STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675361	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident had a right to a safe, clean, comfortable and homelike environment, including housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for 1 of 8 residents (Resident #2) reviewed for environmental concerns.1. The facility failed to ensure there were not dried, thick streaks of mucus covering Resident #2's dresser and the walls surrounding his dresser spanning an area of approximately 5 feet by 5 feet. 2. The facility failed to ensure there were no crayon and/or pen marks of multiple colors on the wall next to Resident #2's bed.These failures could place residents at risk of a diminished quality of life due to exposure to an environment that was unpleasant, unsanitary, and unsafe.The findings include:Record review of Resident #2's admission Record generated on 2/6/26 revealed he was admitted to the facility on [DATE] with diagnoses of Alzheimer's disease, heart failure, bipolar disorder, gastro-esophageal reflux disease and chronic obstructive pulmonary disease. He was [AGE] years of age. Record review of Resident #2's Care Plan Report dated 11/6/24 revealed he had a behavior problem of spitting on the floors and walls in his room. Interventions included, .Anticipate and meet The resident's needs, caregivers to provided (sic) opportunity for positive interaction, attention. Stop and talk with him/her as passing by. If reasonable, discuss The resident's behavior. Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident. In an observation on 2/3/26 at 4:23 PM, Resident #2's dresser, and walls next to his dresser were covered in dried, thick streaks of mucus that were brown, red, or pink in color. They covered an area of approximately 5 feet by 5 feet. On the wall next to his bed there were crayon and/or pen marks of multiple colors, scribbled on the wall in the size of approximately 2 feet by 1 foot. In an interview on 2/3/26 at 4:30 PM, CNA A said she heard Resident #2 spit on the walls. She said the nurses and nurse managers were aware. In an attempted interview with Resident #2 on 2/3/26 at 4:31pm revealed he could not be interviewed. In an interview on 2/6/26 at 12:58 PM, the Maintenance Director, said housekeeping staff would remove the mucus material in Resident #2's room. He said they were going to start using a magic eraser product. He said housekeeping staff were still cleaning the room, and they could not paint over biological material and would want them to remove it as best as they could before they painted the wall or made any repairs. In an interview on 2/6/26 at 2:00 PM, the Environmental Supervisor said Resident #2 spit so much, they had to clean his room twice daily sometimes. She said right now it was clean and in 2 hours some of the wall would be covered again. She said they used disinfectant to clean the walls and washed his curtain. She said they cleaned it last night. She said it was not hard to clean the stain off. She said if it stayed too long it was difficult to clean. In an observation on 2/6/26 at 2:00 PM, Resident #2's walls were clean. There were some small spots on the wall where the sheetrock was damaged. In an interview on 2/6/26 at 4:00 PM, ADON B said Resident #2 spit on his walls. She said she (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not believe the housekeepers were cleaning/removing the mucus from the walls daily because there was so much there. Record review of the facility's, undated, policy regarding General Housekeeping Policies read, The facility provides sufficient housekeeping and maintenance personnel, equipment and supplies to maintain the interior and exterior of the facility in a safe, clean, orderly, and attractive manner. each occupied resident room is cleaned and put in order daily and as needed.

