STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415078	A. Building B. Wing	05/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coventry Operations RI LLC Dba Respiratory and Reh	10 Woodland Drive Coventry, RI 02816

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 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** Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide necessary respiratory care and services in accordance with professional standards of practice for a resident who requires mechanical ventilation (a life-support therapy that assists or replaces natural breathing by delivering oxygen and removing carbon dioxide through a ventilator) who experienced chest pain and was sent via rescue to an acute care hospital for evaluation, Resident ID #1, who ultimately expired in transit to the hospital. Further, the facility failed to ensure that respiratory staff provide respiratory care consistent with professional standards of practice for 4 of 6 respiratory staff reviewed, Staff A, C, D, and E to ensure that a physician's order for mechanical ventilation settings were in place for 1 of 1 resident reviewed for non-invasive ventilation (NIV, a machine that provides breathing support using an external mask or other component, eliminating the need for an invasive surgical airway or breathing tube), Resident ID #1. Additionally, the facility failed to ensure that a resident who requires mechanical ventilation receives the mechanical ventilation settings as prescribed by the provider for 2 of 5 residents reviewed, Resident ID #s 1 and 3.Findings are as follows:Review of a complaint received by the Rhode Island Department of Health on [DATE] alleges in part, .[Resident ID #1].had chest pains so [s/he] agreed to go to the hospital in the ambulance.We [family member] first got a call from a doctor.from [the acute care hospital] telling us that [Resident ID #1] had not made it to the hospital and died on [his/her] way .Additionally, the complaint alleges that the facility failed to ensure that Resident ID #1 was provided with the necessary respiratory equipment prior to leaving the facility via rescue and that Resident ID #1 had been receiving the incorrect ventilator settings.1a. Review of an undated facility policy titled, Ventilator Patient External Transport Procedure states in part, .ensure safe transport of mechanically ventilated patients outside the facility for.hospital transfer while maintaining adequate ventilation and patient stability.All ventilated patients requiring external transport must be assessed by Respiratory Therapy prior to departure to ensure appropriate equipment. Indications.Hospital transfer.Emergency transport. Required Equipment * Portable ventilator with charged battery.Transport Procedure.Transfer patient to portable ventilator if required.According to an article published in April of 2021 in the American Journal of the Medical Sciences titled, Non-Rebreather Mask [NRM, a type of oxygen mask that delivers high concentrations of oxygen to individuals who can breathe on their own]: A Bridge Worth Crossing? states in part, .NRM does not provide any positive pressure to help support the patient mechanically.Record review revealed Resident ID #1 was admitted to the facility in March of 2026 with diagnoses including, but not limited to, duchenne or [NAME] muscular dystrophy (a severe, progressive genetic disorder characterized by the wasting away of skeletal, heart, and respiratory muscles), dependence on respirator (ventilator) status, and chronic respiratory failure.Review of the care plan revealed a focus area dated [DATE] indicating that Resident ID #1 has an alteration in respiratory status and is ventilator dependent. Further, the care plan revealed that s/he receives ventilation support using non-invasive ventilation via mouthpiece ventilation equipment during the daytime. Additionally, s/he uses nasal pillows [soft inserts that fit directly into the nostrils to provide pressurized air from the ventilator machine via a flexible tube to help keep the airway open, improve (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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	breathing, and prevent an individual from not breathing] at nighttime. Further, interventions include, but are not limited to, ventilator check assessments to be conducted every six hours and to use the ventilator for respiratory support per the physician's order.Review of a progress note dated [DATE] at 12:59 AM revealed that Resident ID #1 had complained of chest pain and requested to be transferred to the hospital, and s/he was transported via 911.Review of the Emergency Medical Services (EMS) Run Report documentation dated [DATE] revealed that EMS was dispatched to the facility for Resident ID #1 who was complaining