STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145419	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Elmwood Park	7733 West Grand Avenue Elmwood Park, IL 60707

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 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. 46066 Based on interview and record review, the facility failed to provide care in accordance with professional standards of quality by 1. Failing to provide timely respiratory tracheostomy care; 2. Failed to respond to request from resident for respiratory suctioning to clear airway; 3. Failed to have staff who had the necessary skills to adequately meet the needs of the resident in respiratory distress; 4. Failed to provide adequate supervision and monitoring of tracheostomy patients to avoid life-threatening situations. These failures affect 1 (R2) of 3 residents reviewed for respiratory care in the sample of 4 and have the potential to affect 12 residents in the facility. Findings include: On 03/11/2024 at 2:54 PM, V1 (Administrator) presented surveyor the facility tracheostomy status resident list showing 12 residents with tracheostomy status. On 03/04/2024 at 12:31 PM, Surveyor interviewed V4 (Respiratory Therapist) who stated in summary: My respiratory therapy duties are to: check vital signs for residents with tracheostomies, make sure all residents with tracheostomy status are connected to ventilators, make sure there is water present for humidity, make sure tracheostomy site is clean and secured, and give breathing treatments. Additionally, majority of alarms sounding in this unit, are for suctioning, so I need to respond to those. On Mondays, Wednesdays, and Fridays, we have to assist with transport to dialysis and check on residents while they're in the dialysis. I was here on 02/19/2024. I started at 7:00 AM, I provided R2 with routine morning tracheostomy care, which included suctioning, around 9:25 AM - 9:30 AM. Then code blue was called, and when I came in to R2's room, I noticed his tracheostomy tube was dislodged. R2's tracheostomy would not initiate unit alarms because he was not connected to the ventilator at the time of the incident, and only ventilators trigger unit alarm. 03/04/2024 at 2:19 PM Surveyor interviewed V5 (Licensed Practical Nurse) who stated in summary: Earlier in the day (02/19/2024), around 9:00 AM, I checked on R2's roommate and noticed R2 gesturing and pointing to his tracheostomy, which meant, that he needed to be suctioned. I told V4 (RT) right away. I'm not sure when or whether she went back to provide suctioning for R2. When I was finishing medication pass, around 10:30 AM, a CNA came out of R2's room and said that R2 doesn't look right and asked me to check on him. I went in right away, checked for pulse, didn't feel it, and yelled out to the CNA to call code blue. Code blue protocol was initiated, staff rushed in with emergency cart, and started chest compressions. I could not tell if R2's tracheostomy tube was dislodged at that time, but when V6 (Respiratory Therapy Director) attempted to bag (deliver oxygen) R2, she realized, that R2's tracheostomy tube was dislodged. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024
NAME OF PROVIDER OR SUPPLIER Bria of Elmwood Park		STREET ADDRESS, CITY, STATE, ZIP CODE 7733 West Grand Avenue Elmwood Park, IL 60707	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/06/2024 at 1:20 PM, Surveyor re-interviewed V5 (LPN). Surveyor asked who is qualified to suction resident's air way, V5 (LPN) responded, Respiratory therapy will always suction resident's air way, as it is their primary job. The only event when nurses would be required to suction resident's air way is, if a resident was in any sort of distress. On 03/05/2024 at 10:23 AM, Surveyor interviewed V6 (Respiratory Therapy Director) who stated in summary: On 02/19/2024, during the incident, I was in the morning meeting. The code blue was called, and everyone left the morning meeting immediately and headed out to R2's room. When I got to the room, staff was doing chest compressions. When I looked, I noticed staff bagging (oxygenating) R2 without noticing that his tracheostomy tube was dislodged. I immediately placed a spare tracheostomy tube and continued oxygenating R2. A little later, EMS arrived and took over resuscitation. R2 was under V4's (RT) care that day. Based on R2's orders, he was supposed to be on ventilator at night, and tracheostomy collar throughout the day. We don't have alarm system on residents who are connected to tracheostomy collars, we are supposed to do physical rounds and look at the resident, between nurses, CNAs, and respiratory therapists. Frequency of monitoring is based on secretion load and resident's comfort. R2 fluctuated, there were times when he was calm, but he was combative and aggressive other times. Surveyor clarified who is allowed to suction residents' air way, V6 (RT Director) stated, Nurses and respiratory therapists can suction the residents' air way, whether the nurse is a Licensed Practical Nurse or a Registered Nurse. On 03/05/2024 at 11:29 AM, Surveyor interviewed V2 (Director of Nursing) who stated in summary: Based on nurse's assessment, they can suction any resident in need of suctioning. My expectation for nurses and respiratory therapist is to suction all residents in need for suction. V5 (Licensed Practical Nurse) assessed R2 on the morning of 02/19/2024 and concluded that there was no immediate need for suctioning, so she left the room, saw V4 (RT) and asked her to go in and suction R2. V4 (Respiratory Therapist) who was making morning rounds on 02/19/2024, said that she suctioned R2, but there was not much secretions, and R2's agitation was more so anxiety driven. Surveyor clarified, if a resident remains agitated regardless of suctioning needs, what should the nurse do, V2 (DON) said, If