STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115373	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Lakehaven, LLC	410 East Northside Drive Valdosta, GA 31602

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on record review, interviews, and review of the facility policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property, the facility failed to protect the resident's(s') right to be free from deprivation of services by Licensed Practical Nurse (LPN) QQ. Specifically, the facility failed to ensure one resident (R) (R1) of four sampled residents, was assessed when experiencing a decline in respiratory status as evidenced by becoming hypoxic and cyanotic. On 7/1/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility Administrator and the Director of Health Services (DHS) were informed of Immediate Jeopardy on 7/1/2024, at 10:22 am. The noncompliance related to the Immediate Jeopardy was determined to have existed on 6/2/2024. At the time of exit on 7/3/2024, the Immediate Jeopardy remained ongoing. Findings include: Review of the policy titled Prevention of Patient Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Property reviewed 1/11/2024 revealed the intent is to preserve each patient's right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, neglect, exploitation, mistreatment, and misappropriation of patient property. Neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a patient that are necessary to avoid physical harm, mental anguish, emotional distress. The Organization and its partners should assure that best efforts are made to prevent any occurrences of any form of abuse, neglect, and exploitation. 1. Providers are to identify, correct, and intervene in situations in which abuse, neglect, mistreatment or exploitation may occur. This should include an analysis of the following: The deployment of staff on each shift in sufficient numbers to meet the needs of the patients and to see that staff assigned have knowledge of individual patient's care needs. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the clinical record revealed R1 was admitted to the facility on [DATE] with diagnoses of but not limited to acute and chronic respiratory failure with hypercapnia, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, shortness of breath, pleural effusions in other conditions, generalized muscle weakness, acute diastolic (congestive) heart failure, Non-ST elevation (NSTEMI) myocardial infarction, anxiety disorder, and post-traumatic stress disorder. Further review revealed resident was a Full Code. Review of the Discharge Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 15 indicating R1 was cognitively intact. Review of Physician Order History dated 5/22/2024 to 6/27/2024 revealed R1 had orders for multiple medications to aide in her respiratory care to include: levofloxacin 500 milligram (mg) take 1 dose on 5/28/2024 for diagnosis acute respiratory failure with hypoxia, albuterol sulfate HFA aerosol inhaler 90 microgram (mcg) 2 puff inhalation every 4 hours as needed for shortness of breath, alprazolam 0.25 mg 1 tablet by mouth at bedtime as needed for anxiety disorder, benzonatate 100 mg capsule administer 1 by mouth every 8 hours as needed for cough for Dx: chronic obstructive pulmonary disease (COPD), Breztri Aerosphere HFA aerosol inhaler administer 2 puffs every 12 hours for diagnosis of COPD, Lasix 20 mg 1 tablet by mouth twice a day for heart failure, prednisone 20 mg 1 tablet by mouth once a day for acute respiratory failure with hypoxia, ipratropium-albuterol solution for nebulizer administer 3 milliliter (ml) inhalation every 4 hours as needed for wheezing, and oxygen at 3 liters via nasal cannula continuous for COPD. Review of the report provided from Emergency Medical Service (EMS) revealed on 6/2/2024 at 8:31 pm that a crew was dispatched by 911 to the facility for a report of breathing problem, shortness of breath for an emergent (immediate response) call. Upon arrival at the nursing home the resident was found complaining of shortness of breath tripoding in the bedroom. Blood Pressure - 237/119, Pulse - 97, Respirations -30, saturation of peripheral oxygen (SPO2) - 80. Physical exam: Skin - clammy, hot, cyanotic and pale head. Further review of the report stated upon arrival EMS found the patient: Tripoding in her bed, the patient had labored breathing at a fast rate, the patient was sweating and was clammy. The patients' skin was pale and cyanotic. The patient had a home CPAP on, and she stated she had a history of COPD. Patient stated she had been having shortness of breath for about an hour and that she had told the staff multiple times, but they were not listening to her; she had to call 911 herself. The patient stated that this had happened before at the facility. The patient stated that she felt like she could not catch her breath or take a deep breath. The patient's airway was open, but she had decreased lung sounds. EMS took the patient off her home CPAP (Continuous Positive Airway Pressure) and placed patient on a nasal cannula at 6 liters per minute, moved resident to stretcher, once in the unit (ambulance) vital signs were taken and noted to be unstable. The patient was hypertensive and her SPO2 reading on 6 liters of oxygen was 81%. EMS placed the patient on CPAP with a