of chest pain. The report further revealed that Resident ID #1 was on a bilevel positive airway pressure (BiPAP, a noninvasive ventilator that helps people breathe easier by delivering pressurized air through a face or nasal mask, alternating between a higher pressure for inhaling and a lower pressure for exhaling) device at night. Furthermore, Resident ID #1 was placed on a non-rebreather mask for transportation to the hospital per instruction from the Respiratory Therapist (RT), Staff A. Additionally, Resident ID #1 complained to EMS that s/he was unable to breathe, thus rescue personnel removed the non-rebreather mask and began assisting Resident ID #1 with ventilations using a bag valve mask (a handheld, manual device that provides positive pressure ventilation to individuals who are not breathing or not breathing adequately, often used in emergency situations). Lastly, the report indicates that while in transit to the hospital, Resident ID #1 became unresponsive, s/he stopped breathing, and his/her heart had stopped.Review of the hospital documentation dated [DATE] revealed that Resident ID #1 arrived at the hospital without a pulse or respirations; and was pronounced dead.Record review revealed the following ventilator check assessments completed by Staff A, on the following dates and times:-[DATE] at 9:09 PM: Resident ID #1 was received by Staff A on his/her daytime mouthpiece type ventilator and showed no signs of respiratory distress. Staff A switched Resident ID #1 to his/her nighttime nasal pillows vent [VOCSN, a multi-function respiratory device that combines five separate respiratory therapies into a single portable system] at 8:22 PM. It further revealed that Resident ID #1 tolerated his/her respiratory treatment well, his/her ventilator alarms were on and functioning, and that a bag valve mask was available at his/her bedside.-[DATE] at 12:17 AM: At 10:38 PM (on [DATE]), Resident ID #1 complained of chest pain and Staff A entered to provide him/her respiratory assistance. Resident ID #1 continued to complain of chest pain and a bloated belly and was transported to the hospital at 11:45 PM on a non-rebreather mask.During a surveyor interview on [DATE] at approximately 12:45 PM with the Vent Program Manager, in the presence of RT, Staff B, they indicated that Resident ID #1 is ventilator dependent and is unable to breathe on his/her own. They further revealed that the VOCSN ventilator is portable and can be transported with a resident in the event of an emergency. Additionally, they revealed that Resident ID #1 ideally should have been transported with the VOCSN ventilator, or a bag valve mask used in place of the ventilator, instead of using a non-breather mask to transport Resident ID #1 to the hospital.During a surveyor interview on [DATE] at 9:09 AM with Staff A, she revealed that she was the RT scheduled to care for Resident ID #1 on the evening of [DATE] and began her shift at approximately 7:00 PM. She revealed that Resident ID #1 presented at his/her baseline when she completed her first ventilator check assessment at approximately 8:00 PM; and had switched Resident ID #1 from his/her daytime ventilator to the VOCSN ventilator with nasal pillows per his/her nighttime routine. She revealed that Resident ID #1 had complained of chest pain shortly after his/her first ventilator check assessment and she informed the nurse. She further revealed that after Resident ID #1 initially refused to be hospitalized , but, as the chest pain continued, Resident ID #1 agreed to go to the hospital. Staff A revealed that she stayed with Resident ID #1 to monitor his/her respiratory status and provide necessary respiratory care while waiting for rescue personnel to arrive. Staff A further revealed that, when rescue personnel arrived on scene, they informed her that they did not have a ventilator for the resident to use. Staff A indicated that she had removed Resident ID #1 from his/her ventilator and placed him/her on a non-rebreather mask for transport to the hospital and indicated to rescue personnel that Resident ID #1 would crash fast on a non-rebreather mask and offered rescue (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	personnel a bag valve mask to take. When Staff A was questioned by the surveyor about her choice to place a non-rebreather mask on Resident ID #1 for his/her transport to the hospital, she revealed that Resident ID #1 was stable at the time of the rescue personnel's arrival, s/he had stable blood oxygen levels, and was still alert and speaking. Staff A insisted that she offered rescue personnel a bag valve mask in addition to the non-rebreather mask that she had placed on the resident, but rescue personnel declined because they had a bag valve mask. When the surveyor further inquired as to why Resident