a resident remains agitated, they should be assessed, maybe checked for repositioning or pain needs, and go forward from there. I rounded on R2 that morning, around 9:20 AM, but he looked like he was at his baseline, did not appear to be in distress. On 03/05/2024 at 12:20 PM Surveyor interviewed V3 (Licensed Practical Nurse) who stated in summary: Since I've been working here (5 months), respiratory therapists are the ones who suction residents; however, nurses should be able to suction if they have skills and training to do so. In a critical moment, nurse should suction the resident. Seeing an agitated resident who is pointing to his tracheotomy, the nurse should stay and attend resident's needs until, at least, when respiratory therapist arrives. On 03/05/2024 at 3:18 PM, Surveyor interviewed V8 (Respiratory Program Director) who stated in summary: We have respiratory therapists whose primary duty is to care for residents' air way. Nurses are cross trained to care for an air way, but it's their secondary duty. If there is a resident in respiratory distress, both respiratory therapist and nurse can address the issue. It is not written in the policy but assumed that nurses are expected to address air way issues. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145419	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Elmwood Park	7733 West Grand Avenue Elmwood Park, IL 60707

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/12/2024 at 10:03 AM, Surveyor interviewed V9 (Respiratory Therapist) who stated in summary: Residents who are not connected to the ventilator are not connected to the unit alarm, so, if they were in respiratory distress, we would not know. We check resident's oxygen saturation with pulse oximeter twice a shift, on a 12 hour shift. We also do frequent checks, or we are notified by nurses if any resident needs respiratory therapist attention. There is no camera or any kind of alarm for residents with tracheotomies who are not connected to the ventilator. We wouldn't know if anybody's tracheotomy would be dislodged, so you don't always know if they are breathing ok. I'm not aware of any specific expectation as far as resident monitoring. Facility's policy Oxygen Therapy dated 09/2022 reads in part, Oxygen therapy may be provided through various types of supply and delivery systems. Equipment may include trans-tracheal oxygen catheters. Residents who require O2 therapy will have an ongoing assessment of respiratory status and response to respiratory therapy; Monitoring of SPO2 levels and/vital signs as ordered will be documented in medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46066 Based on interview and record review, the facility nursing staff failed to respond to a resident requiring respiratory care and the nursing staff failed to provide needed suctioning for a resident in potential hypoxia (lack of oxygen); for one (R2) of three residents reviewed for respiratory care in the sample of four. Findings include: R2 is a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Acute and Chronic Respiratory Failure with Hypoxia or Hypercapnia; Dysphagia; Chronic Obstructive Pulmonary Disease; Systolic (Congestive) Heart Failure; Hypertension; and Gastrostomy and Tracheostomy Status. According to R2's face sheet, R2's code status: Full Code. According to R2's MDS (Minimum Data Set) assessment dated [DATE] and [DATE] under section E, R2 had no behaviors that impacted care. R2's care plan dated [DATE] (revised on [DATE]) reads in part, (R2) is Ventilator dependent related to Respiratory Failure. Patient is refusing to turn to ventilator at night. Goal: Will actively participate in the weaning process. Resident will have appropriate ventilator alarm settings. Disconnect Alarm: High Pressure Alarm: Date Initiated: [DATE] Revision on: [DATE]. Resident will maintain a patent airway. [DATE] Revision on: [DATE]. Trach type: Trach size: Will be maintained on the lowest Fi02/PEEP/PS to support an adequate oxygenation level of: (Specify) through the review date. [DATE] Revision on: [DATE]. Interventions: Assess for s/sx of hypoxia: altered level of consciousness, irritability, listlessness, educate resident/family/caregivers purpose/mode/and all treatments; encourage resident to relax and breath with the ventilator; explain alarms; teach importance of deep breathing; Keep call bell within reach. Keep head of bed elevated above 30 degrees unless providing care or resident request. Patient and family educated on the importance of return to ventilator during night. All parties all aware of this behavior. A review of R2's care plan showed revisions made on [DATE] to goals and interventions for R2 on the same day of the resident's death with no explanation. R2's Call Light Ability Screen dated [DATE] reads in part, (R2) is unable to use a call light due to cognitive status. R2's order dated [DATE] reads in part, Ventilator Settings: Mode: AC, Rate: 12, Tidal Volume: 400, PEEP: 5, FiO2: 40%; Ventilator: noc. Every night shift. R2's order dated [DATE] reads in part, Weaning orders: TC 40% dayshift. No oxygen saturation level monitoring nor acceptable oxygen saturation level order noticed among R2's orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:31 PM, Surveyor interviewed V4 (Respiratory Therapist) who stated in summary: The company is trying to cut down on respiratory therapists. There is only 1 respiratory therapist from 07:00 AM to 07:00 PM for over 20 residents with tracheostomy needs. Our manager is on the floor today because you are here. My respiratory therapy duties are to check vital signs for residents with tracheostomies, make sure all residents with tracheostomy status are connected to ventilators, make sure there is water present for humidity, make sure tracheostomy site is clean and secured, and give breathing