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that a resident who needed respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preferences for 1 of 1 resident (Resident #1) reviewed for tracheostomy care. 1. The facility failed to ensure staff caring for Resident #1 were aware of the location of emergency equipment or how to use it in case of accidental extubation of his tracheostomy (a medical emergency where the tracheostomy tube is inadvertently removed. A tracheostomy is a surgically created opening in the neck leading into the trachea to assist with breathing, often using a tube to maintain the airway). 2. The facility failed to ensure Resident #1 had a same-size tracheostomy at the bedside in case of accidental extubation on 1/12/26. 3. The facility failed to ensure staff caring for Resident #1 were aware of tracheostomy sizes and the size Resident #1 required based on his physician's order. An Immediate Jeopardy (IJ) situation was identified on 2/5/26. While the IJ was removed on 2/6/26, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of corrective systems. These failures could place resident at risk of respiratory distress which could lead to low oxygen levels, airway loss, cognitive and emotional damage, organ failure or death. Findings include:Record review of Resident #1's admission Record revealed he was admitted to the facility on [DATE]. Resident #1 had diagnoses which included epileptic seizure (a transient, involuntary alteration in behavior, sensation, or consciousness caused by abnormal, excessive electrical activity in the brain, typically lasting one to two minutes), shortness of breath, other specified respiratory disorders and tracheostomy. He was [AGE] years old.Record review of Resident #1's care plan, dated 4/12/2023 and revised on 1/18/2024, revealed he had a tracheostomy related to injury to his larynx (the hollow muscular organ forming an air passage to the lungs and holding the vocal cords) and was at risk of alterations in respiratory status. Intervention included, Change disposable trach (Shiley #6) inner cannula secure with trach tie every shift for trach care. Tube Out Procedures: Keep extra trach tube and obturator (a guide tool inserted into the outer cannula to facilitate safe insertion of a tracheostomy tube into the airway) at bedside. If tube is coughed out, and tube cannot be reinserted, monitor/document for signs of respiratory distress.obtain medical help Immediately.Record review of Resident #1's quarterly MDS assessment, dated 11/26/25, revealed he had a BIMS of 4, which indicated he had severe cognitive impairment. He was dependent on others for personal and oral hygiene. The assessment indicated he had shortness of breath or trouble breathing when lying flat and required tracheostomy care and suctioning. Record review of Resident #1's Order Summary Report, generated on 2/4/26 revealed he had an order to change disposable trach Shiley 6 inner cannula (a removable liner inserted into the main outer trach tube to prevent mucus build-up) as needed and every shift with an order date of 6/2/24. Record review of Resident #1's progress note, dated 1/2/26, revealed RN A noticed his trach was no longer in place. His oxygen saturation was 94% and he denied shortness of breath. He was sent to the hospital for evaluation and treatment.Record review of Resident #1's emergency provider report from an acute care hospital, dated 1/2/26, revealed Resident #1 was sent to the hospital to have his trach replaced. Chief complaint was noted to be trach dislodged. His first documented pulse oximeter result (a measure of blood oxygen transport) was 96% and he was receiving oxygen by nasal cannula at 1:30 pm. The trach was replaced with the use of bronchoscopy (a procedure in which a doctor inserts a thin, flexible tube with a camera through the nose or mouth to examine the airways, lungs, and (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	included: Shiley size 4, 5, and 6 trachs, ambu bag, concentrator, air compressor, and suction.Interviews with LVN E on 2/5/26 at 6:15 PM and with the DON, LVN A, ADON #2, LVN R and LVN C on 2/6/26 between 3:34 PM and 4:56 PM revealed they could describe their training with the RT, including trach emergency supplies, trach sizing, and procedures of accidental extubation.Record review of the staff sign-in sheet dated 2/5/26 and 2/6/26 revealed RN A was not assigned to work. In an interview on 2/6/26 at 4:56 PM, the DON said she would verify placement of trach supplies in Resident #1's room to ensure emergency supplies were available. She said she would monitor the nursing staff for competency of trach care and emergency procedures. Record review of Resident #1's Respiratory Therapy Note, dated 2/5/26 at 7:40 PM, revealed the RT assessed the resident, determined he was wearing a 6UN75H trach, and stated there were three sizes of trachs, including Shiley 4, 5 and 6 at bedside for the emergency supplies. Record review of an in-service training report, dated 2/5/26, attended by licensed nurses conducted by the RT revealed all nurses received 1-to-1 education on the following topics: Trach care to include trach care supplies with passed return demonstration; Emergency response during an accidental extubation of trach, to include trach tube reinsertion identification of trach size location and related equipment with passed return demonstration; Daily shift observation and documentation for compliance with physician orders for trach size as well as presence of emergency equipment at bedside; Extra trach in current size and size below current size and ambu bag and trach care supplies; POC nurse responsibility for checking and stocking trach supplies each shift and as needed. Nurses who worked last night and today signed the sign-in sheet.Record review of a QAPI sign-in sheet, dated 2/5/26, revealed a meeting was held with the Medical Director, Facility Administrator, Director of Nursing, Regional Clinical Specialist and Regional [NAME] President of Operations. The Administrator was informed the Immediate Jeopardy was removed on 2/6/26 at 5:24 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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	675361	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing and Rehabilitation Center	1220 Sunny Lane Wharton, TX 77488

