STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676297	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rio at Mission Trails	6211 S New Braunfels Ave San Antonio, TX 78223

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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 34957 Based on observation, interview, and record review, the facility failed to ensure each resident was free from neglect for 1 of 5 Residents (Residents #1) reviewed for neglect. During a capping trial on [DATE], Resident #1 was not monitored, and no staff were physically present in her room. Resident #1 became unresponsive and had to be transported to the ER for treatment. The facility did not have a policy/procedure in place for capping trials at the time of the incident. Resident #1 died at the hospital on [DATE]. This failure resulted in an IJ on [DATE] at 5:00 PM. While the IJ was removed on [DATE] at 3:45 PM., the facility remained out of compliance at a level of no actual harm with potential for more than minimal harm that was not immediate jeopardy with a scope of isolated due to facility's need to evaluate the effectiveness of their plan of removal. This failure could place tracheostomy residents recommended for a capping trail at risk for exacerbation of condition up to and including death. The findings included: Resident #1's face sheet, undated, revealed the resident was a [AGE] year-old admitted on [DATE], readmitted [DATE], transferred to hospital [DATE], and deceased [DATE]. Diagnoses included: stroke, cerebral aneurism (blood vessel weakness in the brain), diabetes, DVT (deep vein thrombosis) (blood clots in deep vein), HTN (hypertension), quadriplegic, and seizures. Further review revealed the resident's RP was listed as a family member, and the resident's Code Status was Full Code. Record review of Resident#1's admission note, dated [DATE] and [DATE], reflected the resident was admitted to the facility with a tracheostomy on both occasions. Record review of Resident #1's admissions MDS, dated [DATE], reflected the resident was unable to answer questions in cognition, and had upper and lower extremity impairments due to a diagnosis of stroke. Record review of Resident #1's Care Plan, dated [DATE], reflected: resident had a tracheostomy related to respiratory failure. Interventions included tracheostomy care Q shift and Capping trials 30 mins_1 hour BID as tolerated . Monitor respiratory rate, depth and quality . (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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NAME OF PROVIDER OR SUPPLIER: The Rio at Mission Trails		STREET ADDRESS, CITY, STATE, ZIP CODE: 6211 S New Braunfels Ave San Antonio, TX 78223	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's physician's order, dated ,d+[DATE], reflected orders to administer capping trials for 30 minutes up to 1 hour twice per day on the day shift starting [DATE] and ending [DATE]; and use of nasal cannula at 3L/ minute during capping trials. Record review of Resident #1's Pulmonologist note, dated [DATE] at 11:30 AM, reflected, resident tolerated the second capping trial on [DATE] well and was on a T piece for oxygen. Record review of Resident #1's RT note, dated [DATE] at 11:36 AM authored by RT A, reflected: the resident was placed on a red cap trial with a heart rate of 84 and an oxygen saturation of 97%; and the resident was noted not to be in distress. Record review of Resident #1's RT note, dated [DATE] at 11:59 AM authored by RT A, reflected: RT A checked on the resident at 11:59 AM and the resident's oxygen saturation was at 97 % and heart rated at 84. Resident received 3 L/minute of O2 from nasal cannula. Record review of Resident #1's RT note dated [DATE] at 12:38 PM authored by RT A, reflected: resident was found unresponsive with no pulse felt. CPR was started by the RT A and a Nurse (name not documented) and EMS called and Resident #1 was transferred to the ER. Record review of Resident#1's capping sheet for capping trial #1 ([DATE]) and capping trial # 2 ([DATE]) reflected vitals were normal and the first capping lapse time was 30 minutes; and the second capping #2 time was recorded as 30 minutes. The trach and capping trial sheet reflected that the resident's [RP] was present at bedside. The third capping on [DATE] started at 11:36 AM for one hour of capping and the sheet reflected that RT A saw the resident at 11:59 AM; stop time was not recorded. Record review of Resident #1's Code Blue Record, dated [DATE] at 12:44 PM, reflected the code was initiated at 12:38 PM. The Code Blue Record read: History of Code: RT [A] noted Resident unresponsive and no pulse .Pulse detected @ 62 BPM after 2 rounds. EMS arrived and transported resident to [local ER] . Record review of Resident #1's EMS Run Report, dated [DATE] at 12:41 PM (Incident # 0209529) , read: . According to staff she was last [seen] with a pulse 39 mins prior and no shocks were delivered .After a round of epi, bicarb and calcium [heart medications] was delivered .Pulses were confirmed at a ratee of 60 .En route the pulse was lost .and one more dose of epi (heart medication) was applied . Resident #1's ER report, dated [DATE], revealed, admitted for cardiac arrest; history of trach. The ER report read, She is a nursing home resident with approximately 30 minutes of unresponsiveness prior to EMS arrival. She did require CPR with ROSC (return of spontaneous circulation) obtained in the ER [another heart attack in the ER] . remains unresponsive. Record review of Resident #1's Hospital initial assessment note read: OOH (out of hospital) arrest ,d+[DATE] .ABI (brain injury); mri (scan) anoxic ischemia [tissue dead due to lack of O2] .C diff colitis .[history of brain bleed [DATE]] .AKI (acute kidney injury), likely secondary to hypoperfusion during arrest (lack of blood flow) . chronic respiratory failure s/p (status post) trach .HTN (hypertension) .DM (diabetes). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:14 PM, the DON stated on [DATE] the family came in to speak to the administrator and alleged the resident [Resident #1] was deceased and needed to pick up her belongings. The DON stated, the family felt that the death was suspicious. The DON stated, the administrator informed her that he would make a self-report to HHS of a suspicious death. The DON stated that the resident coded on [DATE] and was resuscitated and sent to the ER for further evaluation. The DON stated the administrator contacted the family on [DATE] and was informed the resident was still alive. The DON stated the resident had a history of pleural infusion (issues with excess fluid in the lungs), HTN, and history of CVA; and chronic stage 3 kidney disease. The DON stated, the resident was on a trach because the resident had respiratory failure after her stroke at home, prior to admissions. The resident arrived at admissions with a trach and a ventilator. The DON stated the resident was weaned off the ventilator around [DATE]. The DON stated the resident was kept on the trach for respiratory reasons. The DON stated an in-service was initiated on ANE on [DATE] was still on-going on [DATE]. The DON stated that there were 18 residents with a trach in the respiratory hall (Hall 400). During a telephone interview on [DATE] at 1:18 PM, the Medical Examiner stated the cause of death involving Resident #1 was still under investigation. During an interview on [DATE] at 3:50 PM, The DON stated no staff was present for Resident #1's initial capping trials for 100% of the time. The DON stated there was no requirement for staff to be present during trach capping trials; and Resident #1 did not start a