STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555709	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Global Medical Center D/P Snf	2601 East Chapman Avenue Orange, CA 92869

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853 Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for two of two sampled residents (Residents 1 and 2) who were dependent on the ventilator with tracheostomy for breathing. * The facility failed to ensure Resident 1's ventilator circuit was effectively monitored. As a result, the resident experienced the respiratory arrest. * The facility failed to ensure the P&Ps for respiratory care and services were followed for Resident 2 when the oxygen therapy and a part of the disposable ventilator circuit was replaced and rinsed by a non-qualified personnel. These failures posed the risk of delayed care and interventions for the residents. Findings: 1. Review of the facility's P&P titled Subacute Ventilator Management reviewed [DATE] showed to establish a mutual understanding and a standard of ventilator management for Nursing staff and Respiratory Therapists, which work as a team to provide quality ventilator support. Ventilator management and support will be provided by doing Ventilator Rounds/Checks every four hours and as needed by the Respiratory Therapist which consists of: a. Providing a complete assessment and support for any needs the patient may have at that time. b. Visual inspection of the ventilator and its equipment. If a ventilator failure/ malfunction is evident, ventilate the resident with a manual resuscitator and replace the ventilator with an operational unit (See Ventilator Failure). c. Document pertinent information/findings and current vent settings/alarm settings. d. Provide airway maintenance by providing suctioning of the trachea or mouth when necessary. e. Keeping the patient care team informed of any changes in patient's condition. f. Assessing and monitoring the status of the resident's stoma. (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 - Minimal harm or potential for actual harm Residents Affected - Few	g. Monitor the HME and other equipment and change per policy. Review of facility's P&P titled Code Blue reviewed [DATE] showed Code Blue is to be called: a. In emergency situations when a patient has a significant change or b. On any patient in cardiac or respiratory arrest unless there is a specific physician order to the contrary. (See withholding/withdrawing life support). Examples of significant changes: i. Decreasing level of consciousness - unresponsiveness ii. Hypotension - lack of audible/palpable BP iii. Dyspnea - apnea iv. Sudden decreasing or absent peripheral pulses v. Uncontrolled hemorrhage vi. Ventricular fibrillation vii. Ventricular tachycardia viii. Asystole c. Rapid Response is to be called when a patient is identified as at risk according to selected criteria. Review of facility's P&P titled Tracheostomy Tube Suctioning with an In-line Catheter reviewed on [DATE] showed the resident with tracheostomy tube will be suctioned every two hours and as needed. Review of [NAME] Respironics Trilogy 202 Ventilator User Manual showed: Alarm Summary Table indication of high, medium, and low priority and recommended clinical actions as follows: - Low Circuit Leak: High priority, recommended clinician action was to remove obstruction in leak device. Reduce the flow rate to in line nebulizer or low pressure oxygen bleed into the circuit. If the alarm continues, have the device serviced. - High Resp Rate: High priority, recommended clinician action was to verify patient status - High Insp Pressure: Escalates from audible indicator to medium priority and then high priority, recommended clinician action was to verify patient status. If the problem continues, have the device serviced. - Circuit disconnect: High priority, recommended clinician action was to reconnect tubing or fix leak. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Low minute ventilation: High priority, recommended clinician action was to verify patient status. 1. Closed medical record review for Resident 1 was initiated on [DATE]. Resident 1 was readmitted on [DATE] at 1330 hours, and discharged on [DATE] at 1706 hours, to the acute care hospital. Review of Resident 1's Patient Orders for [DATE] showed the following orders: - dated [DATE], for mechanical ventilation, vent mode: assist control, Tidal Volume 450, set rate 16, FiO2: 30%, PEEP: 5, Maintain oxygen saturation: above 92% - dated [DATE], suction, artificial airway every twohours PRN: for retained or increased secretions every shift - dated [DATE], full code There was no documented evidence Resident 1 was suctioned on [DATE]. Review of Resident 1's RT note dated [DATE] at 1330 hours, showed Resident 1 was alert, awake, and oriented to person and place. Resident 1 was placed