STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365950	A. Building B. Wing	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Rehabilitation and Care Center	1605 Northwest Professional Plaza Columbus, OH 43220

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 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** Based on closed medical record review, staff interviews, Emergency Medical Technician (EMT) interview, review of Emergency Medical Services (EMS) run report, review of the tracheostomy handbook, and review of the facilities policies and procedures, the facility failed to ensure the proper respiratory support was provided to a resident who was experiencing respiratory distress. This resulted in Immediate Jeopardy and serious life-threatening harm and/or negative health outcomes when Resident #199, who had a tracheostomy (a small surgical opening through the skin and into the windpipe), was not administered respiratory support including suctioning the tracheostomy, administering an as needed breathing treatment which was ordered for shortness of breath, changing the inner cannula of the tracheostomy to ensure its patency or attaching an Ambu (also known as a bag 0 valve-mask resuscitator) to the residents tracheostomy to provide breaths. The lack of providing respiratory support during this emergency resulted in Resident #199 experiencing shortness of breath, loss of consciousness, loss of respirations, loss of pulse and was subsequently pronounced deceased in the emergency room. This affected one (Resident #199) of two residents reviewed for tracheostomy care. The facility does not currently have any residents with tracheostomies. The facility census was 93. On [DATE] at 2:50 P.M., the Administrator, Director of Nursing (DON), and Regional Director of Clinical Operations (RDCO) #306 were notified of Immediate Jeopardy that began on [DATE] between 2:30 P.M. and 3:00 P.M., when Resident #199 had complaints of shortness of breath which led to unconsciousness, loss of respiration and pulse. On [DATE], Resident #199 complained of shortness of breath when Assistant Director of Nursing (ADON) #157 proceeded to check all oxygen tubing connections to ensure there was no leakage and increased Resident #199 ' s oxygen being delivered from 4 to 5 liters per minute. Resident #199 was noted to show no improvement, so ADON #157 left the residents ' room to call 911 (EMS) and prepare this resident ' s medical paperwork for transfer to the hospital. Licensed Practical Nurse (LPN) #303 was to remain in the room with Resident #199. EMS was noted to arrive at the facility at 3:08 P.M. where upon entering Resident #199 ' s room, the resident was found to be alone with no staff at bedside, face appeared pale, and hands and feet appeared cyanotic (bluish) in color. Resident #199 was noted to be laying in a semi-Fowler ' s position (when a person lies on their back with their head and upper body raised 30 - 45 degrees) with no supplemental oxygen in place. EMT ' s were noted to check Resident #199 ' s carotid arteries on both sides of her neck where no pulse was detected. Cardiopulmonary resuscitation (CPR) was immediately initiated with no detectable pulse ever noted. Resident #199 was transported to the local emergency room where she was pronounced deceased . The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	• On [DATE], Resident #199 was transferred to the hospital via EMS. • On [DATE], the DON audited charting over the last seven days to see if any other residents reported respiratory distress with no findings. The DON or designee will complete a weekly audit for the next 30 days regarding residents reporting respiratory concerns and ensure appropriate interventions are put in place. • On [DATE] at 4:30 P.M., the Administrator validated no residents currently reside in the facility with tracheostomies. • On [DATE] at 5:38 P.M., the facility completed a Quality Assurance and Performance Improvement (QAPI) meeting which included a root cause analysis of the event and developed a plan of correction. Participants included Medical Director #300, the Administrator, the DON, Unit Manager #117, Unit Manager #41 and RDCO #306. The QAPI plan was approved by Medical Director #300 and the Interdisciplinary Team (IDT) on [DATE]. • On [DATE], a new Emergency Tracheostomy Care Policy was put into effect. • On [DATE], a Code Blue Competency Drill was conducted by RDCO #306 and the DON. The drill also included education on responding to respiratory distress, suctioning, and monitoring of residents in respiratory distress and education on the Emergency Tracheostomy Care Policy. The Code Blue Competency and education was held on day and night shift on [DATE]. The DON completed the day shift Code Blue Competency Drill at 5:12 P.M. on [DATE] and ADON #157 completed the night shift Competency Drill at 7:18 P.M. on [DATE]. • At this time, the facility does not have a resident with a tracheostomy; however, if the facility admits a resident with a tracheostomy, the resident will be interviewed three times weekly regarding quality of respiratory care. Staff will also be interviewed three times a week for responding to respiratory distress, suctioning, and monitoring of residents in respiratory distress and education on the Emergency Tracheostomy Care Policy. These audits will continue for the next 30 days after admission. • (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 6:00 P.M., the Administrator electronically delivered RN/LPN education to all licensed nurses regarding emergency tracheostomy care via the One Call delivery system. • On [DATE], all facility staff in Environmental Services, Dietary, Administration, Maintenance, Therapy, and Activities departments were educated on responding to respiratory distress by the Administrator. • The DON/designee will educate all agency staff prior to taking an assignment on the Emergency Tracheostomy Care Policy and will ensure they receive competency validation on tracheostomy care at the start of their shift. The DON or designee will ensure on going education with All Agency Nurses. Any nurse who did not complete the