STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675846	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36491 Based on observation, interview, and record review the facility failed to ensure a resident who needs respiratory care, including tracheostomy care, is provided such care consistent with professional standards of practice for 1 of 7 residents (Resident #1) reviewed for respiratory care. The facility failed to ensure that Resident # 1 received monitoring during respiratory treatments while experiencing anxiety/nervous-type behaviors on [DATE]. Resident #1 found in distress with no pulse with ventilator partially disconnected.The resident died on [DATE]. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 5:00 pm. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to monitor and evaluate the effectiveness of their corrective systems. This failure could place residents at risk of a significant reduction in the quality of oxygen being delivered, inadequate oxygen support, and decline in health. The findings included: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of the profile sheet, dated [DATE], revealed Resident #1 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia (acute respiratory failure occurs when the lungs cannot release enough oxygen into the blood, which prevents the organs from properly functioning. Chronic respiratory failure can occur with conditions that cause the respiratory muscles to weaken over time. Hypoxia means low levels of oxygen in the body tissues), pneumonia (an infection that inflames the air sacs in one or both lungs), tracheostomy status (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck. A person with a tracheostomy breathes through a tracheostomy tube inserted in the opening), dependence on respirator (ventilator) status (a mechanized device that enables the delivery or movement of air and oxygen into the lungs of a patient whose breathing has ceased, is failing, or is inadequate), dysphagia (difficulty swallowing), gastro-esophageal reflux disease without esophagitis (happens when acidic stomach contents flow back into the esophagus, esophagitis in the inflammation or irritation of the esophagus, which is an organ which transports food from the mouth to the digestive system), depressive disorder (depression), anxiety disorder (a group of mental disorders characterized by intense feelings of anxiety and fear), insomnia (trouble falling and/or staying asleep), essential (primary) hypertension (high blood pressure), hypotension (low blood pressure), and neuromuscular dysfunction of bladder (refers to urinary bladder problems due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination). Record review of the MDS quarterly assessment, dated [DATE], revealed Resident #1 was understood and made herself understood. The MDS revealed Resident #1 had a BIMS of 11, which indicated moderate cognitive impairment. The MDS revealed Resident #1 had no behaviors or refusal of care. The MDS revealed Resident #1 had an anxiety disorder and depression. The MDS revealed that Resident #1 received oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator. Record review of the baseline care plan for Resident #1, initiated [DATE],showed the baseline care plan did not address Resident #1's ventilator use until [DATE] (after the resident's discharge) and did not address Resident #1's anxiety until [DATE] even though Resident #1 had a diagnosis of anxiety on admission. Record review of physician orders dated [DATE], revealed Resident #1 had a physician's order, which started on [DATE] for Alprazolam 0.5 mg. 1 tablet 3 times a day as needed for anxiety. Record review of physician orders dated [DATE] revealed Resident #1 had a physician's order for ventilator/alarm checks were to be done every 4 hours. Record review of physician orders dated [DATE] revealed Resident #1 had 3 breathing treatment orders: Formoterol fumarate solution every 4 hours Ipratropium-albuterol solution to be given every 6 hours Tobramycin with nebulizer twice a day Record review of the progress notes revealed the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 4:28 p.m. signed by CRT F: Received resident via EMS from hospital around 1500. Shiley 8CN85H midline and secure, BBS Clear and Diminished. Resident transferred from gurney to facility bed with 2 person assist. Resident then placed on facility vent with prescribed settings AC/VC/,d+[DATE]/+, d+[DATE]L bled into it. Resident then showed increased SOB, increased HR 123bpm, Spo2 decreased to 83%. Vent kept alarming circuit disconnect. Switched vents with different circuit with same alarms. RT Director bagged