STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465119	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Provo Rehabilitation and Nursing	1001 North 500 West Provo, UT 84604

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that the resident was free from neglect. Specifically, for 2 out of 9 sampled residents, the facility did not provide the resident with access to an outside provider appointment for the treatment and care of their tracheostomy tube and verbal orders for the tracheostomy change were not followed. In addition, a comatose resident in a vegetative state experienced a broken flange which caused a dislodged tracheostomy, and the resident subsequently went into cardiac arrest and died. This resulted in a finding of harm for 2 residents. Resident identifiers: 1 and 9. Findings included:1. Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, tracheostomy status, pneumonia, and anoxic brain damage. Resident 1's medical records were reviewed. Resident 1's physician orders revealed the following: a. Change Tracheostomy tube Q (every) 45 days and PRN (as needed) every day shift every 30 day(s). The order was initiated on [DATE] and discontinued on [DATE]. The same order was initiated again on [DATE] and discontinued on [DATE]. The Medication Administration Record (MAR) documented that the tracheostomy was changed on [DATE], [DATE], [DATE], and [DATE]. It should be noted that there was no order to change the tracheostomy tube after [DATE]. b. On [DATE], an order was initiated for an ENT (Ears, Nose, and Throat) referral related to stenosis and tracheostomy status. On [DATE], resident 1's hospital History & Physical (H & P) documented, . she had exchange of tracheostomy to Shiley by ENT due to hemoptysis. She went into respiratory arrest that night and was found to have a dislodged trach. She has some anoxic brain injury secondary to the episode where she had a PEA [Pulseless Electrical Activity] cardiac arrest Trach was changed by ENT in OR [operating room] on [DATE]. Given significant subglottic stenosis/proximal tracheal stenosis ENT recommends against trialing PMV [Passy Muir Valves]. They recommend changing trach every 3 months instead of monthly. On [DATE] at 10:38 AM, the Nurse Practitioner note documented continued trach care per Respiratory Therapy (RT) protocol. F/u [follow-up] ENT for subglottic and tracheal stenosis. On [DATE] at 11:00 AM, the RT note documented, Pt [patient] rest in bed on vent @ACPC [Assist Control Pressure Control] 4L [liters]. HOB [head of bed] elevated. Trach [trachestomy] is midline, (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	secure and patent. BS [breath sounds] coarse. Sx [suctioned] x [times] 3 for moderate amount of yellow thick secretions. No s/s [signs and symptoms] of resp [respiratory]. distress noted at this time. Will continue to monitor. The note documented that resident 1's heart rate was 80 beats per minute, respiratory rate was 24 and oxygen saturation was at 100%. On [DATE] at 1:55 PM, the RT note documented, RT performed trach changed as pt mentioned trach is too tight this morning. Pt was placed on 6L O2 [oxygen] for pre-oxygenated. SpO2 [oxygen saturation] 97%, HR [heart rate] 98. During removal and reinsertion of trach tube, resistance was encounter (sic) and insertion was unsuccessful. a smaller size trach tube was attempted, still unsuccessful to insertion. Pt developed acute resp. distress with pallor and cyanosis noted. Code blue was activated immediately. [Note: This note was entered by Respiratory Therapist (RT) 1.] On [DATE] at 2:32 PM, the nursing note documented Per RT report, at approximately at 1355 [1:55 PM] a scheduled tracheostomy tube change was initiated. RT [respiratory therapist 1] and RT [respiratory therapist 2] reported that during removal and attempted reinsertion of the tracheostomy tube, resistance was encountered when advancing the new trach. A second tracheostomy kit was opened and insertion was reattempted. Resistance was again met and placement was unsuccessful. RT reported the resident then exhibited signs of respiratory distress with decreasing oxygen saturation and cyanosis. A Code Blue was initiated immediately, and manual ventilation was initiated via bag-valve device. At approximately 1400 [2:00 PM], I heard the Code Blue call and responded immediately to the room. Upon arrival, both RTs were present and providing ventilatory support via bag-valve mask. Resident was observed to be unresponsive, apneic, cyanotic, and without palpable pulse. Resident was lowered to the floor with assistance for initiation of CPR per facility protocol. Chest compressions were initiated immediately. Staff were directed to: Activate EMS (911), retrieve crash cart, obtain AED [Automated External Difibrillator], and notify RT supervisor [name omitted]. AED was applied and rhythm analyzed three times. No shock was advised. Continuous CPR [cardiopulmonary resuscitation] was performed per protocol. EMS arrived during the third AED rhythm analysis and assumed care upon arrival. Resuscitative efforts were continued by EMS. Time of death was pronounced at 1425 [2:25 PM] by EMS. Attending physician was notified. Facility administration was notified per protocol. Family was called multiple times following the event. Calls were directed to voicemail on each attempt. Messages were left requesting immediate return call. Post-mortem care was completed per facility policy. On [DATE] at 3:13 PM, a note authored by the Transportation Driver (TD) documented, Received an order on [DATE] for Resident to go to ENT R/T [related to] Stenosis and tracheostomy status. Sent the order to Ent on [DATE] was told by Ent that resident didn't have insurance and that it would be self-pay. Tried calling family on multiple occasions with no answer or call back and with not being able to confirm if family can help self-pay the clinic would not schedule. It should be noted that this note was authored 5 days after resident 1 died and 3 months after the order for the ENT referral was initiated. On [DATE] at 1:24 PM, an interview was conducted with Respiratory Therapist (RT) 1. RT 1 stated that she had become an RT in [DATE]. RT 1 stated that the policy for changing the tracheostomy was to change it if it was dislodged or coming out or if the resident was complaining. RT 1 stated that she would only change the tracheostomy if it was coming out, otherwise it was the Medical Doctor (MD) that changed the tracheostomy. RT 1 stated that the inner cannula was changed daily and if a resident was complaining that the trach was too tight she would change the entire tracheostomy out, not just the inner cannula. RT 1 stated that during the morning ([DATE]) resident 1 was complaining (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	that the tracheostomy was too tight and RT 1 visualized that the tracheostomy was coming out. RT 1 stated that the tracheostomy was dislodged approximately 1.5 inches from the stoma. RT 1 stated that resident 1's vital signs were good and she was not in any respiratory distress. RT 1 stated that she pushed the tracheostomy back in and resident 1 continued to report that it felt tight. RT 1 stated that resident 1's complaints of the tracheostomy being too tight could indicate that it was dirty inside and needed to be changed immediately. RT 1 stated that prior to attempting to change resident 1's tracheostomy the current tracheostomy was secure, patent and midline. RT 1 stated that when she attempted to place the new tracheostomy she met resistance. RT 1 stated that she then attempted to insert a smaller size tracheostomy and also met resistance. RT 1 stated that she was being assisted by RT 2 during the tracheostomy replacement. RT 1 stated that resident 1 had stenosis and a smaller airway and she also thought resident 1 had tracheal edema. RT 1 stated that during the attempted tracheostomy change resident 1's oxygenation dropped to 75% and a code blue was called. RT 1 stated that resident 1's oxygenation dropped to 60% and the resident was turning purple at that time. RT 1 stated that while RT 2 was mechanically ventilating resident 1, RT 1 left the room to get assistance from the RT Director, which took approximately 10 seconds. Resident 1 subsequently went into cardiac arrest and was pronounced dead by EMS. On [DATE] at 2:10 PM, an interview was conducted with RT 3. RT 3 stated that resident 1 had complications of tracheal stenosis, and they were not to change her tracheostomy until she was seen by the ENT. RT 3 stated that if the trach was coming out he would readjust it. RT 3 stated that resident 1 needed to go to the ENT to determine if she needed to have the trach changed on a regular basis. RT 3 stated that they had orders to not change her trach until she was seen by the ENT. RT 3 stated that resident 1 frequently complained of tightness in her tracheostomy and he would assess the trach tie to ensure it was not too tight and then provide resident 1 with education on safety reasons for why they could not loosen the trach ties. RT 3 stated that he was told after resident 1's death that resident 1 complained of the trach being too tight and that RT 1 thought it needed to be changed. RT 3 stated that RT 1 attempted the trach change, was unsuccessful, and they lost the airway. RT 3 stated that he recalled seeing resident 1's name on the whiteboard in the manager's office with a note that stated ENT only. RT 3 stated that if the tracheostomy was patent, midline, and secure he would not change an ENT only trach. On [DATE] at 2:55 PM, a telephone interview was conducted with RT 2. RT 2 stated that he had been an RT since [DATE]. RT 2 stated that resident 1 was not supposed to have her trach changed but he was not informed of this until after the resident's death. RT 2 stated that he was