trial until a full evaluation by the Pulmonologist. The DON stated the capping trials did not contribute to the cardiac arrest. The DON stated the initial trials were done daily, one trial per day; the first and second trials started [DATE] in AM shift (12 AM-12 PM) and no staff were physically present during the trial time span of the first and second trials. The DON stated on the third trial on [DATE] started at 11:36 AM the RT discovered resident unresponsive at 12:30 PM. The DON stated that the resident breathing was assessed at 11:59 PM; O2 was at 97 % (normal) and pulse was at 84 (normal). The DON stated based on the timeline the RT [A] entered at 12:38 PM and found the resident unresponsive; with no pulse and code was called. The DON stated there was no policy on capping trials except to follow physician orders. The DON stated the physician's orders did not specify that a staff member had to be present during the time resident was breathing independently. The DON stated no one was required to be present during the time of monitoring. The DON stated the resident's co-morbidities caused the cardiac arrest during the third capping trial. The DON stated the Pulmonologist was working with Resident #1 and felt it was safe to initiate capping trials. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview [DATE] at 9:21 AM, RT Director stated, Resident #1 was doing well after the removal of the ventilator. Resident had hemoglobin issues; needed transfusions. The RT Director stated Resident #1 was stable and capping trials started; [DATE] for two trials. The RT Director stated on the third trial an oximeter [non-audible] placed on Resident #1. The RT Director stated, the oximeter would not alert or alarm if the resident had a cardiac rest. The RT Director stated, at the time of the third trial there was no system in place to monitor the heart rate. The RT Director stated the trial started, and the RT specialist [RT A] checked on the resident within a time frame of 30 minutes. The RT Director stated the resident had underlying issues that included HTN, stroke, anemia, and kidney issues. The RT Director there was no one physically present for one-on-one monitoring during any trial for Resident #1. The RT Director stated existing policy only called for spot checks and no documentation was required for the spot checks. The RT Director did not provide a response as to whether a resident like Resident #1 with co-morbidities needed a physical presence when cap trials were done. The RT Director stated in-service training for the RT staff was started on [DATE] [at time of surveyor's entrance] on trach care and capping procedures. The RT Director stated Resident #1 could not uncap on her own. The RT Director stated that the facility did not have a written policy on capping because capping was based on clinical standards. During a telephone interview on [DATE] at 9:54 AM, RT A stated she was the RT for the 3rd capping trial for Resident #1. RT A stated before the trail started, she checked Resident #1's O2 sats, trach care, breathing treatment, and mental status. RT A stated, she placed an oximeter [non audible] on the resident that read for saturation and heart rate. RT A stated that the oximeter would not alarm if the resident had a cardiac arrest. RT A stated that the resident had previous underlying issues. RT A stated Resident #1's the third capping trial started at 11:16 AM and she returned at 11:59 AM to check on the resident and the resident was not in distress. RT A stated she returned at 12:36 PM and the resident was unresponsive; the resident was pale, not responding to sternal rubbing and calling her name; then the RT called for help; CPR started at 12:38 PM, EMS arrived, and the resident was resuscitated. The RT stated. I did not stay with the resident because she had no previous issues with capping. RT A stated she did not stay with Resident #1 because she had to attend to other residents. Interview on [DATE] at 12:05 PM with the Medical Director revealed Resident #1 suffered a cardiac arrest during the third capping trial on [DATE]. During interview on [DATE] at 1:25 PM with the Pulmonologist stated Resident #1 was a suitable candidate for capping trials because the resident was off the ventilator and had no congestion. The Pulmonologist stated observation during capping only required the RT to view the resident for a few minutes. The Pulmonologist said the RT could leave after the resident was not in distress and return later for further assessment of independent breathing. The Pulmonologist stated the facility had no equipment for monitoring present in Resident #1's room when the capping trial was conducted. The Pulmonologist stated Resident #1's cardiac arrest could not have been predicted, but no alert system or monitoring equipment were present to alert RT staff who were not physically present in the room when Resident #1 coded. During an interview on [DATE] at 4:04 PM, LVN B stated on [DATE] she saw Resident #1 at 12:10 PM and the resident was not in distress. LVN B stated she saw a red cap on the resident's trach and the resident was breathing with the nasal canula receiving ,d+[DATE] liters/ minute. LVN B stated, the resident looked normal. LVN B stated she did not document the observation of Resident #1 during the initial capping trial. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During telephone interview on [DATE] at 10:50 AM, RT G stated he initiated the first capping trial for Resident #1 on [DATE] for 30 minutes and remained with the resident 100% of the time. RT G stated the resident tolerated the 30 minutes of capping and revealed no signs of distress. RT G stated he was not aware of any facility policy on capping. RT G stated his policy was to remain with the resident throughout the trail to ensure the resident did not suffer any distress. During telephone interview on [DATE] at 11:00 AM, RT C stated she initiated capping trial for Resident #1 on [DATE] at 1:30 PM and the resident's RP was present. RT C stated she remained the entire time with the resident and the RP during the trial scheduled for 30 minutes. RT C recalled the second capping trial was halted between ,d+[DATE] minutes because the resident became exhausted. RT C stated she was not aware of any facility policy on capping. Record review of Resident #1's Trach Capping Flow Sheet dated [DATE] read: .Resident coughed. RT [RT C] had resident complete alphabet then ended trial. [family member] of resident @ bedside . During telephone interview on [DATE] at 4:35 PM, the family member stated the family member and the [RP] at admission were told by the RT Director that a staff member would be physically present when capping trials were attempted. The family member stated at a second meeting before the capping trials started the RT Director again assured the family that a staff member would be present all the time during the initial capping trials. The family member stated the family told the RT Director that the family was concerned about the resident's condition and her inability to communicate during an emergency. During telephone interview on [DATE] at 5:02 PM, Resident #1's RP stated he recalled when Resident #1 was admitted to the facility the Rehab Director assured him and the family that during the initial capping trials that staff would be present all the time. The RP stated that at a second CP meeting, unknown date, the RT Director was present and assured the family that staff would be present all the time during the initial capping trials. The RP stated he was happy about the staff being present during the initial capping trial because the resident