peep of 5 and 15 liters per minute (LPM) of oxygen, placed on a cardiac monitor, intravenous line established in patients left antecubital, and was given a Duo-neb nebulizer treatment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital report from the local hospital dated 6/2/2024 - ED (Emergency Department) to Hospital Admission revealed R1 was admitted to the hospital 6/2/2024 and discharged [DATE]. The active hospital problem/diagnosis on admission was COPD with acute exacerbation; acute on chronic hypoxic and hypercapnic respiratory failure; pulmonary emphysema - improved, respiratory distress on admission requiring BIPAP (Bilevel Positive Airway Pressure), Arterial Blood Gas (ABG) initially showed respiratory acidosis with elevated carbon dioxide(CO2) but has since improved to normal. Critical Care was necessary to treat or prevent imminent or life-threatening deterioration of the following conditions: circulatory failure, respiratory failure, metabolic crisis, and cardiac failure. Review of facility progress notes in the electronic record revealed there was not any documentation in the record related to R1 being assessed for respiratory distress or being sent to the hospital on 6/2/2024. Telephone interview on 6/25/2024 at 3:19 pm with R1 revealed that she is now living with a friend who is her caregiver. She further stated that she did not feel comfortable returning to the nursing home after what happened to her. R1 stated the night of 6/2/2024 she was having a very hard time breathing and she asked the nurse working to give her medications and to call 911. R1 stated the nurse ignored her and walked away, therefore she had to call 911 herself. R1 further stated she believed the nurse heard her call 911 because she overheard the nurse on the phone cancelling the 911 call. R1 stated at this point she called 911 again and begged them to please come get her or she was going to die. R1 stated the paramedics did come and they went to work on her immediately. R1 stated she was in bad shape when the paramedics arrived, was taken to the hospital, and admitted to the critical floor. R1 stated she had to be placed on a breathing machine, but not life support. R1 further stated she received great care at the facility during the day, but the night shift nurses were not good and did not take care of her respiratory needs. She also stated that she was afraid to return to the facility because she was not ready to die. Telephone interview on 6/26/2024 at 9:17 a.m. with Registered Nurse (RN) VV who revealed she was the Charge Nurse working in the emergency department (ED) the night of 6/2/2024. RN VV stated she heard a call come in to the dispatcher for a resident at the facility in respiratory distress. She stated the resident sounded very short of breath. She stated shortly afterward a call came over from someone at the nursing home cancelling the call, stating that she was aware and handling the situation. RN VV stated minutes later the resident called again pleading with the dispatcher not to cancel the call and send someone because she was having a hard time breathing. She stated the dispatcher informed EMS and they decided to go to the facility to check on the resident. It was reported that when the EMS arrived at the facility, R1 was in respiratory distress with oxygen saturations initially in the 70s to low 80s. RN VV stated R1 was bent over in tripod position to facilitate breathing and the crew had to implement respiratory interventions prior to arriving at the hospital. RN VV further stated when R1 arrived at the ED, she was very respiratory compromised, was placed in the trauma room, and placed on BIPAP for respiratory support. RN VV stated resident was admitted to the hospital and refused to go back to the nursing home upon discharge. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 6/27/2024 at 9:03 am with Paramedic WW revealed he was a member of the crew that responded to the facility. He stated that the situation was unusual because he had never had a patient to request assistance and the facility staff call to attempt to cancel the call stating they were aware of the situation and could handle it at the facility. He further stated the patient called a 2nd time stating for the ambulance to please come. He stated he and the other paramedic decided to go to the facility to assess the situation, upon arrival at the facility, there was no staff to direct or assist them to the resident. He stated they were able to locate the resident based on the Room number provided by the resident on the 911 call. Paramedic WW stated upon entry into the resident's room, she was sitting on the bed by the window leaning forward trying to breathe. He stated the resident was in obvious respiratory distress, was clammy, and cyanotic. Paramedic WW stated the nurse or no other staff member came into the room to give a report or assist with the care of R1. He further stated after loading R1 onto the stretcher for transport, the other crew member had to go find the nurse. Paramedic WW stated they had to work with R1 to stabilize her while enroute to the hospital and upon arrival at the hospital, respiratory and the nurse began working with R1 immediately to stabilize her. Paramedic WW stated R1 was placed on BIPAP after arriving to the ED. Interview on 6/27/2024 