not sure why the trach needed to be changed. RT 2 stated that he did not visualize resident 1's trach coming out or dislodgement prior to the attempted change. RT 2 stated that after resident 1's death he heard through one of his coworkers that the physician was supposed to change the tracheostomy, but they had orders to do it for the patient one time a month. It should be noted that those orders had expired on [DATE] and resident 1 did not have an active order for a tracheostomy change at the time of her death. RT 2 stated that he had never changed a vented patient's tracheostomy prior to resident 1's. RT 2 stated that after resident 1's death RT 1 had stated that resident 1 wanted the tracheostomy changed and that was what prompted the tracheostomy change. On [DATE] at 10:17 AM, an interview was conducted with the Transportation Driver. The TD stated he scheduled appointments for residents and if he was not able to schedule an appointment it would be documented under a progress note. The TD stated that he had a coaching session 2 weeks ago and was instructed that he needed to start documenting every time he contacted an outside provider or resident representative. The TD stated that he sent resident 1's order to the ENT on [DATE] and again on [DATE]. The TD stated that he was told that the resident did not have any insurance and (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	therefore the ENT office would not see her. The TD stated that he was informed that resident 1 did not have insurance by the Business Office Manager (BOM). On [DATE] at 11:29 AM, a telephone interview was conducted with the Business Office Manager. The BOM stated that resident 1 had a Medicaid Pending status at the facility and that the BOM had been in contact with Medicaid since resident 1 had been admitted . The BOM stated that she had screened resident 1 prior to the resident admitting to the facility in order for resident 1 to obtain Medicaid. The BOM stated that if a Medicaid pending resident required a service from an outside provider and the provider would not accept the resident with the Medicaid pending status then the facility would be responsible for payment to the outside provider. The BOM stated that she was not informed that resident 1 could not be seen by an ENT provider because of her Medicaid pending status and if she had known she would have spoken with the Administrator about this and had resident 1 seen by the ENT provider. On [DATE] at 12:02 PM, an interview was conducted with the RT Director. The RT Director stated that she started at the facility on [DATE]. The RT Director stated that they had a standing order to change a tracheostomy every 30 days unless otherwise specified. The RT Director stated that in the beginning of February 2026 she received a Verbal Order (VO) from the provider that resident 1 should have their tracheostomy changed only by an ENT provider unless it was an emergent situation. The RT Director stated that this order was not in resident 1's chart. The RT Director stated she communicated the VO with the staff and it was also documented on the whiteboard in her office and said trach change was on hold until otherwise notified. The RT Director stated that RT 1 went in and resident 1's tracheostomy was dislodged and starting to come out. RT 1 deflated the cuff and pushed it back in. The RT Director stated that resident 1 was not in any distress, was oxygenating well, the tracheostomy was midline, and patent. The RT Director stated that the RTs could have sent resident 1 to the hospital for a tracheostomy change. The RT Director stated that she provided education to the RTs that they should work with nursing and were able to transfer the resident out if they were concerned about the integrity of the trach. The RT Director stated that she educated the staff about the accuracy of their documentation when she realized that the notes did not contain any details of resident 1's trach being dislodged. The RT Director stated that RT 1 did not inform her of any concerns with resident 1's trach prior to her code. On [DATE] at 3:17 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she had seen a provider note in resident 1's chart that indicated that the tracheostomy should be changed every 3 months. The DON stated that the order was never put into resident 1's medical records. The DON stated that resident 1's prior tracheostomy order to change every 45 days was initiated by the prior RT Director, and then the contracted respiratory company did an audit and changed the order to every 30 days as the new standard protocol. The DON stated that the tracheostomy order dropped off the Medication Administration Record in January and resident 1 had no order to change the tracheostomy after that. The DON stated that the admission process was for the RT Director to manage any respiratory orders and treatments and the licensed nurse would handle all other medication and treatment orders. The DON stated that the contracted respiratory company was responsible for the maintenance and upkeep of all ventilator equipment. The DON stated that the previous communication of respiratory equipment issues was through the RT Director but that was not always communicated to the DON and Administrator clearly. The DON stated that moving forward she expected the RT Director to communicate any concerns with equipment to her. The facility policy on Tracheostomy Tube Changes documented that tracheostomy tubes should be changed per doctor's orders or every 30 days to prevent the risk of tracheal stenosis. As included are (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	emergency changes (i.e. damaged tubes, tubes that are not patent). The policy documented under Replacement of Trach Tube that If airflow is inadequate, or tube cannot be placed properly remove tube, provide ventilation* if necessary and attempt to reinsert tube. If still unable to pass a tube manually ventilate and call 911 or emergency services. The procedure further documented that if you were unable to reinsert a tube Attempt to insert a tube of smaller size, usually the next size down. If the patient's stoma suddenly closes, attempt to pass a suction catheter or tracheal tube exchanger through the stoma to thread the tracheostomy tube. 2. Resident 9 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, acute and chronic respiratory failure, tracheostomy status, and pneumonia due to pseudomonas. A review of resident 9's medical record revealed that on [DATE] at 9:00 PM, respiratory staff entered resident 9's room and found the tracheostomy flange broken, the tracheostomy tube was dislodged, and approximately 1.5 inches out of position, shifted to the right and not midline. Respiratory therapy staff notified nursing and called for a second respiratory therapist to assist with the tracheostomy tube change. During suctioning, respiratory staff observed a significant amount of blood and performed additional passes to clear continued accumulation of blood. Resident 9's oxygen saturation dropped and respiratory staff initiated manual ventilation; however, oxygen levels did not improve. Nursing staff performed a pulse check and no pulse was located. Resident 9 was lowered to the floor and cardiopulmonary resuscitation was performed. Emergency Medical Services arrived and resident 9 was unable to be revived and passed away. On [DATE] at 12:37 PM, an interview was conducted with the DON. The DON stated that the facility had a contract with an outside respiratory company and had used them for two years. The DON stated that respiratory staff identified that resident 9 had a broken trach and the respiratory staff made the decision to change out the trach when there was some increased bleeding and resident 9 went into cardiac arrest and passed away. The DON stated that she was not sure how the flange broke on the trach. The DON stated that she was unaware of any other residents that have had a flange break on the tracheostomy. On [DATE] at 3:01 PM, an interview was conducted with RT 4. RT 4 stated that on [DATE] he entered resident 9's room around 9:00 PM to perform his first assessment. RT 4 stated that resident 9's trach was broken at the flange and it had been dislodged at a 45 degree angle to the right side of the stoma. RT 4 stated that trachs should be centered and midline and if it was not then a resident could have airway obstruction or bleeding. RT 4 stated that the ventilator was not alarming and he was not sure why it was not alarming as high pressure because every breath was pressurized. RT 4 stated that resident 9's lips appeared to be cyanotic and so he replaced her oxygen sensor to another location on her body and resident 9's oxygen saturation was below 90%. RT 4 stated that he called for another RT and a nurse to come into resident 9's room because he needed to change resident 9's trach so that resident 9 would have a patent airway. RT 4 stated that he changed resident 9's trach and suctioned resident 9's airway. RT 4 stated that upon the first suctioning pass a large amount of frank blood and mucus was suctioned out. RT 4 stated that he went back in and suctioned an additional two times and continued to suction larger amounts of blood. RT 4 stated that resident 9's oxygen was showing as low. RT 4 stated that the nurse checked resident 9's pulse and found her without one. RT 4 stated that resident 9 was lowered to the floor and CPR was begun. RT 4 stated that he continued to suction large amounts of blood out of resident 9's trach. RT 4 stated that he believed that resident 9's airway was filled with blood. RT 4 stated that he notified the interim respiratory manager about the ventilator not alarming and made sure that he checked all of his (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	residents' ventilators to make sure they were working correctly. RT 4 stated he was not sure how the flange broke on resident 9's trach because she was comatose and in a vegetative state and could not move. [Cross-refer F695]