could not pull the call light and could not cry out for help. The RP stated he was physically present with the [RT C] all the time on the second capping trial. The RP recalled he repeated the alphabet to the capped resident, and she was able to mimic some sounds. The RP stated the second capping trial lasted about ,d+[DATE] minutes and it was scheduled for 30 minutes. The RP stated he was not sure why the second capping trial did not last for 30 minutes. The RP stated that he was not invited to the third capping trial on [DATE]. Resident #1's RP stated, if I had known that [the resident] was going to be left alone, I would not allow the third trial. The RP stated his expectation was for staff to be physically present 100% of the time during the third capping trial and not just spot checking and monitoring. The RP stated he saw Resident #1 on [DATE] and she was alert and smiling. The RP stated he visited Resident #1 regularly for the past seven months. The RP stated that she (Resident #1) was left by herself [[DATE]] .I was assured that staff would be present all the time . During an interview on [DATE] at 9:18 AM, the ICU RN D stated the hospital clinical notes authored by MD E for Resident #1's record reflected the resident was admitted to ICU on [DATE] with no vasopressors (medications used to raise blood pressure in the emergency room) and intubated and placed on a ventilator. RN D stated the resident was anoxic per the MD note (without oxygen in the brain) and coded. RN D stated with family's approval resident was made an in hospital DNR. RN D stated, the resident deceased on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During second interview on [DATE] at 1:12 PM, the Pulmonologist stated Resident #1 was a suitable candidate for capping trials. The Pulmonologist stated her expectation was at the first capping trail staff needed to be present the entire time of the capping; on the second trial of capping the family was present the entire time. The Pulmonologist stated given that Resident #1 experienced a cardiac arrest on the third trial, Yes staff should have been present all the time. The Pulmonologist stated Yes the facility needed a policy on capping. During an interview on [DATE] at 1:17 PM, RT F stated she was trained on capping procedures in school and had been an RT for five years. RT F stated capping trials were dependent on the resident's condition and being off the ventilator. RT F stated the initial trials ranged from ,d+[DATE] minutes. RT F stated monitoring involved checking on the resident and it could be continuous or sporadic for the initial trials. RT F stated on the first capping it required 100% presence of staff in the room; trial 2 and 3 were dependent on how well the resident did in trial one. RT F stated there was no policy or protocol on capping, and one should be present for resident safety. During an interview an interview on [DATE] at 1:50 PM, the Administrator stated he met with Resident #1's family on [DATE] and was informed by the family that the resident was deceased . The Administrator stated that standards of care dictated the initial capping trials for Resident #1. The Administrator stated the facility's investigation of the incident on [DATE] was still in progress. During an interview on [DATE] at 1:55 PM, the RT Director denied he ever made a commitment to Resident #1's family and RP that staff would be present during the entire time of the capping trials. The RT Director stated at admissions the family and RP were informed they had an open invitation to attend capping trials. The RT Director stated there was no requirement that he call the RP to initiate a capping trial. During interview on [DATE] at 2:30 PM, the DON stated the timeline was as follows: 11:30 AM - Pulmonologist assessed the resident and no contra indications against the third capping trial on [DATE]. 11:36 AM - RT [A] capped the resident. 11:59 AM - RT [A] re-assessed the resident. 12:15 PM - LVN [B] made rounds and observed the resident. The resident was not in distress. 12:38 PM - RT [A] found the resident unresponsive; code called, and CPR started. 12:41 PM - EMS arrived. 12:44 PM - EMS transported resident to ER. In an interview and observation on [DATE] at 11:34 AM, RT C revealed a battery-operated audible pulse oximeter was kept on the Respiratory Therapist cart and the facility had this audible pulse oximeter for about three months. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] from 11:14 AM to 11:35 AM, the Respiratory Therapy Director stated he provided the in-service training to the RTs of the revised capping trial policy either in person or via phone or text message. The Respiratory Therapy Director stated the facility has had the plug-in audible pulse oximeter for about a week or two. Record review of facility's policy titled Tracheostomy Care Procedures dated [DATE] revealed Tracheostomy care will be performed per physician's orders. Record review of facility's policy titled Capping Trial for Tracheostomy Patients dated Revised 2023 [from an unknown author and not signed by the Facility's QAPI leadership team] was presented to the Surveyor on [DATE] at 4:45 PM while template vetting discussion was in progress. Record review of the facility's policy titled Abuse/Neglect, dated revised [DATE], read: .Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Record review of facility's in-service on the topic of Notify MD of any Respiratory Change of condition and Follow Physician's Orders was started on [DATE] [day of the surveyor's entrance]. Of 16 RT employees 13 RTs had attended the training for a completion rate of 81%. On the topic of Monitoring During Capping Trials started [DATE], 13 RTs had attended the training for a completion rate of 81%. The Capping training read: RT will monitor and perform O2 saturation checks and pulse checks at least every 30 minutes during capping trials. The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 5:00 PM and were provided with the Immediate Jeopardy Template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Plan of Removal was accepted on 10:03 a.m. on [DATE] and reflected the following: February 21, 2025 [Facility] Re: F600 NEGLECT Interventions: On [DATE] All medical records of residents with a trach were audited by the DON/ADON/RT supervisor to ensure that an order for capping trails was followed as ordered by the physician. The audit completed on [DATE] revealed no current residents are being trialed on capping of tracheostomies. On [DATE] Procedure for capping trials was developed and implemented. On [DATE] all Respiratory Therapist were/will be in-serviced by the DON, RT supervisor regarding: o Following physician orders will include monitoring to be documented by the respiratory therapist. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o The respiratory therapist will remain at bedside to assess the resident for 10 minutes at the beginning of the capping trial and document assessment to include pulse, oxygen saturation, respiration and lung sounds o Respiratory Therapist will remain on the unit while capping trial is being conducted until determined by physician monitoring is no longer required o Use of an audible pulse oximeter during capping trial time will be indicated in the physician orders for monitoring purposes based on resident individual needs. o The audible pulse oximeter will be audible from other rooms on the unit. o Respiratory Therapist will respond to audible pulse oximeter alarm and assess resident needs if indicated. o Nursing staff will be in-serviced on [DATE] to the capping trial process and available to respiratory therapist if any change of condition occurs by the DON/designee. o Respiratory Therapist will monitor the resident every 30min during capping trail for any change of condition. o Monitoring of tracheotomy capping trial residents will be done by Respiratory Therapist o Monitoring oxygen saturation, respirations and pulse during capping trails o Notifying the physician and family of any change in condition during capping trials. On [DATE] all facility staff were in serviced by the DON, ADON/designee related to Abuse and Neglect. All new hired Respiratory Therapist and nurses as well as any agency therapist/nurses that maybe utilized will receive the in-services upon hire. Any respiratory therapist and nurse that has not received the in-services will complete prior to start of shift. The DON and Respiratory Therapist will ensure that all respiratory therapist and nurses receive in-services, and the Administrator will validate completion of in-services. Monitoring: At least 5 times per week for 4 weeks then 2 times a week for 4 weeks then as needed as capping trials orders occur, orders will be reviewed by the DON/designee to ensure that capping trial orders are complete. The DON / RT supervisor will interview at least 3 Respiratory Therapist per week for 4 weeks then 2 times a week for 4 weeks and questions will include: (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o How frequently do you monitor residents on capping trials? o What vitals are to be monitored during capping trials? o When do you notify the physician and family? o For capping trials whose orders are to be followed? The DON/ADON/RT supervisor will review resident's records (vital signs, progress notes) of capping trials at least 5 times per week for 4weeks then 2 times a week for 2 weeks then as needed to monitor the residents for any changes of condition during the capping trial. And ensure that the physician/family was notified of resident changes in condition. The administrator will monitor and review the findings of the DON/ADON/RT supervisor during morning and stand down meeting at least 5 times per week for 4weeks then 2 times a week for 2 weeks then as needed. Findings will be reviewed by the QAPI committee and changes will be made as needed. Verification of Plan of Removal: In an interview on [DATE] at 11:09 AM, the DON stated there were no residents who were on a ventilator who had an order for capping trials. In an interview on [DATE] at 11:09 AM, the DON stated they had revised their policy on capping trial for residents on a ventilator and provided a copy of the newly revised policy. In an observation and interview on [DATE] at 11:34 AM, RT C revealed a battery-operated audible pulse oximeter was kept on the Respiratory Therapist cart and RT C stated the facility had this audible pulse oximeter for about three months. In an interview and observation at [DATE] at 11:38 AM, the RT Director stated the facility has a continuous audible pulse oximeter that could be plugged in. The Administrator brought the plug-in audible pulse oximeter and took it into a room nearby where the Surveyor H was standing, and the surveyor was able to hear from the hallway the alarm sound from the plug-in audible pulse oximeter. Interviews on [DATE] from 11:24 AM to 5:00 PM and on [DATE] from 8:28 AM to 10:00 AM with 5 Respiratory Therapist (4 worked day shift [6 AM-6 PM], and 1 worked night shift [6 PM - 6 AM]), and 7 LVNs (6 worked day shift, and 1 worked night shift), and 1 RN who worked the night shift revealed they had been in-serviced on the best practice of following the physician orders, the RTs will notify the physician if orders need clarification, clarified orders would be put into the resident's clinical record, the physician would be notified of any change of condition in the resident's respiratory status and any new orders received would be implemented; and the Rt would monitor and perform pulse oximeter blood oxygen saturation checks at least every 30 minutes during capping trials. Also, Interviews on [DATE] from 11:24 AM to 5:00 PM and on [DATE] from 8:28 AM to 11:00 AM with 5 Respiratory Therapist (4 worked day shift [6 AM-6 PM], and 1 worked night shift [6 PM - 6 AM]), 7 LVNs (6 worked day shift, and 1 worked night shift), 1 RN (who worked the night shift), 3 CNAs (who worked day shift), 2 housekeepers, 1 Cook, 2 Dietary Aides and the FSS (Food Service Supervisor) revealed they had been in-serviced on abuse and neglect. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Rio at Mission Trails		STREET ADDRESS, CITY, STATE, ZIP CODE 6211 S New Braunfels Ave San Antonio, TX 78223	

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Medical Director on [DATE] from 4:38 PM to 4:43 PM revealed he attended the Ad hoc (un-planned) QAPI (Quality Assurance/Performance Improvement) meeting by phone that was held with the DON, Administrator and Respiratory Therapy Director; and the POR (plan of removal) for capping trials on residents was discussed. In an interview on [DATE] from 11:14 AM to 11:35 AM, the Respiratory Therapy Director stated he provided the in-service training to the RTs of the revised capping trial policy either in person or via phone or text message. The Respiratory Therapy Director stated the facility has had the plug-in audible pulse oximeter for about a week or two. The Respiratory Therapy Director stated the residents who had ventilators orders were reviewed and there were no residents who had orders for capping trials. The Respiratory Therapy Director stated the policy for Capping Trial was revised to include the use of an audible continuous pulse oximeter, to be with the resident the first 10 minutes of the trial and to check on the resident every 20 minutes after that. Further, the Respiratory Therapy Director stated he would train the new RT staff using a mannequin on how the capping trial process would be done in the facility before they started to work on the floor. The Respiratory Therapy Director stated he attended the Ad hoc QAPI meeting with the DON, Administrator, and the Medical Director to discuss the facility's POR plan. Lastly, the Respiratory Therapy Director stated he would be randomly interviewing three RTs the questions on the monitoring form each week. In an interview on [DATE] from 11:42 AM to 11:58 AM, the DON stated the facility made a video for the nurses to watch of what the Capping Trial policy involved, and it showed the Respiratory Therapy Director doing a capping trial on a mannequin so the nurses would know what was involved and what their role was during the capping trial. [Surveyor H observed portions of the video] The DON stated the training video was sent to the nurses and then they came in and signed the in-service training sheet. The DON stated she had reviewed the orders of residents who had a tracheostomy and were on a vent and there were no residents with an order for capping trial. The DON stated the facility revised their old policy on Capping Trials and added an audible pulse oximeter, which would alarm if the resident had a change in their condition, would be used during the capping trial to the policy and added the RT would stay with the resident for the first 10 minutes of the trial. Also, the DON stated staff were provided a copy of the abuse policy and were informed of the types of abuse, who the abuse coordinator was, and how to find the abuse coordinators phone number. Further, the DON stated newly hired nurses would be shown the video they made of the facility's capping trial procedure during their orientation before they started to work on the floor. The DON stated she had ensured all the nurses had received the training by having the nurses come into the facility to verify they had received the training. Moreover, the DON stated weekly audits would be done, she would review the resident's orders daily for any new orders for capping trials and it would be discussed in the morning meetings. The DON stated she and the RT director would be interviewing three RTs per week to make sure they were aware of the revised capping trial process. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] from 12:04 PM to 12:16 PM, the Administrator stated the DON in-serviced the nurses on the facility's revised Capping Trial policy and the Respiratory Therapy Director in-serviced the RTs on the revised policy. The Administrator stated an audit of residents' charts was done which revealed there were no residents in the facility who were on capping trials. The Administrator stated the facility's policy for Capping Trials was revised to include the use of an audible pulse oximeter during the capping trial. Also, the Administrator stated the facility had a group abuse training that was presented by the DON on [DATE] for staff present in the facility and other staff came into the facility and signed the in-service sheet after they had reviewed the abuse policy. In addition, the Administrator stated the newly hired nurses and RTs would have the revised Capping Trial policy reviewed with them before they started to provide care to residents. The Administrator stated he made sure all the nurses and RTs had received the in-service training on the revised policy when he reviewed the in-service signature page. The Administrator stated an Ad Hoc QAPI meeting was held with the Medical Director, DON, RT Director, and the ADON and the facility's plan to remove the immediacy was reviewed. The Administrator stated results of the facility's monitoring with use of the monitoring tools they developed of the POR would be reviewed at the monthly QAPI meetings. Lastly, the Administrator stated he would use the monit[TRUNCATED]

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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** 34957 Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 5 Residents (Residents #1) reviewed for respiratory care. During a capping trial on [DATE], Resident #1 was not monitored, and no staff were physically present in her room. Resident #1 became unresponsive and had to be transported to the ER for treatment. The facility did not have a policy/procedure in place for capping trials at the time of the incident. Resident #1 died at the hospital on [DATE]. This failure resulted in an IJ on [DATE] at 5:00 PM. While the IJ was removed on [DATE] at 3:45 PM., the facility remained out of compliance at a level of no actual harm with potential for more than minimal harm that was not immediate jeopardy with a scope of isolated due to facility's need to evaluate the effectiveness of their plan of removal. This failure could place tracheostomy residents recommended for a capping trail at risk for exacerbation of condition up to and including death. The findings included: Resident #1's face sheet, undated, revealed the resident was a [AGE] year-old admitted on [DATE], readmitted [DATE], transferred to hospital [DATE], and deceased [DATE]. Diagnoses included: stroke, cerebral aneurism (blood vessel weakness in the brain), diabetes, DVT (deep vein thrombosis) (blood clots in deep vein), HTN (hypertension), quadriplegic, and seizures. Further review revealed the resident's RP was listed as a family member, and the resident's Code Status was Full Code. Record review of Resident#1's admission note, dated [DATE] and [DATE], reflected the resident was admitted to the facility with a tracheostomy on both occasions. Record review of Resident #1's admissions MDS, dated [DATE], reflected the resident was unable to answer questions in cognition, and had upper and lower extremity impairments due to a diagnosis of stroke. Record review of Resident #1's Care Plan, dated [DATE], reflected: resident had a tracheostomy related to respiratory failure. Interventions included tracheostomy care Q shift and Capping trials 30 mins_1 hour BID as tolerated . Monitor respiratory rate, depth and quality . Record review of Resident #1's physician's order, dated ,d+[DATE], reflected orders to administer capping trials for 30 minutes up to 1 hour twice per day on the day shift starting [DATE] and ending [DATE]; and use of nasal cannula at 3L/ minute during capping trials. Record review of Resident #1's Pulmonologist note, dated [DATE] at 11:30 AM, reflected, resident tolerated the second capping trial on [DATE] well and was on a T piece for oxygen. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's RT note, dated [DATE] at 11:36 AM authored by RT A, reflected: the resident was placed on a red cap trial with a heart rate of 84 and an oxygen saturation of 97%; and the resident was noted not to be in distress. Record review of Resident #1's RT note, dated [DATE] at 11:59 AM authored by RT A, reflected: RT A checked on the resident at 11:59 AM and the resident's oxygen saturation was at 97 % and heart rated at 84. Resident received 3 L/minute of O2 from nasal cannula. Record review of Resident #1's RT note dated [DATE] at 12:38 PM authored by RT A, reflected: resident was found unresponsive with no pulse felt. CPR was started by the RT A and a Nurse (name not documented) and EMS called and Resident #1 was transferred to the ER. Record review of Resident#1's capping sheet for capping trial #1 ([DATE]) and capping trial # 2 ([DATE]) reflected vitals were normal and the first capping lapse time was 30 minutes; and the second capping #2 time was recorded as 30 minutes. The trach and capping trial sheet reflected that the resident's [RP] was present at bedside. The third capping on [DATE] started at 11:36 AM for one hour of capping and the sheet reflected that RT A saw the resident at 11:59 AM; stop time was not recorded. Record review of Resident #1's Code Blue Record, dated [DATE] at 12:44 PM, reflected the code was initiated at 12:38 PM. The Code Blue Record read: History of Code: RT [A] noted Resident unresponsive and no pulse .Pulse detected @ 62 BPM after 2 rounds. EMS arrived and transported resident to [local ER] . Record review of Resident #1's EMS Run Report, dated [DATE] at 12:41 PM (Incident # 0209529) , read: . According to staff she was last [seen] with a pulse 39 mins prior and no shocks were delivered .After a round of epi, bicarb and calcium [heart medications] was delivered .Pulses were confirmed at a ratee of 60 .En route the pulse was lost .and one more dose of epi (heart medication) was applied . Resident #1's ER report, dated [DATE], revealed, admitted for cardiac arrest; history of trach. The ER report read, She is a nursing home resident with approximately 30 minutes of unresponsiveness prior to EMS arrival. She did require CPR with ROSC (return of spontaneous circulation) obtained in the ER [another heart attack in the ER] . remains unresponsive. Record review of Resident #1's Hospital initial assessment note read: OOH (out of hospital) arrest ,d+[DATE] .ABI (brain injury); mri (scan) anoxic ischemia [tissue dead due to lack of O2] .C diff colitis .