #1 may go on leave of absence with wheelchair. Interventions directed if warranted staff may perform room search with Resident #1's consent. Record review failed to identify a physician's order regarding Resident #1's LOAs rights. Nursing note dated 5/7/26 at 5:50 AM identified Resident #1 was observed at approximately 5:40 AM lying supine (face up) across the bed pale, unresponsive to verbal stimuli, with agonal respirations (a medical emergency of abnormal gasping, snorting, or labored breathing caused by a lack of oxygen to the brain) at a rate of three (3) breaths per minute (normal adult rate 12 to 18). Staff activated Emergency Medical Services (EMS/911) at approximately 5:45 AM due to unresponsive status and respiratory distress, and Resident #1 remained unresponsive while awaiting EMS arrival. EMS arrived and Resident #1 was transferred to the hospital. Reportable event dated 5/11/26 at 3:30 PM identified on 5/7/26 at approximately 5:40 AM, Resident #1 was found unresponsive and follow-up with the hospital identified Resident #1 had a suspected opioid overdose with positive toxicology findings. Emergency Medical Services (EMS/911) run sheet dated 5/7/26 identified 911 was called at 5:25 AM (15 minutes prior to the time referenced in the nursing note) and they were at Resident #1 at 5:37 AM (3 minutes prior to the time referenced in the nursing note). EMS identified Resident #1 was neither alert nor oriented with a Glasgow Coma Scale (GCS/Level of consciousness, normal score of 15 indicates awake, alert and responsive) score was three (3) (score 3 to 8 indicates severe injury/coma), with agonal respirations and no signs of trauma or bleeding. Pupils were pinpoint. Oxygen saturation at 5:38 AM was 84% (nursing note at 5:50 AM had identified 98%) and had a respiratory rate of six (6), and EMS initiated assisted ventilations via an oral airway with a bag valve mask. The report indicated EMS physical exam identified suspected alcohol or drug use. Paperwork revealed physician order for Naloxone as needed but no evidence of opiates ordered. EMS administered Naloxone two (2) milligrams and continued with assisted respirations and transport to the hospital. Resident #1 began to improve while in transport to the hospital; opened his/her eyes spontaneously, GCS score of 12 (indicating moderate impairment), began to follow commands and slow to respond in one-word answers such as good morning. emergency room documentation dated 5/7/26 identified Resident #1 was diagnosed with opiate overdose, with positive test results for Cocaine and Fentanyl. Nursing note dated 5/11/26 at 3:16 PM identified Resident #1 was readmitted from the hospital. Physician order dated 5/11/26 directed Resident #1 may not go out on LOA. Physician order dated 5/12/26 directed Resident #1 ambulated independently in his/her room (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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only with a rollator walker however requires assist of 1 (contact guard assist) with rollator when ambulating outside of room or throughout the facility. Record review identified Resident #1 was independent mobility in his/her wheelchair. Reportable event summary dated 5/15/26 identified the facility immediately conducted a room search on 5/8/2026 (while Resident #1 was in the hospital) to ensure resident and facility safety. During the search, items identified as potential paraphernalia/substances were noted, including a white powdery substance, marijuana, vape devices, and an empty alcohol container, and the items were removed. Physician order dated 5/22/26 directed Resident #1 may go LOA with supervision (11 days after the readmission order directed no LOAs). Interview with the Director of Rehabilitation on 6/9/26 at 3:29 PM identified Resident #1 was independent with wheelchair use in the facility after he/she returned to the facility, and she did not know of any reason Resident #1 could not go on LOA after readmission. Interview with the DNS and LPN #1 (regional nurse) on 6/9/26 at 3:41 PM identified they did not allow Resident #1 to go on LOA upon readmission to the facility because Resident #1 needed to be cleared by therapy first. Further, although Resident #1 was independent mobility in his/her wheelchair, the interview identified Resident #1 required assist of one with contact guard with rollator walker during ambulation outside of his/her room. Record review identified Resident #1 had independent LOAs prior to the incident on 5/7/2026 and remained independent in wheelchair mobility, and interview failed to identify why Resident #1 was not granted independent LOAs upon readmission on [DATE]. Review of facility undated Leave of Absence from the Facility Policy directed in part, residents will be able to have appropriate LOAs. Review of facility undated Resident Rights Policy and Procedure Policy directed in part, each resident had a right to interact with members of the community and participate in community activities both inside and outside the facility.