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F 0609 Level of Harm - Actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure that all alleged violations involving injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, if the events resulted in serious bodily injury to the administrator, State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, for 1 out of 9 sampled residents, the SSA and APS were not notified when a resident's tracheostomy flange broke, resulting in a dislodged tracheostomy tube. The resident subsequently went into cardiac arrest and died. This will be cited at a harm level. Resident identifier: 9. Findings included: Resident 9 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, acute and chronic respiratory failure, tracheostomy status, and pneumonia due to pseudomonas. A review of resident 9's medical record revealed the following notes:a. On [DATE] at 11:00 PM, a late entry respiratory therapy note documented, At approximately 2100 [9:00 PM] hours, I entered the patient's room to conduct my first rounds. Upon examination, I observed that the tracheostomy tube was broken and dislodged from the tracheostomy flange, with the tube approximately 1.5 inches out of position. Immediate replacement of the trach [tracheostomy] tube was necessary, as the tube was not in midline and was shifted to the right. I promptly notified the nurse to witness the situation and called for a second respiratory therapist to assist with the trach tube change. A Shiley XLT [Extended Length Tracheostomy] 6 and a Shiley XLT 5 were available at the bedside for use. The patient had a Shiley XLT 6 in place. After removing the old tube, I inserted the new tube, which had been tested and lubricated. During suctioning, a significant amount of bloodwas [sic] observed. A second and third pass were performed to address further blood accumulation. The SpO2 [oxygen saturation] alarm signaled low oxygen saturation, prompting disconnection from the ventilator to manually bag the patient. Despite these efforts, the SpO2 levels did not improve. Two additional nurses were called in to assist as a pulse check was performed, which revealed no pulse. The patient was subsequently transferred to the floor. A Shiley XLT 5 was then placed to see if it would enhance oxygenation while continuing manual bagging, with no resistance encountered during ventilation. SpO2 did not improve; chest compressions were going on while manual ventilation continued until EMS [Emergency Medical Services] came and took over the situation.b. On [DATE] at 12:19 AM, a late entry nursing note documented, I was called into resident room by RT [Respiratory Therapist]. RT showed residents tach [sic] was broken and needed to be replaced. Another Rt was called into room to assist with trach change, residents 02 [oxygen] and other V/S [vital signs] were stable at this time. RT's alerted nurse that resident was having copious amounts of bleeding while new trach was being changed out. Residents became unstable at this time and code blue was initiated, other staff arrived to assist and 911 was immediately called. [NAME] [sic] arrived and worked on resident however was unableto [sic] be revived, and time of death was called. Provider DON [Director of Nursing] and family members made away [sic] of death.Review of State Survey Agency (SSA) records revealed that this incident had not been reported to the SSA. On [DATE] at 12:37 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that night shift respiratory staff had identified that resident 9's tracheostomy was broken and they made the decision to change the tracheostomy and while they changed it there was some increased bleeding and resident 9 went into cardiac arrest. The DON stated that this was not reported to the SSA because it was felt that the respiratory staff were following policy and there was no concern for negligence. The DON stated that she was unsure of how the tracheostomy broke. The DON stated that there was another respiratory therapist director at the time of the incident and she was unsure if the respiratory director investigated the incident. On [DATE] at 1:35 PM, a follow-up interview was conducted with the DON. The DON stated that both her and the Administrator were contacted by the Unit Manager on [DATE] and they made a determination to not report because the tracheostomy was (continued on next page)

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F 0609 Level of Harm - Actual harm Residents Affected - Few	identified to be broken and respiratory staff followed policy to change the broken tracheostomy. [Cross refer to F695]

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility in response to an allegation of abuse, neglect, or mistreatment did not have evidence that the alleged violation was thoroughly investigated. Specifically, for 1 out of 9 sampled residents, an investigation into the cause of a broken tracheostomy flange in a comatose resident that was dependent on a ventilator was not investigated. This will be cited at a harm level. Resident identifier: 9.Findings included: Resident 9 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, acute and chronic respiratory failure, tracheostomy status, and pneumonia due to pseudomonas. A review of resident 9's medical record revealed that on [DATE] at 9:00 PM, respiratory staff entered resident 9's room and found the tracheostomy flange broken, the tracheostomy tube was dislodged, and approximately 1.5 inches out of position, shifted to the right and not midline. Respiratory therapy staff notified nursing and called for a second respiratory therapist to assist with the tracheostomy tube change. During suctioning, respiratory staff observed a significant amount of blood and performed additional passes to clear continued accumulation of blood. Resident 9's oxygen saturation dropped and respiratory staff initiated manual ventilation; however, oxygen levels did not improve. Nursing staff performed a pulse check and no pulse was located. Resident 9 was lowered to the floor and cardiopulmonary resuscitation (CPR) was performed. Emergency Medical Services (EMS) arrived and resident 9 was unable to be revived and passed away. On [DATE] at 12:37 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that staff identified the broken tracheostomy and decided to change it. The DON stated increased bleeding occurred, and Resident 9 went into cardiac arrest. The DON stated staff started CPR and called EMS. The DON stated she had not investigated how the tracheostomy broke and was unsure if the respiratory therapy director at the time had investigated it.[Cross refer to F695]

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that the services provided by the facility met professional standards of practice. Specifically, for 1 out of 9 sampled residents, the facility Respiratory Therapist Director did not ensure that a Verbal Order (VO) was entered into the resident's medical record which resulted in the respiratory staff providing a treatment that deviated from the prescribed order. This will be cited at a harm level. Resident identifier: 1.Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, tracheostomy status, pneumonia, and anoxic brain damage.Resident 1's medical records were reviewed.Resident 1's physician orders revealed the following:a. Change Tracheostomy tube Q (every) 45 days and PRN (as needed) every day shift every 30 day(s). The order was initiated on [DATE] and discontinued on [DATE]. The same order was initiated again on [DATE] and discontinued on [DATE]. The Medication Administration Record (MAR) documented that the tracheostomy was changed on [DATE], [DATE], [DATE], and [DATE].It should be noted that there was no order to change the tracheostomy tube after [DATE].On [DATE], resident 1's hospital History & Physical [H & P] documented, . she had exchange of tracheostomy to Shiley by ENT [Ear, Nose and Throat] due to hemoptysis. She went into respiratory arrest that night and was found to have a dislodged trach. She has some anoxic brain injury secondary to the episode where she had a PEA [Pulseless Electrical Activity] cardiac arrest Trach was changed by ENT in OR [operating room] on [DATE]. Given significant subglottic stenosis/proximal tracheal stenosis ENT recommends against trialing PMV [Passy Muir Valves]. They recommend changing trach every 3 months instead of monthly.On [DATE] at 1:55 PM, the Respiratory Therapist (RT) note documented, RT performed trach changed as pt [patient] mentioned trach is too tight this morning. Pt was placed on 6L [liters] O2 for pre-oxygenated. SpO2 [oxygen saturation] 97%, HR [heart rate] 98. During removal and reinsertion of trach tube, resistance was encounter (sic) and insertion was unsuccessful. a smaller size trach tube was attempted, still unsuccessful to insertion. Pt developed acute resp. [respiratory] distress with pallor and cyanosis noted. Code blue was activated immediately. [Note: This note was entered by (RT) 1.]On [DATE] at 2:32 PM, the nursing note documented Per RT report, at approximately at 1355 [1:55 PM] a scheduled tracheostomy tube change was initiated. [RT 1] and [RT 2] reported that during removal and attempted reinsertion of the tracheostomy tube, resistance was encountered when advancing the new trach. A second tracheostomy kit was opened and insertion was reattempted. Resistance was again met and placement was unsuccessful. RT reported the resident then exhibited signs of respiratory distress with decreasing oxygen saturation and cyanosis. A Code Blue was initiated immediately, and manual ventilation