[history of brain bleed [DATE]] .AKI (acute kidney injury), likely secondary to hypoperfusion during arrest (lack of blood flow) . chronic respiratory failure s/p (status post) trach .HTN (hypertension) .DM (diabetes). (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:14 PM, the DON stated on [DATE] the family came in to speak to the administrator and alleged the resident [Resident #1] was deceased and needed to pick up her belongings. The DON stated, the family felt that the death was suspicious. The DON stated, the administrator informed her that he would make a self-report to HHS of a suspicious death. The DON stated that the resident coded on [DATE] and was resuscitated and sent to the ER for further evaluation. The DON stated the administrator contacted the family on [DATE] and was informed the resident was still alive. The DON stated the resident had a history of pleural infusion (issues with excess fluid in the lungs), HTN, and history of CVA; and chronic stage 3 kidney disease. The DON stated, the resident was on a trach because the resident had respiratory failure after her stroke at home, prior to admissions. The resident arrived at admissions with a trach and a ventilator. The DON stated the resident was weaned off the ventilator around [DATE]. The DON stated the resident was kept on the trach for respiratory reasons. The DON stated an in-service was initiated on ANE on [DATE] was still on-going on [DATE]. The DON stated that there were 18 residents with a trach in the respiratory hall (Hall 400). During a telephone interview on [DATE] at 1:18 PM, the Medical Examiner stated the cause of death involving Resident #1 was still under investigation. During an interview on [DATE] at 3:50 PM, The DON stated no staff was present for Resident #1's initial capping trials for 100% of the time. The DON stated there was no requirement for staff to be present during trach capping trials; and Resident #1 did not start a trial until a full evaluation by the Pulmonologist. The DON stated the capping trials did not contribute to the cardiac arrest. The DON stated the initial trials were done daily, one trial per day; the first and second trials started [DATE] in AM shift (12 AM-12 PM) and no staff were physically present during the trial time span of the first and second trials. The DON stated on the third trial on [DATE] started at 11:36 AM the RT discovered resident unresponsive at 12:30 PM. The DON stated that the resident breathing was assessed at 11:59 PM; O2 was at 97 % (normal) and pulse was at 84 (normal). The DON stated based on the timeline the RT [A] entered at 12:38 PM and found the resident unresponsive; with no pulse and code was called. The DON stated there was no policy on capping trials except to follow physician orders. The DON stated the physician's orders did not specify that a staff member had to be present during the time resident was breathing independently. The DON stated no one was required to be present during the time of monitoring. The DON stated the resident's co-morbidities caused the cardiac arrest during the third capping trial. The DON stated the Pulmonologist was working with Resident #1 and felt it was safe to initiate capping trials. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview [DATE] at 9:21 AM, RT Director stated, Resident #1 was doing well after the removal of the ventilator. Resident had hemoglobin issues; needed transfusions. The RT Director stated Resident #1 was stable and capping trials started; [DATE] for two trials. The RT Director stated on the third trial an oximeter [non-audible] placed on Resident #1. The RT Director stated, the oximeter would not alert or alarm if the resident had a cardiac rest. The RT Director stated, at the time of the third trial there was no system in place to monitor the heart rate. The RT Director stated the trial started, and the RT specialist [RT A] checked on the resident within a time frame of 30 minutes. The RT Director stated the resident had underlying issues that included HTN, stroke, anemia, and kidney issues. The RT Director there was no one physically present for one-on-one monitoring during any trial for Resident #1. The RT Director stated existing policy only called for spot checks and no documentation was required for the spot checks. The RT Director did not provide a response as to whether a resident like Resident #1 with co-morbidities needed a physical presence when cap trials were done. The RT Director stated in-service training for the RT staff was started on [DATE] [at time of surveyor's entrance] on trach care and capping procedures. The RT Director stated Resident #1 could not uncap on her own. The RT Director stated that the facility did not have a written policy on capping because capping was based on clinical standards. During a telephone interview on [DATE] at 9:54 AM, RT A stated she was the RT for the 3rd capping trial for Resident #1. RT A stated before the trail started, she checked Resident #1's O2 sats, trach care, breathing treatment, and mental status. RT A stated, she placed an oximeter [non audible] on the resident that read for saturation and heart rate. RT A stated that the oximeter would not alarm if the resident had a cardiac arrest. RT A stated that the resident had previous underlying issues. RT A stated Resident #1's the third capping trial started at 11:16 AM and she returned at 11:59 AM to check on the resident and the resident was not in distress. RT A stated she returned at 12:36 PM and the resident was unresponsive; the resident was pale, not responding to sternal rubbing and calling her name; then the RT called for help; CPR started at 12:38 PM, EMS arrived, and the resident was resuscitated. The RT stated. I did not stay with the resident because she had no previous issues with capping. RT A stated she did not stay with Resident #1 because she had to attend to other residents. Interview on [DATE] at 12:05 PM with the Medical Director revealed Resident #1 suffered a cardiac arrest during the third capping trial on [DATE]. During interview on [DATE] at 1:25 PM with the Pulmonologist stated Resident #1 was a suitable candidate for capping trials because the resident was off the ventilator and had no congestion. The Pulmonologist stated observation during capping only required the RT to view the resident for a few minutes. The Pulmonologist said the RT could leave after the resident was not in distress and return later for further assessment of independent breathing. The Pulmonologist stated the facility had no equipment for monitoring present in Resident #1's room when the capping trial was conducted. The Pulmonologist stated Resident #1's cardiac arrest could not have been predicted, but no alert system or monitoring equipment were present to alert RT staff who were not physically present in the room when Resident #1 coded. During an interview on [DATE] at 4:04 PM, LVN B stated on [DATE] she saw Resident #1 at 12:10 PM and the resident was not in distress. LVN B stated she saw a red cap on the resident's trach and the resident was breathing with the nasal canula receiving ,d+[DATE] liters/ minute. LVN B stated, the resident looked normal. LVN B stated she did not document the observation of Resident #1 during the initial capping trial. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During telephone interview on [DATE] at 10:50 AM, RT G stated he initiated the first capping trial for Resident #1 on [DATE] for 30 minutes and remained with the resident 100% of the time. RT G stated the resident tolerated the 30 minutes of capping and revealed no signs of distress. RT G stated he was not aware of any facility policy on capping. RT G stated his policy was to remain with the resident throughout the trail to ensure the resident did not suffer any distress. During telephone interview on [DATE] at 11:00 AM, RT C stated she initiated capping trial for Resident #1 on [DATE] at 1:30 PM and the resident's RP was present. RT C stated she remained the entire time with the resident and the RP during the trial scheduled for 30 minutes. RT C recalled the second capping trial was halted between ,d+[DATE] minutes because the resident became exhausted. RT C stated she was not aware of any facility policy on capping. Record review of Resident #1's Trach Capping Flow Sheet dated [DATE] read: .Resident coughed. RT [RT C] had resident complete alphabet then ended trial. [family member] of resident @ bedside . During telephone interview on [DATE] at 4:35 PM, the family member stated the family member and the [RP] at admission were told by the RT Director that a staff member would be physically present when capping trials were attempted. The family member stated at a second meeting before the capping trials started the RT Director again assured the family that a staff member would be present all the time during the initial capping trials. The family member stated the family told the RT Director that the family was concerned about the resident's condition and her inability to communicate during an emergency. During telephone interview on [DATE] at 5:02 PM, Resident #1's RP stated he recalled when Resident #1 was admitted to the facility the Rehab Director assured him and the family that during the initial capping trials that staff would be present all the time. The RP stated that at a second CP meeting, unknown date, the RT Director was present and assured the family that staff would be present all the time during the initial capping trials. The RP stated he was happy about the staff being present during the initial capping trial because the resident could not pull the call light and could not cry out for help. The RP stated he was physically present with the [RT C] all the time on the second capping trial. The RP recalled he repeated the alphabet to the capped resident, and she was able to mimic some sounds. The RP stated the second capping trial lasted about ,d+[DATE] minutes and it was scheduled for 30 minutes. The RP stated he was not sure why the second capping trial did not last for 30 minutes. The RP stated that he was not invited to the third capping trial on [DATE]. Resident #1's RP stated, if I had known that [the resident] was going to be left alone, I would not allow the third trial. The RP stated his expectation was for staff to be physically present 100% of the time during the third capping trial and not just spot checking and monitoring. The RP stated he saw Resident #1 on [DATE] and she was alert and smiling. The RP stated he visited Resident #1 regularly for the past seven months. The RP stated that she (Resident #1) was left by herself [[DATE]] .I was assured that staff would be present all the time . During an interview on [DATE] at 9:18 AM, the ICU RN D stated the hospital clinical notes authored by MD E for Resident #1's record reflected the resident was admitted to ICU on [DATE] with no vasopressors (medications used to raise blood pressure in the emergency room) and intubated and placed on a ventilator. RN D stated the resident was anoxic per the MD note (without oxygen in the brain) and coded. RN D stated with family's approval resident was made an in hospital DNR. RN D stated, the resident deceased on [DATE]. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During second interview on [DATE] at 1:12 PM, the Pulmonologist stated Resident #1 was a suitable candidate for capping trials. The Pulmonologist stated her expectation was at the first capping trail staff needed to be present the entire time of the capping; on the second trial of capping the family was present the entire time. The Pulmonologist stated given that Resident #1 experienced a cardiac arrest on the third trial, Yes staff should have been present all the time. The Pulmonologist stated Yes the facility needed a policy on capping. During an interview on [DATE] at 1:17 PM, RT F stated she was trained on capping procedures in school and had been an RT for five years. RT F stated capping trials were dependent on the resident's condition and being off the ventilator. RT F stated the initial trials ranged from ,d+[DATE] minutes. RT F stated monitoring involved checking on the resident and it could be continuous or sporadic for the initial trials. RT F stated on the first capping it required 100% presence of staff in the room; trial 2 and 3 were dependent on how well the resident did in trial one. RT F stated there was no policy or protocol on capping, and one should be present for resident safety. During an interview an interview on [DATE] at 1:50 PM, the Administrator stated he met with Resident #1's family on [DATE] and was informed by the family that the resident was deceased . The Administrator stated that standards of care dictated the initial capping trials for Resident #1. The Administrator stated the facility's investigation of the incident on [DATE] was still in progress. During an interview on [DATE] at 1:55 PM, the RT Director denied he ever made a commitment to Resident #1's family and RP that staff would be present during the entire time of the capping trials. The RT Director stated at admissions the family and RP were informed they had an open invitation to attend capping trials. The RT Director stated there was no requirement that he call the RP to initiate a capping trial. During interview on [DATE] at 2:30 PM, the DON stated the timeline was as follows: 11:30 AM - Pulmonologist assessed the resident and no contra indications against the third capping trial on [DATE]. 11:36 AM - RT [A] capped the resident. 11:59 AM - RT [A] re-assessed the resident. 12:15 PM - LVN [B] made rounds and observed the resident. The resident was not in distress. 12:38 PM - RT [A] found the resident unresponsive; code called, and CPR started. 12:41 PM - EMS arrived. 12:44 PM - EMS transported resident to ER. In an interview and observation on [DATE] at 11:34 AM, RT C revealed a battery-operated audible pulse oximeter was kept on the Respiratory Therapist cart and the facility had this audible pulse oximeter for about three months. (continued on next page)

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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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on [DATE] from 11:14 AM to 11:35 AM, the Respiratory Therapy Director stated he provided the in-service training to the RTs of the revised capping trial policy either in person or via phone or text message. The Respiratory Therapy Director stated the facility has had the plug-in audible pulse oximeter for about a week or two. Record review of facility's policy titled Tracheostomy Care Procedures dated [DATE] revealed Tracheostomy care will be performed per physician's orders. Record review of facility's policy titled Capping Trial for Tracheostomy Patients dated Revised 2023 [from an unknown author and not signed by the Facility's QAPI leadership team] was presented to the Surveyor on [DATE] at 4:45 PM while template vetting discussion was in progress. Record review of the facility's policy titled Abuse/Neglect, dated revised [DATE], read: .Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress . Record review of facility's in-service on the topic of Notify MD of any Respiratory Change of condition and Follow Physician's Orders was started on [DATE] [day of the surveyor's entrance]. Of 16 RT employees 13 RTs had attended the training for a completion rate of 81%. On the topic of Monitoring During Capping Trials started [DATE], 13 RTs had attended the training for a completion rate of 81%. The Capping training read: RT will monitor and perform O2 saturation checks and pulse checks at least every 30 minutes during capping trials. The Administrator and the DON were notified of the Immediate Jeopardy on [DATE] at 5:00 PM and were provided with the Immediate Jeopardy Template. The facility was asked to provide a Plan of Removal to address the Immediate Jeopardy. The Plan of Removal was accepted on 10:03 a.m. on [DATE] and reflected the following: February 21, 2025 [Facility] Re: [Citation Number] Interventions: On [DATE] All medical records of residents with a trach were audited by the DON/ADON/RT supervisor to ensure that an order for capping trails was followed as ordered by the physician. The audit completed on [DATE] revealed no current residents are being trialed on capping of tracheostomies. On [DATE] Procedure for capping trials was developed and implemented. On [DATE] all Respiratory Therapist were/will be in-serviced by the DON, RT supervisor regarding: o Following physician orders will include monitoring to be documented by the respiratory therapist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rio at Mission Trails	6211 S New Braunfels Ave San Antonio, TX 78223