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure licensed nurses had the specific competencies and skill sets to care for resident's needs, as identified through resident assessments and described in the plan of care for 4 of 8 nurses (RN A, LVN O, DON and RCS) reviewed for competency.1. The facility failed to ensure RN A and LVN O, who were assigned to care for Resident #1, were aware of the location of emergency equipment or how to use it in case of accidental extubation of his tracheostomy. 2. The facility failed to ensure the DON and RCS were aware of tracheostomy sizes and the size Resident #1 required based on his physician's order. An Immediate Jeopardy (IJ) situation was identified on 2/5/26. While the IJ was removed on 2/6/26, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with a potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of corrective systems. These failures could place residents at risk of respiratory distress which could lead to low oxygen levels, airway loss, cognitive and emotional damage, organ failure or death.Findings include:Record review of Resident #1's admission Record revealed a male who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included epileptic seizure, shortness of breath, other specified respiratory disorders and tracheostomy. He was [AGE] years old.Record review of Resident #1's care plan dated 4/12/2023 and revised on 1/18/2024 revealed he had a tracheostomy related to injury to his larynx and was at risk of alterations in respiratory status. Intervention included, Change disposable trach (Shiley #6) inner cannula secure with trach tie every shift for trach care. TUBE OUT PROCEDURES: Keep extra trach tube and obturator at bedside. If tube is coughed out, and tube cannot be reinserted, monitor/document for signs of respiratory distress.obtain medical help IMMEDIATELY.Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed he had a BIMS of 4, indicating he had severe cognitive impairment. He was dependent on others for personal and oral hygiene. The assessment indicated he had shortness of breath or trouble breathing when lying flat and required tracheostomy care and suctioning. Record review of Resident #1's Order Summary Report generated on 2/4/26 revealed he had an order to change disposable trach Shiley 6 inner cannula as needed and every shift with an order date of 6/2/24. Record review of Resident #1's progress note dated 1/2/26 revealed RN A noticed his trach was no longer in place. His oxygen saturation was 94% and he denied shortness of breath. He was sent to the hospital for evaluation and treatment.Record review of Resident #1's emergency provider report from an acute care hospital dated 1/2/26 revealed Resident #1 was sent to the hospital to have his trach replaced. Chief complaint was noted to be trach dislodged. His first documented pulse oximeter result (a measure of blood oxygen transport) was 96% and he was receiving oxygen by nasal cannula at 1:30pm. The trach was replaced with the use of bronchoscopy and tolerated well.Record review of Resident #1's progress note dated 1/12/26 revealed RN A was replacing the trach tie when the resident coughed and the trach came out. The trach was replaced. He had difficulty breathing and was given 2L of oxygen. He was sent to the hospital for evaluation.Record review of Resident #1's Emergency Department Report from an acute care hospital dated 1/12/26 revealed Resident #1 visited the emergency department because nursing home staff put the tracheostomy back in after it became dislodged and they are .unsure if it is in correct position. Patient is breathing well and has no complaints now. trach appears to be in appropriate position. In an interview on 1/22/2026 at 4:00 PM, RN A said Resident #1's trach dislodged on two occasions during her shifts. She said the first time, when she notified the nurse practitioner, she said to send the resident to the emergency room. She said the second time it was dislodged, she was changing the (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	gauze during trach care and he coughed hard and the trach blew out. She said she did not know that was possible. She said another nurse replaced the trach. She said she did not feel comfortable replacing the whole trach, only the inner cannula. She said the last training she had on trach care was most likely in 2023.In an interview on 2/3/26 at 3:07 PM, RN B said she was present when Resident #1's trach became dislodged. She said RN A was assigned to care for Resident #1, and she helped her by putting a trach back in when the tube became dislodged. She could not state why RN A was unable to replace the trach. In an observation and interview on 2/3/26 at 5:22 PM, LVN O said if Resident #1's trach fell out, she would call the nurse practitioner and send him to the hospital immediately, because that is how he breaths. She said she would not know how to replace it. In an observation and interview on 2/4/26 at 4:43 AM, LVN W said if Resident #1's trach became dislodged, she would replace it with the kit available in his room. She showed the State Surveyor the kit, which included the insertion tool. There were two