was initiated via bag-valve device. At approximately 1400 [2:00 PM], I heard the Code Blue call and responded immediately to the room. Upon arrival, both RTs were present and providing ventilatory support via bag-valve mask. Resident was observed to be unresponsive, apneic, cyanotic, and without palpable pulse. Resident was lowered to the floor with assistance for initiation of CPR per facility protocol. Chest compressions were initiated immediately. Staff were directed to: Activate EMS (911), retrieve crash cart, obtain AED [Automated External Difibrillator], and notify RT supervisor [name omitted]. AED was applied and rhythm analyzed three times. No shock was advised. Continuous CPR was performed per protocol. EMS arrived during the third AED rhythm analysis and assumed care upon arrival. Resuscitative efforts were continued by EMS. Time of death was pronounced at 1425 [2:25 PM] by EMS. Attending physician was notified. Facility administration was notified per protocol. Family was called multiple times following the event. Calls were directed to voicemail on each attempt. Messages were left requesting immediate return call. Post-mortem care was completed per facility policy.On [DATE] at 1:24 PM, an interview was conducted with Respiratory Therapist (RT) 1. RT 1 stated that she had become an RT in [DATE]. RT 1 stated that the policy for changing the tracheostomy was to change it (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Actual harm Residents Affected - Few	if it was dislodged or coming out or if the resident was complaining. RT 1 stated that she would only change the tracheostomy if it was coming out, otherwise it was the Medical Doctor (MD) that changed the tracheostomy. On [DATE] at 2:10 PM, an interview was conducted with RT 3. RT 3 stated that resident 1 had complications of tracheal stenosis, and they were not to change her tracheostomy until she was seen by the ENT. RT 3 stated that if the trach was coming out he would readjust it. RT 3 stated that resident 1 needed to go to the ENT to determine if she needed to have the trach changed on a regular basis. RT 3 stated that he recalled seeing resident 1's name on the whiteboard in the manager's office with a note that stated ENT only.On [DATE] at 2:55 PM, a telephone interview was conducted with RT 2. RT 2 stated that he had been an RT since [DATE]. RT 2 stated that resident 1 was not supposed to have her trach changed but he was not informed of this until after the resident's death. RT 2 stated that after resident 1's death he heard through one of his coworkers that the physician was supposed to change the tracheostomy, but they had orders to do it for the patient one time a month. It should be noted that those orders had expired on [DATE] and resident 1 did not have an active order for a tracheostomy change at the time of her death. On [DATE] at 12:02 PM, an interview was conducted with the RT Director. The RT Director stated that she started at the facility on [DATE]. The RT Director stated that they had a standing order to change a tracheostomy every 30 days unless otherwise specified. The RT Director stated that in the beginning of February 2026 she received a Verbal Order from the provider that resident 1 should have their tracheostomy changed only by an ENT provider unless it was an emergent situation. The RT Director stated that this order was not in resident 1's chart. The RT Director stated that she believed that the Medical Doctor would put the order in resident 1's medical records. The RT Director stated she had since been informed that she could enter orders into resident records. The RT Director stated she communicated the VO with the staff and it was also documented on the whiteboard in her office and said trach changes were on hold until otherwise notified. On [DATE] at 3:17 PM, an interview was conducted with the Director of Nursing (DON). The DON stated that she had seen a provider note in resident 1's chart that indicated that the tracheostomy should be changed every 3 months. The DON stated that the order was never put into resident 1's medical records. The DON stated that resident 1's prior tracheostomy order to change every 45 days was initiated by the prior RT Director, and then the contracted respiratory company did an audit and changed the order to every 30 days as the new standard protocol. The DON stated that the tracheostomy order dropped off the Medication Administration Record in January and resident 1 had no order to change the tracheostomy after that. The DON stated that the admission process was for the RT Director to manage any respiratory orders and treatments and the licensed nurse would handle all other medication and treatment orders. [Cross-refer F695]

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to provide respiratory care and tracheostomy care to residents who required these services. Specifically, for 3 out of 9 sampled residents, staff did not follow physician orders for changing tracheostomies; staff were not obtaining needed consultations with outside providers; staff were not accurately documenting the resident condition prior to the tracheostomy change; staff did not initiate a hospital transfer for a resident with concerns about the integrity of the tracheostomy. Additionally, staff interviews revealed knowledge of faulty equipment with a resident experiencing a broken flange which caused a dislodged tracheostomy, and subsequently going into cardiac arrest and dying. Finally, a resident found to have his BiPap (Bilevel Positive Airway Pressure) displaced was found to be unresponsive and CPR (cardiopulmonary resuscitation) was begun and the resident was unable to be resuscitated and passed away. The findings for residents 1 and 9 were determined to have resulted in immediate jeopardy (IJ). Resident identifiers: 1, 5, and 9. NOTICEOn [DATE], an Immediate Jeopardy was identified when the facility failed to implement Centers for Medicare and Medicaid Services (CMS) recommended practices to ensure that residents who needed respiratory care, including tracheostomy care, were provided such care consistent with professional standards of practice. This notice was given verbally and in writing to the Administrator, Director of Nursing, and Regional Nurse Consultant regarding residents 1 and 9.On [DATE], the Administrator provided the following written abatement plan for the removal of the Immediate Jeopardy effective on [DATE] at 11:37 AM. [NAME] Rehabilitation & Nursing 3.11.2026Abatement Plan/Plan of Removal: Tag F6951. Immediate Corrective ActionsAudit of All Tracheostomy Supplies: A facility-wide sweep was conducted to identify and sequester any tracheostomy tubes from the faulty batch ([DATE]-Present) mentioned in staff interviews. All XLT [Extended Length] and Shiley supplies were audited and verified to be intact and safe for use.Validation of Physician Orders: A 100% audit of all residents with tracheostomies and BiPap/Ventilator needs was completed to ensure current physician orders match the Electronic Medication Administration Record (EMAR) and Respiratory Therapy (RT) flowsheets. Increased monitoring orders from Q [every]-shift to every 2 hours for residents with CPAP (Continuous Positive Airway Pressure)/BiPap to ensure appropriate placement and functioning added to MAR [Medication Administration Record].ENT [Ears, Nose,Throat] /Specialist Review: Any resident identified with High Risk; airway status (e.g.,tracheal stenosis) will be flagged on the EMAR and at the bedside with a Do Not Change Trach - ENT/Provider Only alert as indicated. Review conducted of any outstanding ENT referrals and scheduled as indicated.2. Staff Education (Competency and Communication)All Respiratory Therapists and Licensed Nurses must complete mandatory training before their next scheduled shift.Key Education Topics:Emergency Airway Management: Re-training on the Difficult Airway protocol, specifically when to cease attempts at reinsertion and initiate emergency transfer to a higher level of care (Hospital/ER [Emergency Room]).Tracheostomy Change Protocol: Education on documentation requirements prior to a change (baseline vitals, stoma integrity, and clinical justification).Equipment Failure Reporting: A new Equipment Variance form and protocol for immediate reporting of faulty flanges or defective supplies to the RT Director, Director of Nursing (DON) and Administrator.CPAP/BiPap/Oxygen Use/Monitoring: Education on CPAP, BiPap, and Oxygen use, monitoring of placement and functioning, and who and when to report faulty/broken equipment to. Education on increased monitoring, particularly for those with behaviors of pulling masks/lines off.Department Head Education:Insurance/Access Advocacy: Education for the Transportation Driver and Business Office on the facility's obligation to pay for necessary outside consultations (like ENT) regardless of Medicaid-pending status to prevent delays in care. (Department Head Team)Ad-Hoc QAP [Quality Assurance Performance Improvement]I: Review conducted of F695 findings and abatement/immediate corrective action plan.4. Systemic ChangesInvestigation Protocol: (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Any death involving a resident with a tracheostomy or ventilator will now trigger a formal internal investigation for each incident and mandatory reporting to the State Survey Agency, if abuse or negligence is suspected.High Risk Alert Notification: Whiteboard will no longer be utilized for High Risk alerts, formal Critical Care Alert, will populate via the Care Profile at the top of every RT and Nursing EMR as indicated for individual residents.Tracheostomy/Ventilator Equipment Audits: Monthly Equipment Audits will be conducted, along with every shift monitoring of equipment per the Respiratory Therapy EMR.Monitoring for residents with Respiratory Care: Increased monitoring orders from every shift to every 2 hours for residents with CPAP/BiPap to ensure appropriate placement and functioning added to MAR. Residents with Ventilator/Tracheostomy orders to have an assessment every shift conducted by Respiratory Staff that will be entered into the resident chart. In addition ventilator check and tracheostomy placement orders increased for monitoring every 4 hours.Date of alleged compliance: 3.11.2026 11:37am.The facility alleged abatement of the Immediate Jeopardy as of [DATE] at 11:37 AM On [DATE] at 4:13 PM, while completing the complaint survey, surveyors conducted an onsite revisit to verify that the Immediate Jeopardy had been removed. The surveyors determined that the Immediate Jeopardy was removed as alleged on [DATE] at 11:37 AM.Findings included: IMMEDIATE JEOPARDY 1. Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, tracheostomy status, pneumonia, and anoxic brain damage. Resident 1's medical records were reviewed. Resident 1's physician orders revealed the following: a. Change Tracheostomy tube Q 45 days and PRN [as needed] every day shift every 30 day(s). The order was initiated on [DATE] and discontinued on [DATE]. The same order was initiated again on [DATE] and discontinued on [DATE]. The Medication Administration Record documented that the tracheostomy was changed on [DATE], [DATE], [DATE], and [DATE]. It should be noted that there was no order to change the tracheostomy tube after [DATE]. b. On [DATE], an order was initiated for an ENT referral related to stenosis and tracheostomy status. On [DATE], resident 1's hospital History & Physical [H & P] documented, . she had exchange of tracheostomy to Shiley by ENT due to hemoptysis. She went into respiratory arrest that night and was found to have a dislodged trach. She has some anoxic brain injury secondary to the episode where she had a PEA [Pulseless Electrical Activity] cardiac arrest Trach was changed by ENT in OR [operating room] on [DATE]. Given significant subglottic stenosis/proximal tracheal stenosis ENT recommends against trialing PMV [Passy Muir Valves]. They recommend changing trach every 3 months instead of monthly. On [DATE], resident 1's hospital H & P documented, 51 yo [year old] female admitted post out of hospital cardiac arrest at [name of nursing facility omitted]. She is s/p [status post] anoxic brain injury and is essentially in a vegetative state. She is trached and pegged. She was found unresponsive with dislodgement of her trach. 35 minutes of cpr was performed by EMS [Emergency Medical Services] when they found her in PEA. On [DATE] at 10:38 AM, the Nurse Practitioner note documented continued trach care per Respiratory Therapy protocol. F/u [follow-up] ENT for subglottic and tracheal stenosis. (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 7:00 AM, the RT documentation revealed that the resident was alert and oriented x [times] 3 to person, place and person. The type of tracheostomy was an XLT that was cuffed and non-fenestrated. The tube size was 7 millimeters. Stoma site had redness noted. The report documented that the cuff pressure was checked, inner cannula was changed and trach tie was changed. The ventilator type was documented as VOCSN and the mode of delivery was assisted control (AC) and pressure control (PC). The ventilator settings were set for a respiratory rate of 24 and was observed at that rate. The report documented that the respiratory pattern was regular and unlabored on the ventilator. Breath sounds were rhonchi, cough effort was strong, and yellow blood tinged secretions were present. Secretions were thick in moderate amount. Resident 1's oxygen saturations were 95%. Pt [patient] `rest in bed on vent @4L [liters]. HOB [Head of Bed] elevated. Trach is midline, secure and patent. Trach and oral care provided. Tx [treatment] given and tolerated well. No s/s [signs and symptoms] of resp. [respiratory] distress noted. Will continue to monitor. On [DATE] at 11:00 AM, the RT note documented, Pt] rest in bed on vent @ACPC [Assist Control Pressure Control] 4L. HOB elevated. Trach is midline, secure and patent. BS [breath sounds] coarse. Sx [suctioned] x3 for moderate amount of yellow thick secretions. No s/s of resp. distress noted at this time. Will continue to monitor. The note documented that resident 1's heart rate was 80 beats per minute, respiratory rate was 24 and oxygen saturation was at 100%. On [DATE] at 1:55 PM, the RT note documented, RT performed trach [tracheostomy] changed as pt mentioned trach is too tight this morning. Pt was placed on 6L O2 [oxygen] for pre-oxygenated. SpO2 [oxygen saturation] 97%, HR [heart rate] 98. During removal and reinsertion of trach tube, resistance was encounter (sic) and insertion was unsuccessful. a smaller size trach tube was attempted, still unsuccessful to insertion. Pt developed acute resp. distress with pallor and cyanosis noted. Code blue was activated immediately. [Note: This note was entered by Respiratory Therapist (RT) 1.] On [DATE] at 2:32 PM, the nursing note documented Per RT report, at approximately at 1355 [1:55 PM] a scheduled tracheostomy tube change was initiated. RT [respiratory therapist 1] and RT [respiratory therapist 2] reported that during removal and attempted reinsertion of the tracheostomy tube, resistance was encountered when advancing the new trach. A second tracheostomy kit was opened and insertion was reattempted. Resistance was again met and placement was unsuccessful. RT reported the resident then exhibited signs of respiratory distress with decreasing oxygen saturation and cyanosis. A Code Blue was initiated immediately, and manual ventilation was initiated via bag-valve device. At approximately 1400 [2:00 PM], I heard the Code Blue call and responded immediately to the room. Upon arrival, both RTs were present and providing ventilatory support via bag-valve mask. Resident was observed to be unresponsive, apneic, cyanotic, and without palpable pulse. Resident was lowered to the floor with assistance for initiation of CPR per facility protocol. Chest compressions were initiated immediately. Staff were directed to: Activate EMS (911), retrieve crash cart, obtain AED [Automated External Difibrillator], and notify RT supervisor [name omitted]. AED was applied and rhythm analyzed three times. No shock was advised. Continuous CPR was performed per protocol. EMS arrived during the third AED rhythm analysis and assumed care upon arrival. Resuscitative efforts were continued by EMS. Time of death was pronounced at 1425 [2:25 PM] by EMS. Attending physician was notified. Facility administration was notified per protocol. Family was called multiple times following the event. Calls were directed to voicemail on each attempt. Messages were left requesting immediate return call. Post-mortem care was completed per facility policy. On [DATE] at 3:13 PM, a note authored by the Transportation Driver (TD) documented, Received an order on [DATE] for Resident to go to ENT R/T [related to] Stenosis and tracheostomy status. Sent (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the order to Ent on [DATE] was told by Ent that resident didn't have insurance and that it would be self-pay. Tried calling family on multiple occasions with no answer or call back and with not being able to confirm if family can help self-pay the clinic would not schedule. It should be noted that this note was authored 5 days after resident 1 died and 3 months after the order for the ENT referral was initiated. On [DATE] at 1:24 PM, an interview was conducted with Respiratory Therapist (RT) 1. RT 1 stated that she had become an RT in [DATE]. RT 1 stated that the policy for changing the tracheostomy was to change it if it was dislodged or coming out or if the resident was complaining. RT 1 stated that she would only change the tracheostomy if it was coming out, otherwise it was the Medical Doctor (MD) that changed the tracheostomy. RT 1 stated that the inner cannula was changed daily and if a resident was complaining that the trach was too tight she would change the entire tracheostomy out, not just the inner cannula. RT 1 stated that during the morning [[DATE]] resident 1 was complaining that the tracheostomy was too tight and RT 1 visualized that the trach was coming out. RT 1 stated that the tracheostomy was dislodged approximately 1.5 inches from the stoma. RT 1 stated that resident 1's vital signs were good and she was not in any respiratory distress. RT 1 stated that she pushed the tracheostomy back in and resident 1 continued to report that it felt tight. RT 1 stated that resident 1's complaints of the tracheostomy being too tight could indicate that it was dirty inside and needed to be changed immediately. RT 1 stated that prior to attempting to change resident 1's tracheostomy the current tracheostomy was secure, patent and midline. RT 1 stated that when she attempted to place the new tracheostomy she met resistance. RT 1 stated that she then attempted to insert a smaller size tracheostomy and also met resistance. RT 1 stated that she was being assisted by RT 2 during the tracheostomy replacement. RT 1 stated that resident 1 had stenosis and a smaller airway and she also thought resident 1 had tracheal edema. RT 1 stated that during the attempted tracheostomy change resident 1's oxygenation dropped to 75% and a code blue was called. RT 1 stated that resident 1's oxygenation dropped to 60% and the resident was turning purple at that time. RT 1 stated that while RT 2 was mechanically ventilating resident 1, RT 1 left the room to get assistance from the RT Director, which took approximately 10 seconds. Resident 1 subsequently went into cardiac arrest and was pronounced dead by EMS. On [DATE] at 2:10 PM, an interview was conducted