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o How frequently do you monitor residents on capping trials? o What vitals are to be monitored during capping trials? o When do you notify the physician and family? o For capping trials whose orders are to be followed? The DON/ADON/RT supervisor will review resident's records (vital signs, progress notes) of capping trials at least 5 times per week for 4weeks then 2 times a week for 2 weeks then as needed to monitor the residents for any changes of condition during the capping trial. And ensure that the physician/family was notified of resident changes in condition. The administrator will monitor and review the findings of the DON/ADON/RT supervisor during morning and stand down meeting at least 5 times per week for 4weeks then 2 times a week for 2 weeks then as needed. Findings will be reviewed by the QAPI committee and changes will be made as needed. Verification of Plan of Removal: In an interview on [DATE] at 11:09 AM, the DON stated there were no residents who were on a ventilator who had an order for capping trials. In an interview on [DATE] at 11:09 AM, the DON stated they had revised their policy on capping trial for residents on a ventilator and provided a copy of the newly revised policy. In an observation and interview on [DATE] at 11:34 AM, RT C revealed a battery-operated audible pulse oximeter was kept on the Respiratory Therapist cart and RT C stated the facility had this audible pulse oximeter for about three months. In an interview and observation at [DATE] at 11:38 AM, the RT Director stated the facility has a continuous audible pulse oximeter that could be plugged in. The Administrator brought the plug-in audible pulse oximeter and took it into a room nearby where the Surveyor H was standing, and the surveyor was able to hear from the hallway the alarm sound from the plug-in audible pulse oximeter. Interviews on [DATE] from 11:24 AM to 5:00 PM and on [DATE] from 8:28 AM to 10:00 AM with 5 Respiratory Therapist (4 worked day shift [6 AM-6 PM], and 1 worked night shift [6 PM - 6 AM]), and 7 LVNs (6 worked day shift, and 1 worked night shift), and 1 RN who worked the night shift revealed they had been in-serviced on the best practice of following the physician orders, the RTs will notify the physician if orders need clarification, clarified orders would be put into the resident's clinical record, the physician would be notified of any change of condition in the resident's respiratory status and any new orders received would be implemented; and the Rt would monitor and perform pulse oximeter blood oxygen saturation checks at least every 30 minutes during capping trials. Also, Interviews on [DATE] from 11:24 AM to 5:00 PM and on [DATE] from 8:28 AM to 11:00 AM with 5 Respiratory Therapist (4 worked day shift [6 AM-6 PM], and 1 worked night shift [6 PM - 6 AM]), 7 LVNs (6 worked day shift, and 1 worked night shift), 1 RN (who worked the night shift), 3 CNAs (who worked day shift), 2 housekeepers, 1 Cook, 2 Dietary Aides and the FSS (Food Service Supervisor) revealed they had been in-serviced on abuse and neglect. (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Medical Director on [DATE] from 4:38 PM to 4:43 PM revealed he attended the Ad hoc (un-planned) QAPI (Quality Assurance/Performance Improvement) meeting by phone that was held with the DON, Administrator and Respiratory Therapy Director; and the POR (plan of removal) for capping trials on residents was discussed. In an interview on [DATE] from 11:14 AM to 11:35 AM, the Respiratory Therapy Director stated he provided the in-service training to the RTs of the revised capping trial policy either in person or via phone or text message. The Respiratory Therapy Director stated the facility has had the plug-in audible pulse oximeter for about a week or two. The Respiratory Therapy Director stated the residents who had ventilators orders were reviewed and there were no residents who had orders for capping trials. The Respiratory Therapy Director stated the policy for Capping Trial was revised to include the use of an audible continuous pulse oximeter, to be with the resident the first 10 minutes of the trial and to check on the resident every 20 minutes after that. Further, the Respiratory Therapy Director stated he would train the new RT staff using a mannequin on how the capping trial process would be done in the facility before they started to work on the floor. The Respiratory Therapy Director stated he attended the Ad hoc QAPI meeting with the DON, Administrator, and the Medical Director to discuss the facility's POR plan. Lastly, the Respiratory Therapy Director stated he would be randomly interviewing three RTs the questions on the monitoring form each week. In an interview on [DATE] from 11:42 AM to 11:58 AM, the DON stated the facility made a video for the nurses to watch of what the Capping Trial policy involved, and it showed the Respiratory Therapy Director doing a capping trial on a mannequin so the nurses would know what was involved and what their role was during the capping trial. [Surveyor H observed portions of the video] The DON stated the training video was sent to the nurses and then they came in and signed the in-service training sheet. The DON stated she had reviewed the orders of residents who had a tracheostomy and were on a vent and there were no residents with an order for capping trial. The DON stated the facility revised their old policy on Capping Trials and added an audible pulse oximeter, which would alarm if the resident had a change in their condition, would be used during the capping trial to the policy and added the RT would stay with the resident for the first 10 minutes of the trial. Also, the DON stated staff were provided a copy of the abuse policy and were informed of the types of abuse, who the abuse coordinator was, and how to find the abuse coordinators phone number. Further, the DON stated newly hired nurses would be shown the video they made of the facility's capping trial procedure during their orientation before they started to work on the floor. The DON stated she had ensured all the nurses had received the training by having the nurses come into the facility to verify they had received the training. Moreover, the DON stated weekly audits would be done, she would review the resident's orders daily for any new orders for capping trials and it would be discussed in the morning meetings. The DON stated she and the RT director would be interviewing three RTs per week to make sure they were aware of the revised capping trial process. (continued on next page)

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