sizes, one Shiley 6 and one Shiley 4. She said he wore a size 6, so she would use the size Shiley 6. She said she had not received trach training or any type of skills checkoff since she started in November 2025. She said she had been trained on the procedure in other positions before she started at the facility. In an interview on 2/4/26 at 11:20 AM, NP said when Resident #1's trach was dislodged, she would expect the nurses to make sure the resident was breathing, try to replace the trach, check the oxygen saturation, then call the nurse practitioner. She said if the nurses did not replace the trach, they could use mechanical ventilation using BVM (bag-valve-mask). She said the resident could stop breathing if the nurses did not know what to do. In an interview on 2/4/26 at 12:08 PM, the DON said they were making sure the nurses were trained on trach care since they had some recent new hires and rehires. She stated RN A and LVN O received competency assessments on tracheostomy care last year. She said the facility's policy was to follow the competency assessment procedures. Record review of the, undated, tracheostomy care competency assessment revealed the following: .able to verbalize steps to take when there is an accidental decannulation. Call for assistance and assess your patient. Replace the old tracheostomy tube with the new tube that is the same-size. Be prepared to manually ventilate the resident in whom respiratory distress develops. Notify emergency personnel, if necessary. Continue to manually ventilate until emergency personnel arrives and takes over ventilation. In a telephone interview on 2/5/26 at 10:15 AM, the previous ADON said the RT visited every year and she did respiratory training and trach training. She said the RT brought a mannequin that showed you how to remove a trach and put another one in. She said the RT would allow the nurses to be checked off for competency one-by one. She said most of the nurses did not attend that training. She said she knew LVN O and RN A did not attend. She said they did not feel comfortable providing that kind of care. In an interview on 2/5/26 at 11:32 AM, the DON said she was not the most knowledgeable about trach sizes and could not explain the different sizes of the trachs and inner cannulas. In an observation and interview on 2/5/26 at 12:08 PM, the DON said Resident #1 wore a trach that had a 7.5 mm outer cannula and 6 mm inner cannula. The DON walked to Resident #1's room. ADON #2, RN B, and RCS were in the room with Resident #1. The RCS said that they were looking at his new trach to determine the size of it. They showed the State Surveyor the tracheostomy boxes in his emergency supplies at bedside and one was labeled 4UN65H and the other 6UN65H. The RCS pointed to the diagram of the inner cannula on the package and said the emergency supply contained the correct sized packages because the diameter of the inner cannula of the smaller trach was 5.5 mm and the diameter of the inner cannula of the correct size trach was 6.5 mm. When asked if the inner cannula size should be 6 mm or 6.5 mm, the RCS said they would look into it. In an interview on 2/5/26 at 12:40 PM, the RCS said she spoke to the RT who said they use the first number of the label to (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	determine the size of the trach supplies. She said Resident #1 used a size 6 Shiley trach, which was the trach labeled 6UN75H. In an interview on 2/5/26 at 1:00 PM, ADON #1 said if a resident's trach was dislodged and they were in respiratory distress, the nurses would insert the trach cannula and use oxygen, then send the resident to the hospital. When asked about the training she had received on trachs and trach care, she said she used to work in a hospital and received training from them. She said they had a skills fair (a training for staff that covers various topics) and RT training in the last few months, but they did not address trachs or trach care. In an interview on 2/5/26 at 2:58 PM with NP, when asked about Resident #1's trach order of size 6 inner cannula, she said that meant the inner cannula was 6 mm in size. She said the nursing staff should use a 6 mm inner cannula.In an interview on 2/5/26 at 3:45 PM, the RT said she completed annual training on tracheostomies that included putting a new trach in during emergencies. She said she was available to complete trainings for new nurses or if a facility had a new admission. She said she was at the facility on 12/2/25 completing a training about oxygen and respiratory care, not regarding trach care. She said Resident #1 required a size 6, which would be a 6UN75H trach. She said the item number included the size (6), whether the trach was uncuffed or cuffed (UN), the size of the ID (75), and whether the trach was disposable or not (H). She said there should be emergency supplies at his bedside that included his trach size and a size smaller, either a size 4 or 5.Record review of a new hire Tracheostomy Care Competency Assessment, dated 9/17/25, revealed LVN O's competencies were checked as 'met' with no comments, which included the following procedures: .able to verbalize steps to take when there is an accidental decannulation, call for assistance and assess your patient, replace the old tracheostomy tube with the new tube that is the same-size, be prepared to manually ventilate the resident in whom respiratory distress develops.make sure extra tracheostomy tubes, obturator and resuscitation bag are readily available in case of emergency. Record review of an annual Tracheostomy Care Competency Assessment, dated 9/24/25, revealed RN A's competencies were checked as 'met' with no comments, including the following procedures: .able to verbalize steps to take