treatments. Additionally, majority of alarms sounding in this unit, are for suctioning needs, so I need to respond to those. On Mondays, Wednesdays, and Fridays, we have to assist with transport to dialysis and check on residents while they're in the dialysis. I was here on [DATE], I started at 7:00 AM. I provided R2 with routine morning tracheostomy care, which included suctioning, around 9:25 AM - 9:30 AM. I don't remember being called by the nurse for additional suctioning needs for R2 at any time before or after that. R2 was agitated before, during, and after tracheostomy care that morning ([DATE]). Then the code blue was called, and, when I came in to R2's room, I noticed his tracheostomy tube was dislodged. R2's tracheostomy would not initiate unit alarms because he was not connected to the ventilator during day shift, and only ventilators trigger unit alarm. [DATE] at 2:19 PM, Surveyor interviewed V5 (Licensed Practical Nurse) who stated in summary: I remember R2, he suffered cardiac arrest on [DATE] while in the facility. Earlier in the day ([DATE]), around 9:00 AM, I checked on R2's roommate and noticed R2 gesturing and pointing to his tracheostomy, which meant, that he needed to be suctioned. I told V4 (RT) right away. I'm not sure when or whether she went back to provide suctioning for R2. When I was finishing medication pass, around 10:30 AM, a CNA came out of R2's room and said that R2 doesn't look right and asked me to check on him. I went in right away, checked for pulse, didn't feel it, and yelled out to the CNA to call code blue. The code blue protocol was initiated, staff rushed in with emergency cart, and started chest compressions. I could not tell if R2's tracheostomy tube was dislodged at that time, but when V6 (Respiratory Therapy Director) attempted to bag (oxygenate) R2, she realized, that R2's tracheostomy tube was dislodged. R2 was paralyzed on the right side but had some strength in the left arm and leg. I've never witnessed R2 pulling on his tracheostomy tube. On [DATE] at 1:20 PM, Surveyor re-interviewed V5 (LPN) to clarify how did V5 know R2 was not in distress despite being agitated and repetitively pointing to his tracheostomy, V5 said, I knew R2 was not in respiratory distress, respiratory distress can be recognized by resident's inability to communicate. R2 just needed to be suctioned and respiratory therapist was next door, so I just told her to go into R2's room. He did not appear to be in respiratory distress because he was able to communicate. Surveyor reiterated that R2 was agitated and was unable to speak. Surveyor asked who and when can suction resident's air way, V5 (LPN) responded, Respiratory therapists will always suction, as it is their primary job. The only event when nurses would be required to suction resident's airway is, if a resident was in any sort of distress. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:23 AM, Surveyor interviewed V6 (Respiratory Therapy Director) who stated in summary: On [DATE], at the time of the incident, I was in the morning meeting. The code blue was called, and everyone left the morning meeting immediately and headed out to R2's room. When I got to the room, staff were doing chest compressions. When I looked, I noticed, staff bagging (oxygenating) R2 without noticing that his tracheostomy tube was dislodged. I immediately placed a spare tracheostomy tube and continued oxygenating R2. A little later, EMS arrived and took over resuscitation efforts. R2 was under V4's (RT) care that day. Based on R2's orders, he was supposed to be on ventilator at night, and tracheostomy collar throughout the day. We don't have alarm system on residents who are connected to tracheostomy collars, we are supposed to do physical rounds and look at the resident, between nurses, CNAs, and respiratory therapists. Frequency of monitoring is based on secretion load and resident's comfort. R2 fluctuated, there were times when he was calm, but he was combative and aggressive other times. Surveyor clarified who is allowed to suction resident's air way, V6 (RT Director) stated, Nurses and respiratory therapists can suction resident's airway, whether the nurse is a Licensed Practical Nurse or a Registered Nurse. Surveyor asked why was R2's ventilator dependency care plan revised on the day of his death, V6 (RT Director stated), I don't know why somebody would revise his care plan after he passed away, but it wasn't me making those changes. On [DATE] at 11:29 AM, Surveyor interviewed V2 (Director of Nursing) who stated in summary: Based on nurses' assessment, they can suction any resident in need of suctioning. My expectation for nurses and respiratory therapists is to suction all residents in need for suction. V5 (Licensed Practical Nurse) assessed R2 on the morning of [DATE] and concluded that there was no immediate need for suctioning, so she left the room, saw V4 (RT) and asked her to go in and suction R2. V4 (Respiratory Therapist) who was making morning rounds on [DATE], said that she suctioned R2's air way, but there was not much secretions, and R2's agitation was more so anxiety driven. Surveyor clarified, if a resident remains agitated regardless of suctioning needs, what should the nurse do, V2 (DON) said, If a resident remains agitated, they should be assessed, maybe checked for repositioning or pain needs, and go forward from there. I rounded on R2 that morning, around 9:20 AM, but he looked like he was at his baseline, did not appear to be in distress. On [DATE] at 12:20 PM Surveyor interviewed V3 (Licensed Practical Nurse) who stated in summary: Since I've been working here (5 months), respiratory therapists are ones who suction residents; however, nurses should be able to suction if they have skills and training to do so. In a critical moment, nurse should suction the resident. Seeing an agitated resident who is pointing to his tracheotomy, nurse should stay and attend resident's needs until, at least, until respiratory therapist arrives. There is no documentation that the facility monitored or provided any follow-up assessment to R2 for an hour after suctioning even though he showed signs of agitation, which is outside of his baseline per his MDS Section E:Behavioral assessment. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:55 PM, Surveyor interviewed V7 (Medical Director) who stated in summary: R2 was a [AGE] year old with chronic respiratory failure, tracheotomy, and congestive heart failure with ejection fraction of 35%. R2 had cardiac arrest followed by intracranial bleeding and stroke before his admission into the facility. R2 was stable on tracheostomy, his main problem, was cardiomyopathy. On [DATE], R2 requested suctioning around 9:15 AM from V5 (LPN), V5 (LPN) asked V4 (RT) to suction R2, who suctioned R2 at 9:30 AM. R2 had minimal secretions. At 10:30 AM, CNA found him unresponsive, and CPR was started. If R2 was in respiratory failure related to mucus plug, they would be cyanotic, their oxygen saturation would drop, they would be unable to talk, and their respiratory rate would be elevated. Surveyor clarified that R2 was unable to talk, was agitated, and was pointing to his tracheostomy site, communicating that his tracheostomy needs to be addressed, V7 (MD) said, Respiratory distress and agitation are completely different. Surveyor further clarified if dislodged tracheostomy could cause respiratory distress, V7 (MD) stated, Tracheostomy dislodgement would not have impact on R2's respiratory status. Based on his vital signs at the time (last known vital signs documented at 09:30 AM), it is very unlikely R2 was in respiratory distress. If resident is in respiratory distress, nurse have to make a clinical judgment, to see if it's appropriate to suction or call for respiratory therapist. I think the nurse did the right thing by looking at the timeline of this incident. On [DATE] at 3:18 PM, Surveyor interviewed V8 (Respiratory Program Director) who stated in summary: We have respiratory therapists whose primary duty is to care for residents' air way. Nurses are cross trained to care for an air way, but it's their secondary duty. If there is a resident in respiratory distress, both respiratory therapist and nurse can address the issue. It is not written in the policy but assumed that nurses are expected to address air way issues. V2 has noted prior to that statement that there is no policy regarding suctioning, monitoring or ratios for ventilated residents. On [DATE] at 10:03 AM Surveyor interviewed V9 (Respiratory Therapist) who stated in summary: Residents who are not connected to the ventilator are not connected to the unit alarm, so, if they were in respiratory distress, we would not know. We check resident's oxygen saturation with pulse oximeter twice a shift, on a 12 hour shift. We also do frequent checks, or we are notified by nurses if any resident needs respiratory therapist attention. There is no camera or any kind of alarm for residents with tracheotomies who are not connected to the ventilator. We wouldn't know if anybody's tracheotomy would be dislodged, so you don't always know if they are breathing ok. I'm not aware of any specific expectation as far as resident monitoring. 3. According to National Library of Medicine article Respiratory Failure in Adults dated [DATE], Type 1 respiratory failure occurs when the respiratory system cannot adequately provide oxygen to the body, leading to hypoxemia. Type 2 respiratory failure occurs when the respiratory system cannot sufficiently remove carbon dioxide from the body, leading to hypercapnia. If either type of respiratory failure is not identified and addressed early, it will become life-threatening and lead to respiratory arrest, coma, and death. Signs of respiratory failure may be present throughout the body. Physical examination findings by region appear below: General inspection: Accessory muscle use, altered mental status, cachectic, conversational dyspnea, diaphoresis, fever, respiratory distress (i.e., at rest or with exertion), obesity, and purse-lipped breathing No comprehensive assessment documented in R2's electronic medical record related to R2's ongoing distress on [DATE]. Altered mental status documented prominently by V4 (Respiratory Therapist) in R2's last known assessment on [DATE] at 09:30 AM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	According to National Library of Medicine article Pain, agitation and delirium in acute respiratory failure dated [DATE], Since pain, agitation and delirium compromise respiratory function they should also be regarded during noninvasive ventilation and during ventilator weaning. Progress Noted dated [DATE] at 9:15 AM, written by V5 (Licensed Practical Nurse) reads in part, While caring for (R2) in bed, alert, and gesturing for respiratory. RT (V4, respiratory therapist) informed that (R2) is in need of suctioning. RT (V4) states, she is on her way to (R2's) room. R2's Ventilator/Aerosol Flowsheet assessment dated [DATE] at 09:30 AM written by V4 (Respiratory Therapist) reads in part, Breath sounds Left: rhonchi. Breath sounds Right: rhonchi. Upon entry, (R2) seemed to be irritated and turned combative while assessing him. Trach care done - trach ties changed, trach secured and intact - (R2) was very aggressive with RT, (R2) was alert and responsive. VS (vital signs): 88 HR (heart rate), 16 RR (respiratory rate), 96% suctioning small amount of thick, yellow secretions from trach, BS rhonchi bilaterally, HOB 35% throughout the entire procedure and after will continue to monitor. Progress note dated [DATE] at 10:30 AM written by V5 (Licensed Practical Nurse) reads in part, (V5) called to (R2's) room via CNA to check on resident. (R2) vs (vital signs) absent at this time with no pulse present. 