at 9:56 am with LPN UU stated she was one of the nurses working the night of 6/2/2024. LPN UU further stated she was not aware R1 was in respiratory distress or that the nurse assigned to R1 potentially needed help. LPN UU stated the nurse assigned to R1 did not inform her of anything going on with the resident. Telephone interview on 6/27/2024 at 10:14 am with LPN QQ revealed she was the nurse working when R1 called 911 on 6/2/2024. LPN QQ stated R1 was having difficulty breathing and wanted to go the emergency room . She stated she called 911 but did not cancel the ride. LPN QQ further stated she did not have any knowledge of anyone calling to cancel the 911 call and she did not call to cancel the 911 call unless her mind was blown at the time. LPN QQ further stated she witnessed R1 tripoding and turning purple. LPN QQ also stated R1 was sick and needed help, however, she stated she did not assess resident, implement any interventions, document the change in condition, or call the physician. LPN QQ stated the change of condition should have been documented and her respiratory status should have been assessed, but because R1 was of thin frame she could see the resident had to use her accessory muscles to breathe. LPN QQ also stated she did not stay with the resident until emergency personnel arrived and she did not alert the more experienced nurse on the shift that something was going on. LPN QQ further stated she did not greet the emergency medical staff or give them a report when they arrived at the facility. LPN QQ stated a paramedic came to her to let her know they were transporting the R1 to the ED. LPN QQ stated she did not call residents emergency contact to inform him of the transport, because she did not see anyone listed on the medication administration record (MAR) to call. LPN QQ also stated she did not call the physician, DHS, or Administrator to inform them of resident's condition and the situation. LPN QQ also confirmed she was aware R1 had a history of respiratory distress and had several medications to treat her condition, but she did not attempt to administer any medications or treatments. LPN QQ stated to surveyor I made too many mistakes and reacted too late. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/27/2024 at 10:20 am with DHS and Administrator, DHS stated he was aware R1 was admitted to the hospital 6/02/2024 for respiratory distress and panic attack. DHS stated that he was not aware of a staff member attempting to cancel the 911 call for resident. DHS further stated the nurse should have assessed R1 and documented her findings in the clinical record. DHS verified the change in condition was not documented anywhere in R1's record. Administrator stated she did not have any knowledge of the nurse or another staff member attempting to cancel the 911 call. She stated residents with chronic respiratory issues typically would call 911 themselves, so this incident did not throw up a red flag for her. She further stated they were aware the documentation was not in place but were unaware of the issues surrounding the change in condition. Both the Administrator and DHS stated no one from the facility should have attempted to cancel a 911 call initiated by R1. Telephone interview on 6/27/2024 at 11:25 am with Paramedic XX who stated he also was a crew member on duty that responded to the 911 call for R1 on 6/2/2024. He stated R1 called 911 needing help because she was having difficulty breathing. He stated dispatch then called them stating the nursing home staff called to cancel the call, but R1 called back a 2nd time requesting the EMS to come. Paramedic XX stated their protocol is, unless the patient cancels the call, then they go out and assess the situation. Paramedic XX stated upon arrival to the nursing home R1 was bent forward, having a hard time breathing and was very cyanotic. Paramedic XX informed surveyor, I am not exaggerating but that patient appeared to be near death. Paramedic XX stated there was not a staff member in the room with R1, they had to put her on their high flow oxygen and CPAP before they could move her to the stretcher. He stated the nursing home staff did not come to R1's room, or give him a report, and were seemingly surprised that they were transporting the resident to the hospital. Telephone interview on 6/27/2024 at 11:53 am with Clinical Competency Coordinator (CCC), revealed that staff who are newly hired into the facility do not complete a competency checklist. CCC stated that he was aware that LPN QQ was a newly licensed nurse, who previously worked at another facility as a certified nursing assistant (CNA) and transferred to this facility to work as a nurse. He stated that LPN QQ orientated with another nurse for a while prior to being able to work on her own. CCC was not sure how long she orientated with the other nurse. He further stated during orientation there is not a checklist completed to ensure that a nurse is ready to care for the residents in the facility. CCC stated there probably should be something in place but at this time, there was not. CCC further stated that he was supposed to have scheduled a training for 1 or 2 days with LPN QQ to make sure she was knowledgeable on the facility protocols related to documentation and processes related to emergency care, but the training was never scheduled, and he did not have an excuse for not doing it. Interview on 6/27/2024 at 12:17 pm with DHS revealed he has always believed in being transparent and that he had not conducted any training with LPN QQ about the lack of documentation related to the change of condition that was not done for R1. He stated that he verbally spoke with the LPN QQ after speaking with the surveyor about the situation this morning. DHS further stated that LPN QQ should have sought help from the experienced nurse who was working with her on 6/2/2024. DHS stated he was not aware that LPN QQ attempted to cancel the 911 call. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 7/1/2024 at 10:01 am with the Medical Director (MD), who stated there is no question that a resident who is in respiratory distress and who is experiencing a change in condition, the physician should be notified. He further stated that the provider staff is on call 24/7, 365 days and there is a call schedule posted at each nurse's station by the phone system. He said he expects the providers to be notified of all residents change in status. He stated that he knows for a fact he was never notified until now about R1 being in respiratory distress. He stated a resident with a long history of respiratory issues should be considered an emergency when that resident is in distress. He stated if the resident called 911 to go to the hospital, no one should have intervened at a level of opposing the transfer. He stated even if the resident's complaints were subjective the resident's wishes should have been honored. MD further stated the nurse had an obligation to the resident to assess her condition, obtain a set of vital signs, called the provider, and stay with and monitored the resident until emergency personnel arrived, and document everything in the electronic record. Telephone interview on 7/1/2024 at 10:51 am with family member of R1 revealed the facility staff did not notify him that R1 was having an acute respiratory problem until sometime after she was in the hospital. He stated he was not quite sure of the time frame, but he had already spoken with his mother. He stated that his mother did inform him that the facility staff attempted to cancel the 911 call she placed, and she had to call again to get some help. He further stated his mother had voiced concerns to him related to her medications and care on the night shift at the facility.

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on staff interviews, record review, and the facility policy titled Care Plans, the facility failed to develop a person-centered baseline care plan for one resident (R) (R1) of three residents reviewed for care and treatment of resident with chronic respiratory complications. This deficient practice had the potential to have an adverse effect for the resident. On 7/1/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator and Director of Health Services (DHS) were informed of the Immediate Jeopardy (IJ) on 7/1/2024 at 10:22 am. The noncompliance related to the Immediate Jeopardy was identified to have existed on 6/2/2024. At the time of exit on 7/3/2024, the Immediate Jeopardy remained ongoing. Findings include: Record review of the facility policy titled Care Plans review and revised dated 7/27/2023 stated, It is the policy of the health center for each patient/resident to have a person-centered baseline care plan followed by a comprehensive care plan developed following completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. New Admission Baseline Plan of Care: 1. Upon a new admission, a baseline care plan will be developed by the admitting nurse/nurses in conjunction with other interdisciplinary team (IDT), the patient/resident and/or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission. 2. The baseline care plan will be updated to reflect changes to approaches, as necessary, that result from significant changes in condition or needs occurring prior to the development of a comprehensive care plan. 3. Within the first few days of admission, a post Admission Care Conference will be held for update and review of the baseline care plan. The baseline care plan should be updated to reflect changes since baseline care plan implementation. Record review of R1's Electronic Medical Record (EMR) revealed that the resident had the following diagnoses but not limited to Acute and chronic respiratory failure with hypercapnia, Acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, shortness of breath, pleural effusion in other conditions classified elsewhere, muscle weakness, acute diastolic (congestive) heart failure, Non-ST elevation (NSTEMI) myocardial infarction, Parkinson's disease without dyskinesia, without mention of fluctuations, cerebral infarction, anxiety disorder, and post-traumatic stress disorder. Review of R1's Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact. (continued on next page)