when there is an accidental decannulation, call for assistance and assess your patient, replace the old tracheostomy tube with the new tube that is the same-size, be prepared to manually ventilate the resident in whom respiratory distress develops.make sure extra tracheostomy tubes, obturator and resuscitation bag are readily available in case of emergency. Record review of a Respiratory Therapy Certificate, dated 12/2/26, revealed RN A completed Respiratory Therapy training presented by RT. Record review of a Respiratory Therapy Certificate, dated 12/2/26, revealed LVN O completed Respiratory Therapy training presented by RT. Record review of Respiratory Certification Tests and Respiratory Skills Checklist, dated 12/2/26, completed by RN A and LVN O revealed there were no questions or areas concerning tracheostomy care. This was determined to be an Immediate Jeopardy (IJ) on 2/5/26 at 4:40pm. The Administrator and DON were notified. The DON and Administrator were provided with the IJ template on 2/5/26 at 4:40 p.m. The following Plan of Removal submitted by the facility was accepted on 2/6/26 at 2:56pm:Letter of Credible Allegationfor Removal of Immediate JeopardyAttention Sir or Madam: On February 5, 2026, the Facility was notified by the surveyor that immediate jeopardy had been called and the Facility needed to submit a letter of removal. The Facility respectfully submits this Letter for a Plan of Removal pursuant to Federal and State regulatory requirements. The alleged Immediate jeopardy allegations are as follows: Issue: F726 - Competent Nursing StaffThe facility failed to have ensure that licensed nurses had the specific competencies and skill sets necessary to care for resident's needs, as described in the plan of care in that 2 of 4 nurses did not know how to use emergency equipment in case of accidental extubation of Resident #1's tracheostomy. Actions for Resident Involved On 2/5/2026, (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	New Admissions/Readmissions with Tracheostomies will be reviewed by the Director of Nursing and/ or designee for compliance with physician orders for tracheostomy size, as well as the presence of appropriate tracheostomies sizes, equipment and Ambu bag at bedside. Completion date: 2/5/2026Monitoring: Beginning 2/5/2026 and going forward, the Director of Nursing and/or designee will monitor compliance with physician orders for tracheostomy care and presence of accurate emergency tracheostomy equipment at the bedside by validating through rounding on residents with a tracheostomy. Beginning 2/5/2026 and going forward, the Director of Nursing and/ or designee will monitor compliance with Licensed Nurse competency in tracheostomy care via observations and competency checks. Beginning 2/5/2026 and going forward, the Director of Nursing and/ or designee will monitor compliance with daily verification and documentation of presence of emergency supplies at resident bedside (i.e extra tracheostomy in current size, one sicxe down and Ambu bag) by rounding on residents with tracheostomy. On 2/5/2026, an Ad Hoc QAPI meeting was held with the Medical Director, Facility Administrator, Director of Nursing, Regional Clinical Specialist and Regional [NAME] President of Operations to discuss the immediate jeopardy and review the plan of removal.We respectfully submit this action plan for the removal of Immediate Jeopardy. Monitoring of the POR included the following:Record review of Resident #1's Respiratory Therapy Note dated 2/5/26 at 7:40pm revealed the RT assessed the resident, determined he was wearing a 6UN75H trach, and stated there were three sizes of trachs, including Shiley 4, 5 and 6 at bedside for the emergency supplies. In an observation on 2/6/26 at 10:30am revealed Resident #1 had emergency equipment at the bedside which included: Shiley size 4, 5, and 6 trachs, ambu bag, concentrator, air compressor, and suction.Record review of an in-service training report dated 2/5/26 attended by licensed nurses conducted by the RT revealed all nurses received 1-to-1 education on the following topics: Trach care to include trach care supplies with passed return demonstration; Emergency response during an accidental extubation of trach, to include trach tube reinsertion identification of trach size location and related equipment with passed return demonstration; Daily shift observation and documentation for compliance with physician orders for trach size as well as presence of emergency equipment at bedside; Extra trach in current size and size below current size and ambu bag and trach care supplies; POC nurse responsibility for checking and stocking trach supplies each shift and as needed. Nurses who worked last night and today signed the sign-in sheet.Interviews with LVN E on 2/5/26 at 6:15pm and with DON, LVN O, ADON #2, LVN R and LVN C on 2/6/26 between 3:34pm and 4:56pm revealed they could describe their training with the RT, including trach emergency supplies, trach sizing, and procedures of accidental extubation. In an interview on 2/6/26 at 4:56pm, the DON said she would verify placement of trach supplies in Resident #1's room to ensure emergency supplies were available. She said she would monitor the nursing staff for competency of trach care and emergency procedures. Record review of a QAPI sign-in sheet dated 2/5/26 revealed a meeting was held with the Medical Director, Facility Administrator, Director of Nursing, Regional Clinical Specialist and Regional [NAME] President of Operations. The Administrator was informed the Immediate Jeopardy was removed on 2/6/26 at 5:24 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for more than minimal harm that was not immediate and a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.