on the ventilator with ventilator settings as per the physician's order. Further review of Resident 1's RT notes failed to show any documentation of the ventilator and/or settings after 1330 hours on [DATE]. Review of Resident 1's Nurse Progress Notes dated [DATE], showed the following sequence of events: - At1345 hours, Resident 1 was alert and oriented and denied pain. - At 1453 hours, Resident 1 indicated she wanted to get up and sit at the edge of the bed. - At 1600 hours, Resident 1 was found lying on her side, disconnected from the ventilator, and unresponsive. The resident was immediately connected to an ambu bag while the resident's pulse oximetry was assessed. The peripheral oxygen saturation level was initially in the 60s range (normal range: 95%-100%). The manual ventilation continued while the RT was called. The interventions were maintained until the RT arrived. The CAT was activated, followed by a Code Blue. Review of Resident 1's Code Blue Record dated [DATE], showed the following sequence of events: - At1645 hours, the time of arrest. The type of arrest was respiratory, initial ventilation via tracheostomy ambu bag. Resident 1's heart rhythm was sinus bradycardia. - From 1648 hours to 1651 hours, Resident 1's heart rhythm was Pulseless Electrical Activity. - At 1652 hours, Resident 1's heart rhythm was supraventricular tachycardia. - At1653 hours, Resident 1's heart rhythm was sinus tachycardia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Progress Note dated [DATE] at 1530 hours, showed about 1515 hours, the resident suddenly turned blue. The Fi02 was temporarily increased to 100%. The RT arrived around 1520 hours and by this time the resident's color was pink. On [DATE] at 1346 hours, an interview was conductedwith Family Member 1. Family Member 1 stated the ventilator machine was beeping continuously and had told the nurse to suction Resident 2. The nurse told Family Member 1 she would give the resident's medication and call the RT to suction Resident 2. Resident 2 was turning purple. CNA 1 came in to help the resident because the nurse did not know what to do. Family Member 1 further stated there was no designated RT in the facility and usually not there when needed because they work also in the acute care unit of the hospital. On [DATE] at 0843 hours, a phone interview was conducted with CNA 1. CNA 1 stated RN 2 asked for his help. When CNA 1 went to Resident 2, Resident 2 was having difficulty breathing, had excessive secretion in the tracheostomy tube, and the skin looked purple. CNA 1 stated he called the RT. CNA 1 stated RN 2 was standing in front of the alarming ventilator machine and heard RN 2 stated, I don't know what is going on. CNA 1 stated he asked RN 2 to suction the resident, and she did, but there was still excessive secretion. CNA 1 further stated RN 2 asked him to get suction catheter from the supply room to get suction, when he returned the resident was still purple. CNA 1 further stated he replaced the HME filter and rinsed the T-adapter in the sink because it had excessive secretion then RN 2 put the ventilator tubing together. CNA 1 further stated he increased the FiO2 to 100%. CNA 1 stated after less than a minute, Resident 2's color became normal. CNA 1 stated the RT came to the room after the resident stabilized. CNA 1 stated he knew he was not supposed to increase the oxygen and touch the ventilator circuit, rinse the T-adapter however, it was an emergency, and he did what he could at the time to help Resident 2. On [DATE] at 0935 hours, an interview was conducted with the RT Manager. The RT Manager stated the T adapter should not have been rinsed. The RT Manager further stated the RN was trained and were expected to take care of the residents with the ventilators in the facility. The RT Manager stated the CNAs were not allowed to touch the HME and increase the FiO2. On [DATE] at 1036 hours, an interview was conducted with RN 2. RN 2 stated CNA 1 rinsed the T-adaptor because it had excessive secretion. When asked if CNA 1 was allowed to rinse the adapter RN 2 stated CNA 1 was trying to help. RN 2 verified CNA 1 increased Resident 2's FiO2 to 100%. RN 2 verified Family Member 1 had requested for Resident 2 to be suctioned and informed the family member she would suction the resident after hanging the IV medication. On [DATE] at 1640 hours, an interview and concurrent medical record review was conducted with Subacute Manager. The Subacute Manager verified the progress notes on [DATE], when the resident suddenly turned blue, and the Fi02 was temporarily increased to 100%. The Subacute Unit Manager stated there was no dedicated RT in the unit, and he RT was usually called in the subacute unit when needed. On [DATE] at 1640 hours, an interview was conducted with the DON. The DON was informed and acknowledged the findings as above.