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F 0655 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a nurses progress note in R1's electronic record revealed a progress note dated 5/27/2024 at 11:00 am. that indicated resident was readmitted to facility 5/26/2024 with clinical pathway diagnosis acute on chronic respiratory failure, COPD, shortness of breath, pleural effusions, acute diastolic CHF, cerebral infarction, NSTEMI, and chronic kidney disease (CKD). Oxygen noted via nasal cannula. Poor air movement through lung fields. Respirations even and unlabored. Complaints of anxiety due to COPD but is in no visible distress at present. There was no baseline care plan or interventions in place to address the chronic respiratory conditions of R1. Review of an Emergency Medical Services (EMS) report revealed EMS was dispatched to the facility on [DATE] in reference to a [AGE] year old female having shortness of breath. Upon arrival R1 was found tripoding in bed with labored breathing with pale and cyanotic skin. Resident was also noted to be wearing a CPAP. The report stated that the resident had been having shortness of breath for about an hour and this had been reported to the nursing home staff multiple times. EMS removed the CPAP and placed R1 on 6 LPM oxygen. When vitals were taken resident was hypertensive and SPO2 of 81%. Resident was then placed on a CPAP with a peep of 5, 15 LPM of oxygen, and given an inline duo-neb treatment before being transferred to the hospital. Further review of the medical record for R1 did not reveal any documented interventions for R1 while experiencing a respiratory crisis. During a telephone interview on 6/25/2024 at 3:19 pm with R1 she stated that she did not feel comfortable returning to the nursing home after what happened to her. R1 stated the night of 6/2/2024 she was having a very hard time breathing and she asked the nurse working to give her medications and to call 911. R1 stated the nurse ignored her and walked away, therefore she had to call 911 herself. R1 further stated she believed the nurse heard her call 911 because she overheard the nurse on the phone cancelling the 911 call. R1 stated at this point she called 911 again and begged them to please come get her or she was going to die. R1 stated the paramedics did come and they went to work on her immediately. R1 stated she was in bad shape when the paramedics arrived, was taken to the hospital, and admitted to the critical floor. R1 stated she had to be placed on a breathing machine, but not life support. R1 further stated she received great care at the facility during the day, but the night shift nurses were not good and did not take care of her respiratory needs. She also stated that she was afraid to return to the facility because she was not ready to die. Interview with the Director of Health Services (DHS) on 6/27/2024 at 12:17 pm. DHS confirmed a plan of care related to R1's respiratory diagnoses was not listed, and he was not aware until now. DHS reported that a respiratory problem should be done for residents who have a known history of respiratory related illnesses. DHS further reported R1 discharged from the facility prior to a comprehensive care plan was scheduled to be completed, but the baseline care plan should have reflected resident's chronic respiratory issues. Cross refer F695

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45813 Based on record review and interviews, review of the facility's tools Using SBAR Communication, the facility failed to ensure one resident (R) (R1) of four sampled residents received necessary respiratory care. Nursing staff did not assess resident during an acute change in condition, did not notify the physician, and attempted to cancel a 911 call which R1 initiated. In addition, facility's nursing staff did not document anything in R1's clinical record related to the change in condition. On July 1, 2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had caused, or had the likelihood to cause, serious injury, harm, impairment, or death to residents. The facility's Administrator and Director of Health Services (DHS) were informed of the Immediate Jeopardy (IJ) on July 1, 2024, at 10:22 am. The noncompliance related to the immediate jeopardy was identified to have existed on June 2, 2024. At the time of exit on 7/3/2024, the Immediate Jeopardy remained ongoing. Findings Include: Review of the document titled Using SBAR Communication dated 2019, The Situation-Background-Assessment-Recommendation (SBAR) is used by nurses to communicate with other healthcare professionals including other nurses and physicians. SBAR is an effective intervention for patient safety through improved communication. Predictability and consistency are two of the advantages for using SBAR, however SBAR does more than just aid with communication. It promotes critical thinking skills necessary for a thorough assessment, prioritization and collaboration between nurses and physicians. SBAR Techniques: The SBAR prompts nurses on completing a comprehensive assessment and collection of important information prior to calling a doctor to report a change in condition. Summary: Ensuring effective communication between all members of the healthcare team is critical to avoiding errors and misunderstandings that can lead to grave outcomes for healthcare recipients. Review of R1's clinical record revealed an admitted [DATE] with diagnoses of Acute and chronic respiratory failure with hypercapnia, Acute respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), shortness of breath, pleural effusion in other conditions classified elsewhere, muscle weakness, acute diastolic (congestive) heart failure, Non-ST elevation (NSTEMI) myocardial infarction, Parkinson's disease without dyskinesia, without mention of fluctuations, cerebral infarction, anxiety disorder, and post-traumatic stress disorder. Review of R1's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident with a Brief Interview for Mental Status (BIMS) assessment score of 15 indicating the resident was cognitively intact. Review of R1's Physician's Order History (PO) revealed the following: 5/26/2024 - Albuterol Sulfate HFA aerosol inhaler 90 microgram (mcg) /actuation 2 puffs inhalation every 4 hours as needed. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/27/2024 - Benzonatate capsule 100 milligrams (mg), 1 capsule every eight hours for cough as needed. 5/26/2024 - Breztri Aerosphere (budesonide-glycopyrformoterol) HFA aerosol inhaler 160-9-4.8 mcg/actuation 2 puffs inhalation every 12 hours. 5/26/2024 - Ipratropium-albuterol solution for nebulization 0.5 mg-3 mg/3 ml inhalation every 4 hours. 5/29/2024 - Oxygen at 3 liters per minute (LPM) via nasal cannula continuous for COPD. 5/31/2024 - Alprazolam 0.25 mg 1 tablet by mouth twice daily. 5/26/2024 - Lasix 20 mg 1 tablet by mouth twice a day. 5/26/2024 - Full Code. Review of R1's electronic Medication Administration Record (eMAR) dated 5/23/2024 through 6/4/2024 revealed the PRN Ipratropium-Albuterol solution, scheduled 9 p.m. alprazolam, Breztri Aerosphere HFA aerosol inhaler, and Lasix were not administered to R1 on 6/2/2024 when the resident was observed to be in respiratory distress. Review of R1's Patient Progress Notes electronically signed 5/27/2024 by the nurse Practitioner and 5/29/2024 by the medical director revealed the following: Date of visit at the facility 5/27/2024 revealed a female with a past medical history significant for COPD with chronic hypoxemic respiratory failure on 3 L (liters) home oxygen, mood disorder, CVA, hypertension, dyslipidemia, CAD, PAD, Parkinsons disease and nicotine dependence but quit smoking 2 years ago, who presented from nursing facility for respiratory distress. Patient was discharged from the hospital on 5/23/2024 for COPD acute exacerbation however she was unable to receive her medications after discharge and returned to the hospital for cough with secretions and generalized fatigue. Resident was readmitted to facility R1 reported using Xanax 0.25 mg twice daily for several years to manage her COPD symptoms. Resident uses a nasal cannula but clarifies that she does not use a BiPAP machine for sleep. Review of the Plan Notes revealed the Anxiety Assessment and Treatment Plan: patient has been on Xanax 0.25 mg twice a day for several years, continue current medication regimen and monitor for any changes in anxiety level; COPD Assessment and Treatment Plan: patient uses a nasal cannula for oxygen therapy, encourage patient to continue using prescribed oxygen therapy and monitor for changes in respiratory status: Review of an Emergency Medical Services (EMS) report revealed EMS was dispatched to the facility in reference to a [AGE] year old female having shortness of breath. Upon arrival R1 was found tripoding in bed with labored breathing with pale and cyanotic skin. Resident was also noted to be wearing a CPAP. The report stated that the resident had been having shortness of breath for about an hour and this had been reported to the nursing home staff multiple times. EMS removed the CPAP and placed R1 on 6 LPM oxygen. When vitals were taken resident was hypertensive and SPO2 of 81%. Resident was then placed on a CPAP with a peep of 5, 15 LPM of oxygen, and given an inline duo-neb treatment before being transferred to the hospital. There was no documentation in the medical record indicating R1 had been monitored or assessed during her respiratory distress event on 6/2/2024. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Telephone interview on 6/25/2024 at 3:19 pm with R1 revealed that she is now living with a friend who is her caregiver. She further stated that she did not feel comfortable returning to the nursing home after what happened to her. R1 stated the night of 6/2/2024 she was having a very hard time breathing and she asked the nurse working to give her medications and to call 911. R1 stated the nurse ignored her and walked away, therefore she had to call 911 herself. R1 further stated she believed the nurse heard her call 911 because she overheard the nurse on the phone cancelling the 911 call. R1 stated at this point she called 911 again and begged them to please come get her or she was going to die. R1 stated the paramedics did come and they went to work on her immediately. R1 stated she was in bad shape when the paramedics arrived, was taken to the hospital, and admitted to the critical floor. R1 stated she had to be placed on a breathing machine, but not life support. R1 further stated she received great care at the facility during the day, but the night shift nurses were not good and did not take care of her respiratory needs. She also stated that she was afraid to return to the facility because she was not ready to die. Telephone interview on 6/26/2024 at 9:17 am with Registered Nurse (RN) VV revealed that she was the Charge Nurse working in the emergency department (ED) the night of 6/2/2024. RN VV stated she heard a call come in to the dispatcher for a resident at the