10:32 am (V5) called for CNA to call code blue, code blue called and 911 called, all available staff on scene 10:34 am Chest Compressions initiated, trach observed dislodged 10:35 am RT (V6, respiratory therapy director) at bedside, trach immediately replaced via RT without difficulty,02 applied 10:37am AED applied, no shock advised 10:41am Peripheral IV line placed and 0.9 NACL infusing 10:45 am Paramedics arrived and continue with CPR 10:50 am 1 round of epi (epinephrin) given, (R2) remains asystole, CPR continues 10:55 am 2nd round of epi (epinephrin) given, (R2) remains asystole, CPR continues 11:07am Code called to end, (R2) declared deceased at this time. Ambulance run sheet dated [DATE] 01:37 PM reads in part, Dispatched to above location for a reported cardiac arrest. U/a (upon arrival) found (R2) lying supine in bed, nursing staff doing CPR and ventilating (R2) via BVM (bag valve mask) to trach. Per staff, (R2) was last seen alive 30 minutes ago. AED (automated external defibrillator) was applied (R2) with no shock advised. Crew placed (R2) on monitor and asystole noted, IO (intraosseous) established in right leg. CPR (cardiopulmonary) continued by crew throughout duration of call, only pausing for rhythm checks, asystole noted on all rhythm checks. Pupils noted to be fixed and dilated. (Local hospital) contacted and orders to terminate resuscitation given. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Facility's policy Oxygen Therapy dated ,d+[DATE] reads in part, Oxygen therapy may be provided through various types of supply and delivery systems. Equipment may include trans-tracheal oxygen catheters. Residents who require O2 therapy will have an ongoing assessment of respiratory status and response to respiratory therapy; Monitoring of SPO2 levels and/vital signs as ordered will be documented in medical record.

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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** 46066 Based on interview and record review, the facility nursing staff failed to provide timely respiratory care to a resident with a tracheostomy and failed to provide documentation of monitoring for an agitated resident for an hour after suctioning. These failures affected one (R2) of three residents reviewed for respiratory care in the sample of four. This failure resulted in R2 left being agitated with no follow up for one hour after trach care from RT, found with this trach out and in respiratory arrest. The Immediate Jeopardy began on [DATE] when R2 gestured and pointed to his trach, was not immediately suctioned by nursing staff, but later was by respiratory who admitted R2 was agitated before, during, and after trach care. V1 (Administrator), V2 (Director of Nursing), V10 (Regional Consultant), and V11 (Regional Director of Operations) were notified on [DATE] at 11:29 AM of the Immediate Jeopardy. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training. Findings include: R2 is a [AGE] year old male admitted to the facility on [DATE] with diagnosis including but not limited to Acute and Chronic Respiratory Failure with Hypoxia or Hypercapnia; Dysphagia; Chronic Obstructive Pulmonary Disease; Systolic (Congestive) Heart Failure; Hypertension; and Gastrostomy and Tracheostomy Status. According to R2's face sheet, R2's code status: Full Code. According to R2's MDS (Minimum Data Set) assessment dated [DATE] and [DATE] under section E, R2 had no behaviors that impacted care. R2's care plan dated [DATE] (revised on [DATE]) reads in part, (R2) is Ventilator dependent related to Respiratory Failure. Patient is refusing to turn to ventilator at night. Goal: Will actively participate in the weaning process. Resident will have appropriate ventilator alarm settings. Disconnect Alarm: High Pressure Alarm: Date Initiated: [DATE] Revision on: [DATE]. Resident will maintain a patent airway. [DATE] Revision on: [DATE]. Trach type: Trach size: Will be maintained on the lowest Fi02/PEEP/PS to support an adequate oxygenation level of: (Specify) through the review date. [DATE] Revision on: [DATE]. Interventions: Assess for s/sx of hypoxia: altered level of consciousness, irritability, listlessness, educate resident/family/caregivers purpose/mode/and all treatments; encourage resident to relax and breath with the ventilator; explain alarms; teach importance of deep breathing; Keep call bell within reach. Keep head of bed elevated above 30 degrees unless providing care or resident request. Patient and family educated on the importance of return to ventilator during night. All parties all aware of this behavior. A review of R2's plan showed revisions made on [DATE] to goals and interventions for R2 on the same day of the resident's death with no explanation. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R2's Call Light Ability Screen dated [DATE] reads in part, (R2) is unable to use a call light due to cognitive status. R2's order dated [DATE] reads in part, Ventilator Settings: Mode: AC, Rate: 12, Tidal Volume: 400, PEEP: 5, FiO2: 40%; Ventilator: noc. Every night shift. R2's order dated [DATE] reads in part, Weaning orders: TC 40% dayshift. No oxygen saturation level monitoring nor acceptable oxygen saturation level order noticed among R2's orders. On [DATE] at 12:31 PM, Surveyor interviewed V4 (Respiratory Therapist) who stated in summary: My respiratory therapy duties are to: check vital signs for residents with tracheostomies, make sure all residents with tracheostomy status are connected to ventilators, make sure there is water present for humidity, make sure tracheostomy site is clean and secured, and give breathing treatments. Additionally, majority of alarms sounding in this unit, are for suctioning, so I need to respond to those. On Mondays, Wednesdays, and Fridays, we have