training above will not be permitted to take an assignment until completed. • The DON and/or designee will perform three staff interviews five times a week, across all shifts times 4 weeks to ensure all LPNs and RNs are knowledgeable in responding to situations of respiratory distress and steps to take to maintain oxygenation. • The QAPI committee will review the results of these audits and processes to determine if additional audits or education is needed. Although the Immediate Jeopardy was removed on [DATE], the deficiency remains at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #199 revealed an admission date of [DATE] and a discharge date of [DATE]. Diagnoses included acute respiratory failure with hypoxia (absence of enough oxygen in the tissue to sustain bodily function) and hypercapnia (occurs when there is too much carbon dioxide [CO2] in the bloodstream), bacterial pneumonia, morbid obesity, and tracheostomy status. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission Assessment for Resident #199 dated [DATE] at 2:41 P.M. revealed this resident admitted to this facility from a local hospital with an admission diagnosis including acute hypoxic/hypercapnic respiratory failure. Resident #199 was noted to have a full code status indicating if this patient ' s heart stops or they stop breathing, all possible medical interventions, including CPR, intubation, and defibrillation will be used to try and revive them. Resident #199 ' s respiratory assessment revealed clear bilateral lung sounds with no abnormal sounds noted and shortness of breath was experienced when Resident #199 was laying flay. Resident #199 was noted with a non-productive cough. Resident #199 was noted to be alert and orientated to person, place, time, and situation and able to make needs known and understood others. Resident #199 was noted to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition for daily decision-making abilities. Review of the care plan for Resident #199 failed to identify a plan to provide respiratory or tracheostomy (trach) care. Review of physician orders for Resident #199 revealed the following: -Elevate the head of bed to prevent shortness of breath related to Asthma. -Trach care every shift and as needed. -Change oxygen tubing filters and humidification bottle every week and as needed on Sunday night. -Supplemental oxygen continuously via trach at 4 liters per minute every shift for Chronic Obstructive Pulmonary Disease (COPD) -Albuterol Sulfate Nebulization Solution (2.5 milligrams [mg]/3 milliliter [ml]) 0.083% Inhale 3 ml orally via nebulizer every 6 hours as needed for shortness of breath. -Clonazepam oral tablet, 0.5 mg. Give 1 tablet by mouth every 12 hours as needed for anxiety for 14 days. Review of the medication administration record revealed no administration of the ordered nebulizer treatment on [DATE] for shortness of breath. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the nursing progress note dated [DATE] at 3:30 P.M., created by LPN #303, revealed Resident #199 requested to be suctioned due to reported difficulty clearing secretions. This nurse obtained assistance from another nurse (ADON #157) to perform suctioning. Procedure was completed with a moderate amount of mucus suctioned. After suctioning resident requested to be changed, while this nurse and aids were assisting resident with repositioning, resident began complaining of shortness of breath, appearing in acute respiratory distress with labored breathing and cyanosis noted. Pulse oximeter (non-invasive equipment used to measure the percent of oxygen in a person ' s blood) applied and oxygen saturations were found critically low fluctuating between 50-20%, heart rate dropped rapidly. Resident #199 maintained a weak pulse initially. 911 was immediately called by an assisting nurse (ADON #157). The face sheet, medication list and necessary documentation were printed and prepared for EMS. Upon EMS arrival the resident lost pulse, and CPR was initiated by the EMT. The resident was transported to a local hospital for further evaluation and treatment. On call clinical staff were notified and provided full report. Power of Attorney (POA) contacted and informed of the incident and resident transfer to hospital. Review of the EMS run report dated [DATE] revealed the 911 call from the facility was received at 3:02 P.M. for Resident #199 who was unconscious, Medic Unit #72 was notified of the dispatch at 3:03 P.M., Medic Unit #72 was enroute to the facility at 3:04 P.M. and arrived at the facility at 3:08 P.M. Resident #199 was found lying in her bed unconscious and not breathing. Primary assessment of Resident #199 when medics arrived was cardiac arrest which was noted prior to any EMS arriving. No vitals were able to be obtained due to this patient ' s condition. Continued reviews indicated that no CPR was being performed by facility staff prior to EMS arriving at the facility. Medic Unit was noted to leave the facility at 3:26 P.M. and arrived at the local hospital at 3:32 P.M. Interview on [DATE] at 2:56 P.M. with ADON #157 revealed she has worked at this facility for about six years and over the years they have had multiple trach patients. ADON #157 stated that on [DATE] she came in just to grab some paperwork and that was when LPN #303 asked her if she could just help with suctioning Resident #199. LPN #303 stated she knew how to do it but was busy. ADON #157 stated that while she set up the sterile suctioning kit, she had placed the pulse oximeter on Resident #199 ' s finger to see what her oxygen saturations were, and they were in the high 90s and her pulse per what she remembered was fine. ADON #157 reported that she placed the suction catheter in once and there were not a lot of secretions noted. The resident requested to be suctioned again so she waited about 5 minutes and then did it again all while the pulse oximeter was in place and her sats were still at baseline and good. After the second time suctioning, Resident #199 requested to be pulled up in bed, which she assisted with. Then she said she needed to be changed. As the Certified Nursing Assistants (CNAs) were