facility in respiratory distress. She stated the resident sounded very short of breath and shortly afterward a call came over from someone at the nursing home cancelling the call, stating that she was aware and handling the situation. RN VV stated minutes later the resident called again pleading with the dispatcher not to cancel the call and send someone because she was having a hard time breathing. She stated the dispatcher informed EMS and they decided to go to the facility to check on the resident. She stated when the EMS arrived at the facility, R1 was in respiratory distress with oxygen saturations initially in the 70s to low 80s. RN VV stated R1 was bent over tripoded to facilitate breathing and the crew had to implement respiratory interventions prior to arriving at the hospital. RN VV further stated when R1 arrived at the ED, she was very respiratory compromised, was placed in the trauma room, and placed on BIPAP for respiratory support. RN VV stated resident was admitted to the hospital and refused to return to the nursing home upon discharge. Telephone interview on 6/27/2024 at 10:14 am with LPN QQ revealed she was the nurse working when R1 called 911 on 6/2/2024. LPN QQ stated R1 was having difficulty breathing and wanted to go the emergency room . LPN QQ further stated she witnessed R1 tripoding and turning purple. LPN QQ also stated R1 was sick and needed help, however, she stated she did not assess resident, implement any interventions, document the change in condition, or call the physician. LPN QQ stated the change of condition should have been documented and her respiratory status should have been assessed, but because R1 was of thin frame she could see the resident had to use her accessory muscles to breathe. LPN QQ also stated she did not stay with the resident until emergency personnel arrived and she did not alert the more experienced nurse on the shift that something was going on. LPN QQ further stated she did not greet the emergency medical staff or give them a report when they arrived at the facility. LPN QQ also stated she did not call the physician, DHS, or Administrator to inform them of resident's condition and the situation. LPN QQ also confirmed she was aware R1 had a history of respiratory distress and had several medications to treat her condition, but she did not attempt to administer any medications or treatments. LPN QQ stated to surveyor I made too many mistakes and reacted too late. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on 6/27/2024 at 10:20 am with DHS and Administrator. DHS stated he was aware R1 was admitted to the hospital 6/2/2024 for respiratory distress and panic attack. DHS further stated the nurse should have assessed R1 and documented her findings in the clinical record. DHS verified the change in condition was not documented anywhere in R1's record. The Administrator stated residents with chronic respiratory issues typically would call 911 themselves, so this incident did not throw up a red flag for her. She further stated they were aware the documentation was not in place but were unaware of the issues surrounding the change in condition. Telephone interview on 7/1/2024 at 10:01 am with the Medical Director (MD), who stated there is no question that a resident who is in respiratory distress and who is experiencing a change in condition, the physician should be notified. He stated a resident with a long history of respiratory issues should be considered an emergency when that resident is in distress. MD further stated the nurse had an obligation to the resident to assess R1's condition, obtain a set of vital signs, call the provider, and stay with and monitor the resident until emergency personnel arrived, and document everything in the electronic record. Interview on 7/2/2024 at 10:04 am with the Administrator who stated the facility does not have a policy related to acute change in conditions or respiratory assessments. She further stated the facility utilizes the SBAR tool to assess and document any acute changes with residents.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 45813 Based on interviews, record reviews, and review of the job summaries for the Administrator and Director of Health Service (DHS), the facility Administration failed to effectively oversee an abuse prevention program to promote, foster, and maintain an abuse-free environment, failed to provide monitoring and oversight for respiratory care, and failed to develop a care plan to address chronic respiratory conditions which were present on admission to the facility for one resident (R) R1. The facility census was 75. On 7/1/2024, a determination was made that a situation in which the facility's noncompliance with one or more requirements of participation had the likelihood to cause serious injury, harm, impairment, or death to residents. Facility Administrator and Director of Health Services (DHS) were informed of the Immediate Jeopardy (IJ) on 7/1/2024 at 10:22 p.m. The noncompliance related to the Immediate Jeopardy was identified to have existed on 6/22/2024. At the time of exit on 7/3/2024, the Immediate Jeopardy remained ongoing. Findings include: Review of job summary for the Administrator revealed, directs the day-to-day functions of the nursing center in accordance with federal, state, and local