to assist with transport to dialysis and check on residents while they're in the dialysis. I was here on [DATE]. I started at 7:00 AM, I provided R2 with routine morning tracheostomy care, which included suctioning, around 9:25 AM - 9:30 AM. Then code blue was called, and when I came in to R2's room, I noticed his tracheostomy tube was dislodged. R2's tracheostomy would not initiate unit alarms because he was not connected to the ventilator at the time of the incident, and only ventilators trigger unit alarm. [DATE] at 2:19 PM, Surveyor interviewed V5 (Licensed Practical Nurse) who stated in summary: Earlier in the day ([DATE]), around 9:00 AM, I checked on R2's roommate and noticed R2 gesturing and pointing to his tracheostomy, which meant, that he needed to be suctioned. I told V4 (RT) right away. I'm not sure when or whether she went back to provide suctioning for R2. When I was finishing medication pass, around 10:30 AM, a CNA came out of R2's room and said that R2 doesn't look right and asked me to check on him. I went in right away, checked for pulse, didn't feel it, and yelled out to the CNA to call code blue. Code blue protocol was initiated, staff rushed in with emergency cart, and started chest compressions. I could not tell if R2's tracheostomy tube was dislodged at that time, but when V6 (Respiratory Therapy Director) attempted to bag (deliver oxygen) R2, she realized, that R2's tracheostomy tube was dislodged. On [DATE] at 1:20 PM, Surveyor re-interviewed V5 (LPN). Surveyor asked who is qualified to suction resident's air way, V5 (LPN) responded, Respiratory therapy will always suction resident's air way, as it is their primary job. The only event when nurses would be required to suction resident's air way is, if a resident was in any sort of distress. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:23 AM, Surveyor interviewed V6 (Respiratory Therapy Director) who stated in summary: On [DATE], during the incident, I was in the morning meeting. The code blue was called, and everyone left the morning meeting immediately and headed out to R2's room. When I got to the room, staff was doing chest compressions. When I looked, I noticed staff bagging (oxygenating) R2 without noticing that his tracheostomy tube was dislodged. I immediately placed a spare tracheostomy tube and continued oxygenating R2. A little later, EMS arrived and took over resuscitation. R2 was under V4's (RT) care that day. Based on R2's orders, he was supposed to be on ventilator at night, and tracheostomy collar throughout the day. We don't have alarm system on residents who are connected to tracheostomy collars, we are supposed to do physical rounds and look at the resident, between nurses, CNAs, and respiratory therapists. Frequency of monitoring is based on secretion load and resident's comfort. R2 fluctuated, there were times when he was calm, but he was combative and aggressive other times. Surveyor clarified who is allowed to suction residents' air way, V6 (RT Director) stated, Nurses and respiratory therapists can suction the residents' air way, whether the nurse is a Licensed Practical Nurse or a Registered Nurse. On [DATE] at 11:29 AM, Surveyor interviewed V2 (Director of Nursing) who stated in summary: Based on nurse's assessment, they can suction any resident in need of suctioning. My expectation for nurses and respiratory therapist is to suction all residents in need for suction. V5 (Licensed Practical Nurse) assessed R2 on the morning of [DATE] and concluded that there was no immediate need for suctioning, so she left the room, saw V4 (RT) and asked her to go in and suction R2. V4 (Respiratory Therapist) who was making morning rounds on [DATE], said that she suctioned R2, but there was not much secretions, and R2's agitation was more so anxiety driven. Surveyor clarified, if a resident remains agitated regardless of suctioning needs, what should the nurse do, V2 (DON) said, If a resident remains agitated, they should be assessed, maybe checked for repositioning or pain needs, and go forward from there. I rounded on R2 that morning, around 9:20 AM, but he looked like he was at his baseline, did not appear to be in distress. Review of R2's MDS section E:Behavior did not show that R2 had any assessed behaviors related to agitation. On [DATE] at 12:20 PM, Surveyor interviewed V3 (Licensed Practical Nurse) who stated in summary: Since I've been working here (5 months), respiratory therapists are ones who suction residents; however, nurses should be able to suction if they have skills and training to do so. In a critical moment, nurse should suction the resident. Seeing an agitated resident who is pointing to his tracheotomy, nurse should stay and attend resident's needs until, at least, when respiratory therapist arrives. Even though R2 presented with agitation, there was follow-up or increased monitoring provided by the facility. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 1:55 PM, Surveyor interviewed V7 (Medical Director) who stated in summary: On [DATE], R2 requested suctioning around 9:15 AM from V5 (LPN), V5 (LPN) asked V4 (RT) to suction R2, who suctioned R2 at 9:30 AM. R2 had minimal secretions. At 10:30 AM, CNA found him unresponsive, and CPR was started. There was no documentation or report on interviews that any other contact was made with R2 between 9:30 AM and 10:30AM. V7 continued, if R2 was in respiratory failure related to mucus plug, they would be cyanotic, their oxygen saturation would drop, they would be unable to talk, and their respiratory rate would be elevated. Surveyor clarified that R2 was unable to talk, was agitated, and was pointing to his tracheostomy site, communicating that his tracheostomy needs to be addressed, V7 (MD) said, Respiratory distress and agitation are completely different. Surveyor further clarified if dislodged tracheostomy