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1), reviewed for accidents, the facility failed to ensure a quarterly Minimum Data Set (MDS) and a Discharge MDS assessment were completed and transmitted timely. The findings include:Resident #1 had a diagnosis of opioid dependence. The quarterly Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 indicating an intact cognition, no behaviors, and was independent with transfers and wheelchair use. The Resident Care Plan dated 2/17/26 identified Resident #1 may go on leave of absence with wheelchair. Interventions directed if warranted staff may perform room search with Resident #1's consent. Record review identified the clinical record identified Resident #1 was discharged from the facility with return anticipated on 3/29/2026. Review of the discharge MDS dated [DATE] identified Section Z was signed and dated 5/15/2026 to indicate the MDS was complete (48 days after the discharge). Additional review identified the MDS was transmitted to CMS on 5/22/2026 (55 days after Resident #1 was discharged). Review of the quarterly MDS dated [DATE] identified Section Z was not signed to indicated it was completed and it was not submitted prior to prior to review on 6/9/2026. Review of the discharge MDS dated [DATE] identified Section Z was not signed to indicated it was completed, and it was not transmitted prior to prior to review on 6/9/2026. Interview with LPN #2 (MDS coordinator) on 6/9/2026 at 10:42 AM identified she does not know why the quarterly MDS dated [DATE] and the Discharge return anticipated MDS dated [DATE] were not signed and submitted timely. LPN #2 stated both MDS assessments should have been signed as complete and submitted to CMS timely. LPN #2 stated she was not aware the prior MDS coordinator did not submit them and that it was the MDS coordinators responsibility for ensuring MDSs are submitted timely per the regulation. Subsequent to surveyor inquiry, Section Z on the quarterly MDS dated [DATE] and the discharge MDS dated [DATE] were signed and dated 6/9/2026, and were both transmitted to CMS on 6/9/2026. Interview with the Director of Nursing (DNS) and LPN #3 (Regional nurse) on 6/9/26 at 2:47 PM identified they did not know why the MDS assessments above were not completed and were not submitted timely. Interview identified it was their expectation that MDS assessments were to be completed and transmitted/submitted/submitted timely, and that it was the MDS coordinators responsibility for ensuring they are submitted timely. Review of facility MDS Assessment and Completion and Submission Policy dated 2/2/26 directed the facility will ensure all MDS assessments are completed accurately, timely, and submitted in accordance with the Center for Medicare and Medicaid Services (CMS) and state requirements. Review of the CMS Resident Assessment Instrument (RAI) Manual, directed in part, the RN coordinator reviews and signs Section Z to indicate the MDS assessment is complete. The entire assessment must be completed, signed, and certified that the whole assessment is complete, which must be done within 14 days of the ARD (assessment reference date). Additional review directed the quarterly MDS must be transmitted to CMS within 14 days after the Care Plan completion, and the discharge MDS must be transmitted to CMS within 14 days following the discharge.

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F 0658 Level of Harm - Minimal harm or potential for actual harm 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** .Based on record review, facility documentation review, and staff interviews for one of three residents (Resident #1) reviewed for professional standards of care, the facility failed to ensure a licensed nurse remained with Resident #1 when staff identified a change in condition that included the resident was unresponsive with agonal respirations at a rate of three (3) per minute, until Emergency Medical Services (EMS) arrival. The findings include: Resident #1 had a diagnosis of opioid dependence and diabetes. The quarterly Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition and was independent with transfers and wheelchair mobility. The Resident Care Plan (RCP) dated 2/17/26 identified Resident #1 may go on Leave of Absence (LOA) with a wheelchair. Interventions directed independent LOA, and perform room search with consent. Nursing note dated 5/7/26 at 5:50 AM identified Resident #1 was observed at approximately 5:40 AM lying supine (face up) across the bed. Resident #1 appeared pale, unresponsive to verbal stimuli, and did not respond to repeated calling of his/her name or to a sternal rub. Resident #1 was noted with agonal respirations (a medical emergency of abnormal gasping, snorting, or labored breathing caused by a lack of oxygen to the brain) at a rate of three (3) breaths per minute (normal adult rate 12 to 18). Initial assessment identified pulse was 83 beats per minute, blood pressure was 98/60, temperature was 97.8, oxygen saturation was 98% on room air (normal 90% and above), and blood glucose was at 