resident until vent was working correctly. Once vent issue was resolved, the resident began to breathe easier and was no longer showing signs of respiratory distress. Residents family member arrived at facility, explaining she has severe anxiety, will hold her breath, and desaturate often. This information was passed on the RT Director, Asst. RT Director and LVN. Resident is now resting comfortably in semi-Fowler's position with husband at bedside. Will continue to monitor. [DATE] at 10:30 signed by LVN P: This nurse called to residents room by CRT. CRT states resident complaining of S.O.B, O2 lower 80's. R.T. suctioned with very little return. CRT started bagging resident, O2 up to 94%, attempted to put resident back on vent and O2 dropped again. Resident heart rate ,d+[DATE]. Called and spoke with Medical Director, ordered to send resident to hospital. E.R. [DATE] [Recorded as Late Entry on [DATE] 03:10 a.m.] at 7:03 p.m. signed by LVN Q: Arrived to facility via stretcher by EMS. AAOx3. Family member at bedside. Trach and vent care and monitoring per R.T. Resp even, non-labored. No SOB. Denies pain or discomfort at this time. HOB elevated. Transferred to bed per staff. G/T patent. Flushes freely with H2O. No residual. Placement checked and confirmed. Continuous Isosource 1.5 @ 45mL/hr with 10mL/hr of H2O flushes per pump. V/S WNL. Awaiting meds to be delivered from a pharmacy. Incontinent care provided and repositioned every 2 hours and as needed. Both heels floated with pillow. No wounds or skin issues noted. NPO. Call light within reach. Checked frequently for needs, all needs met per staff. [DATE] at 6:35 p.m. signed by CRT R: Received resident on ventilator, settings of AC/,d+[DATE]/+5 with 4LPM of O2. Alarms on and active, ambu bag and ER kit at HOB, E-cylinder sufficient. Spo2 97, HR 102, RR 17, BBS unlabored and diminished. Resident asleep comfortably in her bed. Shiley 8CN85H secure and at midline. 0 complications and 0 distress noted at this time will continue monitor resident. Review of the progress notes dated [DATE] at 6:45 p.m. signed by CRT E: Received resident on vent settings AC/,d+[DATE]/+,d+[DATE]L. Shiley 6CN75H secure and at midline and secure. Ambu bag and ER kit at HOB, E-cylinder sufficient. Resident awake and alert 0 distress noted at this time. Spo2 95, HR 64, RR 22. BBS unlabored and diminished. Will continue to monitor resident. Edited By: CRT E on [DATE] 08:18 PM Reason: Incorrect data [DATE] at 6:50 a.m., signed by CRT A: Received resident awake and alert on ventilator, settings of AC/, d+[DATE]/+7 with 4LPM of O2. Alarms on and active, ambu bag and ER kit at HOB, E-cylinder sufficient. Suctioned resident x4 with heavy lavage dt high insp. pressure, resident produced grape sized mucous plug. Spo2 99, HR 83, RR 19, ETCO2 ,d+[DATE]mmhg. BBS unlabored and diminished. Shiley 8CN85H secure and at midline. Installed heat chamber and placed in line with vent. 0 complications and 0 distress noted at this time will continue monitor resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE: 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 7:15 a.m., signed by CRT A: Received resident awake and alert on ventilator, settings of AC/, d+[DATE]/+7 with 4LPM of O2. Alarms on and active, ambu bag and ER kit at HOB, E-cylinder sufficient. Spo2 93, HR 97, RR 25, ETCO2 ,d+[DATE]mmhg. BBS unlabored and diminished. Shiley 8CN85H secure and at midline. 0 complications and 0 distress noted at this time will continue monitor resident. Review of the progress notes dated [DATE] at 8:06 a.m., signed by CRT F: Received resident resting on vent, settings of AC/,d+[DATE]/+,d+[DATE]L. Shiley 8CN85H secure and at midline. Alarms on and active, Spo2 98, HR 74, RR 18, BBS unlabored and diminished. Ambu bag and ER kit at HOB, E-cylinder sufficient. 0 complications and 0 distress noted at this time will continue monitor resident. [DATE] at 8:14 a.m. Oral and trach care done at this time. No complications. No distress noted at this time. Resident tolerated procedure well. Will continue to monitor. Signed off by CRT F. [DATE] at 9:15 p.m. Resident very anxious and fidgety at this time, nurse notified. Signed off by CRT E. [DATE] at 11:30 p.m. CRT E walked in Resident #1's room and found that the ventilator had become partially disconnected. Resident #1 was unresponsive, CRT E called for the nurse and CPR was started immediately. O2 Sat reading 60% This CRT E bagged resident (using an ambu bag which is a medical tool that forces air into the lungs of patients who have either ceased breathing completely or who are struggling to breath properly and need additional assistance) with 