could cause respiratory distress, V7 (MD) stated, Tracheostomy dislodgement would not have impact on R2's respiratory status. Based on his vital signs at the time (last known vital signs documented at 09:30 AM), it is very unlikely R2 was in respiratory distress. If resident is in respiratory distress, the nurse has to make a clinical judgment, to see if it's appropriate to suction or call for respiratory therapist. I think the nurse did the right thing by looking at the timeline of this incident. On [DATE] at 3:18 PM, Surveyor interviewed V8 (Respiratory Program Director) who stated in summary: We have respiratory therapists whose primary duty is to care for residents' air way. Nurses are cross trained to care for an air way, but it's their secondary duty. If there is a resident in respiratory distress, both respiratory therapist and nurse can address the issue. It is not written in the policy but assumed that nurses are expected to address air way issues. On [DATE] at 10:03 AM Surveyor interviewed V9 (Respiratory Therapist) who stated in summary: Residents who are not connected to the ventilator are not connected to the unit alarm, so, if they were in respiratory distress, we would not know. We check resident's oxygen saturation with pulse oximeter twice a shift, on a 12 hour shift. We also do frequent checks, or we are notified by nurses if any resident needs respiratory therapist attention. There is no camera or any kind of alarm for residents with tracheotomies who are not connected to the ventilator. We wouldn't know if anybody's tracheotomy would be dislodged, so you don't always know if they are breathing ok. I'm not aware of any specific expectation as far as resident monitoring. According to National Library of Medicine article Pain, agitation and delirium in acute respiratory failure dated [DATE], Since pain, agitation and delirium compromise respiratory function they should also be regarded during noninvasive ventilation and during ventilator weaning. Progress Noted dated [DATE] at 9:15 AM, written by V5 (Licensed Practical Nurse) reads in part, While caring for (R2) in bed, alert, and gesturing for respiratory. RT (V4, respiratory therapist) informed that (R2) is in need of suctioning. RT (V4) states, she is on her way to (R2's) room. R2's Ventilator/Aerosol Flowsheet assessment dated [DATE] at 09:30 AM by V4 (Respiratory Therapist) reads in part, (R2) in no respiratory distress. Upon entry, (R2) seemed to be irritated and turned combative while assessing him. Trach care done - trach ties changed, trach secured and intact - (R2) was very aggressive with RT, (R2) was alert and responsive. VS (vital signs): 88 HR (heart rate), 16 RR (respiratory rate), 96% suctioning small amount of thick, yellow secretions from trach, BS rhonchi bilaterally, HOB 35% throughout the entire procedure and after will continue to monitor. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Progress note dated [DATE] at 10:30 AM written by V5 (Licensed Practical Nurse) reads in part, (V5) called to (R2's) room via CNA to check on resident. (R2) vs (vital signs) absent at this time with no pulse present. 10:32 am (V5) called for CNA to call code blue, code blue called and 911 called, all available staff on scene 10:34 am Chest Compressions initiated, trach observed dislodged 10:35 am RT (V6, respiratory therapy director) at bedside, trach immediately replaced via RT without difficulty,02 applied 10:37am AED applied, no shock advised 10:41am Peripheral IV line placed and 0.9 NACL infusing 10:45 am Paramedics arrived and continue with CPR 10:50 am 1 round of epi (epinephrin) given, (R2) remains asystole, CPR continues 10:55 am 2nd round of epi (epinephrin) given, (R2) remains asystole, CPR continues 11:07am Code called to end, (R2) declared deceased at this time. Ambulance run sheet dated [DATE] 01:37 PM reads in part, Dispatched to above location for a reported cardiac arrest. U/a (upon arrival) found (R2) lying supine in bed, nursing staff doing CPR and ventilating (R2) via BVM (bag valve mask) to trach. Per staff, (R2) was last seen alive 30 minutes ago. AED (automated external defibrillator) was applied (R2) with no shock advised. Crew placed (R2) on monitor and asystole noted, IO (intraosseous) established in right leg. CPR (cardiopulmonary) continued by crew throughout duration of call, only pausing for rhythm checks, asystole noted on all rhythm checks. Pupils noted to be fixed and dilated. (Local hospital) contacted and orders to terminate resuscitation given. From the National Library of Medicine: https://www.ncbi.nlm.nih.gov/books/NBK593189/ After completing suctioning, the outcomes from the procedure should be evaluated and documented, including the following: Improvement of lung sounds Removal of secretions Improvement of pulse oximetry Decreased work of breathing Stabilized respiratory rate (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Decreased dyspnea Facility's policy Oxygen Therapy dated ,d+[DATE] reads in part, Oxygen therapy may be provided through various types of supply and delivery systems. Equipment may include trans-tracheal oxygen catheters. Residents who require O2 therapy will have an ongoing assessment of respiratory status and response to respiratory therapy; Monitoring of SPO2 levels and/vital signs as ordered will be documented in medical record. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: 1. Affected resident corrective actions. A. Resident #1 - Resident 1 is no longer a resident in the facility. 