206. Respirations remained shallow. irregular, and labored. Resident #1 was unable to follow commands, was unable to communicate needs, and exhibited no purposeful movement during assessment. Pupils were sluggish and skin was cool to touch. No signs of acute trauma or injury were observed. Staff activated Emergency Medical Services (EMS/911) at approximately 5:45 AM due to unresponsive status and respiratory distress, and Resident #1 remained unresponsive while awaiting EMS arrival. Further, the note indicated continuous monitoring and supportive measures were maintained by nursing staff. EMS arrived and Resident #1 was transferred to the hospital, and the provider was notified and updated on resident status. Reportable event dated 5/11/26 at 3:30 PM identified on 5/7/26 at approximately 5:40 AM, Resident #1 was found unresponsive in bed with agonal respirations. Nursing staff activated EMS/911 services, and Resident #1 was transferred to the hospital. Facility follow-up with the hospital identified Resident #1 had a suspected opioid overdose with positive toxicology findings. Emergency Medical Services (EMS/911) run sheet dated 5/7/26 identified 911 was called at 5:25 AM (15 minutes prior to the time referenced in the nursing note) and they were at Resident #1 at 5:37 AM (3 minutes prior to the time referenced in the nursing note). EMS identified Resident #1 was lying sideways on the hospital-style bed, legs hanging off the bed, with his/her head supported by a side table and was neither alert nor oriented. Facility reported Resident #1 was last seen about 2 AM and was checked at 5 AM when they found him/her in the present condition. Blood glucose was 125. Glasgow Coma Scale (GCS/Level of consciousness, normal score of 15 indicates awake, alert and responsive) score was three (3) (score 3 to 8 indicates severe injury/coma), with agonal respirations and no signs of trauma or bleeding. Pupils were pinpoint. Oxygen saturation at 5:38 AM was 84% (nursing note at 5:50 AM had identified 98%) and had a respiratory rate of six (6), and EMS initiated assisted ventilations via an oral airway with a bag valve mask. EMS noted lungs had good compliance with ventilations, lung sounds were clear and no evidence of possible aspiration or choking. Staff denied knowing anything about prescribed medications or access to narcotics and had insufficient answers for EMS questions. The report indicated EMS physical exam identified suspected alcohol or drug use. Paperwork revealed physician order for Naloxone as needed but no evidence of opiates ordered. EMS administered Naloxone two (2) milligrams and continued with assisted respirations and transport to the hospital. Resident #1 began to improve while in transport to the hospital; opened his/her eyes spontaneously, GCS score of 12 (indicating moderate impairment), began to follow commands and slow to respond in (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one-word answers such as good morning. Record review identified although the nursing note at 5:50 AM indicated Resident #1's oxygen saturation was 98% on room air, EMS report indicated PO 84% when they arrived. Staff called 911, and additional record review failed to identify any additional interventions were taken by RN #1 or LPN #1. Although attempted, an interview with NA #1 was unable to be obtained during the survey. Interview with LPN #1 on 6/8/26 at 12:19 PM identified she was the charge nurse on 5/15/26 and about 5:30 AM she observed Resident #1 laying supine across the bed and was unresponsive to verbal and physical stimulation, and unresponsive to a sternal chest rub. LPN #1 stated NA #1 was in the room giving care to the roommate, and she told NA #1 to stay in the room and LPN #1 left the room to notify RN #1 and obtain the crash cart. LPN #1 then obtained vital signs and identified a respiratory rate of three (3), and indicated she left the room to call 911 while RN #1 tried to contact the on-call provider. Interview failed to identify a licensed staff member remained with Resident #1 until EMS arrived. Interview with RN #1 on 6/8/26 at 12:45 PM identified LPN #1 notified her about 5:40 AM that Resident #1 was short of breath, and she observed Resident #1 laying across the bed and unresponsive to verbal and physical stimulation. RN #1 noted Resident #1 was not breathing well and was breathing at a rate of three (3) breaths per minute. RN #1 then left the room and called 911. Interview failed to identify a licensed staff member remained with Resident #1 until EMS arrived. Record review and interviews failed to identify licensed staff remained with Resident #1 while awaiting EMS arrival. Interview with the Director of Nursing (DNS) on 6/8/26 at 3:10 PM identified she believed staff stayed in Resident #1s room while until EMS arrival. No policy was provided for surveyor review regarding staff remaining with a resident experiencing a change in condition until EMS arrived.