regulations that govern long-term care centers, and as may be directed by the Area [NAME] President to provide appropriate care for the patients/residents. Overall operation programs and activities of the Long-Term Care Facility, ensuring the delivery of competent and age-appropriate care that encompasses the physiological and psychological needs of the resident. Promote a culture of safety, follow established policies, and adhere to all stated and federal regulatory requirements, Joint commission requirements, and national patient safety standards. The description included key responsibilities: Ability to apply standards of professional practice to operations of nursing facility and to establish criteria to assure that care provided meets established standards of quality, ability to develop and implement administrative policies and procedures that reflect the center's philosophy and mission in compliance with federal and state laws and regulations, demonstrates knowledge of and respect for the rights, dignity and individuality of each patient/resident in all interactions. Demonstrates competency in the protection and promotion of residents rights. Able to act as a role model for center and staff, carries out all duties in accord with the center's mission and philosophy. Knowledge, Skills, Abilities: Honor patient/residents' rights to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights, including the right to wage complaints. Comply with corporate compliance program. Able to foster interdisciplinary cooperation and coordination of quality assurance and quality improvement efforts. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of job summary for Director of Nursing revealed, plans, organizes, develops, and directs the overall operation of the facility Nursing Services Department in accordance with current federal, state, and local regulations governing the nursing center, and as may be directed by the Administrator and the Medical Director, to provide appropriate care. The description included key responsibilities for: Delivery of medications (setting up, rotating, charting, ordering, giving to patient, etc.), use and delivery of PRN medications, knowledge of procedure for sending a patient to the hospital, maintain knowledge of documentation procedures including appropriate use of forms, timelines, and Medicare documentation, etc.), and maintain a working knowledge of current licensure standards and the survey process. 1.The Administration failed to protect resident (R) 1's right to be free from neglect by not assessing, medicating, and effectively assisting her with emergency care needed for an acute change in condition. Specifically, facility staff attempted to intercept a 911 call made by R1. This deficient practice resulted in R1 receiving a delay in treatment for her chronic respiratory issues while in acute respiratory distress. Cross-reference: F600 2. Administration failed to monitor, assess, document, and effectively address R1's chronic respiratory issues. This deficient practice resulted in R1 being admitted to the hospital on critical care unit and initially being placed on BiPAP. Telephone interview 6/27/2024 at 10:14 am with LPN QQ revealed she was the nurse working when R1 called 911 on 6/2/2024. LPN QQ stated R1 was having difficulty breathing and wanted to go the emergency room . LPN QQ further stated she witnessed R1 tripoding and turning purple. LPN QQ also stated R1 was sick and needed help, however, she stated she did not assess resident, implement any interventions, document the change in condition, or call the physician. LPN QQ stated the change of condition should have been documented and her respiratory status should have been assessed, but because R1 was of thin frame she could see the resident had to use her accessory muscles to breathe. LPN QQ also stated she did not stay with the resident until emergency personnel arrived and she did not alert the more experienced nurse on the shift that something was going on. LPN QQ further stated she did not greet the emergency medical staff or give them a report when they arrived at the facility. LPN QQ also stated she did not call the physician, DHS, or Administrator to inform them of resident's condition and the situation. LPN QQ also confirmed she was aware R1 had a history of respiratory distress and had several medications to treat her condition, but she did not attempt to administer any medications or treatments. LPN QQ stated to surveyor I made too many mistakes and reacted too late. Cross-reference: F695 3.Administration failed to develop and implement person-centered baseline care plans related to risks associated with chronic respiratory problems for resident R1. Interview with the Director of Health Services (DHS) on 6/27/2024 at 12:17 pm. DHS confirmed a baseline plan of care related to R1's respiratory diagnoses was not listed, and he was not aware until now. DHS reported that a respiratory problem should be done for residents who have a known history of respiratory related illnesses. The DHS further reported R1 discharged from the facility prior to a comprehensive care plan was scheduled to be completed, but the baseline care plan should have reflected resident's chronic respiratory issues. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cross-reference: F655