100% oxygen while nurse proceeded with compressions. EMS was called. RT director and administrator notified. EMS arrived around 11:54 p.m. to transport Resident #1 to the hospital. Signed off by CRT E. [DATE] 3:55 a.m. At approximately 11:30 p.m. this writer was called to Resident #1's room by CRT E who stated Resident #1 was not responsive. I immediately got the cordless phone and hurried to the room while calling 911. Upon entering the room, I observed CRT E bagging Resident #1. I checked for a pulse but did not find one. I then began chest compressions. I applied the AED to the resident and was advised of no shock advised. I then began compressions again. We continued to run the code (a medical emergency usually cardiac or respiratory arrest) per facility protocol until EMS arrived at the facility at 11:54 p.m. and took over. Resident #1 had a pulse when she departed the facility with EMS. Signed off by LVN D. [DATE] 10:55 p.m. Skilled nurse spoke with nurse at hospital, he stated resident passed away, DON notified. Signed off by LVN G. Record review of facility nurses notes indicated that on [DATE] there were no relevant entries made between 9:15 p.m. and 11:30 p.m. Record review of hospital records revealed the following: A hospital physician note dated [DATE] revealed the following: The patient is an elderly female on a chronic ventilator who comes in after cardiac arrest following her coming unplugged with the ventilator. Patient had roughly 20 minutes of down time. She seems to have significant anoxic insult from the cardiopulmonary arrest. Will continue current supportive treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospital physician note dated [DATE] revealed the following: Assessment: status post cardiac arrest, shock, cardiogenic versus septic. Atrial fibrillation with rapid ventricular response. Diabetes, anxiety. Plan: Patient continues to be on the ventilator, unresponsive on bedside evaluation. Review of hospital documents provided did not include any notes regarding cause or time of death. During an interview on [DATE] at 9:45 a.m. the Administrator said Resident #1 had recently been admitted to the vent unit. Administrator said Resident #1 was not clinically stable and was on a ventilator. Administrator said that on [DATE] the ventilator connecting tubing came loose. The CRT went into Resident #1's room and found her unresponsive. Administrator said the alarm never went off. The CRT started CPR and called for the nurse. The Administrator said EMS came and Resident #1 was transferred to the hospital and passed away on [DATE]. The Administrator said she was told Resident #1 had a pulse when she left the facility. The Administrator said she had interviewed all the staff who were working. During an interview on [DATE] at 10:15 a.m., CRT A said she had worked in the facility since 2021. CRT A said she was not working the day Resident #1 coded (term used when a cardiopulmonary arrest occurs, and patient needs immediate resuscitative efforts). CRT A said she was told by other staff that there was a slight disconnect of the vent tubing to the trach. CRT A said she had witnessed Resident #1 reach for her trach and pull at it when she was anxious. CRT A said at the disconnection site, she was told the leak was so small that the vent could not register it and the alarms did not go off. CRT A said the vents had routine maintenance done every 10,000 hours, and alarms were checked every shift. CRT A said there had not been any issues with any vents or alarms that she was aware of. CRT A said the CRTs made frequent rounds on all the residents checking settings and doing trach observation. CRT A said the vent alarms were set to go off if 2 breaths were not received. CRT A said the physician had recently tried to decrease Resident #1's vent settings, and after 5 minutes Resident #1's heart rate went up and they had to turn the vent back to full support. CRT A said there were a few residents that would frequently have anxiety, and staff would check them, and sometimes adjusting room temperatures would help. CRT A said Resident #1 had disconnected her vent one time prior to this event, and it was a full disconnect and the alarms went off. CRT A said Resident #1's tube was not fully disconnected at the time of the incident. During observations on [DATE] at 10:45 a.m., Residents #2, #3, #4, #5, #6, and #7, were found to be lying in bed. All ventilator tubing appeared to be connected appropriately, and all tubes connected to trach were intact. Alarms were all functional. No residents were interviewable at the time of the observations. No resident appeared in any respiratory distress. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:33 p.m. CNA B said she had worked as an aide for 3 months. CNA B said she worked the night of the incident with Resident #1. CNA B said she came in about 6:30 p.m. and made rounds and picked up trays. CNA B said she had gone in Resident #1's room around 8:30 p.m. to check on her. CNA B said she changed Resident #1's bed and cleaned her. CNA B said Resident #1 was very alert and aware. CNA B said Resident #1 told her she was a good aide and gave her two thumbs up and told CNA B she was comfortable. CNA B said around 10:00 p.m. she made rounds and noticed Resident #1 was asleep. CNA B said she did not notice anything abnormal and turned the light out over the bed. CNA B said later that night, she was unsure of time but thought it was around ,d+[DATE]:30 p.m., she heard the CRT call for help. The nurse came and CPR was started. EMS arrived maybe ,d+[DATE] minutes later and they took over the CPR. CNA B said EMS put Resident #1 on a stretcher and put a machine on her that did the CPR. CNA B said she heard someone say Resident #1 had a pulse. During an interview on [DATE] at 1:45 p.m. CNA C said she had worked in the facility for 1 year. CNA C said she worked the first day Resident #1 arrived at the facility. CNA C said Resident #1 had some anxiety. CNA C said Resident #1 was able to move around well in the bed by herself, and if she was rolling over for care, she knew to be cautious. CNA C said if any alarms went off, you could hear them in the rooms as well as the hall. During a telephone interview on [DATE] at 2:46 p.m. LVN D said she worked the day Resident #1 coded. LVN D said on [DATE] around 8:00 p.m. she gave Resident #1 her medications. Resident #1 was alert and oriented at that time. LVN D said she thought it was around 10:00 p.m., the aide went and turned the light out in Resident #1's room. LVN D said around 11:,d+[DATE]:35 p.m. CRT E called her and said Resident #1 was not breathing. LVN D said 911 was called, and CPR initiated. LVN D said the AED was placed and did not indicate a shock was needed. LVN D said EMS arrived and took over and transported the Resident #1 to the hospital. LVN D said CRT E told her around 9:15 p.m. that evening that Resident #1 had anxiety. LVN D said she was in the hall with CRT E and went in Resident #1's room at that time. LVN D said when she went in the room, she did not notice any anxiety and did not offer Resident #1 any medication. LVN D said CRT E had just checked Resident #1's vital signs, and O2 sats and everything was fine. LVN D asked Resident #1 if she was feeling ok and if she had any anxiety. Resident #1 told her she was okay. LVN D said she had not witnessed Resident #1 have any episodes of anxiety, and never saw her touch her trach tubing, or try to remove it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit Nursing & Rehab of San Augustine	902 E Main St San Augustine, TX 75972

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 4:29 p.m. CRT E said she was working the night Resident #1 coded. CRT E said she had started doing her breathing treatments around 9:,d+[DATE]ish p.m. as they were due by 11:00 p.m. CRT E said she usually started in one room and went down the line doing all breathing treatments. CRT E said she went in Resident #1's room and was talking with her. CRT E said Resident #1 would get anxious at the time of her treatments. Resident #1's vital signs were good and vent settings were good. CRT E said she had told the nurse to come look at the resident because she felt anxious, which she did, but was not sure if she gave Resident #1 any medication. CRT E said she started the breathing treatment around 10:00 p.m. and everything was good. CRT E said she had gone to chart and when she went back to the room approximately an hour later she saw that Resident #1 was lifeless. CRT E said she looked at the vent, and the tubing had become partially disconnected close to the airway, and that it was partially, not totally disconnected, and Resident #1 was still receiving breaths. CRT E said she contacted the nurse and started bagging Resident #1 and the nurse started compressions. CRT E said EMS arrived approximately 20 minutes later. CRT E said the AED was applied and did not recommend a shock. CRT E said the tubing was not disconnected enough to set the alarm off on the machine. CRT E said she thought the resident may have pulled it loose. EMS arrived and Resident #1 was transferred to the hospital. CRT E said that the vent machines would beep if the resident missed receiving 2 breaths. CRT E said Resident #1 did have a pulse before her transfer. During