ID #1 was not transported with his/her ventilator, Staff A revealed that she did not think about it despite rescue personnel informing Staff A that they did not have a ventilator for the resident. Additionally, she revealed that Resident ID #1 was transported from the facility on a non-rebreather mask.During a surveyor interview on [DATE] at 9:47 AM with the Director of Nursing Services (DNS), she revealed that a bag valve mask should have been used if Resident ID #1 was removed from his/her ventilator to be transported to the hospital. Additionally, she revealed that it is not the facility's practice to send a resident with his/her ventilator when 911 is called. However, the policy states .Hospital transfer.Emergency transport. Required Equipment * Portable ventilator with charged battery .During a surveyor interview on [DATE] at 9:50 AM with the Administrator, he revealed that he would expect staff to follow the facility's policy regarding transportation of a mechanically vented resident. Further, he was unable to provide evidence that the facility followed their policy relative to transporting a ventilator dependent resident with the required equipment that includes a portable ventilator. Additionally, he indicated that he would expect staff to provide the ventilator only if the rescue personnel had requested it.During a surveyor interview on [DATE] at approximately 10:35 AM with the Pulmonary Consultant, Nurse Practitioner, she revealed that she would not expect staff to place a non-rebreather mask on a ventilator dependent resident. She further revealed that she would expect the facility to follow their policy regarding transporting mechanically vented residents. Additionally, she revealed that in the absence of a ventilator, she would expect staff to use a bag valve mask.During a surveyor interview on [DATE] at approximately 10:50 AM with RT, Staff C, she revealed that the facility has transported a ventilator dependent resident with his/her ventilator during an emergency in the past. Additionally, she revealed that all the VOCSN ventilators they use for their residents are portable. This indicates that the VOCSN ventilator for Resident ID #1 could have accompanied the resident to the hospital. During a follow up surveyor interview on [DATE] at approximately 1:45 PM with the Vent Program Manager, she declined to answer whether she would place Resident ID #1 on a non-rebreather mask but indicated that placing him/her on a non-rebreather mask, the resident would eventually crash.1b. Review of an undated facility policy titled, Non-Invasive Ventilator (NIV) Policy & Procedure states in part, .Purpose.Promote patient safety and improve respiratory support management.Procedure.Verify physician/provider order and prescribed settings.Record review revealed Resident ID #1 utilized the following three ventilators while at the facility between [DATE] through [DATE]:-Astral (daytime mouthpiece ventilator)-LTV (nighttime nasal pillow ventilator)-VOCSN (nighttime nasal pillow ventilator)Record review revealed the following physician's orders for the resident's ventilators with the prescribed settings:-[DATE] Astral ventilator:-Tidal volume (VT, the amount of air inhaled or exhaled during a normal breath) 600-Respiratory rate (RR, the number of breaths a person takes per minute) 8-Positive end-expiratory pressure (PEEP, the pressure in the lungs above atmospheric pressure at the end of exhalation that prevents the lungs from collapsing when breathing out) 0-Fraction of inspired oxygen (FiO2, refers to the oxygen concentration; room air is considered 21% oxygen) 21%-[DATE] LTV ventilator:-VT 1100-RR 14-PEEP 6-FiO2 21%-Pressure support (PS, a mode of mechanical ventilation that assists patients by providing a preset level of pressure during inhalation) 8Record review failed to reveal evidence of a physician's order for the VOCSN ventilator or ventilator settings.Additional record review revealed that the facility discontinued using the LTV ventilator and began using the VOCSN ventilator beginning at nighttime on [DATE].Further record review revealed that Resident ID #1 utilized the VOCSN ventilator at nighttime without a physician's order or associated ventilator (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	settings in place from [DATE] through [DATE], when s/he was emergently transported via rescue to the hospital where s/he was pronounced dead on arrival.During a surveyor interview on [DATE] at approximately 11:25 AM with the Physician Assistant (PA), he revealed that he expects a provider's order to be in place for a ventilator and ventilator settings. Additionally, he would expect that staff would verify the ventilator order and settings each time a ventilator check assessment is conducted.Record review of the ventilator check assessments conducted between [DATE] through [DATE] revealed 23 ventilator check assessments were completed for Resident ID #1 while s/he utilized the VOCSN ventilator, indicating 23 of 23 opportunities were missed for staff to identify that there was no provider's order or settings for the VOCSN ventilator involving Staff A, C, D, and E.Record review revealed the following clinical competency validations for ventilator management for the above-mentioned RTs:-[DATE] Staff A: Revealed criteria as Met for demonstrating knowledge of what is included in complete and appropriate physician orders and the ability to adjust the ventilator controls to the ordered settings.