with RT 3. RT 3 stated that resident 1 had complications of tracheal stenosis, and they were not to change her tracheostomy until she was seen by the ENT. RT 3 stated that if the trach was coming out he would readjust it. RT 3 stated that resident 1 needed to go to the ENT to determine if she needed to have the trach changed on a regular basis. RT 3 stated that they had orders to not change her trach until she was seen by the ENT. RT 3 stated that resident 1 frequently complained of tightness in her tracheostomy and he would assess the trach tie to ensure it was not too tight and then provide resident 1 with education on safety reasons for why they could not loosen the trach ties. RT 3 stated that he was told after resident 1's death that resident 1 complained of the trach being too tight and that RT 1 thought it needed to be changed. RT 3 stated that RT 1 attempted the trach change, was unsuccessful, and they lost the airway. RT 3 stated that he recalled seeing resident 1's name on the whiteboard in the manager's office with a note that stated ENT only. RT 3 stated that if the tracheostomy was patent, midline, and secure he would not change an ENT only trach. On [DATE] at 2:55 PM, a telephone interview was conducted with RT 2. RT 2 stated that he had been an RT since [DATE]. RT 2 stated that resident 1 was not supposed to have her trach changed but he was not informed of this until after the resident's death. RT 2 stated that he was not sure why the trach needed to be changed. RT 2 stated that he did not visualize resident 1's trach coming out or (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	dislodgement prior to the attempted change. RT 2 stated that after resident 1's death he heard through one of his coworkers that the physician was supposed to change the tracheostomy, but they had orders to do it for the patient one time a month. It should be noted that those orders had expired on [DATE] and resident 1 did not have an active order for a tracheostomy change at the time of her death. RT 2 stated that he had never changed a vented patient's tracheostomy prior to resident 1's. RT 2 stated that after resident 1's death RT 1 had stated that resident 1 wanted the tracheostomy changed and that was what prompted the tracheostomy change. On [DATE] at 12:02 PM, an interview was conducted with the RT Director. The RT Director stated that she started at the facility on [DATE]. The RT Director stated that they had a standing order to change a tracheostomy every 30 days unless otherwise specified. The RT Director stated that in the beginning of February 2026 she received a Verbal Order (VO) from the provider that resident 1 should have their tracheostomy changed only by an ENT provider unless it was an emergent situation. The RT Director stated that this order was not in resident 1's chart. The RT Director stated she communicated the VO with the staff and it was also documented on the whiteboard in her office and said trach change was on hold until otherwise notified. The RT Director stated that RT 1 went in and resident 1's tracheostomy was dislodged and starting to come out. RT 1 deflated the cuff and pushed it back in. The RT Director stated that resident 1 was not in any distress, was oxygenating well, the tracheostomy was midline, and patent. The RT Director stated that the RTs could have sent resident 1 to the hospital for a tracheostomy change. The RT Director stated that she provided education to the RTs that they should work with nursing and were able to transfer the resident out if they were concerned about the integrity of the trach. The RT Director stated that she educated the staff about the accuracy of their documentation when she realized that the notes did not contain any details of resident 1's trach being dislodged. The RT Director stated that she was not informed that resident 1 was having issues with her tracheostomy until she was in cardiac arrest. On [DATE] at 3:17 PM, an interview was conducted with the DON. The DON stated that she had seen a provider note in resident 1's chart that indicated that the tracheostomy should be changed every 3 months. The DON stated that the order was never put into resident 1's medical records. The DON stated that resident 1's prior tracheostomy order to change every 45 days was initiated by the prior RT Director, and then the contracted respiratory company did an audit and changed the order to every 30 days as the new standard protocol. The DON stated that the tracheostomy order dropped off the Medication Administration Record in January and resident 1 had no order to change the tracheostomy after that. The DON stated that the admission process was for the RT Director to manage any respiratory orders and treatments and the licensed nurse would handle all other medication and treatment orders. The DON stated that the contracted respiratory company was responsible for the maintenance and upkeep of all ventilator equipment. The DON stated that the previous communication of respiratory equipment issues was through the RT Director but that was not always communicated to the DON and Administrator clearly. The DON stated that moving forward she expected the RT Director to communicate any concerns with equipment to her. The facility policy on Tracheostomy Tube Changes documented that tracheostomy tubes should be changed per doctor's orders or every 30 days to prevent the risk of tracheal stenosis. As included are emergency changes (i.e. damaged tubes, tubes that are not patent). The policy documented under Replacement of Trach Tube that If airflow is inadequate, or tube cannot be placed properly remove tube, provide ventilation* if necessary and attempt to reinsert tube. If still unable to pass a tube manually ventilate and call 911 or emergency services. The procedure further documented that if you were unable to reinsert a tube Attempt to insert a tube of smaller size, usually the next size down. If the patient's stoma suddenly closes, attempt to pass a suction catheter or tracheal tube exchanger (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	through the stoma to thread the tracheostomy tube. 2. Resident 9 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, acute and chronic respiratory failure, tracheostomy status, and pneumonia due to pseudomonas. A review of resident 9's medical record revealed the following notes: a. On [DATE] at 11:00 PM, a late entry respiratory therapy note documented, At approximately 2100 [9:00 PM] hours, I entered the patient's room to conduct my first rounds. Upon examination, I observed that the tracheostomy tube was broken and dislodged from the tracheostomy flange, with the tube approximately 1.5 inches out of position. Immediate replacement of the trach tube was necessary, as the tube was not in midline and was shifted to the right. I promptly notified the nurse to witness the situation and called for a second respiratory therapist to assist with the trach tube change.A Shiley XLT 6 and a Shiley XLT 5 were available at the bedside for use. The patient had a Shiley XLT 6 in place. After removing the old tube, I inserted the new tube, which had been tested and lubricated. During suctioning, a significant amount of bloodwas [sic] observed. A second and third pass were performed to address further blood accumulation. The SpO2 alarm signaled low oxygen saturation, prompting disconnection from the ventilator to manually bag the patient. Despite these efforts, the SpO2 levels did not improve. Two additional nurses were called in to assist as a pulse check was performed, which revealed no pulse. The patient was subsequently transferred to the floor. A Shiley XLT 5 was then placed to see if it would enhance oxygenation while continuing manual bagging, with no resistance encountered during ventilation. SpO2 did not improve; chest compressions were going on while manual ventilation continued until EMS [Emergency Medical Services] came and took over the situation. b. On [DATE] at 12:19 AM, a late entry nursing note documented, I was called into resident room by RT. RT showed residents tach [sic] was broken and needed to be replaced. Another Rt was called into room to assist with trach change, residents 02 and other V/S [vital signs] were stable at this time. RT's alerted nurse that resident was having copious amounts of bleeding while new trach was being changed out. Residents became unstable at this time and code blue was initiated, other staff arrived to assist and 911 was immediately called. [NAME] [sic] arrived and worked on resident however was unableto [sic] be revived, and time of death was called. Provider DON [Director of Nursing] and family members made away [sic] of death. On [DATE] at 2:11 PM, an interview was conducted with RT 3. RT 3 stated that he had changed out resident 9's trach ties earlier in the day and had not seen a problem with the trach. RT 3 stated that resident 9 could not move and was in a comatose state. RT 3 stated that resident 9 was unable to forcefully cough unless she was being suctioned. RT 3 stated that resident 9 used a XLT trach which twisted to lock. RT 3 stated that if the flange broke then the inner cannula would not lock and it would be loose. RT 3 stated that he asked other RTs if they had any issues with XLT trachs that broke because he was concerned for other residents in the facility that used them and the possibility that they may break. On [DATE] at 12:02 PM, an interview was conducted with the Respiratory Director. The Respiratory Director stated that she had heard that there was a batch of trachs that facilities had problems with the flange breaking. The Respiratory Director stated that she was not the director when resident 9 passed away. The Respiratory Director stated if a flange broke on a trach there was an increased risk that the