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and staff interviews for one of three residents (Resident #1) reviewed for a change in condition, the facility failed to appropriately respond to an emergency situation in which a resident experienced a medical emergency, and failed to provide interventions when the resident was identified to be unresponsive and had a respiratory rate of three (3) breaths per minute, resulting in a finding of Immediate Jeopardy. The findings include: Resident #1 had a diagnosis of opioid dependence and diabetes. The quarterly Minimum Data Set, dated [DATE] identified Resident #1 had a Brief Interview Mental Status (BIMS) score of 15 indicating intact cognition and was independent with transfers and wheelchair mobility. The Resident Care Plan (RCP) dated [DATE] identified Resident #1 may go on Leave of Absence (LOA) with a wheelchair. Interventions directed independent LOA, and perform room search with consent.Physician order dated [DATE] directed independent with outdoor mobility and community outings with use of a walker or wheelchair. Physician order dated [DATE] directed to administer Naloxone (Narcan - used to reverse drug overdose) one (1) dose as needed for opioid overdose, may repeat three (3) times, three (3) minutes apart, call the provider and call 911.Record review identified Resident #1 went on an independent LOA on [DATE].Nursing note dated [DATE] at 5:50 AM identified Resident #1 was observed at approximately 5:40 AM lying supine (face up) across the bed. Resident #1 appeared pale, unresponsive to verbal stimuli, and did not respond to repeated calling of his/her name or to a sternal rub. Resident #1 was noted with agonal respirations (a medical emergency of abnormal gasping, snorting, or labored breathing caused by a lack of oxygen to the brain) at a rate of three (3) breaths per minute (normal adult rate 12 to 18). Initial assessment identified pulse was 83 beats per minute, blood pressure was 98/60, temperature was 97.8, oxygen saturation was 98% on room air (normal 90% and above), and blood glucose was at 206. Respirations remained shallow. irregular, and labored. Resident #1 was unable to follow commands, was unable to communicate needs, and exhibited no purposeful movement during assessment. Pupils were sluggish and skin was cool to touch. No signs of acute trauma or injury were observed. Staff activated Emergency Medical Services (EMS/911) at approximately 5:45 AM due to unresponsive status and respiratory distress, and Resident #1 remained unresponsive while awaiting EMS arrival. Further, the note indicated continuous monitoring and supportive measures were maintained by nursing staff. EMS arrived and Resident #1 was transferred to the hospital, and the provider was notified and updated on resident status.Reportable event dated [DATE] at 3:30 PM identified on [DATE] at approximately 5:40 AM, Resident #1 was found unresponsive in bed with agonal respirations. Nursing staff activated EMS/911 services, and Resident #1 was transferred to the hospital. Facility follow-up with the hospital identified Resident #1 had a suspected opioid overdose with positive toxicology findings. Emergency Medical Services (EMS/911) run sheet dated [DATE] identified 911 was called at 5:25 AM (15 minutes prior to the time referenced in the nursing note) and they were at Resident #1 at 5:37 AM (3 minutes prior to the time referenced in the nursing note). EMS identified Resident #1 was lying sideways on the hospital-style bed, legs hanging off the bed, with his/her head supported by a side table and was neither alert nor oriented. Facility reported Resident #1 was last seen about 2 AM and was checked at 5 AM when they found him/her in the present condition. Blood glucose was 125. Glasgow Coma Scale (GCS/Level of consciousness, normal score of 15 indicates awake, alert and responsive) score was three (3) (score 3 to 8 indicates severe injury/coma), with agonal respirations and no signs of trauma or bleeding. Pupils were pinpoint. Oxygen saturation at 5:38 AM was 84% (nursing note at 5:50 AM had identified 98%) and had a respiratory rate of six (6), and EMS initiated assisted ventilations via an oral airway with a bag valve mask. EMS noted lungs had good compliance with ventilations, lung sounds were clear and no evidence of possible aspiration or choking. Staff denied knowing anything about prescribed medications or access to narcotics and had insufficient answers for EMS questions. The (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	report indicated EMS physical exam identified suspected alcohol or drug use. Paperwork revealed physician order for Naloxone as needed but no evidence of opiates ordered. EMS administered Naloxone two (2) milligrams and continued with assisted respirations and transport to the hospital. Resident #1 began to improve while in transport to the hospital; opened his/her eyes spontaneously, GCS score of 12 (indicating moderate impairment), began to follow commands and slow to respond in one-word answers such as good morning. Record review identified although the nursing note at 5:50 AM indicated Resident #1's oxygen saturation was 98% on room air, EMS report indicated PO 84% when