2. Immediate Actions and Actions to prevent recurrence. (Initiated on [DATE] at 12:00 noon and will continue until all staff are in-serviced and trained prior to the start of their shift.) The facility took the following immediate actions to address the citation and prevent any additional residents from suffering an adverse outcome. A. The Respiratory Program Director checked and verified proper function of all ventilator alarm system. There was no concern identified. (This immediate action was initiated and completed on [DATE], 12:30pm) B. Respiratory assessment was completed for all residents requiring respiratory care - on ventilators and tracheostomy. There was no concern identified. (This immediate action was initiated and will be completed on [DATE], 2:30pm) C. All Nurses and respiratory staff were provided with education by the DON/ Respiratory Program Director. The training will include but is not limited to appropriate assessments to recognize potential respiratory distress on residents on ventilators and tracheostomy and identifying appropriate interventions to address any identified respiratory problem. (This immediate action was initiated and will be completed on [DATE], 3:30pm) D. All Nurses and Respiratory Therapists were educated by the DON/ Respiratory Program Director on timely response to the ventilator alarm system and appropriately address any identified safety concerns. (This immediate action was initiated and will be completed on [DATE], 3:30pm) E. The Medical Director, Administrator, Director of Respiratory Program and DON reviewed the facility's policies which includes but are not limited to: a. Respiratory Care b. Suctioning c. Ventilator alarm (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no revision necessary. This was initiated and completed on [DATE]. F. The DON/Respiratory Program Director provided all nurses and respiratory therapists with training related to the above-mentioned policies, focusing on appropriate respiratory assessment, hypoxia and appropriate interventions. (This immediate action was initiated and will be completed on [DATE], 3:30pm) G. New hires will be trained by the DON, ADON or RT Director. All staff members who are currently on vacation, or are not available, will also receive the same education upon their return to work. The staff members will also be provided with the same educational materials. H. The facility will utilize the same process of providing education to ensure that Agency staff will receive the same training as the facility staff prior to the start of their shift. The Administrator/DON will send the same training materials to the staffing agency. (This immediate action was initiated and will be completed on [DATE], 3:30pm) Additionally, the agency staff will be provided with the same training as mentioned above. An agency staff will not start the shift without finishing the training first. I. The DON/ADON/RT Director will conduct daily rounds to identify any potential concerns related to this plan of removal. (This immediate action was initiated on [DATE]) J. The DON/ADON/RT Director will also conduct staff (nurses & respiratory therapists) interview, with at least five employees, daily to gauge knowledge retention and determine if additional training is required. (This immediate action will be initiated on [DATE]) K. During the weekends, the assigned Nursing Supervisor/Respiratory Therapist will conduct unit rounds to identify any concern related to Ventilator/tracheostomy residents' respiratory status. Any identified concern will be addressed immediately. L. Residents are monitored every two hours by respiratory therapists or nursing staff. a. Staff make rounds every two hours. b. Any change in the resident's condition will be identified such as difficulty breathing, changes in color, change in mental status, or other changes that may signal further evaluation is needed. c. The nurse or respiratory therapist will assess the resident whenever changes are identified. d. If the change requires immediate intervention (resident is in distress, having difficulty breathing, etc.), the assessment will be completed and appropriate interventions implemented. M. During the Q2H rounds, a. if there is any change of condition observed which includes but not limited to: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. change in vitals signs including Respiratory Rate ii. signs of dyspnea iii. cyanosis, iv. coughing, v. change of characteristics of sputum,signs of potential infection, or vi. presence of behavioral changes that may reflect hypoxia including anxiety, apprehension, level of consciousness b. the RT will do the following: i. Notify the MD. ii. Increase the respiratory monitoring from Q2 hours to either q15, Q30, or QH based on the RT's discretion and MD orders iii. The increased respiratory monitoring by RT will be continued for a minimum of 24 hours. iv. The RT will notify the MD after 24 hours to report results of the increased respiratory monitoring. v. The RT will notify the MD to obtain order to downgrade the respiratory monitoring based on the collected information for 24 hours. (Downgrade maybe done as follows: Q15 minutes to Q30 minutes, or Q30 minutes to Q-hour rounds.) vi. To ensure resident safety, the same frequency of increased monitoring will not be used for less than 24 hours. vii. The MD will order to discontinue the increased respiratory monitoring, based on the RT's assessment. viii. The RT will resume the Q2H rounds after receiving a discontinuation order of the increasing respiratory monitoring from the MD. ix. Care plan will be revised accordingly. x. The resident will be sent to the hospital for further evaluation is deemed necessary. N. To ensure compliance, the result of the flowsheet will be reviewed daily during the meeting which is attended by the Director of Respiratory Therapy and clinical leadership which includes but is not limited to the: DON, ADON, MDS, IP, Restorative, and the Administrator. O. Any identified concern will be addressed immediately and will also be discussed during the weekly Adhoc QAPI. (continued on next page)

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