trach would lose patency. The Respiratory Director stated that there have been two residents (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in the facility who have had flanges break, but that this was before she was the director. On [DATE] at 12:37 PM, an interview was conducted with the DON. The DON stated that the facility had a contract with an outside respiratory company and had used them for two years. The DON stated that respiratory staff identified that resident 9 had a broken trach and the respiratory staff made the decision to change out the trach when there was some increased bleeding and resident 9 went into cardiac arrest and passed away. The DON stated that she was not sure how the flange broke on the trach. The DON stated that she was unaware of any other residents that have had a flange break on the tracheostomy. On [DATE] at 3:01 PM, an interview was conducted with RT 4. RT 4 stated that on [DATE] he entered resident 9's room around 9:00 PM to perform his first assessment. RT 4 stated that resident 9's trach was broken at the flange and it had been dislodged at a 45 degree angle to the right side of the stoma. RT 4 stated that trachs should be centered and midline and if it was not then a resident could have airway obstruction or bleeding. RT 4 stated that the ventilator was not alarming and he was not sure why it was not alarming as high pressure because every breath was pressurized. RT 4 stated that resident 9's lips appeared to be cyanotic and so he replaced her oxygen sensor to another location on her body and resident 9's oxygen saturation was below 90%. RT 4 stated that he called for another RT and a nurse to come into resident 9's room because he needed to change resident 9's trach so that resident 9 would have a patent airway. RT 4 stated that he changed resident 9's trach and suctioned resident 9's airway. RT 4 stated that upon the first suctioning pass a large amount of frank blood and mucus was suctioned out. RT 4 stated that he went back in and suctioned an additional two times and continued to suction larger amounts of blood. RT 4 stated that resident 9's oxygen was showing as low. RT 4 stated that the nurse checked resident 9's pulse and found her without one. RT 4 stated that resident 9 was lowered to the floor and CPR was begun. RT 4 stated that he continued to suction large amounts of blood out of resident 9's trach. RT 4 stated that he believed that resident 9's airway was filled with blood. RT 4 stated that he notified the interim respiratory manager about the ventilator not alarming and made sure that he checked all of his residents' ventilators to make sure they were working correctly. RT 4 stated he was not sure how the flange broke on resident 9's trach because she was comatose and in a vegetative state and could not move. On [DATE] at 2:36 PM, an interview was conducted with the RT Director, and the RT contract company representative. The RT Director stated that she currently had one XLT left for a patient and it was not part of the back order. The RT Director stated that they had two trach issues with patency issues in December and [DATE], but that neither of those devices were part of a recall. The RT Director stated that they did not do an investigation because there was not a ventilator that was malfunctioning. The RT Director also stated that they looked into the issue with alarms; they were using a nipple adapter that was causing back pressure and that it wasn't alarming for a high pressure alarm. The RT Director additionally stated that was reported to her but she was not here at the time that was implemented. The RT Director stated they took the nipple adapter off the vent and they have not had any issues since, but she was not sure if it was related to this patient. The RT Director stated that the interim manager was called yesterday and the interim manager told her there were no malfunctioning alarms that were reported to her during the time with resident 9's displacement. The RT contract company representative stated that RT 4 had meant that had an alarm been going off it would have likely been a high pressure alarm and that it was not an actual equipment issue. The RT contract company representative stated the issue was that the resident had a broken trach and not an actual equipment problem. The RT contract company representative stated that RT 4 checked on his patients because it was an unusual incident. (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 4:23 PM, a follow-up interview was conducted with RT 4. RT 4 stated that when he entered resident 9's room the ventilator was not alarming and the tracheostomy was severely deviated to the side. RT 4 stated that he would determine if a tracheostomy was occluded from the alarm. RT 4 stated the ventilator alarm should have been going off if there was an occlusion and it would have been a pressure alarm. RT 4 stated that resident 9's tracheostomy could have been partially occluded and that may have been why it was not alarming. RT 4 stated that all he could see was from the stoma out and he could not determine if it was occluded. RT 4 stated that the tracheostomy could have been partially occluded and still have adequate air movement and then it would not necessarily alarm. RT 4 stated that resident 9 coughed a lot and with those involuntary movements could have caused the tracheostomy to dislodge, especially with the broken flange. RT 4 stated that his concern was that the tracheostomy was going to come out. RT 4 then stated that he did question why it was not alarming and if it was more than 50% occluded it should have alarmed. RT 4 stated that later he spoke to the interim supervisor about some of the alarms and pulse oximeters that needed to be replaced. RT 4 stated that he was concerned about the alarm cables that were breaking, which would result in the ventilator not alarming to the call system. Additionally, some of the pulse oximeters were not working and they were separated from the supply. RT 4 stated that there was an instance when he needed a functioning pulse oximeter and he did not have one at the facility. RT 4 stated that he told the CNAs that he was taking their vital signs cart to use for a patient's pulse oximeter monitoring. RT 4 stated that he had some situations when he did not have supplies and equipment that was needed to provide care to the residents. RT 4 stated that he repeatedly asked for alarms, pulse oximeters, and cables for the pulse oximeters that did not have in supply to provide care for the resident. RT 4 stated that as soon as the current RT Director took over the supplies were available. RT 4 stated that he attributed the lack of supplies to the previous RT Director. POTENTIAL FOR HARM 3. Resident 5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included quadriplegia, anoxic brain damage, chronic respiratory failure with hypoxia, and acute and chronic respiratory failure with hypercapnia. A review of resident 5's physician orders revealed to check for proper body positioning and nasal cannula placement and BiPAP vent [ventilator] setting with humidity AVAPS [Average Volume Assured Pressure Support] Trilogy settings: VT [Tidal Volume] 550, Max [maximum] P-25 [inspiratory pressure], Max PS-10 [pressure support], Min PS-2,

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F 0840 Level of Harm - Actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined that the facility did not ensure that the resident was provided access to an outside provider when the qualified professional person was not employed by the facility, and the facility assumed responsibility for obtaining those services in a timely manner. Specifically, for 1 out 9 sampled residents, the facility did not obtain an appointment with an Ear, Nose, and Throat (ENT) provider for the evaluation of a resident's tracheostomy and tracheal stenosis as ordered. This resulted in a finding of harm for resident 1. Resident identifier:1.Findings included: Resident 1 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, tracheostomy status, pneumonia, and anoxic brain damage.Resident 1's medical records were reviewed.Resident 1's physician orders revealed the following:On 12/3/25, resident 1 had an order initiated for an Ear, Nose, and Throat (ENT) referral related to stenosis and tracheostomy status.On 9/25/25, resident 1's hospital History & Physical (H & P) documented, . she had exchange of tracheostomy to Shiley by ENT [Ear, Nose and Throat] due to hemoptysis. She went into respiratory arrest that night and was found to have a dislodged trach. She has some anoxic brain injury secondary to the episode where she had a PEA [Pulseless Electrical Activity] cardiac arrest Trach was changed by ENT in OR [operating room] on 9/17/ 25. Given significant subglottic stenosis/proximal tracheal stenosis ENT recommends against trialing PMV [Passy Muir Valves]. They recommend changing trach every 3 months instead of monthly.On 2/17/26 at 10:38 AM, the Nurse Practitioner note documented continued trach care per Respiratory Therapy (RT) protocol. F/u [follow-up] ENT for subglottic and tracheal stenosis.On 2/23/26 at 3:13 PM, a progress note authored by the Transportation Driver (TD) documented, Received an order on 12/3/25 for Resident to go to ENT R/T [related to] Stenosis and tracheostomy status. Sent the order to Ent on 12/8/25 was told by Ent that resident didn't have insurance and that it would be self-pay. Tried calling family on multiple occasions with no answer or call back and with not being able to confirm if family can help self-pay the clinic would not schedule.On 3/10/26 at 10:17 AM, an interview was conducted with the TD. The TD stated he scheduled appointments for residents and if he was not able to schedule an appointment it would be documented under a progress note. The TD stated that he had a coaching session 2 weeks ago and was instructed that he needed to start documenting every time he contacted an outside provider or resident representative. The TD stated that he sent resident 1's order to the ENT on 12/8/25 and again on 12/30/25. The TD stated that he was told that the resident did not have any insurance and therefore the ENT office would not see her. The TD stated that he was informed that resident 1 did not have insurance by the Business Office Manager (BOM). On 3/10/26 at 11:29 AM, an interview was conducted with the BOM. The BOM stated that resident 1 had a Medicaid Pending status at the facility and that the BOM had been in contact with Medicaid since resident 1 had been admitted . The BOM stated that she had screened resident 1 prior to the resident admitting to the facility in order for resident 1 to obtain Medicaid. The BOM stated that if a Medicaid pending resident required a service at an outside provider and the provider would not accept the resident with the Medicaid pending status then the facility would be responsible for payment to the outside provider. The BOM stated that she was not informed that resident 1 could not be seen by an ENT provider because of her Medicaid pending status and if she had known she would have spoken with the Administrator about this and had resident 1 seen by the ENT provider. [Cross-refer F695]