an interview on [DATE] at 9:30 a.m. the Director of Respiratory said she had started work in the facility on [DATE] of this year. Director said she had worked as a Respiratory Director for [AGE] years. Director said Resident #1 had a habit of holding the connection tubing prior to the incident but had never tried to pull anything off or out. Director said residents' breathing treatments are given in line with the vent circuit through the nebulizer. The tubing for breathing treatments is connected to the vent. Director said Resident #1's vent was providing every breath for her. Director said staff were not required to stay with the resident during treatments unless they were utilizing a handheld nebulizer. Treatment time depends on how many medications are given. Director said most last ,d+[DATE] minutes but could be longer if more medications were to be received. Director said none of the residents on the unit were able to hold a nebulizer on their own for a breathing treatment. Director said she had looked at Resident #1's vent after she coded and looked at the alarms and everything was functioning normally. Director said while providing care on Resident #1, she would sometimes get anxious and hold her tubing. Director said she never saw Resident #1 try to pull anything out, and no one had reported to her that this had occurred. Director said she made rounds every day. Director said leaving the tubing/nebulizer connected when breathing treatment was finished would not cause any problems for Resident #1. The Director said the sensitivity settings on their ventilators were ,d+[DATE]. Director said if they are set on 1, any movement made would set the alarms off. Director said it was standard practice to set them on 2. She said it was the same grade used in hospitals, and all their vents were set to that. Director said the machines received maintenance every 10,000 hours and would also beep if maintenance was needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 10:30 a.m. CRT F said she had worked in the facility since [DATE]. CRT F said Resident #1 always appeared to be anxious. CRT F said Resident #1's family member had told her that when Resident #1's oxygen levels would go down her anxiety was through the roof. CRT F said all residents were checked at least every hour. CRT F said she had never seen Resident #1 pull on her trach until last week. CRT F said Resident #1's anxiety would get worse when she would hear other alarms going off in the hall. CRT F said Resident #1 had pulled on her inline suction tubing at one time. CRT F said they used a white cloth tie to hold the trach secure to the trach collar on all residents. CRT F said she had seen Resident #1 touching it 2 or 3 times. CRT F said when she would do trach care on Resident #1, which did not take long at all, Resident #1 would desat (when the oxygen saturation level in the blood decreases). CRT F said she was not working the day of the incident but was told the tubing over the trach had come off. CRT F said she could not run a history report from the vent as it had already been set up for another resident. During an interview on [DATE] at 11:00 a.m. The Medical Director said he had been notified of the partial disconnect of Resident #1's tubing. Medical Director said Resident #1 was very frail, and from what he had been told, Resident #1 had been checked before the incident. Medical Director said he felt nothing differently could have been done for Resident #1 and it seemed reasonable that the alarm did not go off. Medical Director said something happened from when the breathing treatment started until she was found. Medical Director said he did not feel there was anything that could have made this avoidable. Medical Director said Resident #1 was capable of using her hands, and unlike the hospital they cannot use restraints in the nursing home, which made it tricky. Medical Director said it could have been a mucous plug, we don't know. Medical Director said he did not think this incident was preventable. Medical Director said people respond differently and if Resident #1 had a cardiac episode or a mucous plug, she may have pulled it out. Medical Director said he would be in the nursing home on Friday [DATE] to review the chart. During an interview on [DATE] at 2:15 p.m. The DON stated that Resident #1 would touch her tubing but had not tried to pull it out. The DON said Resident #1 was able to use her call light when she needed something. The DON said Resident #1 was a very anxious, nervous person and would calm down when staff talked to her and explained things. During a confidential interview on [DATE] at 2:28 p.m. the interviewee said the night Resident #1 coded, the tubing was completely disconnected. Interviewee said there were no alarms heard on the vent unit the entire shift which was unusual. Interviewee said they had never worked a shift where the alarms did not go off. Interviewee said when the day shift arrived, the alarms started going off. Interviewee said the CRT who was working at the time stated the tubing had come apart and she had witnessed the tubing on the floor. Interviewee said some of the staff were afraid to speak up. Interviewee said all the staff working had to meet with Administration to get their stories straight. Interviewee said she did not know if the alarms were turned off but felt if they had alarmed when the tubing became disconnected something more could have been done for Resident #1. Interviewee stated a coworker told her she was to say the tubing had been partially disconnected if anyone asked. Record review of the VOCSN Clinical and Technical Ventilator Manual revealed the following: The ventilator will emit an audible series of tones whenever a high or medium priority alarm activates. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE: 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The visual alarm (indicating the alarm condition and priority) will remain on the ventilator screen. The apnea alarm will activate when the ventilator has not delivered assist or spontaneous breaths. The check 02 source alarm activates when a connected source of external low-pressure oxygen is used and the monitored Fi02 (represents the percentage of oxygen a person inhales from the air or through supplemental oxygen) falls below 24%. The check patient circuit alarm activates when the ventilator detects an inadequate leak in a passive or valveless circuit, or an error on the flow sensor of an active circuit. The low breath rate alarm activates when the monitored breath rate is less than the set low breath rate alarm limit. The low Fi02 alarm activates when the monitored Fi02 falls below the set alarm limit. The low inspirator pressure alarm activates when the monitored Peak Inspiratory Pressure (the highest level of pressure applied to the lungs during inhalation) falls below the set low Inspiratory pressure alarm The patient circuit disconnect alarm will activate when the ventilator detects a large leak. The patient circuit disconnect alarm will activate when no patient breathing is detected for 20 seconds. The Administrator and DON were notified of an IJ on [DATE] at 5:00 p.m. and were given a copy of the IJ template and a Plan of Removal (POR) was requested. The Plan of Removal was accepted on [DATE] at 9:55 am and included the following: [DATE] Plan of Removal - F695 Immediate Action Taken Resident Specific Resident #1 was sent toER on [DATE] at 11:54 p.m. MD was notified of Resident #1's cardiac arrest, CPR, and transport to the emergency roiagnom on [DATE]. Family was notified of Resident #1's cardiac arrest, CPR, and transport to the emergency roiagnom on [DATE]. Medical Directors were notified of IJ on [DATE] at 6:32 p.m (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER: Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE: 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	System Changes All residents with a tracheostomy or ventilator were assessed on [DATE] by Respiratory Therapists. No issues noted during assessment. Residents were assessed for trach patency/placement, adequate oxygenation/ventilation, s/sx of respiratory distress, s/sx of anxiety. Assessment documented on Vent/Trach Resident Assessment (paper form.) All residents with tracheostomy or ventilator will have their care plan reviewed/revised by the MDS Coordinator to ensure that all interventions related to tracheostomy/ventilator status remain adequate and appropriate. Care plan review to be completed by 12pm on [DATE]. Charge Nurse will assess all residents with tracheostomy or ventilator for anxiety at least once per shift and document on the Treatment Administration Record, beginning on [DATE]. If s/sx of anxiety exist, Charge Nurse is to intervene appropriately, non-pharmacologically or pharmacologically. Respiratory Therapist will assess all residents with tracheostomy or ventilator for anxiety, prior to nebulizer treatments and document on the Treatment Administration Record, beginning on [DATE]. If s/sx of anxiety exist, Respiratory Therapist is to notify the Charge Nurse for appropriate intervention. Vents and Alarms are checked by Respiratory Therapist every 4hrs and documented on the Respiratory Treatment Administration Record. (Alarms to be checked are: breath rate, apnea rate, inspiratory pressure, high PEEP, low PEEP and disconnection.) Education Director of Nursing provided education to all staff on signs/symptoms of anxiety, and how to intervene appropriately. All staff present in the facility were educated on [DATE]. Staff not present for the education will receive education prior to their next shift. Director of Nursing provided education to nurses and Respiratory Therapists on monitoring for anxiety Q shift, and prior to administering nebulizer treatments. All nurses and Respiratory Therapists present in the facility were educated on [DATE]. Nurses and Respiratory Therapists not present for the education will receive education prior to their next shift. Director of Respiratory Therapy provided education to Respiratory Therapists on vent/alarm checks every 4hrs and to visualize tubing/connections when they are in the room. All Respiratory Therapists present in the facility were educated on [DATE]. Respiratory Therapists not present for the education will receive education prior to their next shift. Director of Respiratory Therapy provided education to Respiratory Therapists on what alarms to check during the vent/alarm checks. Alarms to be checked are: breath rate, apnea rate, inspiratory pressure, high PEEP, low PEEP and disconnection. All Respiratory Therapists present in the facility were educated on [DATE]. Respiratory Therapists not present for the education will receive education prior to their next shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675846	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/14/2025
NAME OF PROVIDER OR SUPPLIER Summit Nursing & Rehab of San Augustine		STREET ADDRESS, CITY, STATE, ZIP CODE 902 E Main St San Augustine, TX 75972	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Director of Respiratory Therapy provided education to nursing staff on notifying Respiratory Therapist immediately if they hear an alarm or see any issues with vent or tubing. All nursing staff present in the facility were educated on [DATE]. Nursing staff not present for the education will receive education prior to their next shift. Monitoring DON or designee to monitor completion of Anxiety Assessment by Nurses and Respiratory Therapists 5x/week X 4 weeks, then refer to QAPI committee for efficacy of plan and revision of monitoring frequency. On [DATE] the surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by: Verified 9 other residents were in the facility that required mechanical ventilation and 4 that required trach care with supplemental oxygen therapy. Record review of care plans for all 13 residents with tracheostomy or ventilator indicated their care plan was reviewed/revised by the MDS Coordinator to ensure that all interventions related to tracheostomy/ventilator status remain adequate and appropriate. Record review of all 13 residents' orders indicated interventions for Charge Nurse will assess all residents with tracheostomy or ventilator for anxiety at least once per shift and document on the Treatment Administration Record, beginning on [DATE]. If s/sx of anxiety exist, Charge Nurse is to intervene appropriately, non-pharmacologically or pharmacologically. Record Review of all 13 residents' orders indicated Respiratory Therapist will assess all residents with tracheostomy or ventilator for anxiety, prior to nebulizer treatments and document on the Treatment Administration Record, beginning on [DATE]. If s/sx of anxiety exist, Respiratory Therapist is to notify the Charge Nurse for appropriate intervention. Record Review of all 13 residents' orders indicated Vents and Alarms are checked by Respiratory Therapist every 4hrs and documented on the Respiratory Treatment Administration Record. (Alarms to be checked are breath rate, apnea rate, inspiratory pressure, high PEEP, low PEEP and disconnection.) Record review of Inservice/education sign in sheets dated [DATE] indicated the Director of Nursing provided education to 44 staff on signs/symptoms of anxiety, and how to intervene appropriately. Staff not present for the education will receive education prior to their next shift. Record review of Inservice/education sign in sheets dated [DATE] indicated the Director of Nursing provided education to nurses and Respiratory Therapists on monitoring for anxiety every shift, and prior to administering nebulizer treatments. All nurses and Respiratory Therapists present in the facility were educated on [DATE]. Nurses and Respiratory Therapists not present for the education will receive education prior to their next shift. Record review of Inservice/education sheets dated [DATE] ind [TRUNCATED]