-[DATE] Staff C: Revealed criteria as Met for verifying completeness of a physician's ventilator order and the ability to adjust the ventilator settings to the prescribed parameters.-[DATE] Staff D: Revealed criteria as Met for demonstrating knowledge of what is included in complete and appropriate physician orders and the ability to adjust the ventilator controls to the ordered settings.-[DATE] Staff E: Revealed criteria as Met for verifying completeness of a physician's ventilator order and the ability to adjust the ventilator settings to the prescribed parameters.Record review of a ventilator check assessment dated [DATE] at 1:58 AM completed by Staff C, revealed that Resident ID #1 was on the VOCSN ventilator as ordered and indicated that the ventilator settings were in the electronic medical record, despite having no order or settings for the ventilator.During a surveyor interview on [DATE] at approximately 5:00 PM with Staff C, she acknowledged that there was no physician's order in place for the VOCSN ventilator or any prescribed settings for the ventilator and indicated that there should be an order. She revealed that when ventilator check assessments are conducted, the RT is expected to verify the physician's order for the ventilator and the prescribed settings. She further revealed that if there is no order in place, the RT is expected to contact a provider. She was unable to explain why Resident ID #1 was receiving ventilation support from a ventilator that was not ordered by a provider nor had prescribed ventilation settings to program it.During a surveyor interview on [DATE] at 12:53 PM with the DNS, she was unable to provide evidence that the facility provided necessary respiratory care and services in accordance with professional standards of practice and per the facility policy.The facility failed to ensure that Resident ID #1, a ventilator-dependent resident with chronic respiratory failure, was provided with the necessary respiratory equipment and physician-ordered ventilator settings in accordance with professional standards of practice and facility policy. Specifically, the facility failed to ensure that Resident ID #1 was transported with appropriate ventilatory support during an emergency transfer to the hospital and failed to ensure that a physician's order and prescribed settings were in place for the resident's VOCSN ventilator from [DATE] through [DATE]. As a result, Resident ID #1, who staff acknowledged was unable to breathe independently and would crash fast without appropriate ventilatory support, was transported on a non-rebreather mask rather than a portable ventilator or bag valve mask, became unresponsive during transport, and was pronounced dead upon arrival at the hospital. These deficient practices placed the resident at immediate risk for serious harm, impairment, or death. 2a. Review of a physician's ventilator order for Resident ID #1 dated [DATE] revealed in part, the following ventilator settings for the LTV vent:-VT: 1100-PEEP: 6-PS: 8Record review revealed that Resident ID #1 did not receive his/her LTV ventilator settings as prescribed as evidence by the following ventilator check assessments:-[DATE] at 9:22 PM: PS 15, PEEP 8-[DATE] at 1:54 AM: PS 15, PEEP 8-[DATE] at 8:29 PM: PS 2, VT 850During a surveyor interview on [DATE] at approximately 12:40 PM with the Vent Program Manager, she acknowledged that Resident ID #1 did not receive his/her ventilator settings as prescribed.During a surveyor interview on [DATE] at approximately 11:25 AM with the PA, he revealed that he expects staff to (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	follow the prescribed ventilator settings. He further indicated that staff do not have the autonomy to adjust ventilator settings without first speaking to a provider.2b. Record review revealed Resident ID #3 was readmitted to the facility in April of 2026 with a diagnosis including, but not limited to, dependence on respirator (ventilator) status.Review of a care plan focus area dated [DATE] revealed that Resident ID #3 is ventilator dependent with an intervention to use the ventilator for respiratory