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F 0865 Level of Harm - Actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility did not demonstrate identification, reporting, investigation, analysis and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective action. Specifically, the facility did not identify or investigate in their Quality Assurance Performance Improvement (QAPI) three respiratory-related resident deaths. This will be cited at a harm level. Resident identifiers: 1, 5, and 9.Findings included:1. There was noncompliance identified at an IJ (Immediate Jeopardy) level for residents who were on ventilators and had a tracheostomy changed by respiratory staff when they were not supposed to and another resident's tracheostomy broke. Both of these residents went into cardiac arrest and subsequently died. Resident identifiers: 1 and 9. [Cross refer to F695] 2. Based on interview and record review it was determined that the facility did not ensure that the resident was free from neglect. Specifically, for 2 out of 9 sampled residents, the facility did not provide the resident with access to an outside provider appointment for the treatment and care of their tracheostomy tube and verbal orders for the tracheostomy change were not followed. In addition, a comatose resident in a vegetative state experienced a broken flange which caused a dislodged tracheostomy, and the resident subsequently went into cardiac arrest and died. Resident identifiers: 1 and 9. [Cross refer to F600]3. Based on interview and record review the facility did not ensure that all alleged violations involving injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, if the events resulted in serious bodily injury to the administrator, State Survey Agency (SSA) and Adult Protective Services (APS). Specifically, for 1 out of 9 sampled residents, the SSA and APS were not notified when a resident's tracheostomy flange broke, resulting in a dislodged tracheostomy tube. The resident subsequently went into cardiac arrest and died. Resident identifier: 9. [Cross refer to F609]On [DATE] at 3:28 PM, an interview was conducted with the Administrator (ADM). The ADM stated that if the facility identified a process that was not working as intended this led to a quick Quality Assurance (QA) meeting. The ADM stated that in the quick QA they would identify the issue, what caused the issue, and what was the process to resolve the issue. The ADM stated that was how the process entered into the QAPI program and then it was reviewed monthly with QAPI. The ADM stated that the facility reviewed the residents' deaths in QAPI and focused on whether staff was following procedure. The ADM stated that the facility had addressed resident 1 and resident 9 in QAPI, but had not reviewed resident 5's death. The ADM stated that he was not informed of resident 9's death and the circumstances that had occurred with the broken flange until the following morning. The ADM stated that the contracted respiratory company was responsible for supplying all equipment needed for the respiratory unit. The ADM stated that the contracted respiratory company had not reported any equipment issues or equipment that was not functioning properly. The ADM stated that it was his expectation that the respiratory company report any equipment concerns that they may have.

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F 0908 Level of Harm - Actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility did not maintain all mechanical, electrical, and patient care equipment in a safe and operating condition. Specifically, a ventilator did not alarm when a resident's tracheostomy tube's flange broke and dislodged and the resident went into cardiac arrest and died. This will be cited at a harm level. Resident identifier: 9. Resident 9 was admitted to the facility on [DATE] with diagnoses which included anoxic brain damage, acute and chronic respiratory failure, tracheostomy status, and pneumonia due to pseudomonas. A review of resident 9's medical record revealed that on [DATE] at 9:00 PM, respiratory staff entered resident 9's room and found the tracheostomy flange broken, the tracheostomy tube was dislodged, and approximately 1.5 inches out of position, shifted to the right and not midline. Respiratory therapy staff notified nursing and called for a second respiratory therapist to assist with the tracheostomy change. During suctioning, respiratory staff observed a significant amount of blood and performed additional passes to clear continued accumulation of blood. Resident 9's oxygen saturation dropped and respiratory staff initiated manual ventilation; however, oxygen levels did not improve. Nursing staff performed a pulse check and no pulse was located. Resident 9 was lowered to the floor and cardiopulmonary resuscitation (CPR) was performed. Emergency Medical Services (EMS) arrived and resident 9 was unable to be revived and passed away. On [DATE] at 3:01 PM, an interview was conducted with Respiratory Therapist (RT) 4. RT 4 stated that he had entered the room of resident 9 on [DATE] and found the tracheostomy flange broken and the tracheostomy was deviated significantly to the right at approximately a 45 degree angle and partially out of the stoma. RT 4 stated that resident 9's lips were blue in color. RT 4 stated that the ventilator was not alarming and it should have been alarming with at least a high pressure alarm because each ventilated breath was pressurized. RT 4 stated that he moved the continuous pulse oximeter sensor to a different location because the oxygen saturation alarm was not going off and resident 9's oxygen level was below 90%. RT 4 stated that after resident 9 passed away, he checked all the ventilators to see if they were disconnected because the ventilator had not alarmed. RT 4 stated that he gave a report about the ventilator to the interim respiratory therapist director. On [DATE] at 3:28 PM, an interview was conducted with the Administrator (ADM). The ADM stated that the contracted respiratory company was responsible to supply all equipment needed for the respiratory unit. The ADM stated that it was his expectation that the contracted respiratory company communicate with the facility if there were any problems with equipment. The ADM stated that no equipment issues had been reported to him. On [DATE] at 3:43 PM, an interview was conducted with the Respiratory Therapist Interim Director. The Respiratory Therapist Interim Director stated that she was at the facility for a couple of days in [DATE] and then for a week at the beginning of [DATE]. The Respiratory Therapist Interim Director stated that while she was at the facility she was working on compliance with the supplies and ensuring that the respiratory therapists had all the supplies that they needed. The Respiratory Therapist Interim Director stated that she had received a text message about the flange breaking from a tracheostomy and that resident 9 had passed away after this occurred. The Respiratory Therapist Interim Director stated that she returned to the facility after this had occurred and was informed that the facility had everything handled. On [DATE] at 4:23 PM, a follow-up interview was conducted with RT 4. RT 4 stated that when he entered resident 9's room on [DATE] the ventilator was not alarming. RT 4 stated that the tracheostomy was severely deviated to the side. RT 4 stated that he questioned why the ventilator was not alarming because he was concerned that the tracheostomy was going to come out. RT 4 stated that he later spoke with the interim respiratory supervisor about his concerns with the ventilator and that some of the alarms and pulse oximeters needed to be replaced. RT 4 stated that he was concerned about the alarm cables that were breaking, which would result in the ventilator not alarming to the call system, and some of the pulse oximeters were not working. RT 4 (continued on next page)

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F 0908 Level of Harm - Actual harm Residents Affected - Few	stated that there had been an instance when he needed a functioning pulse oximeter and he did not have one. RT 4 stated that he told the Certified Nursing Assistants (CNAs) that he was taking their vital signs cart to use for patients. RT 4 stated that he had some situations where he did not have the equipment that he needed for the resident.