STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676184	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Park Rehabilitation and Skilled Nursing	5505 New Copeland Rd Tyler, TX 75703

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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who need respiratory care are provided with such care, consistent with professional standards of practices for 1 of 9 residents (Resident #1) reviewed for respiratory care.The facility failed to ensure Resident #1, whom had a history of respiratory distress, received continuous oxygen as ordered by his physician. These failures resulted in the identification of an Immediate Jeopardy (IJ) on [DATE] at 12:08 PM. While the IJ was removed on [DATE] at 12:37 PM, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.These failures could place residents who receive respiratory care at risk of developing respiratory complications and death. Findings included:Record review of Resident #1's face sheet, dated [DATE] revealed an [AGE] year old male admitted on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease (a common lung disease that makes it difficult to breathe), Acute on chronic diastolic (congestive) heart failure (a chronic condition where the heart can't pump blood efficiently, leading to fluid buildup and symptoms like shortness of breath and swelling), Acute and chronic respiratory failure with hypoxia (a medical emergency where a patient with an existing chronic breathing problem experiences a sudden and severe drop in blood oxygen levels), Acute respiratory failure with hypoxia (a sudden and life-threatening condition where the lungs can't get enough oxygen into the blood), and Shortness of breath (the uncomfortable feeling of not being able to get enough air.)Record review of Resident #1's quarterly MDS assessment, dated [DATE], revealed Resident #1 had a BIMS of 12, which indicated mild cognitive impairment. The MDS also indicated Resident #1 required oxygen therapy, had shortness of breath when lying flat, had respiratory failure, was in a wheelchair and dependent for transfers. Record review of Resident #1's Care Plan dated [DATE] revealed that Resident #1 had a problem initiated on [DATE] CHF: Potential for shortness of breath, chest pains, edema, high blood pressure due to history of CHF, Problem initiated on [DATE] COPD: At risk for shortness of breath, impaired breathing pattern secondary to COPD. Will maintain oxygen saturation > 91% per MD order Monitor for episodes of shortness of breath and implement interventions as ordered, notify MD if ineffective and follow up and indicated. Provide reassurance and support to prevent anxiety during episode of shortness of breath. Provide rest periods as needed. Problem initiated on [DATE] Resident needs XXL sling with two plus person support due to residents' inability to bear weight on two legs. Will be moved in and out of bed mechanically without injury Provide total assistance with bed mobility Problem initiated on [DATE] SOB: Has shortness of breath while lying flat. Problem initiated on [DATE] Oxygen therapy related to CHF Will have no complications related to oxygen therapy Observe for shortness of breath, cyanosis (bluish discoloration of the skin and mucous membranes due to a low level of oxygen in the blood, caused by a high concentration of deoxygenated hemoglobin), anxiety. Report abnormal findings to MD with follow up as needed. Record review of a physician order for Resident #1, dated [DATE], indicated 02 at 3LPM by NC Acute and chronic respiratory failure with hypoxia . Record review of hospital visit for Resident #1 dated [DATE] revealed that Resident #1 presented to the emergency room at 2:54 p.m. with cardiac arrest. 2:55 p.m. Bicarb was given.2:57 p.m. Pulse check. Cardiac standstill on US. Asystole (absence of ventricular contractions in the context of a lethal heart arrhythmia). CPR continued.2:59 p.m. [NAME] Check. Cardiac standstill. Asystole. (absence of ventricular contractions in the context of a lethal heart arrhythmia)2:59 p.m. Time of death called. During an interview on [DATE] at 9:29 a.m., with Resident #1's Family Member she said she had video from a camera that was in Resident #1's room. The video showed that on [DATE] at about 2:08 p.m. two aides, whom she did not know their names, had transferred Resident #1 from his wheelchair to his bed. She said the female CNA took off Resident #1's oxygen and started a hoyer transfer. She said that it took the female and male CNA several minutes to transfer him to his bed and the entire time he was without oxygen. She said that it was obvious that they did not know what they were doing as they struggled to get him into position over his bed. She said she heard Resident #1 saying, Hurry Hurry and I need oxygen Give me oxygen. She said she heard the female CNA say, We have to hurry he is turning blue. She said after they finally got him laid down to bed Resident #1 didn't say anything anymore. She said the female CNA said, Oh my God as she ran out of the room. She said the male CNA had placed the oxygen back on to Resident #1 by this point it was already too late they had already done the damage. She said the nurses entered the room, call 911, and are listening to his chest