they arrived. Staff called 911, and additional record review failed to identify any additional interventions were taken by RN #1 or LPN #1.emergency room documentation dated [DATE] identified Resident #1 was diagnosed with opiate overdose, with positive test results for Cocaine and Fentanyl.Hospital Discharge summary dated [DATE] at 12:14 PM identified Resident #1's toxicology was positive for Cocaine and Fentanyl and was treated for acute kidney injury.Reportable event summary dated [DATE] identified upon notification of the toxicology results, the facility conducted a room search on [DATE] and identified a white powdery substance, Marijuana, vape devices, and an empty alcohol container. Items were removed and local authorities were notified.Although attempted, an interview with NA #1 was unable to be obtained during the survey.Interview with LPN #1 on [DATE] at 12:19 PM identified she was the charge nurse on [DATE] and last saw Resident #1 about 3:30 AM to 4 AM laying in the middle of the bed. When she returned to the room about 5:30 AM, Resident #1 was laying supine across the bed and was unresponsive to verbal and physical stimulation and unresponsive to a sternal chest rub. LPN #1 stated NA #1 was in the room giving care to the roommate, and she told NA #1 to stay in the room and LPN #1 left the room to notify RN #1 and obtain the crash cart. LPN #1 then obtained vital signs and identified a respiratory rate of three (3). LPN #1 stated she did not perform any additional interventions while awaiting EMS arrival because she thought Resident #1 was just sleeping. She kept trying to wake him/her up and did not know Resident #1 had an active order for Narcan at the time of the incident.Interview with RN #1 on [DATE] at 12:45 PM identified LPN #1 notified her about 5:40 AM that Resident #1 was short of breath, and she observed Resident #1 laying across the bed and unresponsive to verbal and physical stimulation. RN #1 noted Resident #1 was not breathing well and was breathing at a rate of three (3) breaths per minute. The crash cart was there but was not used because Resident #1 was still breathing. RN #1 then left the room and called 911. RN #1 stated no additional interventions were performed while EMS was enroute because the resident was still breathing. RN #1 further stated she knew Resident #1 had an order for Narcan, but she did not administer it because she did not believe he/she was having an overdose. Further, RN #1 stated it was not a code (CPR) situation because Resident #1 was still breathing and she did not think Resident #1 needed any form of oxygen.Interview with the Director of Nursing (DNS) on [DATE] at 3:10 PM identified she did not believe Narcan should have been administered because there was no reason to suspect an overdose, and to her knowledge neither oxygen nor rescue breaths should have been administered because the resident had an oxygen saturation of 98%.Interview with the Medical Director on [DATE] at 9:37 AM identified staff called him regarding the incident and stated he did not recall that staff informed him Resident #1 was unresponsive to verbal or physical stimulation and was taking only three (3) breaths per minute. The Medical Director stated he asked staff if CPR needed to be performed, and staff had informed him that Resident #1 was fine and breathing on his/her own. He was informed the oxygen saturation was fine, and Resident #1 only had shallow breathing. The Medical Director stated if staff had informed him the resident was breathing at a rate of three (3) breaths per minute and not responding to stimulation, then he would have directed staff to put place oxygen on the resident, to perform rescue breaths, and to administer Narcan.Review of facility undated Opioid Overdose Management/Use of Naloxone directed in part, any licensed nurse shall be allowed to administer Naloxone upon reasonable suspicion of an opioid overdose and if the resident was not breathing or breathing remains shallow to continue to perform rescue breathing while awaiting Naloxone to take (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	effect.Review of facility documentation identified education was initiated on [DATE] for all nursing staff and included education on the recognition of signs and symptoms of a suspected drug overdose, including opioid overdose, and the immediate nursing response required to protect resident safety, including prompt administration of naloxone (Narcan). The education included to perform the following while awaiting EMS arrival: to maintain the resident's airway, provide oxygen if available and ordered per facility protocol, to begin rescue breathing if indicated, initiate CPR if he resident becomes pulseless, place resident in recovery position if breathing resumes and continue monitoring respiratory status, oxygen saturation, level of consciousness, vital signs, and remain with resident until EMS assumes care. Audits were initiated and will be reviewed by facility QAPI. Based on review of facility documentation, a finding of past non-compliance was identified.