coming in to do this care, Resident #199 started to complain she could not breathe, ADON 157 noticed her pulse and oxygen level started to decline. Resident #199 was already receiving 4 liters of oxygen, so she bumped it up to 5 liters with no positive outcome. ADON #157 stated she called 911 and the EMS arrived quickly. All during this time, the primary nurse (LPN #303) remained at bedside and this resident was still alert and had a pulse during this time. EMS took this resident to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 6:38 P.M. with Agency LPN #303 reported Resident #199 requested to have her tracheostomy suctioned and ADON #157 was at the facility so she figured the resident would be more comfortable with a full-time staff member doing this care instead of her, so she asked ADON #157 to complete this care. After this care was completed twice, this resident requested to be changed. When Resident #199 ' s head of bed was lowered to provide care, she started to complain of shortness of breath. Her head was raised up and ADON #157 increased her oxygen level from 3 to 4.5 or 5, she could not remember the exact number. Resident #199 did not appear to be any better, so ADON #157 went to call 911 and get the residents ' paperwork ready. During this time, she remained with the resident until EMS arrived. The pulse oximeter remained in place and while she could not recall the patient ' s pulse, she remembered her oxygen saturations reading in the low 80%. Until EMS arrived at the facility, her oxygen saturation was in the low 80s and then it suddenly dropped to about 25% but again she could not recall the pulse because she was more focused on her respiration and oxygen saturations. LPN #303 claimed Resident #199 ' s head of bed was raised high, and she was receiving oxygen support via trach mask when EMS arrived. LPN #303 confirmed that no one attempted to suction the patient, did not administer as needed breathing treatment for shortness of breath, did not change the inner trach cannula nor did they attempt to attach an Ambu bag for breathing assistance. An interview was conducted on [DATE] at 2:45 P.M. with EMT #308 and Battalion Chief #310. EMT #308 revealed he has been a medic for two years now. He stated he was the lead of Medic Unit #72 who responded to this facility for Resident #199 who was reported in respiratory distress. The station received the call at 3:02 P.M., and they arrived at the facility at 3:08 P.M. When they walked through the facility ' s ambulance entrance her room was right there. EMT #308 reported they walked into her room and no staff members were in the room, and the patient was laying in a semi-Flowers position and had no supplemental oxygen on. Her face was pale, and her hands and feet were blue. He immediately checked both carotid arteries and felt no pulse. Chest compressions were immediately started, and he then instructed another Medic to obtain an airway. This was when they realized this patient had a trach but due to how she was laying and her size, they could not see it. They were able to obtain an airway with her trach and CPR continued. Epinephrine was administered, which is a medication used during CPR which acts as adrenaline to stimulate the body ' s sympathomimetic system or the Fight-or-Flight response. Medic #308 stated CPR was started within 60 seconds of arriving at the facility. He could not recall if there was a pulse oximeter on her finger or not, but she did not have a pulse per his assessment. Per Medic #308 and Battalion Chief #310, per the appearance of this patient, her pulse had not just stopped when they entered the facility. Each patient is different in the way they decline but the pale face and blue feet and hands do not happen immediately. Further interview revealed they cannot say for sure what the facility did or did not do but they strongly feel not all respiratory measures were taken to help this patient with respiratory distress. Interview on [DATE] at 4:25 P.M. with CNA #191 revealed she did work the day shift on [DATE] but was not Resident #199's primary caregiver. CNA #191 stated she assisted the other CNAs with changing her that morning. After this, Resident #199 requested to be suctioned so they told the nurse. CNA #191 reported Resident #199 pulled her call light multiple times during the day requesting to be suctioned and the nurse would say okay but would not do it. Around 2:00 P.M. on [DATE] when she came into Resident #199 ' s room she was upset and looking on the Internet for different facilities for her to transfer to, claiming she did not feel safe. CNA #191 stated she gave the patient the Administrators number for her to contact him and let him know what was going on. The patient was claiming that she had not been suctioned since she arrived at the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the undated Smiths Adult trach handbook the facility provided revealed that during an emergency, a bag ventilation device is used when resident is not able to breathe with ease or has stopped breathing. Using the bag allows you to assist his/her breathing or to completely take over breathing for him/her. This is to be used with CPR if the resident is not breathing and you cannot find a pulse. It may also be used to help resident breathe whenever there is difficulty or shortness of breath. Review of the facility policy titled, Lower Airway (tracheostomy tube) Suctioning dated [DATE] revealed, the purpose was to remove secretions, maintain a patent airway, and prevent infection to the lower respiratory tract. Review of facility policy titled, Advanced Directives dated [DATE] revealed under the section titled Full Code, when a resident is identified as a full code the facility staff will provide emergent measures in an attempt to resuscitate the patient. This may involve chest compressions, electric shocks, and emergency medications that act to temporarily keep blood moving to essential organs such as the brain. The facility staff must continue any resuscitative efforts until EMS arrives and takes over. This deficiency represents noncompliance under Complaint Number OH00164689.