support per the physician's order.Review of a physician's order dated [DATE] revealed in part, the following ventilator setting:-FiO2: 3 liters of oxygenDuring a surveyor observation and simultaneous interview on [DATE] at approximately 1:40 PM of Resident ID #3, in the presence of Staff C, Resident ID #3 was noted lying in his/her bed connected to his/her ventilator. Further, his/her ventilator settings were observed, and s/he was noted to be receiving only room air, and was not receiving the 3 liters of oxygen, as prescribed.During a surveyor interview immediately following the above observation with Staff C, she was unable to provide evidence that Resident ID #3 had his/her ventilator settings set to include the 3 liters of oxygen, as prescribed.During a surveyor interview on [DATE] at 12:53 PM with the DNS, she was unable to provide evidence that the facility provided necessary respiratory care and services in accordance with professional standards of practice and per the facility's policies.Cross reference F 842

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to maintain complete and accurate resident medical records in accordance with accepted professional standards and practices for 1 of 1 resident reviewed for non-invasive ventilation (NIV, a machine that provides breathing support using an external mask or other component, eliminating the need for an invasive surgical airway or breathing tube), Resident ID #1. Findings are as follows:Review of a complaint received by the Rhode Island Department of Health on 5/19/2026 alleges, in part, that Resident ID #1 had been receiving the incorrect ventilator settings.Record review revealed Resident ID #1 was admitted to the facility in March of 2026 with diagnoses including, but not limited to, duchenne or [NAME] muscular dystrophy (a severe, progressive genetic disorder characterized by the wasting away of skeletal, heart, and respiratory muscles), dependence on respirator (ventilator) status, and chronic respiratory failure.Review of the care plan revealed a focus area dated 3/5/2026 indicating that Resident ID #1 has an alteration in respiratory status and is ventilator dependent. Further, the care plan revealed that s/he receives ventilation support using non-invasive ventilation via mouthpiece ventilation equipment during the daytime. Additionally, s/he uses nasal pillows [soft inserts that fit directly into the nostrils to provide pressurized air from the ventilator machine via a flexible tube to help keep the airway open, improve breathing, and prevent an individual from not breathing] at nighttime. Further, interventions include, but are not limited to, ventilator check assessments to be conducted every six hours and to use the ventilator for respiratory support per the physician's order.Review of an undated facility policy titled, Non-Invasive Ventilator (NIV) Policy & Procedure states in part, .Purpose.Promote patient safety and improve respiratory support management.Procedure.Verify physician/provider order and prescribed settings.Record review revealed Resident ID #1 utilized the following three ventilators while at the facility between 3/2/2026 through 3/14/2026:-Astral (daytime ventilator)-LTV (nighttime ventilator)-VOCSN (nighttime ventilator)Record review revealed the following physician's order for the resident's LTV ventilator with the prescribed settings:-Tidal volume (VT, the amount of air inhaled or exhaled during a normal breath) 1100-Respiratory rate (RR, the number of breaths a person takes per minute) 14-Positive end-expiratory pressure (PEEP, the pressure in the lungs above atmospheric pressure at the end of exhalation that prevents the lungs from collapsing when breathing out) 6-Fraction of inspired oxygen (FiO2, refers to the oxygen concentration; room air is considered 21% oxygen) 21%-Pressure support (PS, a mode of mechanical ventilation that assists patients by providing a preset level of pressure during inhalation) 8Record review revealed that the facility discontinued using the LTV ventilator and began using the VOCSN ventilator at nighttime beginning on 3/4/2026 through 3/14/2026.Review of the March 2026 Treatment Administration Record revealed that staff continued to document that Resident ID #1 was receiving his/her LTV ventilator at the prescribed settings as denoted above, on the following dates, after it was discontinued on 3/4/2026:-3/4-3/5-3/6-3/8-3/9-3/10-3/11-3/12-3/14/2026During a surveyor interview on 5/22/2026 at approximately 11:25 AM with the Physician Assistant, he revealed that he expects staff to document accurately.During a surveyor interview on 5/22/2026 at 12:53 PM with the Director of Nursing Services, she was unable to provide evidence that the facility maintained accurate medical records for Resident ID #1.Cross reference F 695